

**2017**

**Hospice Legislative  
Blueprint for Action**

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2017 LEGISLATIVE BLUEPRINT FOR ACTION**

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## **INTRODUCTION**

Hospice and palliative care services reinforce and supplement the care provided by family members and friends and encourage maximum independence of thought and functioning, while preserving human dignity. Hospice is a crucial part of humane, cost-effective care in the final stage of life. The Medicare hospice benefit was created in 1982 primarily to serve terminally-ill cancer patients. Based on this success, hospices have now greatly expanded their end-of-life care expertise to include caring for terminally ill Americans with other diagnoses such as congestive heart failure, dementia, and lung disease.

The Hospice Association of America (HAA), an affiliate of the National Association for Home Care & Hospice (NAHC), is proactively representing its members in this new and challenging environment. HAA's 2017 Legislative Blueprint for Action presents a comprehensive plan for addressing major health care initiatives facing hospice providers and reflects our agenda for the 115th Congress. The Blueprint emphasizes the increasingly important role hospice plays in the continuum of health care delivery. This publication includes our members' priorities and recommendations concerning hospice care.

The Blueprint is divided into two sections. Section I is dedicated to hospice-specific items in order of priority based on the input of HAA members. Section II contains items addressing issues of joint interest to hospice organizations and home health agencies.

This document has been produced by the Hospice Association of America, a professional association representing hospices and their thousands of caregivers who provide services to America's terminally ill patients and their families. HAA hopes this document will be helpful to Congress in its deliberations in 2017 and that it will result in the enactment of legislation to preserve the Medicare hospice benefit and improve the quality of life for the thousands of Americans who must trust others for their care and protection.

# **SECTION I: HOSPICE-SPECIFIC ITEMS**

## **SUPPORT EFFORTS TO MEET THE GROWING NEED FOR TRAINED PALLIATIVE CARE PROFESSIONALS**

**ISSUE:** Rapid changes in the health care delivery system -- among them a growing Medicare population, increased interest in and use of hospice care, an expanded number of palliative care programs associated with hospitals and health systems nationwide, and the Centers for Medicare & Medicaid Services' (CMS) activation of advance care planning codes under Medicare Part B - indicate that our nation's need for appropriately trained hospice and palliative care professionals will continue to grow at a fast pace. As an example of this growth, in 1998 only 15 percent of hospitals with more than 50 beds had an inpatient palliative care program; by 2013 that number had grown to 67 percent of hospitals with more than 50 beds. Unfortunately, research indicates that only one quarter of these palliative care programs meet nationally-set staffing guidelines (for funded positions). Even when unfunded positions were included, only 39 percent of programs met the guidelines.

Studies indicate that patients receiving earlier (rather than later) exposure to palliative care had:

- Lower rates of inpatient admissions in the last 30 days of life (33 percent vs. 66 percent)
- Lower rates of ICU use in the last month of life (5 percent vs. 20 percent)
- Fewer emergency department visits in the last month of life (34 percent vs. 39 percent)
- A lower rate of inpatient death (15 percent vs. 34 percent)
- Fewer deaths within three days of hospital discharge (16 percent vs. 39 percent)
- Lower 30-day mortality rates post hospital admission (33 percent vs. 66 percent)

In 2010, the American Academy of Hospice and Palliative Medicine estimated an existing need for 6,000 or more full time physician equivalents to serve current needs in hospice and palliative care programs. However, at maximum capacity, the current system would produce only about 5,300 new hospice and palliative medicine certified physicians over the next 20 years. This falls far short of the projected growing needs of the rapidly aging population and does not address the growing need for similarly trained non-physician professionals, including palliative nurses.

To begin to address the anticipated need for trained palliative care professionals, during 2015 Reps. Elliott Engel (D-NY), Tom Reed (R-NY) and others reintroduced the Palliative Care and Hospice Education and Training Act (PCHETA), which would amend the Public Health Service Act to increase the number of permanent faculty in palliative care at accredited allopathic and osteopathic medical schools, nursing schools, social work schools, and other programs (including physician assistant education programs) to promote education and research in palliative care and hospice, and to support the development of faculty careers in academic palliative medicine. Companion legislation was introduced in 2016 by Sen. Tammy Baldwin (D-WI). Despite significant support, the legislation was not enacted prior to the completion of the 114<sup>th</sup> Congress.

**RECOMMENDATION:** Congress should enact legislation along the lines of the Palliative Care and Hospice Education and Training Act, and provide appropriations to implement the legislation.

**RATIONALE:** As knowledge and understanding of the nature of palliative and hospice care become more widespread, many patients and family caregivers are finding these services more appropriate for their needs and more consistent with their desires for treatment of advanced and terminal illnesses. It is anticipated that the demand for the compassionate, supportive care supplied by hospice and palliative care programs will only grow over the coming years. Given the clear benefits associated with such care, our nation must prepare for this growing need. Enactment of the Palliative Care and Hospice Education and Training Act – or similar legislation -- would make important inroads toward an increased supply of well-trained palliative care practitioners.

## **REJECT EFFORTS TO INCLUDE HOSPICE AS PART OF THE MEDICARE ADVANTAGE BENEFIT PACKAGE**

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

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

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

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

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

could arise between the MA plans and a contracted hospice relative to whether a patient does or does not meet Medicare's eligibility requirements;

- Additionally, the hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the comfort and palliation of the terminal illness and related conditions. Financial incentives may lead MA plans to shift responsibility for unrelated services to a contracted hospice provider;
- There is no deductible applicable to Medicare hospice care, and strict limitations on beneficiary coinsurance that may be charged. MA plans, however, are permitted to charge different out-of-pocket costs than under fee-for-service which could result in increased costs to patients and their families at a particularly vulnerable time;
- The Medicare Hospice Benefit is currently undergoing significant change. Starting on January 1, 2016, hospices are paid one of two payment rates for RHC depending on how long the patient has been on hospice care. There remain uncertainties about the impact of these changes on the delivery of hospice care, as well as about potential additional changes in the hospice program. These uncertainties will impact hospices' willingness to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs; and
- The terms under which MA plans enter into contracts with hospice organizations could run counter to the current payment reform goal of ensuring that hospice payments better reflect actual costs of care over the course of a patient's stay on hospice.

In December 2016, the Working Group introduced the Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016 (S. 3504), but the legislation did NOT contain a provision to bring hospice services under the MA benefit package.

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

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

**RATIONALE:** Beneficiaries entering MA are, as a general rule, anticipating their needs for curative rather than end-of-life care. Decisions about care at the end of life are deeply personal and of great significance to patients and their families. When a beneficiary is diagnosed with a terminal illness, he or she should retain the right to determine what level of care to pursue and under what provider's care.

## **REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS**

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

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

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

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

On Dec. 23, 2010, CMS announced a three-month delay in enforcement of the face-to-face requirements to allow time for hospices to establish operational protocols necessary to comply with the new law. In early 2011, CMS modified requirements so that under well-documented "exceptional circumstances" (for example, a hospice is unable to schedule a timely

face-to-face prior to beginning needed services for a newly readmitted hospice patient or a hospice is not aware that a patient requires a face-to-face encounter because CMS' data systems do not contain adequate information) hospices are given an additional two days within which to complete the face-to-face.

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

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

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

**RATIONALE:** The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.

## **ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT**

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

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

In late 2016, the Medicare Payment Advisory Commission (MedPAC) met to discuss its planned recommendations to Congress and is expected to endorse a proposal to eliminate any market basket update for FY2018.

**RECOMMENDATION:** Congress should reject efforts to impose hospice market basket cuts and creation of a hospice-specific market basket. The Congress should also closely examine any other recommendations that would alter existing hospice policies, giving close consideration to their potential impact on access to high quality hospice services. Further, Congress should make every effort to restore the market basket and productivity reductions authorized under PPACA, and cancel the 2 percent across-the-board sequester. Congress should oppose any reductions in the annual hospice updates or other major payment system changes until such time as the impact of hospice payment reforms (and other changes) is fully known.

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

- Significant payment reductions that, in combination, have resulted in FY2016 hospice payments that were 12 percent LESS than they would otherwise have been:
  - In FY2010, CMS began phasing out by regulatory issuance the BNAF to the hospice wage index over seven years. In the years following FY2010 the phase out reduced payments by 0.6 percentage points. Elimination of the BNAF has reduced hospice payments by 4 percent overall.
  - The FY2014, 2015, 2016, and 2017 payment cycles reflect reductions mandated by the PPACA, including productivity cuts and a 0.3 percentage point market

basket reduction. Hospice payments are further reduced by the 2 percent sequester.

- A dramatic increase in costly administrative obligations, such as a dramatic expansion in cost reporting requirements; increased reporting of visit, drug and diagnosis data on hospice claims; new quality measure collection and reporting responsibilities; timely filing requirements for hospice Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) that have become burdensome and costly as the result of CMS systems inadequacy; and other changes. In the near future it is expected that CMS will impose additional administrative requirements on hospice programs that will further increase costs.
- Hospice financial margins are decreasing -- MedPAC calculated an average Medicare margin of 8.6 percent for 2013; its projected hospice Medicare margin for 2017 is 7.7 percent. These estimates exclude costs related to volunteer, bereavement, and other nonreimbursable services, which would further reduce margin calculations by as much as 1.7 percentage points. Financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is concern that MedPAC's estimates may not take into full account costs associated with the face-to-face encounter requirements that went into effect Jan. 1, 2011, and other recently-imposed regulatory burdens (referenced above).
- While the payment system changes that became effective January 1, 2016, were designed to redistribute payments so that they better reflect the actual costs of providing care over the course of a patient's election, hospices with relatively short average lengths of stay are reporting losses under the system. Further, hospices nationwide are reporting later referrals to hospice, which increases overall costs of care.
- Imposition of across-the-board cuts to hospice services run counter to Congress' intent in requiring reform of the hospice payment system, which was to ensure that payments over the course of care better reflect actual costs incurred and to reapportion payments within the system.
- Across-the-board payment reductions will disproportionately harm those providers whose patients have shorter overall lengths of stay on hospice care. According to MedPAC, the 20 percent of providers with the shortest average lengths of stay in 2012 had average margins of MINUS 6.5 percent, while providers in the next lowest quintile for length of stay had margins averaging 3.6 percent. These providers cannot continue to operate if their rates are further reduced.
- While the FY2017 proposed budget recommended a change in the market basket used for hospice payment updates, hospices have not received a full market basket update since FY2012. Further, hospices are subject to special regulatory requirements (such as the requirement that they provide core services -- nursing, medical social services, and counseling -- by way of direct employees) that increase costs and would be difficult to incorporate into a hospice-specific market basket index.
- CMS has revised and expanded the cost reporting requirements for all types of hospice providers, some of which are only beginning to be submitted to CMS. This means that CMS does not currently have enough data in sufficient detail to create a hospice-specific market basket.

In recent years hospices have been subjected to numerous changes, the combined impact of which can not be fully known as yet. Until such time as any proposed policy can be fully analyzed for its impact on delivery of care and in the context of all other recent hospice policy changes, Congress should reject proposals that would further diminish hospices' ability to provide services to patients in their final days of life and support to those patients' loved ones.

## **REJECT ADDITIONAL BENEFICIARY COST SHARING FOR HOSPICE SERVICES UNDER MEDICARE REFORM EFFORTS**

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

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

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

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

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

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

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

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

In some areas of the country, a large number of residents receive health care through Rural Health Centers (RHC) or Federally-Qualified Health Centers (FQHC). Medicare law recognizes some of the higher costs associated with delivery of care in these areas and pays on a different basis than under regular fee-for-service reimbursement. However, neither RHCs nor FQHCs are able to bill for visits provided by center physicians for hospice attending physician services. This creates a disincentive for RHCs and FQHCs to provide these services, resulting in a greater burden for rural hospices. During the 114<sup>th</sup> Congress, Sen. Shelley Moore Capito (R-WV) introduced S. 2786, which would allow RHCs and FQHCs to bill Medicare for hospice attending services provided by their physician and NP employees when they are working on behalf of the RHC or FQHC. Rep. Lynn Jenkins (R-KS) introduced companion legislation (H.R. 5799) in the House of Representatives. No action was taken on either bill prior to the end of the Congress.

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

**RECOMMENDATION:** Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas. Further, Congress should enact legislation that would allow RHCs and FQHCs to bill Medicare for attending physician services provided for hospice patients, as permitted under state law. Finally, Congress should enact legislation to allow PAs to serve as attending physicians for hospice patients and conduct the hospice face-to-face encounter if this does not conflict with state law.

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

Budget in the core-based statistical areas followed by the budget neutrality adjustment. In most states, the rural wage index is lower, resulting in comparatively lower reimbursement rates.

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

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

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

Over the years, the average length of stay (LoS) has increased to about 88 days, but the more important median LoS remains at about 18 days, according to MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. Additionally, 25 percent of hospice patients are on care for five days or less before expiring. The current reimbursement structure was created by estimating the original cost of delivering routine home care (RHC) – which represent well over more than 95 percent of hospice care days -- by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project.

Despite the changes noted by MedPAC and significant technological, pharmaceutical, and medical care delivery advances over the first 33 years of the hospice program, there had been no associated reimbursement adjustment to reflect the changes. In March 2009, MedPAC recommended that Congress mandate revision of the hospice reimbursement system to better reflect variation in costs over a patient's length of stay and expansion of data collection efforts. The final 2010 health care reform legislation (Public Law 111-148) authorized hospice payment system reforms to be enacted no earlier than October 1, 2013.

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

During 2015, CMS promulgated and finalized modifications to payments for RHC under hospice that sets out two payment rates -- a higher rate (\$190.55 in FY2017) for days one through 60 of hospice care and a lower rate (\$149.82) for days 61 and over. Despite a break in service, unless a patient is off hospice care for more than 60 days, the "count of days" for purposes of determining the appropriate RHC rate includes previous hospice service days. CMS also created a Service Intensity Add-on (SIA) applicable to in-person RN and Social Worker visits that are provided during the final seven days of life. The SIA is payable at the hourly rate for Continuous Home Care (CHC, paid at \$40.29 in FY2017) for up to four hours per day. CMS was required to make the payment system changes budget neutral in the first year of application. However, given that provision of RN and Social Worker visits in the payment changes, CMS has indicated that in future years it will apply budget neutrality to account for changes in SIA utilization.

Public Law 111-148, the Affordable Care Act, also includes some interim payment

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

**RECOMMENDATION:** Congress must closely monitor the impact of the payment reform changes implemented by CMS and any future activities related to hospice payment to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress must also monitor the impact of payment changes to ensure that CMS has achieved a proper balance between the costs of providing hospice care and payment levels, particularly for short-stay patients. Given that the initial “balance” of payments for hospice services were based on some assumptions, Congress must monitor to ensure that the assumptions used to calculate budget neutrality in the first year of payment reform did not result in less spending for hospice services than would have otherwise been the case. Congress must ensure that CMS does not overstep its charge to refine the hospice payment system by implementing changes like rebasing of RHC or reduced payments for care provided to NF residents that could go far beyond the payment refinement sought by the Affordable Care Act. Finally, any future discussion related to potential rebasing of hospice rates should not take place until a reasonable set of standards for rebasing has been developed and made public. In the meantime, Congress should oppose any reductions in the annual hospice updates until the full impact of the payment reform changes are fully examined. Any system reforms must assure preservation of access to care, quality of care, and sufficient reimbursement rates to maintain a viable and stable delivery system.

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

## **PROVIDE FULL DISCLOSURE OF HOSPICE AVAILABILITY AND CHOICE OF HOSPICE PROVIDER TO TERMINALLY ILL BENEFICIARIES RESIDING IN SNFs/NFs**

**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 is not required to offer hospice services, nor is it required to disclose at admission if residents will be able to access hospice services without the need to transfer to another facility. Further, if the facility does have an arrangement to provide hospice, it is not required to disclose the hospice program with which it has a contract to provide services to residents. Finally, a resident does not have the right to choose the hospice program that he/she will receive hospice services from in the facility.

**RECOMMENDATION:** Congress should require that SNF/NFs disclose at the time an individual is admitted whether or not hospice services are available at the facility, and the name(s) of the hospice(s) with which the facility has contracted to provide hospice services on site. Additionally, Congress should mandate that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from the Medicare-certified hospice of their choice.

**RATIONALE:** SNF/NFs should provide full disclosure regarding the availability of hospice services through the facility at admission so that potential residents are fully aware of whether or not they will be able to access hospice services at some time during their stay if needed. Such disclosure could help to avoid the significant upheaval and trauma that could result from a resident's transfer to a different facility in order to exercise his/her right to the hospice benefit. Potential residents should also be notified regarding the names of the program(s) through which hospice services would be provided if they elect the hospice benefit while in residence at the facility. Finally, Medicare beneficiaries eligible for the hospice benefit should have the right to choose which hospice will serve them. Currently, a terminally ill SNF/NF resident may only access the Medicare hospice benefit if the SNF/NF has a formal arrangement with a hospice program to provide services in the facility.

## **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; at the same time, inappropriate use of pain medications has, in some areas of the country, become a public health crisis. In an effort to address inappropriate use of controlled substances, some legislative proposals in recent years have held the potential for compromising palliative care because they could empower 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, and unnecessarily depriving terminally ill patients of 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 adequate treatment of terminally ill patients.

## **ALLOW PAs TO SERVE AS HOSPICE ATTENDING PHYSICIANS AND NPs AND PAs TO CERTIFY/RECERTIFY PATIENTS FOR MEDICARE HOSPICE SERVICES**

**ISSUE:** While a nurse practitioner (NP) is allowed to serve as a hospice patient's attending physician, since inception of the hospice benefit the Medicare program has permitted only physicians (medical doctors or doctors of osteopathy) to certify or recertify a patient as terminally ill and eligible for hospice services. The 2010 health reform legislation (The Patient Protection and Affordable Care Act -- Public Law 111-148) allows either a hospice physician or hospice NP to gather clinical findings that support continuing eligibility for Medicare hospice care to satisfy the face-to-face encounter requirement for hospice patients expected to enter a third or later benefit period. Under current law, physician assistants (PAs) are not permitted to serve as a patient's attending physician; nor are they permitted to certify/recertify patients for Medicare hospice services.

NPs are currently permitted under Medicare to order skilled nursing facility care if working in collaboration with a physician.

During the 114<sup>th</sup> Congress, Senators Michael B. Enzi (R-WY) and Thomas Carper (D-DE) introduced S. 1354, which would permit physician assistants to serve as attending physician to hospice patients. Identical legislation was introduced in the House of Representatives by Reps. Lynn Jenkins (R-KS) and Mike Thompson (D-CA) as H.R. 1202.

**RECOMMENDATION:** Congress should enact legislation along the lines of S. 1354/H.R. 1202, which would authorize PAs to serve as attending physicians for hospice purposes under the same circumstances as NPs are permitted; further, Congress should authorize NPs and PAs to certify and recertify eligibility for the Medicare hospice benefit.

**RATIONALE:** Given current concerns about the growing shortage of primary care health professionals and growing outlays in federal health care programs, full advantage should be taken of the significant clinical skills and capabilities that NPs and PAs could bring to the palliative and hospice care settings. The Institute of Medicine (IoM) of the National Academy of Sciences reported in October 2010 (*The Future of Nursing: Leading Change, Advancing Health*) that care provided by NPs and primary care physicians are similar in terms of their complexity, and advanced practice nurses are trained to provide many of the same services offered by physicians. In many areas NPs are helping to fill a growing gap. The IoM also notes the significant overlap in scope of practice among physicians, physician assistants, and advanced practice nurses. However, IoM noted that a number of regulatory and institutional obstacles still exist that prevent the health system from reaping "the full benefit of nurses' training, skills, and knowledge in patient care." Among these are prohibitions under the Medicare program that prevent NPs from practicing to the full extent of their training and experience, including prohibitions against NPs certifying/recertifying beneficiaries eligible for hospice care. These limitations should be recognized and corrected.

## **PROTECT AND EXPAND HOSPICE COVERAGE UNDER MEDICAID**

**ISSUE:** In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an optional benefit under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient's life as comfortable and meaningful as possible. As of 2011, 48 states had chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states experience growing budget concerns, some are considering elimination of hospice coverage under their Medicaid programs or limiting the number of covered days, which would leave some of the country's most vulnerable individuals without appropriate care at the end of life. Alternatively, many states have opted to cover hospice under Medicaid managed care, which has led to some difficulty in securing timely authorization and sufficient payment for hospice services.

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

**RECOMMENDATION:** Congress should mandate Medicaid hospice coverage for all populations served. Congress should also closely monitor Medicaid hospice services covered through managed care contracts to ensure that plan practices (care authorization and payment policies) do not reduce timely access to high quality end of life care.

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

## **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 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 Medicare Administrative Contractor (MAC) claims processing issues, and pending claims from other providers. Hospices must continue 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:** Many 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. Further, the significant expansion of regulatory requirements and factors related to outdated CMS systems, in combination with sequential billing policy, have resulted in reimbursement loss for hospice providers despite no fault on the part of the hospice provider.

## **OPPOSE IMPOSITION 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. About 25 percent of persons use hospice for five days or less, while approximately 12 percent of patients receiving Medicare hospice survive longer than six months. The median length of stay on hospice care is 18 days.

It is often difficult to make the determination that a patient will live no longer than six months because the course of terminal illness is different for each patient. Studies have 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 is well known by those in the hospice community: that prognostication is an inexact science. In a letter to all Medicare-certified hospices in the country, the then-Centers for Medicare & Medicaid Services Administrator reiterated that "In no way are hospice beneficiaries restricted to six months of coverage."

Under current law, no penalties are proposed for erroneous certification of a terminal illness by a physician. However, the 2010 Affordable Care Act does require that continuing eligibility for patients entering their third or later benefit period be contingent upon certification by a hospice physician following a face-to-face encounter between a hospice physician or nurse practitioner and the patient; as part of the encounter the practitioner is required to gather clinical information that is used to help support a six-month prognosis. The hospice physician or NP who conducts the encounter must also attest that the encounter has taken place. There is no separate payment by Medicare to cover the costs of the face-to-face encounter.

**RECOMMENDATION:** Congress should oppose any effort to impose civil monetary penalties upon physicians for erroneous certification of eligibility for hospice care. Congress should also ensure proper reimbursement is provided for visits to confirm continuing 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 by such a penalty 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.

## OVERSEE HOSPICE QUALITY REPORTING PROGRAM

**ISSUE:** The June 2008 hospice conditions of participation (CoP) require hospices to develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement (QAPI) program. The Centers for Medicare & Medicaid Services (CMS) has directed 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 includes retaining the information in a database that permits analysis over time.

The final 2010 health care reform legislation provides a strong start towards the development and implementation of a quality reporting program (the Hospice Quality Reporting Program – HQRP) by mandating that the Department of Health and Human Services (HHS) publish hospice quality measures covering all dimensions of hospice quality and care efficiency by October 1, 2012, and that hospices begin reporting these measures by FY2014. Failure to submit quality measures by a hospice would result in a 2 percentage point reduction in the annual market basket index update (Section 3004). CMS initiated a voluntary quality measure collection and reporting program in late 2011 and early 2012; mandatory quality measure data collection began October through December 2012, with mandatory data reporting in January and April of 2013. Failure to report data in early 2013 resulted in a 2 percent payment reduction for FY2014. Starting January 2013 hospices were required to collect and report the first full year of data, which must be reported by April 1, 2014, or hospices will have their FY2015 payments reduced by 2 percentage points. Beginning in July 2014, the HQRP entered a new phase with the requirement that hospices collect and submit data for a patient-specific Hospice Item Set (HIS). Subsequently, beginning in Jan. 2015, hospices are required to contract with an outside vendor to collect responses to a hospice experience of care survey (Hospice CAHPS) that will be completed by hospice patient family members. CMS has begun to release data related to hospice quality measures and will launch a Hospice COMPARE website during 2017.

CMS and others have additional hospice quality measures under development, in addition to plans for public reporting of hospice quality measures and, ultimately, development of a pilot program for hospice value-based purchasing.

**RECOMMENDATION:** Congress should monitor efforts by CMS to advance the HQRP and ensure the agency works with the hospice industry to select appropriate measures for reporting and establish a reasonable time frame for incorporating new measures. Congress should also ensure that sufficient funds are available to CMS to support these efforts.

The following conditions must be met in implementing any outcome measurement system:

- Reliable and valid indicators.
- Number of outcome measures limited to those that most accurately predict quality.
- Method for risk adjustment.
- Standard assessment limited to items needed for outcomes measurement and risk adjustment.
- A simple system with clinical utility.
- A mechanism enabling CMS to validate agency data.
- Ongoing evaluation of the entire system.

**RATIONALE:** The ideal hospice quality reporting program would be based on what happens to patients. Research and demonstration projects are not factored into the current per diem reimbursement structure. Every effort must be made to keep data collection and the paperwork burden to a minimum to allow concentration of resources on patient care.

## **SUPPORT THE PORTABILITY OF ADVANCE DIRECTIVES; CREATE AN ADVANCE CARE PLANNING BENEFIT UNDER MEDICARE**

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

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

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

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

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

should also enact the Care Planning Act to establish a benefit under which Medicare beneficiaries receive broad-based support from trained professionals to assist them in development of their care planning goals, and assurance that documentation of those goals will be shared with relevant health care providers.

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

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

## **ENACT HOSPICE-SPECIFIC COMPLIANCE MEASURES**

**ISSUE:** Hospice, like most other health care segments, is not immune to the presence of participants that engage in improper, unethical and possibly 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 delivery of services.

The Affordable Care Act (Public Law 111-148) allows the Department of Health and Human Services (HHS) to require compliance plans and background screening of owners and managers, as well as authorizes the Secretary of HHS to impose a moratorium on new providers (Section 6401). The law also extends the criminal background check pilot program at CMS (Section 6201).

**RECOMMENDATION:** Congress should continue its work to ensure compliance with federal requirements and to combat waste, fraud, and abuse in our nation's health care system by passing a hospice-specific compliance package that would:

- Require that CMS make every effort to target program integrity efforts toward “bad actors” rather than toward imposing costly across-the-board requirements on compliant hospice programs
- Implement hospice-specific requirements enacted as part of the Patient Protection and Affordable Care Act (PPACA) and take appropriate next steps related to PPACA reforms
- Strengthen admission standards for new Medicare hospice organizations through probationary initial enrollment, prepayment claims review, initial capitalization requirements, and early-intervention oversight by Medicare surveyors
- Require credentialing of hospice agency executives
- Require criminal background checks on hospice agency owners, significant financial investors, and management
- Require all Medicare participating hospice agencies to implement a comprehensive corporate compliance plan
- Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of hospice program standards
- Implement a targeted, temporary moratorium on new hospice organizations
- Create a joint Hospice Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
- Require that curricula for residents and interns contain hospice and palliative care-related training and experience.

**RATIONALE:** A comprehensive compliance package that is specifically focused on hospice is good “preventive medicine” to help maintain compliance and ensure proper expenditures of limited health care dollars for appropriate hospice care. It is in the best interests of compliant hospice organizations to take steps to keep unscrupulous providers from operating within federal

and state programs. The health care reform proposals go a long way toward meeting the compliance measures needed to succeed.

## **SECTION II: HOSPICE AND HOME HEALTH-RELATED ITEMS**

## **ANY RESTRUCTURING OF MEDICARE COST SHARING SHOULD NOT LEAD TO BARRIERS TO HOME HEALTH SERVICES OR HOSPICE CARE**

**ISSUE:** Proposals have been raised that would change the beneficiary cost-sharing structure of Medicare from its current system of premiums and deductibles, coinsurance, and copayments targeted to certain care. Among the proposals is one from President Obama's National Commission on Fiscal Responsibility and Reform 2010 report that would essentially blend much of the service-specific cost sharing into a non-specific global deductible and copayment. If such a change is enacted, Medicare beneficiaries who now receive home health services and hospice care without cost sharing would face significant financial obligations to access this care.

The proposals also include limitations on coverage of cost sharing obligations by so-called Medigap supplemental insurance policies, prohibiting first dollar coverage

The use of global cost sharing may have surface appeal, but it can act as a barrier to care that is less costly and clinically better than care in other settings. Over the years, Congress intentionally excluded home health services from cost sharing and allowed only very limited hospice cost sharing because it wanted to encourage the use of these services as better alternatives than costly institutional care or curative care at the end-of-life.

The "Better Way" plan proposed by Speaker of the House Paul Ryan in 2016 would institute a uniform cost sharing system into Medicare that would impose deductibles and copayments on home health and hospice patients.

**RECOMMENDATION:** Congress should preserve the principle operative in Medicare that encourages the use of cost effective care alternatives such as home health services and hospice care in any restructuring of beneficiary cost sharing. Any proposals to revise the current cost sharing approaches through global deductibles and copayments (or their equivalents) should be rejected. Cost sharing standards should be designed to bring financial stability to Medicare through incentives to use high value services such as home health and hospice. Medicare beneficiaries should be able to purchase supplemental insurance to cover co-pays and deductibles without any limitation. Congress should reject any legislative proposals that establish limits on Medigap insurance.

**RATIONALE:** Studies have shown that Medicare beneficiaries will avoid lower cost, but clinically sufficient, services if it means also avoiding increased cost sharing. Any restructuring of Medicare beneficiary cost sharing should come about only with recognition of this fact. Medigap insurance should not be restricted as beneficiaries should have the right to protect themselves against the cost of health care.

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

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

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

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

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

In 2015 Senators Johnny Isakson (R-GA), Mark Warner (D-VA), Orrin Hatch (R-UT) and Ron Wyden (D-OR) formed the Finance Committee chronic care working group. The working group solicited and evaluated chronic care proposals with the intent of introducing comprehensive legislation to better address the management of chronic illness. This vision was realized in December of 2016 with the release of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act. Among others, this bill extend the Independence at Home Demonstration program, expands access to home dialysis therapy, and expanding the use of telehealth services.

**RECOMMENDATION:** Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care

management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

**RATIONALE:** Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.

## **ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE**

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

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

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

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

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

- Assure access to care comparable to the non-Medicaid patient population;

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

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

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

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

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

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

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

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

During deficit reduction discussions in 2011 and 2012, proposals surfaced to establish per beneficiary caps on Medicaid spending or, alternatively, to block grant all Medicaid spending to control the federal share of Medicaid costs. Such proposals continued to surface thereafter, including the "Better Way" plan presented by Speaker of the House Paul Ryan. President Trump has indicated potential support for block granting Medicaid to the states or using per capita caps to limit federal spending.

**RECOMMENDATION:** Congress should reject any consideration of placing caps on federal

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

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

## **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.

## **PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CLINICAL STAFF**

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

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

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

Increasingly, efforts are being made to document the relationship between wages and quality of care. Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care, pay competitive wages, and foster job satisfaction.

## **ENSURE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL TO MEET THE GROWING NEEDS OF THE BABY BOOM GENERATION, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS**

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

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

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

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

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

Congress took legislative action in the 107th Congress to help alleviate the nurse shortage. Specifically, the Nurse Reinvestment Act (H.R. 3487, P.L. 107-205) would establish a National Nurse Service Corps to provide scholarships and loans to nursing students who agree to serve in a public or private non-profit health facility, including home care agencies and hospices,

determined to have a critical shortage of nurses. The legislation also establishes nurse retention and patient safety enhancement grants to assist health care facilities to retain nurses and improve patient care delivery by encouraging more collaboration between nurses and other health care professionals and more involvement by nurses in the decision-making process.

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

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

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

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

## **REQUIRE FEDERALLY FUNDED CRIMINAL BACKGROUND CHECKS AND ESTABLISH A NATIONAL REGISTRY SYSTEM**

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

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

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

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

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

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

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

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

In state laws the trend is toward background check requirements for nursing and home care aides only; however, there is currently no consistent systematic mechanism through which other direct care staff is checked. It is in the best interest of consumers of home care and other health services for all direct care staff to be screened.

## **RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE AND MEDICAID SERVICES**

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

With increasing expectations for quality care delivery, the use of technology to deliver home health and hospice care is increasingly being recognized as an invaluable tool for an industry challenged by diminished reimbursement formulas. For example, The Department of Veterans Affairs (VA) has made a strong commitment to telehealth among its veterans by developing a national program called the Care Coordination/Home Telehealth (CCHT) program. The VA has broadly deployed a range of remote patient monitoring (RPM) technologies in 50 different health management programs across 18 Veterans Integrated Service Networks, and conducted various studies showing improved chronic disease management, cost savings and reduced hospital admissions and emergency department (ED) visits. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology. Home care agencies have also been readily adopting remote monitoring technologies. There has been measured growth in telehealth use by HHAs from 17.1% in 2007 to 28.7% in 2013 (data is from National State of the Homecare Industry Study conducted by Fazzi Associates).

However, the absence of uniform federal Medicaid and Medicare telehomecare guidelines is creating barriers to more widespread adoption of telehomecare and the establishment of services employing telehomecare. Currently, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow for telehomecare technology costs to be reimbursed by Medicare in the home setting.

As of 2016, 48 states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service, 12 states reimburse for store and forward delivered services, and 19 states reimburse for remote patient monitoring (RPM) Unfortunately, to date, Congress has not passed a law to update the Social Security Act with regard to telehealth use in Medicare nor has CMS expanded the definition of home health services "provided on a visiting basis in a place of residence" under the Medicare program to include a home telehealth site. CMS regulations (42 CFR 484.48(c)) defines a home health "visit" as "an episode of personal contact with the beneficiary by staff of the HHA [home health agency]."

Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senators John Thune (R-SD) and Amy Klobuchar (D-MN) introduced the "Fostering Independence Through Technology (FITT) Act" to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare program to provide monetary incentives for HHAs to utilize home monitoring and communications technologies. The FITT Act was included as an amendment to the Sustainable Growth Rate "Doc Fix" bill that will be considered by the 113<sup>th</sup> Congress. In

2008, and again in 2009, Representative Mike Thompson (D-CA) introduced “The Medicare Telehealth Enhancement Act” which provided a number of provisions that addressed the need for enhanced telehealth services including, for Medicare’s purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions. In 2012, Thompson introduced “The Telehealth Promotion Act of 2012” which removes arbitrary coverage restrictions on telehealth from federal health care programs and also increases the Medicare prospective payment rates to home health agencies to include remote monitoring services for three years. In 2013 the “The Telehealth Promotion Act of 2013” was introduced to encourage the use of telehealth technologies in the certification of home care services and enable the home to be a telehealth site. Lastly, in 2015 the Telehealth Enhancement Act and the Medicare Telehealth Parity Act included phased in expansion of telehealth coverage, the definition of a “home telehealth site” and telehealth services for the remote delivery of home care and hospice services.

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

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

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

## **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) has been based upon 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 health-specific wage index failed due to the unavailability of reliable wage data. The hospice wage index also is based upon hospital wage data.

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

On a related note, concerns are on the rise that the home health PPS case-mix adjuster has proven difficult to refine sufficiently so that agencies are appropriately reimbursed for care. Refinement to the home health wage index calculation method could help in this regard.

During 2007 the Medicare Payment Advisory Commission (MedPAC) recommended to Congress that it give authority to the Secretary of the Department of Health & Human Services to fashion a new system for calculating the wage index for hospitals as well as several other providers, including home health. MedPAC’s recommendation would base the wage indices for all providers on a different data set than the one currently in use by Medicare. In doing so, it also would eliminate any need for geographic reclassifications and the rural floor. MedPAC continues to support a new wage index model for all Medicare providers.

The Patient Protection and Affordable Care Act provides for comprehensive reform of the Medicare hospital wage index system that takes into account MedPAC’s 2007 recommendations (PPACA Section 3137). This provision requires that CMS submit a report to Congress by December 31, 2011, setting out a plan to reform the wage index consistent with the 2007 MedPAC recommendations.

CMS issued the report to Congress on April 11, 2012. The report recommends the use of Commuting Based Wage Index (CBWI) that sets wage index values using the commuting patterns of hospital workers. The consulting group on the report expressed that the CBWI could be adapted for non-hospital providers including home health agencies. It stated: “Medicare could implement one of three options to adapt the index for use in these settings. First, Medicare could adapt the CBWI methodology to develop wage indices specifically for each one of the providers that use the Medicare wage index to adjust their payments. The administrative burden and resource requirements associated with this approach might be considerable. Second, as long as a hospital is located in close proximity to one of these other providers, Medicare could use the hospital’s CBWI as the basis for the other healthcare provider’s wage index. Using hospital wages assumes that the relative wage differences between areas are similar for hospital workers and for other healthcare provider workers. Third, Medicare could base providers’ values on those of nearby hospitals using the nearest-neighbor method. For each healthcare provider, this method would approximate wage index values based on a weighted average of the wage index values for nearby hospitals.”

The report did recognize the complexities of using a CBWI in home health and hospice “given that the Hospice and Home Health payment methods use the beneficiary residence or place of service to adjust payments, the relevant commuting patterns would be from the employee residence to the beneficiary residence. This would add a new level of complexity to the collection of commuting data and is unlikely to be feasible.” As of January 2014, CMS has not moved forward with any wage index reforms.

**RECOMMENDATION:** Congress should authorize Medicare to implement and apply a wage index model in line with the system recommended by MedPAC no later than 2017. The CMS proposed CBWI model fails to provide home health agencies and hospices with a level playing field with other health care entities that employ comparable workers, including hospitals and nursing facilities. Otherwise, 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.