

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE 2023 LEGISLATIVE BLUEPRINT FOR ACTION

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ABOUT THE BLUEPRINT

The 2023 Legislative Blueprint for Action represents the legislative agenda for the National Association for Home Care & Hospice (NAHC). This document contains a discussion of the Association's priorities and other important issues and recommendations concerning home care and hospice. It was prepared through a series of meetings with home care and hospice professionals, state association representatives, and a survey of the NAHC members. It has been reviewed and approved by the NAHC Board of Directors at its 2022 meeting.

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

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

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

With the Blueprint for Action serving as the foundation, the NAHC Board of Directors annually approves a series of issues to be prioritized for advocacy efforts before the Congress. These priorities are listed on an additional document for ease of utilization and separated by service line into four categories: Industry Priority, Home Health, Hospice, and Private Duty.

WHAT IS HOME CARE?

"Home care" encompasses a broad spectrum of both health and social services that can be delivered to the recovering, disabled, chronically or terminally ill person primarily in their place of residence. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, medical social services, and nutritional services.

Hospice is a special component of home care. Hospice care involves medical, social, psychological, and spiritual care for terminally ill patients and their families. A concept aimed at relieving pain and suffering and providing the most comfortable environment possible, hospice care is designed to allow a terminally ill person to die with dignity.

The home care industry is separate and distinct from the industry that supplies medical equipment. Although a relatively few home care organizations sell and rent medical equipment as a sideline to the services they provide, the bulk of medical equipment is marketed by other organizations, which are generally referred to as home medical equipment (HME) dealers.

Generally home care is appropriate whenever a person needs assistance that cannot be easily or effectively provided only by a family member or friend on an ongoing basis for a short or extended period of time. There are many situations and conditions for which home care is especially appropriate. Because of ever-advancing technology that is yielding equipment and people trained to use the equipment, every day more people can leave institutions or never enter them. They can be cared for effectively and efficiently at home even if they have illnesses that at one time were only treatable in a hospital or institutional setting.

Among those who can benefit from home care services are people in the following situations:

- because of age, illness, or disability they need additional assistance to live independently at home.
- have conditions such as congestive heart disease, kidney disease, diabetes, muscle-nerve problems, or respiratory disease.
- are terminally ill and want to die in dignity and comfort at home.
- can be discharged from a hospital or nursing home but need additional care at home.
- require short-term assistance at home because of same-day or outpatient surgery or maternity-related incapacity.

While many people are choosing home care and services because of financial considerations, there are sound medical and humane reasons for medical treatment at home. Recent studies have shown that people improve and recover faster at home than in institutions. For instance, when chemotherapy is required for treatment of cancer conditions, the smaller doses that can be administered at home result in less adverse patient reactions than massive doses delivered in hospital settings. Also, [surveys consistently validate](#) the fact that whenever people have a choice, they prefer home care^[1].

Home care and hospice services are provided for people of all ages. Increasingly older people electing to live independent, non-institutionalized lives are taking advantage of home care and hospice services as their physical capabilities diminish. Younger adults who are disabled or recovering from acute illness are choosing to be cared for at home whenever possible. Infants and children requiring even the most sophisticated treatment for serious childhood illness can return to loving families and a secure home environment thanks to advanced technology and pediatric home care services.

WHO PROVIDES HOME CARE?

Home care services are provided by various types of home care agencies. Home care agencies are public organizations, or private nonprofit or for-profit organizations that have developed over the past century around a core of professional nursing services and home care aide services. Many home care organizations also provide a wide variety of other services, including physical therapy, occupational therapy, speech therapy, medical social services, spiritual counseling, and nutritional services. Home care agencies bring these services into the home, singly or in combination, to achieve and sustain an optimum state of health, activity, and independence for individuals of all ages who require such services because of acute illness, exacerbation of chronic illness, terminal illness, or long term or permanent limitations due to chronic illness and disability. Home care agencies are categorized into three main groups: home health agencies, hospices, and private duty home care agencies.

HOME HEALTH AGENCIES

A large segment of home care agencies consists of "home health agencies." Home health agencies are primarily or exclusively concerned with the treatment or rehabilitation of patients who need skilled nursing care or therapy. Their patients are predominantly under the care of a physician and the skilled care they receive through the home health agency is furnished in accordance with a physician's order. These agencies offer services from a variety of disciplines—usually nursing and home care aide services at a minimum. The Medicare-certified agency is the prototype home health agency. By 2022, there were 11,507 Medicare-certified home health agencies in the United States^[2]

HOSPICES

"Hospices" provide palliative care for patients in the final stages (usually the last 6 months or less) of a terminal illness through a team composed of physicians, nurses, social workers, and counselors who are concerned with the physical, psychological, social, and spiritual welfare of the patient. While the hospice concept is ancient, the development of the modern hospice dates from the 1960s, when attention turned to the management of the pain and symptoms associated with terminal illness. The vast majority of hospice services in the United States are provided by Medicare-certified hospices, which numbered 6,009 in 2022.^[3] The number of Medicare beneficiaries receiving hospice services has grown from 584,438 in FY 2001 to over 1.7 million in 2020.

PRIVATE DUTY HOME CARE AGENCIES

Private duty home care refers to the delivery of a broad range of services by caregivers to allow persons to remain independent in their personal residences. While these services may be provided by RNs, LPNs, or other licensed professionals, the largest segment of these services are concerned with the delivery of care to functionally impaired individuals who need help with personal care – such as bathing, dressing, feeding, etc. – or with homemaking or other services.

Note: Medical equipment is supplied by a separate and distinct industry. Although a relatively few home care organizations sell and rent medical equipment as a sideline to the services they provide, the great bulk of the medical equipment is marketed by other organizations, which are referred to as "home medical equipment dealers."

PERSONNEL

Home care agencies employ a variety of professionals and paraprofessionals to deliver home care services.

AIDE

In home care, a general term referring to an individual who provides personal care and supportive services. Aides help patients in a variety of ways, which may include taking their vital signs or giving them medicine under a nurse's direction. They must record and report this data as medically necessary. Aides also help patients with their daily functions such as dressing or taking a bath, shopping for groceries, preparing meals, grooming, and handling basic logistics such as paying bills or scheduling appointments. They can assist with planning for doctor's appointments or other meetings and may arrange for transportation. Depending on the site of care and the payor source, an aide may be referred to as any one of the following:

- Direct care worker
- Home care aide
- Home health aide
- Hospice aide
- Personal care aide

DIETITIANS

Dietitians consult with home care providers on diets for patients and suggest appropriate modifications to foster recovery and optimal functioning.

NURSES

Advance Practice Nurse (APN): These are Registered Nurses with specialized education and training beyond the basic registered nurse level. Some are called clinical nurse specialists, and some are called nurse practitioners (NP). Source: Pioneer Network©2011.

Registered Nurse (RN): An individual responsible for managing the individualized patient care by promoting and restoring patients' health through the nursing process; collaborating with physicians and other team members; and providing physical and psychological support to patients, friends, and families.

Licensed Practical Nurse (LPN): An individual who plans and manages patient care according to each patient's needs. Interviews patients and records their medical history and physical condition.

Registered nurses (RN) and licensed practical nurses (LPN) provide the direct skilled nursing services for the patient, supervise other caregivers as required, coordinate patient care with the physician and train family members and friends in functions they can perform to assist the professional caregivers and maintain the patient when professional services no longer are necessary.

PHARMACISTS

Pharmacists provide consultation to home health agencies on drugs being presented and dispensed to home care patients, as well as possible drug interactions.

PHYSICIANS

The physician is a key element in home care. Frequently the physician may be the initiator of home care services by recommending them to a patient returning home from an institution such as a hospital or nursing home; or suggesting that home care services could allow a patient with increasing disability to remain at home. For a patient with terminal illness and a prognosis of six months, it is a physician who may suggest to the patient or family member that hospice services may be an appropriate option. In most cases a physician will authorize a coordinated plan of treatment for home care services and periodically review the delivery and effectiveness of those services, sometimes recommending changes.

SOCIAL WORKERS

Social workers assist the patient and family in vital areas including evaluation of the financial circumstances and ability to pay for necessary home care services. Knowledgeable in community resources, often the social workers can direct people to needed local support systems. Social work in the home setting also involves making sure that the emotional needs of the patient and the family are fulfilled.

THERAPISTS

Another key component of the home care team is the professional therapist. Physical, occupational, speech and respiratory therapists provide essential services according to the needs of the individual patient. The therapist also plays a vital role in educating nonprofessionals who may be available to assist the patient with exercises and routine care that can allow the patient to function in the home and recover more effectively.

ADDITIONAL KEY TERMS

CARE PLAN

A detailed written plan that describes what is needed for an individual's care and provided by a range of health professionals, including nurses, therapists, social workers, and aides. For those living at home, a good care plan should also list the caregiving activities that family members are able to do, need help learning how to do, and will be doing. Creating the care plan should involve an interdisciplinary team of the care recipient, caregivers including the aide, as well as the family as appropriate. (Adapted from Pioneer Network©2011.)

DAY CARE

A center outside the home where people may gather for social interaction, meals, entertainment, and recreation. Day care programs vary from community to community. Some provide full-day activities and others operate on a part-time basis.

INTERDISCIPLINARY TEAM

A group comprised of health care professionals from various disciplines who work in collaboration and actively coordinate to meet treatment goals and address a patient's physical and psychosocial needs.

PALLIATIVE CARE

A specialized form of medicine that aims to enhance the quality of life of patients and their families who are faced with serious illness. It focuses on increasing comfort through the prevention and treatment of distressing symptoms. In addition to expert symptom

management, palliative care focuses on clear communication, advance care planning, and coordination of care.

RESPITE CARE

Short-term, intermittent home care, while it provides no specific medical or therapeutic services, gives the friend or family member who is the primary caregiver in the home some time off. Essentially an adult-sitting service, respite care can be an important factor in easing the caregiving strain on a patient's family or friends.

Under the Medicare hospice benefit, inpatient respite services are available on an intermittent basis to relieve caregiver burden.

^[1] The Long Term Care Poll, AP/NORC, [https://www.longtermcarepoll.org/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving/#:~:text=Most%20Americans%20age%2040%20and,nursing%20home%20\(4%20percent\).](https://www.longtermcarepoll.org/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving/#:~:text=Most%20Americans%20age%2040%20and,nursing%20home%20(4%20percent).)

^[2] <https://qcor.cms.gov/main.jsp>, accessed February 26, 2022.

^[3] Ibid

I. ENSURE ENACTMENT OF A COMPREHENSIVE, HOME-BASED NATIONAL HEALTH CARE POLICY

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

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

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) included 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 and advanced 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 other provisions, this bill extended the Independence at Home Demonstration program, expanded access to home dialysis therapy, and expanded the use of telehealth services. Reintroduced in the 115th Congress by the same four Senators, the CHRONIC Care Act (S. 870) was approved by the chamber on September 26, 2017. An identical companion bill was introduced in the House of

Representatives on December, 8 2017, by Representatives Peter Welch (D-VT) and Kurt Schrader (D-OR). The CHRONIC Care Act was included as part of the larger Bipartisan Budget Act (BBA) of 2018 that became law on February 9, 2018. Of particular note was the extension of the Independence at Home demonstration program for an additional two years.

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 must closely monitor CMS's implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met, and that timely referral to home care and hospice services is strongly incentivized. 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 and advanced illness 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, bundling of payments, or other delivery of care innovations. Finally, Congress should encourage demonstrations to test waiving of existing eligibility requirements for home health and hospice care to determine whether greater flexibility and improved ease of access to services can result in better health care outcomes and/or reduced health care spending.

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

ENACT A COMPREHENSIVE, HIGH-QUALITY HOME- AND COMMUNITY-BASED LONG-TERM CARE PROGRAM

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

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

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

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

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

The health care reform legislation also included enhanced federal Medicaid matching funds to encourage state Medicaid programs to increase diversion of Medicaid patients from costly institutional long-term care to more cost-effective home and community-based care. It also extends to spouses of individuals receiving Medicaid home and community-based care the same protections against impoverishment that are currently provided to spouses of nursing home residents. However, these protections have gone through a series of extensions while Congress works towards a solution providing for permanent protections. The National Association for Home Care and Hospice is working alongside the Leadership Council of Aging Organizations, and other coalitions to drive legislation that would make permanent protections against spousal impoverishment.

RECOMMENDATION: The federal government must take the lead in providing adequate coverage of long-term care needs for the physically disabled, chronically and terminally ill, and

cognitively impaired. The foundation of this initiative should be home and community-based care and hospice.

The following provisions should be included in a federal long term care plan:

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

basic employee benefits and other support.

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

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

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

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

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) expands the availability of health insurance to an estimated 32 million of the current uninsured population. It does so through Medicare spending reductions, certain tax increases, fees payable by insurance companies and others, a penalty on uninsured individuals, though repealed in 2017, and a penalty on businesses with more than 50 employees that do not provide health insurance to their employees. This legislation imposes a \$2000 penalty for each full-time employee that does not get health insurance from the employer where the business employs 50 or more full time equivalent employees and at least one of the employees qualifies for a federal subsidy to purchase health insurance. The definition of “full-time employee” in the calculation of target employers is based upon the total of the number of employees working at least 30 hours a week.

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

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

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

A 2014 survey by the National Association for Home Care & Hospice indicates that 35% of Medicare home health agencies do not offer health insurance to their employees while 75% of Medicaid home care companies and private pay home care companies do not offer health insurance.

On June 19, 2013, Senators Susan Collins and Joe Donnelly introduced the “Forty Hours Is Full Time Act”, which would modify the definition of full time from 30 hours per week to 40 hours per week. The reasoning behind the bill is to prevent employers from having to limit workers’ hours to only 29 hours per week, which would be damaging for the employee, the employer and, most importantly, people receiving care from home care workers who became limited to only 29 hours of work per week. The bill was reintroduced in 2015 as S. 30 for the 114th Congress, and then again in 2017 as S. 1782 for the 115th.

The House of Representatives had comparable bills in 2013, 2015, and 2017 entitled

“Save the American Workers Act,” That bill, HR 30, passed the House in January 2015. Additional legislation with similar intent has been before Congress. In 2014, The House also had HR 5098, a bill which would have delayed the employer mandate for 2 years for health care businesses primarily providing Medicare or Medicaid services.

In January 2016, the House and Senate passed a bill that would repeal many parts of the Affordable Care Act. It was the first such measure to pass both houses of Congress. The employer mandate and penalty provisions were part of that bill. However, on January 8, 2016, President Obama vetoed the bill. There was insufficient support for the bill to override the veto. Throughout 2017, multiple attempts through various legislative approaches were taken by Congress to repeal the Affordable Care Act. Most versions included repeal of the employer mandate. Ultimately, all of these attempts were unsuccessful. However, it should be noted that the Tax Cuts and Jobs Act included a provision to repeal the individual mandate. The legislation passed both chambers of Congress and was signed by President Trump (P.L. 115-97).

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

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

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

responsibilities should accommodate the varied work schedules of home care workers in a way that does not disadvantage the employers, employees, or patients.

ESTABLISH FEDERAL SUPPORT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE

ISSUE: Employer-based health insurance is on the decline nationally primarily due to growing costs. According to the Kaiser Family Foundation, in 2002, 58 percent of our nation's smallest businesses, those with less than 10 employees, offered health insurance as a workplace benefit. In 2021, just 49 [percent](#) of the smallest businesses are able to offer health insurance. Small businesses are challenged to offer health insurance, particularly by rising costs because they are unable to obtain health insurance at rates that are available to larger groups. Home care and hospice is primarily a "small business" enterprise.

The Patient Protection and Affordable Care Act of 2010 (PPACA) establishes an employer financial responsibility to help fund health insurance where the entity employs 50 or more full time equivalents (FTEs). The reforms exempt small companies with less than 50 FTEs and offer tax credits to companies with 25 or fewer employees to encourage them to provide health insurance. The credit varies depending on the size of the company and the average worker wages. The highest credit goes up to 50 percent of premium costs where wages are less than \$25,000 average.

Legislation was introduced in the 111th, 112th, and 113th Congresses, and again most recently in the 115th Congress as H.R. 4616, the Employer Relief Act of 2018 to repeal any federal requirement for financial responsibility of an employer for health insurance. Expanded tax credits are a viable alternative to encourage employers to help employees with the cost of health insurance.

RECOMMENDATION: With any replacement plan for the ACA, Congress should increase tax credit support for health insurance for employees of small businesses and raise the definition of a "small employer" to allow expanded eligibility for the credits. Further, there should be a standard benefit package that includes home care and hospice.

RATIONALE: Home health agencies, home care companies, and hospices have limited access to affordable health insurance for their employees. The solutions to this growing problem may surface with the health care insurance exchanges developed as part of the health care reform legislation. However, even with 50 percent tax credits (the highest available), small home care businesses face a daunting task securing health insurance for their employees because the increased cost of such is not likely to be addressed with higher service payment rates from government home care benefit programs or through the ability to increase charges to private pay disabled and elderly clients living on limited fixed incomes.

ENACT A CATASTROPHIC LONG-TERM CARE PROGRAM

ISSUE: Long-term care coverage has long been an underfunded and overlooked segment of the continuum of care leaving many seniors vulnerable to the availability of able and capable family caregivers. Various attempts have been made at providing coverage with the Community Living Assistance Services and Supports Act (CLASS Act) included in the Patient Protection and Affordable Care Act coming closest to realization before being repealed as part of the American Tax Relief Act of 2012 following the Department of Health and Human Services deeming it not a viable program.

Under current practice, should a disabled individual need long-term care their options are limited to paying out of pocket for private duty care, which not all are financially equipped for, or depend on family caregivers, which not all will have. In the event their needs are at the level requiring nursing home coverage they will be forced to spend down their assets to the point of impoverishment to qualify for state Medicaid coverage.

RECOMMENDATION: To help combat this looming long-term care crisis Congress should enact the Well-Being Insurance for Seniors (WISH) Act, H.R. 4289 as introduced by Rep. Tom Suozzi in the 117th Congress. This bill would create a benefit of approximately \$3,600 per month, to be geographically and wage indexed, for caregiver services. The \$3,600 is designed to cover approximately six hours of daily service. For the public source of funding a new federal payroll tax of 0.3 percent of wages from both employer and employee, or a combined 0.6 percent from the self-employed. On the private side, it is expected that insurance companies would be unburdened of providing catastrophic levels of coverage and would create more affordable long-term care coverage options.

RATIONALE: Over the next 15 – 20 years the over 65 demographic is expected to nearly double, yet many of these people will not possess the resources to pay for long-term care. This will ultimately result in Medicaid covered nursing homes coming at great expense to federal and state budgets. Meanwhile, private insurance companies continue to offer fewer long-term care coverage plans with those that remain too expensive for the majority of seniors.

B. MEDICARE

CREATE ENHANCED HOME HEALTH BENEFIT AS ALTERNATIVE TO THE SKILLED NURSING FACILITY BENEFIT

ISSUE: Since its creation, the Medicare home health benefit has been limited in the scope of beneficiary services and supports that are covered. As a result, when a beneficiary's needs exceed the level of part-time care covered under the home health benefit, the individual has no viable option than to seek care in a skilled nursing facility (SNF) where Medicare provides for extended post-hospital care on a daily basis. In many instances, beneficiaries could safely and effectively receive needed care at home if additional services were covered by Medicare beyond those available through the home health benefit.

These limitations along with the emerging opportunities for health care at home were highlighted in the coronavirus pandemic. With added support, individuals who otherwise meet the Medicare SNF benefit standards requiring a need for skilled nursing or therapy services on a daily basis can have all their needs met at home while reducing overall Medicare spending. Additionally, extended care at home can help control the risk of transmission of infections as the patient remains in a comfortable state of isolation in their own home. Medicaid programs have long embraced the value of home and community-based care as an alternative to institutional care. However, Medicare has not seen comparable modernization as it remains with essentially the same limited home health benefit as was implemented in 1965.

RECOMMENDATION: Congress should enact a Medicare reform that creates an option for home-based extended care services for individuals who would otherwise meet Medicare standards for the Skilled Nursing Facility benefit. The new benefit would provide sufficient clinical and non-clinical resources to meet the individual's needs in his/her own home while providing a guaranteed savings to Medicare.

A model that meets those standards is Choose Home. It is an add-on to the existing Medicare home health 30-day care and payment period by providing an enhanced offering of caregiver services and supplemental health care supports designed as an alternative to the SNF benefit. Patients, who otherwise would be eligible for the Medicare SNF benefit, would be provided the option of care under the Choose Home model. As a key component in meeting patients unique needs, the Choose Home model would be designed to address social determinants of health. While not an exhaustive list, any one or combination of the following supports would be included in the Choose Home model:

- Daily skilled nursing and/or therapy services, as needed
- Ongoing telehealth supports
- Extended Personal Care Services
- Meal Delivery
- Minor Home Modifications
- Non-emergent Medical Transportation
- Respite Care

- Overall care coordination

Payment is based on a case-mix adjustment model tied to four ranges in the number of hours of personal care service. An add-on payment to the traditional home health episodic payment would cover the cost of the full panoply of additional resources required by the individual. The beneficiary would not have any co-payment or coinsurance as cost sharing occurs through use of the individual's home and likely support of family caregivers. To guarantee savings to the Medicare program, the amount of the add-on would be capped at 80% of the national median 30-day payment for extended care in a SNF.

A Choose Home provider would be required to meet Medicare Conditions of Participation for home health agencies and additional standards related to the 24/7 nature of the expanded services.

RATIONALE: Skilled Nursing Facilities play a key role in the health care continuum in post-hospital extended care. In many instances SNFs are the only appropriate setting of care for the patients they serve. However, some SNF-level patients do not need institutional placement if home-based extended care services were covered by Medicare. Medicare beneficiaries prefer to receive care in the comfort of their own homes. Health care at home can also provide immense value as a lower cost setting. For beneficiaries that do not need the full capabilities of a SNF, additional services beyond that available under the existing home health benefit can bring positive clinical outcomes, improved patient satisfaction, and savings to Medicare.

Home health agencies have decades of experience in caring for people as an alternative to institutional care. Medicaid programs throughout the nation have proven such for decades in caring for custodial care patients who would otherwise need a nursing home. A comparable option as an alternative to the Medicare SNF benefit is fully viable, but needing legislative change by Congress.

ESTABLISH A CHRONIC CARE MANAGEMENT BENEFIT UNDER MEDICARE

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

Medicare initiated a pilot “Chronic Care Improvement Program” that does not provide the direct, face-to-face support that is necessary for productive care management. Relying on statistical analyses, broad-based educational efforts, and very limited direct intervention, the pilot program falls short of the care management that can be provided by home care entities or teams.

Additional concepts of chronic care management are emerging. These include a medical/health home model. A medical/health home model is a physician-centered approach wherein physicians are reimbursed to focus on managing the medical needs of individuals with one or more chronic illness diagnoses. In December of 2018, the House of Representatives passed the IMPROVE Act (H.R. 7217). This legislation would have allowed for the establishment of state Medicaid options to coordinate care for children with medically complex conditions through a health home. The measure did not receive consideration in the Senate. However, there are serious weaknesses in the medical home model. Specifically, there is a severe shortage of physicians with training in managing chronically ill individuals in the community setting. In addition, physicians lack the infrastructure necessary to extend services outside their office practices using modern technologies, data driven actions, and home visitations of patients. Finally, a medical home model does not integrate the wide variety of non-medical services and supports that are needed to achieve the comprehensive goals of effective chronic care management.

In the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress authorized the establishment of several pilot programs and demonstration projects designed to test new models of chronic care management. One model to be tested in the Centers for Medicare and Medicaid Innovation (CMMI), uses home health agencies as a base to be provided by an interdisciplinary team approach that includes physicians and other health care professionals along with high tech remote monitoring systems. This project would include in-home face to face support of the chronic care patient. This program is recommended by Congress, but not required.

Another program in the reform legislation is a required pilot program known as Independence at Home (IAH), a physician-centered model that incorporates a team approach along with technology supports. This model focuses on certain high-risk categories of chronic care patients and uses a reimbursement method that shares the Medicare spending savings from the care between Medicare and the providers. In 2015, Congress extended the lifespan of the IAH program as it has shown success in reducing overall Medicare spending for the patient

population involved in the pilot. Congress extended IAH again in the Bipartisan Budget Act of 2018 for an additional two years, and further extended the model for three additional years in 2020 as part of year-end budget legislation.

In late 2013, CMS modified the physician Medicare reimbursement model to include procedure codes on management of chronically ill beneficiaries. This is a step in the right direction but it still falls short in that it does not recognize the value and importance of non-physician services in the management of a chronic care population.

The Senate Finance Committee (SFC) has taken up the issues presented in caring for Medicare beneficiaries with chronic illnesses. In 2016, the SFC outlined its proposed action relative to reforming Medicare to address the growing needs of individuals with chronic conditions. The SFC plans did include extending and expanding the Independence at Home program. In 2017, the Senate approved this legislation as authorized by the SFC that took modest steps to address needs of patients with chronic illness, including extension of the Independence at Home demonstration program, but did not include a home care based chronic care management benefit.

RECOMMENDATION: Congress should monitor the development and implementation of the demonstration programs and pilot projects on chronic care management to ensure CMS compliance with its mandates and recommendations. Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients based on the outcomes of the various demonstration projects and pilot programs. The service should be provided by professional nurses and others within home health agencies to ensure a discipline-integrated, community care-based approach to care management. The patient care should be under the guidance and supervision of the patient's attending physician who should be included as a member of the care team. The services should include:

1. An interdisciplinary team approach to care management that includes physicians, nurses, therapists, medical social workers, and pharmacists;
2. Evidence-based care plan development;
3. Direct patient care services in the home setting;
4. The application of telehealth services for appropriate remote monitoring as needed by the individual patient;
5. Care counseling, care coordination, medication management, and oversight of services related to activities of daily living;
6. The use of interoperable electronic health care records and efficient electronic-based communication tools;
7. Patient education and support; and
8. Integration and support of informal caregivers such as family members.

In addition, Congress should:

1. Permit non-physician practitioners to authorize Medicare home health services as NPPS are becoming the primary care practitioner for millions of Medicare beneficiaries;
2. Expand availability of patient remote monitoring services (telehealth) by allowing home health agency professionals to provide telehealth in patient homes;
3. Waive the Medicare home health services "homebound" requirement in program innovations; and

4. Support application of the “management and evaluation of the care plan” skilled nursing service in the existing home health benefit to create a nationwide care management system for individuals with chronic diseases.

RATIONALE: The existing Medicare benefit structure encourages individuals to await condition deterioration before attending to ongoing health-related needs. Higher-cost care for acute episodes results from the absence of direct care management of the chronic care population. A care management benefit can help avoid these complications and costs.

A chronic care management delivery system is already available through existing home health agencies that possess the skill and experience in managing chronically ill individuals in the community. Through the existing infrastructure of home health agencies, an effective chronic care management system can be created with minor refinements and minimal re-engineering of the delivery system to achieve nearly immediate cost savings and improved patient care. However, Congress needs to modify some elements of current law to secure a full range of home-based solutions in the care of individuals with chronic illnesses.

ESTABLISH A HOME AND COMMUNITY-BASED DEMONSTRATION PROGRAM UNDER MEDICARE

ISSUE: Advances in technology allow more and more services to be provided in the home or community setting. Further, care often times can be provided more cost- effectively, and most elderly and disabled individuals would prefer to be cared for in the comfort of their homes. As the baby boom generation reaches the age of Medicare eligibility, there is growing concern over chronic disease and the toll it will exact from federally-financed health care programs. Home care services, provided on a timely basis, could help to alleviate the need for more complex care at an institution. However, existing requirements under the home health benefit (part-time and intermittent care) deny access to more timely home-based interventions. The result can mean admission to a skilled nursing facility (SNF) or hospital, at a much higher cost to Medicare. The average cost of a home health care stay (60-day episode) is around \$3,000, while the average Medicare SNF stay costs about \$11,000.

In the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148), Congress authorized the creation of a Center for Medicare and Medicaid Innovation (CMS Center on Innovation). In Section 3021 (xiv) of the Act, it calls for the Center to conduct a demonstration project that would fund “home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.”

RECOMMENDATION: The Congress should authorize a home and community-based demonstration program under Medicare that waives the part-time and intermittent care standards, allows greater flexibility relative to services provided than currently under the home health benefit, and covers services in the home for patients that otherwise would be cared for under the Medicare SNF benefit or in a hospital if it can be shown that the cost to Medicare of caring for the individual in the home would be less than the cost of placement in a SNF or hospital. Congress should ensure that the CMS Center on Innovation promptly implements demonstration projects pursuant to Section 3021 (xiv) that meets these guidelines.

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

CREATE A PHARMACEUTICAL SERVICE HOME HEALTH BENEFIT

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

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

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

C. MEDICAID

REQUIRE TRANSPARENCY IN THE STATE PLAN AMENDMENT PROCESS

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

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

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

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

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

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

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

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding the Community First Choice optional benefit. In this rule, CMS suggested that states offer a self-directed care model and an agency model for the delivery of services. In 2016, CMS issued guidance (SMD # 16-011) to State Medicaid Directors providing States flexibility related to the design of a CFC program. For example, states could design a program that is limited to only mandatory services and one service delivery model (i.e., self-directed model with service budget) as an approach to establishing the program in the state. Over time, the state could add multiple optional services and service delivery models to expand the choices available to beneficiaries or the state could design a program that provides maximum choice at the outset. The regulation does not require states to offer sufficient options to meet all beneficiaries’ needs and/or capabilities. Therefore, it is possible that different levels of care may be available under the different models.

RECOMMENDATION: Congress should require all states contracting with individuals to provide paraprofessional home care services through federally-funded programs to provide adequate assurances that consumers receiving care from such individuals are assessed to be capable (for example, a person receiving highly skilled services such as catheter care must be

capable of directing the caregiver in the performance of that task) and willing to assume the required employer responsibilities. Consumers should also be given the full option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice, and should have access to the same frequency and type of care regardless of the chosen delivery model. States should also provide a mechanism for resolving any problems that arise between a consumer and providers and should devise a method for ensuring that backup workers are available. Consumers directing their own care and their caregivers should be afforded the same important protections that are required when care is provided through an agency. The same needs should be met under each model for the same level of care. Caregivers should be trained, tested, and competent to provide services.

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

ENSURE ACCESS TO HOME CARE IN MEDICAID MANAGED LONG TERM SERVICES AND SUPPORTS

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

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

Managed care entities have a great deal of experience in delivering medical care under Medicaid, and many Medicaid beneficiaries have had positive experiences. There is a high risk, though, that given managed care plans' inexperience, and lack of federal oversight, aspects of the long-term services and supports now being managed by managed care plans will suffer. Payment rates, network adequacy, continuity of care and patient access to care can all be easily jeopardized by a lack of guidance and oversight.

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

State Medicaid programs, with the support of CMS, are rapidly moving to managed LTSS delivery models. As of 2017, [according to CMS](#), 41 managed LTSS programs were in operation across 24 states. It is apparent that this trend will continue to expand. Early indications are that enrollment standards that steer individuals away from the traditional program into a managed care provider model, and Medicaid beneficiaries face limited choices of home care providers. In addition, access to care appears to be restricted through a combination of payment rate reductions and restrictive care authorizations. CMS issued a set of regulations on managed care under Medicaid in 2016 that included guidance on prioritizing home and community based care. Also, in September of 2016 the Government Accountability Office (GAO) issued a report that recommends that Health Resources and Services Administration (HRSA) take steps to produce projections of direct care workforce supply and demand and develop methods to address data limitations in order to do so. HHS concurred with GAO's recommendation, stating that developing projections for the direct care workforce is timely and important.

RECOMMENDATION: Congress should require that any LTSS Medicaid managed care

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

RATIONALE: A transition to managed care should not result in a change in the scope of the Medicaid home care benefits or any jeopardy to home care providers or patients. Likewise, Olmstead v. L.C. and managed care share similar goals, including that community-based care be provided in the most clinically appropriate and economical manner possible. While the 2016 Medicaid managed care rules emphasize a state's responsibility to ensure access to home and community-based care in managed care arrangements, the rules do not mandate that a managed care plan present and get approval for an Olmstead compliance plan.

ESTABLISH FEDERAL STANDARDS FOR MEDICAID PERSONAL CARE SERVICES

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

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

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

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

REFORM MEDICAID HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

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

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

CMS issued a formal regulation on the Medicaid face-to-face encounter requirements on February 2, 2016. This regulation provided significant discretion to state Medicaid programs regarding the manner in which the encounters must occur and the documentation of those encounters. The compliance date of the regulation was originally set on July 1, 2016 but depending on the nature of the state's powers to change Medicaid requirements with or without legislative approval, the compliance deadline was delayed until July 1, 2017 or July 1, 2018 to allow state legislatures and providers to implement the rule appropriately.

The experiences with the Medicare face-to-face physician encounter requirements demonstrate that little or no positive program integrity outcomes occur. Instead, the requirements simply block access to care. The CMS rule permits, but does not require, states to implement the Medicaid requirement in a manner different than the Medicare rule.

RECOMMENDATION: Congress should repeal the Medicaid face-to-face physician encounter requirements. If such does not occur, Congress should mandate that:

1. CMS monitor state implementation of the federal standards for the Medicaid face-to-face encounter requirement to ensure that the state standards are reasonable and do not create a barrier to care. Congress should review CMS' findings on the impact of the face-to-face encounter requirements and, if necessary, repeal the provision and devise more constructive ways to secure physician involvement in home health care.
2. Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.
3. Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health

agency.

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

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

ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM SERVICES AND SUPPORTS EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE

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

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

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

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

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

- Establishment of the Community First Choice Option, which allows for enhanced federal matching for community-based attendant supports and services to disabled individuals up to 150 percent of federal poverty level who require an institutional level of care;
- Extension of the Money Follows the Person (MFP) Rebalancing Demonstration Grant;

- Protections against spousal impoverishment in Medicaid home and community- based services;
- Enhanced federal matching through the Balancing Incentive Program for select states to increase the proportion of non-institutionally based long-term services and supports; and
- New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

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

Congress has continued the Money Follows the Person demonstration program through a series of short-term extensions while efforts around making the program permanent continue.

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

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

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

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

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

ISSUE: The National Governors Association reports that the states are suffering severe shortfalls in their budgets and have begun, or are planning, to cut back 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. This also threatens to reduce coverage for hospice under Medicaid, while hospice is an optional benefit; most states currently cover it under Medicaid.

There have been repeated attempts to make sweeping financing and programmatic changes to Medicaid. Proposals included establishing a per capita cap on federal Medicaid spending to restrict 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 and should support further federal matching payment assistance to the states.

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 (R-WI). President Trump has indicated potential support for block granting Medicaid to the states or using per capita caps to limit federal spending. As of 2017, several legislative proposals were introduced as part of an effort to repeal and replace Obamacare. For example, H.R. 1628, the “American Health Care Act of 2017,” as passed by the House of Representatives on May 4, 2017, included per capita caps and block granting of Medicaid and would have rescinded the federal Medicaid matching rate for Community First Choice Options home and community-based services (HCBS) program. All of these efforts fell short in the Senate.

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 and most states cover hospice despite the fact that it is an optional benefit under Medicaid. 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 and it is possible that states may look first to trim optional benefits under Medicaid as part of this effort. States are required to balance their budgets, so federal assistance is essential to preserve and expand home and community-based care within the Medicaid

program.

ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

ISSUE: Medicaid plays an increasingly important 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 indicates that Medicaid expenditures for home care and hospice services already exceed Medicare expenditures. A significant 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 three years, the proposed standards are now considered abandoned under the Administrative Procedures Act.

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

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

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

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

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

REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES

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

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

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

REJECT MEDICAID WAIVERS THAT REDUCE BENEFITS FOR CURRENT BENEFICIARIES

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

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

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

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

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

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

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

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

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

EXEMPT HOME CARE AND HOSPICE FROM COST-SHARING BY MEDICAID BENEFICIARIES

ISSUE: Expenditures for Medicaid, the nearly \$600 billion federal-state safety net program that, along with the Children's Health Insurance Program (CHIP), provides health care services to about 95 million Americans, have grown from about 11 percent of the average state budget in 1988 to 28 percent in 2017 (MACPAC). According to state governments, in testimony before Congress and the Medicaid Commission on Medicaid Reform, this growth is unsustainable from both the state and the federal standpoint. To address this spending growth many states are looking for ways to increase revenues and cut program costs. Potential budget reductions in some states may lead to decrease Medicaid spending resulting in limiting benefits and imposing premiums and cost sharing for beneficiaries. This raises concerns that states may look increasingly more to the imposition of cost sharing for home care services to help fund the program. At the same time, many states are shifting Medicaid program to managed care systems. This shift creates further risks that the managed care plans will restructure Medicaid benefits to include some forms of cost sharing for enrollees.

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

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

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

Finally, federal Medicaid regulations on cost sharing prohibit providers from denying access to services based on a beneficiary's inability to pay the cost sharing amounts. With already inadequate payment rates, providers would be forced to assume significant bad debt.

ESTABLISH MINIMUM FEDERAL STANDARDS FOR HOME HEALTH COVERAGE UNDER MEDICAID

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

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

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

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

REQUIRE COVERAGE OF HOME CARE, HOSPICE AND PERSONAL CARE SERVICES IN ANY MEDICAID REFORM

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

- Inpatient and outpatient hospital services;
- Prenatal care;
- Physician services;
- Skilled nursing facility services for individuals age 21 and older;
- Home health care for persons eligible for nursing facility care;
- Family planning services and supplies;
- Rural health clinic services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioners services;
- Certain ambulatory and health center services;
- Nurse midwife services; and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children.

Home health services covered by Medicaid include three mandatory services: part-time nursing, home health aide, and medical supplies and equipment; and one optional service category: physical therapy, occupational therapy, or speech pathology and audiology services. States may also receive federal funding for 32 optional services, including personal care services and hospice care.

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

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

Home care and hospice services are cost-effective and should be available to all those in need. The Medicaid program could realize substantial cost savings by caring for people in their homes.

In addition, the US Supreme Court held in *L.C. v. Olmstead* that the Americans with Disabilities Act (ADA) requires state Medicaid programs to meet health care needs in the least restrictive environment. However, so long as home care services are optional benefits the promise of the ADA will not be realized.

EXTEND SPOUSAL IMPOVERISHMENT PROTECTIONS TO HOME CARE

ISSUE: Before 1989, when an elderly woman was forced to place her husband in a Medicaid nursing home, she was forced to live in poverty herself. The Medicaid program required that, in order for the husband to qualify for Medicaid nursing home care, nearly all of the couple's assets and income had to be spent down, leaving the spouse at home with, in many states, less than \$400 per month to pay for housing, food, and other expenses. In 1989, Congress created the Medicaid "spousal impoverishment" protections to end this unfair treatment. In 2017, under these provisions, the spouse at home will be able to retain assets, in addition to the home, of up to \$120,900 and income of up to \$3,022.50 a month.

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

The Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148), extends these spousal impoverishment protections to all home and community-based Medicaid services beginning January 1, 2014 and ending December 31, 2018. Congress has continued to provide for these protections through a series of short-term extensions while an agreement towards permanency is negotiated. Most recently, the Congress extended the protections for an additional five years expiring September 30th, 2027. This extension was provided for in the Consolidated Appropriations Act, 2023, P.L. 117-328.

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

RATIONALE: A spouse should not be penalized when his or her loved one becomes infirm and needs long-term care at home. Current law makes a husband or wife choose between having enough money to live on by putting his or her spouse in a nursing home, and keeping the loved one home and living in poverty. In some instances, couples have legally divorced as an alternative to spousal impoverishment. Passage of legislation to extend the spousal impoverishment protections would enable couples to remain together at home.

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

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

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

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

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

RATIONALE: Medicare is the primary payer over Medicaid. Medicare beneficiaries have greater freedoms to choose care and providers under Medicare than under Medicaid. These beneficiary rights should not be lost or subordinated through consolidation of Medicare and Medicaid programs for dual-eligibles. Medicaid beneficiaries also should have rights to choose their provider of care rather than to be mandatorily enrolled in a managed care plan. At a minimum, Medicaid beneficiaries should have a full and transparent understanding of their home care benefits.

D. PROTECTING CONSUMERS/QUALITY OF CARE

PROMOTE DEVELOPMENT OF QUALITY MEASURES FOR VOLUNTARY USE IN PRIVATE DUTY HOME CARE

BACKGROUND: The National Academy of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Increasingly federally-financed health care programs are developing quality metrics to maximize patient satisfaction and to ensure value.

The Medicare program has adopted a series of process and outcome measures that are applicable to home health services, and, more recently, has launched a value-based purchasing program under which home health agencies are offered financial incentives to improve the quality of care they provide in comparison with other agencies. Most quality measures applied to Medicare home health services focus on skilled services, such as nursing and physical therapy, in large part because the home health benefit is predicated on a patient's need for skilled care and the services of home care aides must be directly linked to the home health plan of care.

Medicaid is the largest single payer of long-term services and supports in the U.S. Over recent years, the Centers for Medicare & Medicaid Services (CMS) has worked with states to assure and improve quality across the Medicaid authorities that support long term services and supports, including the Medicaid section 1915(c) Home and Community-Based Services (HCBS) waiver program. These efforts include creation of draft quality measures for Medicaid HCBS and solicitation of public feedback on the HCBS measures. Additionally, a 69-question HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey has been developed, and other steps have been taken to promote quality for these services.

Many individuals in need of personal care and supportive services are not eligible for HCBS under the Medicaid program. In most cases, these individuals will receive such services from a private duty home care agency. The private duty home care market is a rapidly growing field due to the aging of the nation's population and the expanding need for supportive services to enable individuals to age in place. The private duty market is licensed at the state level, and in most cases is not subject to specific quality standards.

In response to many Medicare beneficiaries' need for personal care and other supportive services, in recent years CMS has included caregiver support and in-home supportive services as allowable Medicare Advantage (MA) supplemental benefits. This opens the door to even greater use of private duty home care through contracting with MA plans.

RECOMMENDATION: Congress should direct an appropriate body to:

- Identify the various patient populations served by private duty home care agencies.
- Develop a combination of reasonable and appropriate process and outcome measures for voluntary use by private duty agencies. These measures should be tailored to the various private duty patient populations and to the nature of the services provided.

- In development of these standards, there shall be consultation and involvement of stakeholders and consideration of existing standards, such as those that have been developed for HCBS.

RATIONALE: As the demand for private pay care in the home increases so will the questions related to how payers and the public can ensure the quality of care provided. Federal initiatives towards development of quality measures could support development of voluntary quality improvement programs in the private duty market.

SUPPORT EFFORTS TO INCREASE HEALTH EQUITY AND REDUCE DISPARITIES FOR TRADITIONALLY UNDERSERVED MEDICARE AND MEDICAID BENEFICIARIES AND THEIR FAMILIES SERVED BY HOME-BASED CARE PROVIDERS.

ISSUE: The National Association for Homecare and Hospice (NAHC) recognizes that for far too long, people and families from historically marginalized communities have faced unique structural barriers that continue to limit their access to and acceptance of high-quality and timely home-based care and services. Individuals from non-white racial and ethnic backgrounds, those that identify as LGBTQ+, and those struggling with poverty and related social determinant of health (SDOH) challenges, amongst others, have all suffered as a result of intentionally and unintentionally discriminatory processes and structures that are baked into the very fabric of our healthcare system.

Hospice, home health and home care providers of all kinds are uniquely positioned to drive progress on health equity outcomes for underserved patients and families. Providing services in the comfort of someone's home allows for more authentic trust-building between an individual and their health care team. Lack of trust in the medical establishment has been identified as a contributor to health inequities, so being able to bolster trust by meeting a patient and family "where they are" in their own homes and communities can set the stage for a more productive partnership between patient and provider. Being in a patient's home also affords the opportunity to identify and intervene more quickly to address social and environmental challenges that may be negatively impacting a patient's care or quality of life. Examples include being able to more easily interact with the individual's caregiver, identify possible food insecurity, fall risks, unsafe social situations, or transportation limitations. The connection built through an interaction in the patient's home can also help solidify a longer-term relationship that will contribute to better adherence to care plans, and improved care coordination.

While public policy is by no means the only mechanism by which to address the health disparities facing these disadvantaged groups, it nevertheless is an important tool in the fight for lasting health equity. Given the outsized impact federal policy has on the delivery of home and community-based care, NAHC is committed to advocating for legislative and regulatory solutions that are intentional and specific in their goals to increase access and utilization of home-based supports for all underserved populations.

RECOMMENDATION: Congressional and regulatory initiatives aimed at reducing disparities in the health care system should recognize home care and hospice as key partners with a unique perspective into the lived experience of patients and families. Policymakers should strive to ensure the participation of home-based care providers in any policy reform efforts intended to address health equity within government health programs. Areas to more deeply explore and refine targeted recommendations for include:

- Better and more inclusive data collection and analysis

- In the past, identifying disparities and effectively monitoring efforts to reduce them has been limited by a lack of specificity, uniformity, and quality in data collection and reporting procedures. Consistent methods for collecting and reporting health data, and the inclusion of data elements such as race, ethnicity, sexual orientation, gender identify, primary language, and other indicators of social determinant of health (SDOH) challenges, will help us respond more effectively to the unique needs of underserved homecare populations.
- Enhanced training and education for homecare providers
 - For providers to promote health equity through their practice, they need to understand the complexity of the intersection of these factors and how they impact treatment outcomes. Policies are needed that will incentivize training vehicles, such as licensing board requirements and graduate medical education standards, to integrate instruction on culturally-competent home-based care for marginalized groups.
- Equity-focused quality measurement
 - While quality measurement is used throughout the health and homecare system to evaluate clinical outcomes, capture patient experiences, and inform provider payment, it has largely failed as a movement to meaningfully measure equity. Quality measures first must be stratified by race and ethnicity at a minimum, as well as by language, disability, and other important factors. Beyond this, efforts should be made to ensure that quality measurement programs and delivery system transformation projects directly incentivize the reduction of disparities.

RATIONALE: As the over-65 population increases in the next few decades, much of that increase will be due to the aging of racial and ethnic minorities. In 2015, about 22% of those over 65 were members of minority groups; by 2050 that will increase to 39%. In addition to significant income disparities based on race, there is a greater, and accelerating, gap between the median net worth of African-American and Latino families and that of white families. The changing demographics and the racial wealth gap mean those seeking home-based care will be more likely to be racial or ethnic minorities and to have fewer resources to pay for their care. We need policy solutions that can address the needs of this growing population.

As a reflection and example of the gaps in care that still exist, black patients received only 8.2% of all hospice care in 2018, while representing 13.4% of the US population. Unsurprisingly, given the lower likelihood of hospice use, black individuals are also more likely to have multiple emergency department visits and hospitalizations and undergo intensive treatment in the last 6 months of life compared with white patients. Minority patients receiving home health care services have been found to have more adverse events, less functional improvement and worse patient experience. African-American and Hispanic patients receiving home health were found to be more likely to go to the emergency department or be readmitted to the hospital. These figures begin to show us where the disparities exist in home-based care, and can help inform policy development going forward.

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

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

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

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

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

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

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

RATIONALE: Workers are not well served by mandating participation in a public authority,

which is at heart a monopoly composed of a union combined with an employer with the authority of government. There is no compelling evidence that imposing a public authority is the best way to achieve increased wages and benefits for employees; there are other means for attaining this goal.

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

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

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

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

REQUIRE NON-DISCRIMINATION IN MEDICAID HOME CARE ELIGIBILITY

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

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

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

REQUIRE CONTRACTORS OF HOME CARE SERVICES AND/OR CONSUMER-DIRECTED HOME CARE SERVICES TO ENSURE QUALITY AND SUPERVISION OF SUCH SERVICES

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

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

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

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

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

RATIONALE: Basic standards of care, including training, testing, and supervision must be met to assure minimum levels of safety for care recipients and caregivers. A clear line of accountability for the quality and consistency of care provided is essential. Caregivers should have FICA withheld and paid, worker’s compensation paid, and appropriate state, local and federal taxes withheld and paid. These concerns are particularly important in light of increased

bipartisan interest and support in the U.S. Congress for consumer- directed home care services.

ENHANCE CONSUMER PROTECTIONS FOR HOME CARE RECIPIENTS

ISSUE: The overwhelming majority of home care workers are honest and perform their duties with compassion and integrity. Likewise, the vast majority of home care agencies provide reputable, legitimate, quality care. Cases of consumer abuse in home care are rare. Home care providers are often in a position of identifying abuse committed by others. In fact, Congressional testimony by the Government Accountability Office regarding elder abuse indicates “in-home services were considered the most effective factor for both prevention and treatment of elder abuse.” However, as in any industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients. It is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse, in any form, cannot be tolerated.

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

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

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

RECOMMENDATION:

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

provide home care services or those who have been found in violation of the law or safety standards should be established.

- Quality assurance standards should be required in all federal and state funded long-term care programs. Such standards should include minimum standards of training, testing, supervision, and practice in the delivery of in-home services. Quality and safety standards should apply regardless of consumer, provider or payer.
- Education programs should be approved by the state or by state or federally-approved accrediting organizations.
- Congress should require states to establish mechanisms for resolving problems that arise between consumers and independent providers.
- Congress should increase funding for adult protection programs and mandate that state elder abuse reporting laws include immunity from prosecution for persons reporting incidence of abuse.
- Congress should establish a commission to investigate elder abuse and make recommendations for increasing penalties.

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

ELIMINATE ELDER ABUSE

ISSUE: A [comprehensive review](#) of elder abuse conducted in 2015 found that 1 in 10 seniors are subject to some type of abuse. It is also widely believed that only a small portion of abuse cases, 1 in 14, are reported to the authorities. As the population continues to age, it becomes increasingly important to protect older persons from physical and emotional abuse, neglect, intimidation, and financial exploitation by their families and institutions. Although statistics indicate that most elder abuse is actually carried out by family members, there are still too many reports of abuse carried out by unrelated caregivers.

Stimulated by Congressional attention, many states passed elder abuse protection statutes between 1978 and 1985. Congress, in 1988, passed legislation to assist the states in this effort. In fiscal year 1991, the Congress, for the first time, provided for separate, distinct funding for elder abuse and nursing home ombudsman activities under the Older Americans Act. This separate funding has been continued in subsequent years. Section 705 of the Older Americans Act Amendments of 2000 (P.L. 106-501) authorized a “Prevention of Elder Abuse, Neglect, and Exploitation” study of financial exploitation of older individuals.

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; Public Law 111-148) incorporated the provisions of the Elder Justice Act, a bill authorizing a coordinated national effort to confront the issue of elder abuse. This includes the collection of accurate and uniform data and education and training in the identification and reporting of abuse. Under this program the federal government takes the lead in assisting the states in this effort. It authorizes increased funding for adult protection programs, requires reporting of elder abuse, and protects from prosecution persons reporting incidences of abuse. While PPACA authorized \$777 million over four years for these programs, no funds have been appropriated for use by the states; as a result states have been left to do what they are able with limited funding to develop programs from which vulnerable elders could benefit.

RECOMMENDATION: Congress should fully fund the Elder Abuse Act provisions by appropriating the authorized amounts.

RATIONALE: Elder abuse is a hidden problem. Out of fear or dependence, many victims never report the abuse. It is clear that adequate state and federal resources must be allocated to address this national disgrace.

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

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

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

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

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

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

REQUIRE COMMUNITY PARAMEDICS THAT PROVIDE NON-EMERGENCY SERVICES IN THE HOME TO MEET REGULATORY AND LICENSING HOME CARE STANDARDS

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

RECOMMENDATION: Require community paramedics and similar parties to comply with the same regulations and licensing standards that home care agencies operate under in order to provide services and to receive payment for services from Medicaid or other governmental programs. In addition, community paramedics should only provide services that are not a duplication of what home care providers already provide in the community.

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

A well-trained and reliable work force is critical to successful patient care. A home care worker consistently providing care and building a relationship with a patient is an essential piece of successful home care. Community paramedics will not always be available to spend the time developing those relationships or have the availability to consistently provide high quality care. Paramedics are employed to provide medical care in emergency situations and it is unreasonable to put patients in danger of waiting for emergency care or waiting to receive home care. It is even more unreasonable to bill Medicaid for services provided when the services are being

provided outside of home care requirements mandated by Medicaid.

REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO CONTRACT WITH ANY WILLING AND QUALIFIED PROVIDER

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

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

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

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

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

DEVELOP STANDARD QUALITY METRICS AND MINIMUM MANDATORY UNIFORM DATA SETS

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

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

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

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

E. CAREGIVER SUPPORT

PROMOTE RESPITE CARE FOR FAMILY CAREGIVERS

ISSUE: The bulk of long-term care is provided by friends and family caregivers. According to the Caregiver Action Network (CAN), more than [90 million](#) Americans provide care for a chronically ill, disabled or aged family member or friend. The value of the services family caregivers provide for “free” is estimated to be worth an estimated [\\$375 billion per year](#); more than twice that spent on formal home health care and nursing home services combined.

Persons are burdened by many responsibilities and demands associated with providing long-term care services to a disabled relative or friend. Such problems include limitations on one’s personal life, the competing demands of financial obligations and work conflicts, meeting the care recipient’s emotional and physical demands, and emotional, financial and family strains. According to a study by the American Council of Life Insurers, family caregivers who provide care 36 or more hours a week are more likely than non-caregivers to experience symptoms of depression or anxiety; for those caring for a parent the rate is twice as high; for spouses the rate is six times higher. According to the American Council of Life Insurers, a typical working family caregiver lost \$109 per day in wages and health benefits due to the need to provide full time care at home.

AARP has concluded that many caregivers incur direct out-of-pocket expenses to help support a family member or friend with a disability. The average caregiver spent an average of [approximately \\$7,000 per year](#) in out-of-pocket costs on household goods, food and meals, medical equipment and supplies, travel and transportation, medical co-pays and pharmaceuticals in 2016. Furthermore, the loss in productivity to employers related to informal caregiving has been estimated to be as high as \$33.6 billion for full-time employed caregivers according to the MetLife Mature Market Institute’s study on the cost of caregiving in 2006.

Late in 2006, President Bush signed into law the Lifespan Respite Care Act (P.L. 109-442). The bill amends the Public Health Service Act and authorizes the Secretary of Health and Human Services (HHS) to award grants or enter into cooperative agreements with state agencies to develop lifespan respite care at the state and local levels. The term “Lifespan” respite care is defined as a coordinated system of accessible, community- based respite care services for family caregivers. Eligible states will be required to fund at least 25 percent of the program costs. The legislation will empower states to provide respite care services for family caregivers, training and recruitment of workers and volunteers, as well as training and education for family caregivers. The bill also creates a National Resource Center that will be tasked with maintaining a national database on lifespan respite care. Congress authorized appropriations of \$94.8 million for FY 2011, rising to 94.8 million by 2011; however; only \$2 million was appropriated for the Lifespan Respite Care Act for FY 2011. Most recently, In July of 2019, the House of Representatives approved \$10 million per year from FY2020 – 2024 for the reauthorization of the Lifespan Respite Care Act. As of writing the Senate has yet to vote on the legislation.

During the 106th Congress, the Older American Act Amendments (OAA) of 2000 (P.L. 106-501), established a National Family Caregiver Support Program for state area agencies on aging to develop respite care programs to enable caregivers to be temporarily relieved of their caregiving responsibilities. Congressional appropriators have called for the National Family Caregiver Support Program to receive \$181 million for FY2020.

In the 115th Congress, the RAISE Family Caregivers Act (S. 1028/H.R. 3759) passed

both chambers of Congress, and was signed into law in January 2018 (PL 115-119). This act requires the Secretary of Health and Human Services to develop a strategy to support family caregivers. The bill calls for an advisory body to bring together representatives from both the private and public sectors to advise and make recommendations. The strategy is intended to identify recommended actions that communities, providers, government, and others are taking and may take to recognize and support family caregivers and be updated biennially.

Legislation introduced in the 115th Congress addressing respite care included the Military and Veteran Caregiver Services Improvement Act (S. 591/H.R. 1472), and the Support our Military Caregivers Act (H.R. 1910).

RECOMMENDATION: Congress should monitor the Department of Health and Human Services' implementation of provisions contained in the RAISE Act, and enact legislation that further expands support for family caregivers, particularly through respite care.

RATIONALE: Family members cannot continue to carry the burden and responsibility for care without getting a chance to have a break and recharge. Respite care is in the best interest of public programs that finance long term care, the patients receiving the care, and the system of family caregiving.

SUPPORT TAX INCENTIVES FOR FAMILY CAREGIVERS

ISSUE: Currently federal and state programs offer limited assistance to informal unpaid caregivers. Federal law allows a caregiver, under specific circumstances, to classify the older person receiving care as a dependent and claim a personal exemption on their taxes. Those circumstances stipulate that the caregiver and recipient must live in the same home, the caregiver must provide 50 percent of the senior's support for the year, and the older person's income must not exceed the personal exemption amount. Few caregivers can claim the exemption because many older persons receive a Social Security benefit or pension income that exceeds the amount. A limited form of caregiver assistance included in the Health Insurance Portability and Accountability Act allows taxpayers who itemize their tax deductions to deduct long-term care (LTC) expenses if combined medical and LTC expenses exceed 10 percent of the taxpayer's adjusted gross income.

Several bills were introduced in the 115th Congress that would provide various tax incentives for family caregivers who care for sick or disabled family members. One such approach is the Social Security Caregiver Credit Act (S. 1255), which recognizes certain levels of unpaid caregiving as a credit to an individual's Social Security account. Another is the Credit for Caring Act (S. 1151/H.R. 2505). Although these bills have attracted much support, the prospect for enactment of caregiver tax incentives is uncertain because the Congressional Budget Office (CBO) has scored these provisions as costly. The Social Security Caregiver Credit Act has been reintroduced in the 116th Congress as S. 2317/H.R. 4126, while the Credit for Caring Act has been introduced as S. 1443/H.R. 2730.

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

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

SUPPORT FAMILY CAREGIVING AND INNOVATION IN PERSONAL CARE DELIVERY

ISSUE: The home care market is a rapidly growing field due to the aging of the nation's population and the expanding need for supportive services to enable individuals to age in place. Between 50 and 60 percent of adults aged 18-49 say they want to remain in their communities and homes as they age, while nearly 80 percent of adults age 50 and older indicate this same desire¹ However, the home care market does not serve only the aging population. It serves a wide array of disabled, seriously ill, and chronically ill individuals who wish to remain in their home and does so mostly through the state Medicaid Home & Community Based Services (HCBS) programs. Nationally, 3.0 million people receive HCBS through waivers, and over 2.5 million people receive HCBS as part of the state plan benefit package (primarily home health and personal care services).² These HCBS programs are dependent upon the direct care workforce which has been experiencing a growing shortage while the Bureau of Labor Statistics predicts the demand for the direct care workforce to grow by 25% from 2020 – 2030. The already unmet need for these workers was exacerbated by the COVID-19 pandemic. A Kaiser Family Foundation survey on the impact of the COVID-19 pandemic on state Medicaid HCBS found that most of the 39 states responding to the survey experienced the closure of at least one HCBS provider. Workforce shortage was cited as the primary reason.

Outside of HCBS programs, family caregivers help make staying in the home possible. According to the National Alliance for Caregiving (NAC) and AARP, at least 53 million people provide informal, and usually unpaid, care and support to older adults and disabled people of all ages in the United States (AARP and National Alliance for Caregiving, 2020). Fourteen percent of family caregivers care for a special needs child with an estimated 16.8 million caring for special needs children under 18 years old. Fifty-five percent of these caregivers are caring for their own children.³

Without these caregivers there would be more individuals in facilities and institutions causing the financial costs for the healthcare system and states to burgeon. Of great concern is the fact that skyrocketing inflation and the overall economic downturn resulting from the pandemic is causing some of these family caregivers to leave or reduce their caregiving role to find employment or increase their working hours in order to meet basic living expenses.

One solution to this difficult situation is for family caregivers to be paid for their caregiving role and for the federal government and state Medicaid offices to examine innovative policies and programs that support family caregivers and address the workforce shortage. Some Medicaid programs prohibit relatives, legally responsible individuals, and legal guardians from

¹ AARP Research (2018, August) *Home and Community Preferences: A National Survey of Adults Age 18-Plus*.

² Watts, M., Musumeci, M., Ammula, M. (2022, March) *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*. <https://www.kff.org/medicaid/issue-brief/medicaid-home-community-based-services-people-served-and-spending-during-covid-19/>

³ *National Alliance for Caregiving in collaboration with AARP. November 2009*

being paid as caregivers. The [2022 National Strategy to Support Family Caregivers](#) addresses this and related issues by outlining a framework to achieve 27 recommendations of the Recognize, Assist, Include, Support, and Engage (RAISE) Act Family Caregiving Advisory Council and The Advisory Council to Support Grandparents Raising Grandchildren which leads to recognizing, assisting, including, supporting, and engaging family caregivers.

RECOMMENDATION: Congress should:

- Eliminate the prohibition on payment made under Medicaid programs to relatives, legally responsible individuals, and legal guardians for caregiving.
 - 42 U.S.C. § 1396d(a)(24)(B) (“not a member of the individual’s family”);
 - 42 C.F.R. § 440.167 (personal care services are not provided by a member of the individual’s family and for purposes of this section, family member means a legally responsible relative). This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. CMS, STATE MEDICAID MANUAL § 4442.3.B.1.
- Increase federal funding to states for studying, implementing and expanding programs that incorporate family caregivers and build and strengthen the direct care workforce.
- Institute minimum training requirements for caregivers and increase program integrity oversight.
- Adopt the 2022 National Strategy to Support Family Caregivers.

RATIONALE: The COVID-19 pandemic has had a disproportionate impact on people who are seriously ill, chronically ill and/or disabled including children with special health care needs highlighting the importance of health insurance coverage, affordability, and benefit package contents, like HCBS⁴. A survey conducted by the Kaiser Family Foundation found that many states have experienced worsening direct care workforce shortages that have affected providers of home- and community-based services (HCBS) and that the HCBS provider infrastructure has declined during the course of the PHE. A looming “care gap” will be exacerbated by an inadequate supply of workers to meet future consumer demand. There must be innovations to create a stable, well-trained and highly valued direct care workforce and barriers to such removed.

States have implemented a variety of approaches to finance family caregivers through Medicaid for the services they provide to children and youth with special health care needs (CYSHCN) including reimbursement for family caregivers delivering care through HCBS.⁵ States are doing the same for family caregivers of adults. This often requires legislative changes at the state

⁴ Williams, E., Musumeci, M. (2021, October) *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access*. www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/

⁵ State Approaches to Reimbursing Family Caregivers of Children and Youth with Special Health Care Needs through Medicaid <https://nashp.org/state-approaches-to-reimbursing-family-caregivers-of-children-and-youth-with-special-health-care-needs-through-medicaid/>

level with changes being successful in Colorado and Arizona among others. Removing the federal prohibition on payment made under some Medicaid programs to relatives, legally responsible individuals, and legal guardians for caregiving opens the door for innovation at the state level. The 27 recommendations of the 2022 National Strategy to Support Family Caregivers addresses many of the barriers as well as other issues and creates a framework for strengthening family caregiving.

All direct care workers need to be trained for the services they are delivering and there is no exception for family caregivers. Such caregivers may have provided care to their family member for some time, but this does not mean they are knowledgeable about the safest and best way to deliver the care. Nor does it mean the patient is protected from abuse or neglect. Minimum training standards for all direct care workers would provide consistency across states and initiating and strengthening program oversight would improve protection for patients from abuse and neglect.

F. VETERANS/MILITARY

IMPROVE HOME CARE SERVICES FOR VETERANS

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

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

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

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

In 2018 the VA Mission Act was signed into law. Among other provisions, this law is intended to fix issues with the CHOICE Act by making changes to the Community Care Program. This includes modified eligibility criteria and better integrated care coordination, as well as a focus on improving quality of care. Included in this transition was a change in the third-party administrator (TPA) overseeing the community care office. Optum was awarded

regions 1-3, TriWest has been awarded regions 4 and 5. Region 6 has not been awarded at time of writing. Home health agencies interested in providing care to veterans are required to go through a contract and credentialing process with Optum, followed by being “loaded” into their system. Reports to NAHC demonstrated that in many instances the loading process is not taking place following successful completion of the contracting and credentialing. In addition, home health agencies have reported issues with obtaining authorizations, insufficient payment rates, and lacking communication from the VA.

RECOMMENDATION: Congress should require the coverage of home care services by qualified home health agencies for all veterans who would prefer to stay in the home as opposed to a VA hospital or nursing home. Moreover, use of existing home care providers should be encouraged by the government to avoid increasing taxpayer costs by creating new VA provider entities. Congress should continue to monitor the implementation of the VA MISSION Act to ensure that care access is improved, prohibit unreasonable waits for home care, ensure that providers are reimbursed in a timely manner to avoid access concerns, and institute transparency and efficiency into the MISSION Act operations. Congress should ensure that home health agencies willing to provide care to veterans be made available within applicable TPAs to receive referrals for veteran patients.

RATIONALE: Congress should continue to improve upon the scope of home health services available to veterans. Alternative levels of care should be available to our nation’s veterans. Institutionalization should not be the only method for providing care to chronically ill or rehabilitating veterans. Since Congress saw fit to provide home care services to veterans, this care should include the full range of services and be provided by qualified home health agencies.

EVALUATE THE IMPLEMENTATION OF THE HOME CARE BENEFIT IN THE MILITARY HEALTH SERVICES SYSTEM

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

The 2002 legislation marked the first time that Congress had authorized a specific, structured home care benefit in the military health program for retirees and military dependents. The effort now shifts to proper implementation. In June 2002, the Department of Defense (DoD) published an Interim Final Rule regarding the TRICARE home health benefit. The new TRICARE home health services benefit was phased in across the country during 2004. An extended benefit program also has been implemented with the Final Rule published by the DoD on July 28, 2004.

The implementation of these two new benefits has been saddled with administrative difficulties as DoD contractors struggle to understand and manage the intricacies of a Medicare-like home health benefit and a Medicaid-like home and community-based service extended benefit. From 2005 to 2008, complaints surfaced regarding the “mysteries” of TRICARE home care, particularly regarding service authorization, claims processing, and payments. Home care providers indicated that significant confusion continued to exist at the DoD contractors. The primary response from home care providers appears to be resignation, leading to a near abandonment of participation in the program.

While the DOD has greatly improved its home care programs in TRICARE, concerns continue to surface regarding inadequate guidance, delayed program updates, and insufficient integration of home care with other TRICARE programs.

RECOMMENDATION: Congress should legislate that DoD conduct a comprehensive study of its implementation of the home health benefit and the extended benefit program to ensure that military families receive the benefits of home care that Congress intended. A congressional hearing should be scheduled with the assistance of TRICARE consumers and home care providers to attempt to develop a plan to eliminate the program’s confusion and complexities.

RATIONALE: DoD contractors have limited experience in administering comprehensive home care benefits. The contractors have experienced difficulties in the implementation of the home health benefit. In the five years since the implementation of the home health benefit, the contractors appear to have gained only a limited understanding of the benefit structure. The new Medicare payment model that was implemented on January 1, 2008, was not adopted on a timely and consistent basis. Oversight is needed to satisfy congressional intent.

G. LONG TERM CARE INSURANCE

ESTABLISH MEANINGFUL STANDARDS FOR LONG-TERM CARE INSURANCE

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

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

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

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

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

RECOMMENDATION: Congress should amend the “Health Insurance Portability and Accountability Act” and the “Deficit Reduction Act” to require that all long-term care insurance policies meet the most up-to-date federal minimum standards. The federal minimum standards should include the most current NAIC model and should require that all long-term care policies cover a full range of home care and hospice services. Home care services should be reimbursed at levels at least equal to that of nursing home care. Favorable tax treatment should be extended

to more generous plans which provide home care benefits for those who need assistance with one activity of daily living (ADL) or one instrumental activity of daily living (IADL), or when home care is otherwise deemed medically necessary by a physician. Congress should continue to look for ways to encourage creative use of the private long-term care insurance market to strengthen the Medicaid program.

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

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

H. CHILDREN’S SERVICES

MONITOR STATES’ COMPLIANCE WITH IDEA OBLIGATIONS

ISSUE: The Individuals with Disabilities Education Act (IDEA) was reauthorized by the 108th Congress and signed into law on December 3, 2004 (H.R.1350; P.L.108-446). IDEA Part C provides early intervention services for infants and toddlers and Part B allows for skilled care to be given to school children ages 3-21 to assure their access to a free, appropriate public education. This care includes one-on-one nursing, if needed. Under Part B, the provider of the care is considered the school district, which must then bill Medicaid and private pay for reimbursement.

As originally written in 1975, the federal government made a commitment to pay up to 40 percent of the additional cost of educating children with disabilities. Even though the 2004 reauthorization bill was intended to put the federal government on a six year “glide path” to reach the original funding goal of 40 percent, this goal has not been met. IDEA needs full and proper funding to help school districts provide the care.

Two Senate bills were introduced in the 112th Congress, S.103 introduced by Senator David Vitter (R-LA) and S.1403 introduced by Senator Tom Harkin (D-IA), that would amend the Individuals with Disabilities Education Act to reauthorize and make appropriations for the grant program to assist states and outlying areas to provide special education and related services to children with disabilities. Similar legislation was introduced in the 109th, 110th, and 111th Congresses. In the 115th Congress, H.R. 2902 - IDEA Full Funding Act -- was introduced by Rep. Jared Huffman (D-CA-2) to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding through September 30, 2028. This bill was referred to the Education and Workforce committee where it did not receive any further consideration. Congressman Huffman reintroduced his bill in the 116th Congress in March of 2019 as H.R. 4673 and again in the 117th Congress as H.R. 5984.

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

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

IMPROVE REIMBURSEMENT REQUIREMENTS FOR PEDIATRIC HOME CARE UNDER MEDICAID

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

The Centers for Medicare and Medicaid Services (CMS) issued a proposed regulation in 2011 that set standards for states to establish provider payment rates. The rule was finalized in 2015, creating new standards for determining the adequacy of payment rates along with revised processes for review of state rate setting. However, with severe limitations on judicial review of state rate setting, CMS has become the only viable overseer of state actions that have significant impact on care access.

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

In 2015, a federal court in Florida held that the states pediatric home care program was severely flawed and non-compliant with multiple federal laws relating to payment rates, eligibility determinations, and care authorizations. The end result of the non-compliance is a compromised access to care for pediatric patients in need of home care.

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

RATIONALE: No state has yet designed a home care reimbursement system under Medicaid that achieves the standard of access established under federal law. Virtually all Medicaid home care reimbursement systems are driven by state budgetary concerns with little concern for the patients’ access to care or the costs of delivering services. Adequate, national Medicaid reimbursement rates will ensure access to appropriate pediatric home care services.

PROVIDE ACCESS TO HOME CARE SERVICES FOR PEDIATRIC PATIENTS WITH MORE INTENSIVE CARE NEEDS

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

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

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

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

RATIONALE: Certain pediatric patients are best cared for in the home, where they can remain with their families. Because home care agencies have fewer pediatric patients and because more specialized staff is needed, services for pediatric patients with more intensive care needs are far more costly.

II. PROMOTE EFFICIENT USE AND ENSURE ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND HOSPICE PERSONNEL

SUPPORT FAMILY CAREGIVING AND INNOVATION IN PERSONAL CARE DELIVERY

ISSUE: The home care market is a rapidly growing field due to the aging of the nation's population and the expanding need for supportive services to enable individuals to age in place. Between 50 and 60 percent of adults age 18-49 say they want to remain in their communities and homes as they age, while nearly 80 percent of adults age 50 and older indicate this same desire⁶ However, the home care market does not serve only the aging population. It serves a wide array of disabled, seriously ill, and chronically ill individuals who wish to remain in their home and does so mostly through the state Medicaid Home & Community Based Services (HCBS) programs. Nationally, 3.0 million people receive HCBS through waivers, and over 2.5 million people receive HCBS as part of the state plan benefit package (primarily home health and personal care services).⁷ These HCBS programs are dependent upon the direct care workforce which has been experiencing a growing shortage while the Bureau of Labor Statistics predicts the demand for the direct care workforce to grow by 25% from 2020 – 2030. The already unmet need for these workers was exacerbated by the COVID-19 pandemic. A Kaiser Family Foundation survey on the impact of the COVID-19 pandemic on state Medicaid HCBS found that most of the 39 states responding to the survey experienced the closure of at least one HCBS provider. Workforce shortage was cited as the primary reason.

Outside of HCBS programs, family caregivers help make staying in the home possible. According to the National Alliance for Caregiving (NAC) and AARP, at least 53 million people provide informal, and usually unpaid, care and support to older adults and disabled people of all ages in the United States (AARP and National Alliance for Caregiving, 2020). Fourteen percent of family caregivers care for a special needs child with an estimated 16.8 million caring for special needs children under 18 years old. Fifty-five percent of these caregivers are caring for their own children.⁸

Without these caregivers there would be more individuals in facilities and institutions causing the financial costs for the healthcare system and states to burgeon. Of great concern is the fact that skyrocketing inflation and the overall economic downturn resulting from the pandemic is causing some of these family caregivers to leave or reduce their caregiving role to find employment or increase their working hours in order to meet basic living expenses.

One solution to this difficult situation is for family caregivers to be paid for their caregiving role and for the federal government and state Medicaid offices to examine innovative policies and programs that support family caregivers and address the workforce shortage. Some

⁶ AARP Research (2018, August) *Home and Community Preferences: A National Survey of Adults Age 18-Plus*.

⁷ Watts, M., Musumeci, M., Ammula, M. (2022, March) *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*. <https://www.kff.org/medicaid/issue-brief/medicaid-home-community-based-services-people-served-and-spending-during-covid-19/>

⁸ National Alliance for Caregiving in collaboration with AARP. November 2009

Medicaid programs prohibit relatives, legally responsible individuals, and legal guardians from being paid as caregivers. The [2022 National Strategy to Support Family Caregivers](#) addresses this and related issues by outlining a framework to achieve 27 recommendations of the Recognize, Assist, Include, Support, and Engage (RAISE) Act Family Caregiving Advisory Council and The Advisory Council to Support Grandparents Raising Grandchildren which leads to recognizing, assisting, including, supporting, and engaging family caregivers.

RECOMMENDATION: Congress should:

- Eliminate the prohibition on payment made under Medicaid programs to relatives, legally responsible individuals, and legal guardians for caregiving.
 - 42 U.S.C. § 1396d(a)(24)(B) (“not a member of the individual’s family”);
 - 42 C.F.R. § 440.167 (personal care services are not provided by a member of the individual’s family and for purposes of this section, family member means a legally responsible relative). This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. CMS, STATE MEDICAID MANUAL § 4442.3.B.1.
- Increase federal funding to states for studying, implementing and expanding programs that incorporate family caregivers and build and strengthen the direct care workforce.
- Institute minimum training requirements for caregivers and increase program integrity oversight.
- Adopt the 2022 National Strategy to Support Family Caregivers.
- States should be required to deliver information about the family caregiver model to recipients of applicable programs. The information should also be posted the appropriate Medicaid program website(s)/webpage(s) in a conspicuous manner.
- CMS should consider requiring Electronic Visit Verification (EVV) for paid family caregivers.

RATIONALE: The COVID-19 pandemic has had a disproportionate impact on people who are seriously ill, chronically ill and/or disabled including children with special health care needs highlighting the importance of health insurance coverage, affordability, and benefit package contents, like HCBS⁹ A survey conducted by the Kaiser Family Foundation found that many states have experienced worsening direct care workforce shortages that have affected providers of home- and community-based services (HCBS) and that the HCBS provider infrastructure has declined during the course of the PHE. A looming “care gap” will be exacerbated by an inadequate supply of workers to meet future consumer demand. There must be innovations to create a stable, well-trained and highly valued direct care workforce and barriers to such removed.

States have implemented a variety of approaches to finance family caregivers through Medicaid for the services they provide to children and youth with special health care needs (CYSHCN)

⁹ Williams, E., Musumeci, M. (2021, October) *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access*. www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/

including reimbursement for family caregivers delivering care through HCBS.¹⁰ States are doing the same for family caregivers of adults. This often requires legislative changes at the state level with changes being successful in Colorado and Arizona among others. Removing the federal prohibition on payment made under some Medicaid programs to relatives, legally responsible individuals, and legal guardians for caregiving opens the door for innovation at the state level. The 27 recommendations of the 2022 National Strategy to Support Family Caregivers addresses many of the barriers as well as other issues and creates a framework for strengthening family caregiving.

All direct care workers need to be trained for the services they are delivering and there is no exception for family caregivers. Such caregivers may have provided care to their family member for some time, but this does not mean they are knowledgeable about the safest and best way to deliver the care. Nor does it mean the patient is protected from abuse or neglect. Minimum training standards for all direct care workers would provide consistency across states and initiating and strengthening program oversight would improve protection for patients from abuse and neglect.

¹⁰ State Approaches to Reimbursing Family Caregivers of Children and Youth with Special Health Care Needs through Medicaid <https://nashp.org/state-approaches-to-reimbursing-family-caregivers-of-children-and-youth-with-special-health-care-needs-through-medicaid/>

SUPPORT PROPOSALS THAT WILL SUPPLY A QUALIFIED, STABLE, DIRECT CARE WORKFORCE FOR LONG-TERM CARE CONSUMERS

ISSUE: As the baby-boom generation ages and the elderly population grows, the demand for the services of home health and personal care aides will continue to increase. According to the U.S. Department of Labor’s Bureau of Labor Statistics, overall employment of home health aides and personal care aides is projected to grow by more than 25% percent from 2021 to 2031, much faster than the average for all occupations. As of 2021, more than 3.6 million individuals were employed as either home health or personal care aides across the United States.

The U.S. relies heavily upon immigrants to help address direct care workforce demands. It is estimated that one in four direct care workers is an immigrant. Some policies aimed at tightening immigration to the U.S. – including proposals to reduce the number of immigrants, ban travel from specific countries, or deny legal admission to individuals who might become a “public charge” (require access to food stamps or Medicaid) – have the potential to further reduce the availability of individuals to serve in the direct care workforce.

Many direct care workers earn very low wages and too few receive health insurance and other benefits. These factors, combined with challenging working conditions and inadequate training and support, lead to high turnover rates and vacancies. During the COVID-19 Public Health Emergency (PHE), the situation has worsened. A survey conducted by the Kaiser Family Foundation found that many states have experienced worsening direct care workforce shortages that have affected providers of home- and community-based services (HCBS) and that the HCBS provider infrastructure has declined during the PHE. A looming “care gap” will be exacerbated by an inadequate supply of workers to meet future consumer demand. Innovative approaches are needed to create a stable, well-trained and highly valued direct care workforce.

In early 2021, Congress passed the American Rescue Plan Act (P.L. 117-2), which included a temporary 10 percentage point increase in federal Medicaid matching funds for HCBS to support increased provider payment rates and promote workforce recruitment. This funding stream was available for only one year. Separately, President Biden proposed a \$400 billion federal investment in Medicaid HCBS, which was introduced as the Better Care, Better Jobs Act (S. 2210). Other legislation proposed in the 117th Congress -- the Build Back Better legislation (H.R. 5376) – would have addressed this priority of the Biden Administration by expanding the federal contribution for the Medicaid HCBS program by 6 percent annually (or about \$150 billion over 10 years) and envisioned significant improvements to the HCBS program, including requirements that support the recruitment and retention of the direct care workforce. This legislation also included \$1.0 billion in support for planning and development of measures that would increase the workforce in home and community-based services.

RECOMMENDATION: Enactment of HCBS funding along the lines recommended in the Better Care, Better Jobs Act would create a solid foundation for addressing a growing service need of the nation’s aging population. In addition, Congress should enact legislation to encourage wage pass-through initiatives, publicly-supported health insurance coverage, career ladder and training initiatives, and new worker pools to address current and future recruitment and retention problems. Finally, while seeking to address concerns about the influx of immigrants to this country the Administration and Congress must also examine potential policy

changes thoroughly to ensure that they do not inadvertently diminish access to care for some of our nation's most vulnerable citizens by reducing the available pool of workers.

RATIONALE: The use of direct care workers in long-term care settings forms the centerpiece of the formal long-term care system. Improving the availability and quality of the direct care workforce for long-term care support and services requires a long-term financial commitment and the support of partnerships among various stakeholders, including providers, consumers and their families, labor representatives and public education institutions, and various agencies within the state and federal governments.

REQUIRE MEDICAL RESIDENTS AND OTHER PROFESSIONAL LICENSED STAFF TO HAVE HOME CARE AND HOSPICE EXPERIENCE AS PART OF THEIR EDUCATION

ISSUE: Medicare provides financial support for the education of medical residents at virtually all hospitals in the United States. Additionally, the federal Health Resources and Services Administration (HRSA) funds numerous programs to support training of various health professions. Much of the education is biased toward care provided in the hospital or other clinical setting. However, a great deal of medical and health care has moved out of hospitals into the community. Several factors precipitated this shift, including:

- 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;
- Special arrangements for intensive home therapy prior to hospitalization in the case of chemotherapy, for example, are increasingly commonplace; and
- Emerging model of care – including the hospital at home and physician house calls models – have grown in popularity as potential routes for increasing access to care and improving patient satisfaction.

In addition, the marked increase in lifespan has resulted in an increasingly elderly population with chronic illnesses that limit functioning but are not necessarily life-threatening, and therefore can be managed in non-acute settings, primarily the home. Medicare requires physicians to sign a plan of care for beneficiaries to receive home health 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 available resources.

More recently, as the result of the COVID-19 pandemic, seniors have become increasingly sensitive to the potential risk of infection in a hospital or other institutional or group setting. As a result, more seniors are seeking care that can be provided in the home or seeking to decrease the length of any necessary institutional stay in order to reduce potential exposure to disease. It is anticipated this trend will continue into the future. For these reasons, physicians and other licensed health professionals must learn to function and manage care effectively in “non-traditional” care sites, particularly the home setting. As few medical or health professions schools provide their students with comprehensive home care experiences, such education must take place at the residency level.

RECOMMENDATION: Congress should mandate that all medical residents and licensed health professionals who receive support through federally-funded programs have home care and hospice experience as part of their curriculums. Further, federally-funded health care demonstration models (specifically those initiated through the Center for Medicare & Medicaid Innovations) that focus on care delivery in the home and community should require participating professionals to have home care and hospice experience, as appropriate.

RATIONALE: Medicare pays for the direct costs of graduate medical education, and HRSA

funds a wide variety of programs that support training for various health professions. The mandate that residents and other professionals spend time in the community as part of their training 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 and other professionals in training will learn about the available services 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 and hospice care will aid physicians in later determining appropriate levels of Medicare home health utilization and eligibility for hospice for individual beneficiaries. At a minimum, resident education should include pain and symptom management and a requirement to make home visits.

PRESERVE WORKERS' RIGHTS AND PRIVACY PROTECTIONS IN THE FORMATION OF UNIONS

ISSUE: The National Association for Home Care & Hospice (NAHC) supports the enforcement of laws that allow for the organization of labor free of undue outside influence. The Employee Free Choice Act (EFCA), H.R. 800/S. 1041, which was passed by the House of Representatives during 2007, would amend the National Labor Relations Act to change the requirements for the formation of a union in a way that eliminates workers' right to a private vote. This legislation was reintroduced in the 111th Congress (H.R. 1409/S. 560). Under present labor law employers and workers have the right to demand a secret ballot vote to certify a union. EFCA would eliminate the right to a secret ballot and permit the formation of a union if a majority of the workers sign a card authorizing a union. It would also impose some mandatory arbitration requirements and increased penalties on employers for certain practices. In September 2016, the EFCA was again introduced as H.R. 5000. The legislation saw no action and died with the end of the 114th Congress. While the EFCA has not been introduced in subsequent Congresses, legislation that would impact worker privacy in various ways is introduced on a routine basis.

RECOMMENDATION: Congress should preserve worker privacy rights in the formation and certification of unions.

RATIONALE: The EFCA would be harmful to home health and hospice workers and their employers by removing the right of the employees to a federally-supervised, private ballot when deciding whether or not to certify a union. Under this system, paid union organizers – not the federal government – oversee the process, and the workers' choice is ultimately made public to the employer, the union organizers, and co-workers.

EFCA is fundamentally incompatible with protecting the interests of individual liberty and the principles of a sound democracy. If Congress passes this proposal, it will be stripping away federally-protected private ballots from the hands of American workers. The only way to guarantee worker protection is through the continued use of a federally-supervised private ballot so that personal decisions about whether to join a union remain private and free of undue influence.

EFCA also includes language that would force binding arbitration on both the employer and the collective bargaining unit. This creates uncertainty for business planning and diminishes the control employers have over their operations and property.

RESTORE THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT

ISSUE: In 1974, Congress established an exemption for companionship services from the Minimum Wage and Overtime Requirements of the Fair Labor Standards Act. The term “companionship services” includes services performed by workers such as companions, home health aides, and personal care aides. At the time Congress made a societal choice in balancing the interests of the worker relative to addressing the care needs of the elderly and the infirm. Current law provides the Secretary of the U.S. Department of Labor (DoL) the authority to define and determine the scope of the companionship exemption.

In June 2007, the US Supreme Court ruled that the DoL companionship services exemption regulation was valid (reversing a previous Court of Appeals decision). Subsequent to the Supreme Court ruling, entities opposed to the DoL rule launched regulatory and legislative efforts at the federal and state levels to eliminate the companionship services exemption for home care aide workers. Federal legislative efforts along these lines during the 110th, 111th, and 112th Congresses were opposed by the National Association for Home Care & Hospice (NAHC) because they did not go far enough to protect workers. Some states have passed laws that eliminate the companionship services exemption. In others, there are efforts to interpret the regulations in a manner different than the federal rules.

Advocates for changing the exemption encouraged the Obama Administration to change the existing companionship services regulation. DoL issued a proposed rule on December 27, 2011, that would significantly restrict the exemption and make it inapplicable to workers employed by home care companies. The proposed rule was made final on October 1, 2013, with an effective date delayed until January 1, 2015, 78 Fed. Reg. 60453 (October 1, 2013). In the absence of a mandate that government-funded programs increase payment rates to cover the added cost of wages that would result from these efforts, employers of home care aides are expected to restrict working hours to avoid overtime pay. Further, these efforts do nothing to create career opportunities for home care aides or to address their need for health insurance. This isolated action related to a single element of the home care aide working conditions will have a reverse negative impact on those workers.

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

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

With the rules having gone into effect, few states adjusted Medicaid rates to

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

Legislation was introduced in the 114th Congress to return the FLSA standards to the pre-rule change standards (S.2221/H.R. 3860 -- Ensuring Access to Affordable and Quality Home Care for Seniors and People with Disabilities Act). In July 2019 several members of the House of Representatives wrote to the DoL urging that the agency open rulemaking to potentially rescind the 2013 regulations and restore the companionship services exemption.

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

RATIONALE: The unique employment nature of home care warrants a tailored approach to wage and hour requirements that takes into account that the focus of the employment is serving a population of vulnerable and infirm elderly persons with disabilities in their own homes. Most home care providers are small businesses with limited resources. Action taken to eliminate the companionship services exemption has reduced the availability of care to the elderly and the infirm and increased the costs of service delivery with no corresponding payment increase from third party payers, such as Medicaid. A comprehensive rather than a piecemeal approach to worker compensation and working conditions is necessary if access to high quality of care and continuity of services is to be achieved.

PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CAREGIVINGSTAFF

ISSUE: Severe limitations on reimbursement under Medicare and Medicaid, and, more recently, rapid inflation, make it extremely difficult for home care and hospice agencies to comply with any requirements to increase wages, much less provide wages and benefits that reflect the full worth of the care provided by nurses, paraprofessionals, and other caregiving staff. In fact, despite the public push to raise the 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 Medicare and Medicaid for home health, home care, and 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), and annual pay increases for all caregiving staff. Additionally, Congress should consider implementing a wage pass through for home care and hospice workers under Medicare and Medicaid.

RATIONALE: According to the Paraprofessional Healthcare Institute (PHI), 45 percent of direct care workers lived at or near the poverty level in 2018, and nearly half rely on some form of public 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, INNER CITY, 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. Home care and hospice providers continue to report shortages of nurses, home care aides, therapists and social workers, especially in rural and inner-city areas. In addition to other cuts, periodic reductions or freezes in agencies' market basket inflation updates have made it increasingly difficult for agencies to offer competitive wages and benefits. Most recently, increased costs of providing care during the COVID-19 public health emergency (PHE) and reduced staff availability due to burnout and illness have exacerbated these financial strains. 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 locations, inner cities, 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. Relative to inner cities, there are numerous dangers associated with delivery of services in the home that at times require additional investments, such as the provision of escort services for home visiting staff to protect against potential violence.

In 2022, the Department of Labor's Office of Occupational Statistics and Employment Projections at the Bureau of Labor Statistics updated their employment projections for the American workforce for 2021-2031. According to their report, "The healthcare and social assistance sector is projected to create the most jobs over the 2021–31 decade, growing in tandem with the segment of the population that is aged 65 and over. This should, in turn, boost demand for various healthcare occupations, especially those involved in caring for the elderly and those expected to benefit from the increased prevalence of team-based healthcare." The projected job growth in the health care sector between 2021 and 2031 includes increases in the following occupations: home health and personal care aides, an increase of 25 percent; physical therapist assistants, an increase of 24 percent; physical therapists, an increase of 17 percent; and occupational therapy assistants, an increase of 25 percent. It is also expected that the demand for all types of nurses during the same time period will exceed average occupational growth.

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) was designed to 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 established 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.

Employers in the health care sector -- and home care providers specifically -- hire immigrant workers to meet a variety of patient care needs, including nursing, therapies, and personal care. Home care agencies also utilize various programs (such as the H1B visa program) to sponsor foreign workers. Members of Congress have proposed numerous policies to reform the immigration system in the U.S. to support hiring of health care workers, particularly in light of the accelerating shortage of qualified health care workers. One such proposal during the 117th Congress -- S. 1024/H.R. 2255, the Healthcare Workforce Resilience Act -- would help to address health care worker shortages by making previously unused immigrant visas available to nurses and physicians who petition for such a visa before the date that is 90 days after the end of the COVID-19 PHE. An additional legislative proposal during the 117th Congress that could increase the availability of foreign workers for health care positions is the Essential Workers for Economic Advancement Act (H.R. 7239), which would establish a new nonimmigrant visa for temporary nonagricultural workers (H-2C visa) to fill jobs that have been open for an extended period of time and do not require a college degree. Further, the Citizenship for Essential Workers Act (S. 747/H.R. 1909) would establish a mechanism for eligible aliens who worked as essential workers during the COVID-19 PHE to apply for and obtain permanent resident status.

Since the onset of the PHE, the prevalence and awareness of “caregiver burnout” has increased dramatically. According to Dr. Victor Dzau, president of the National Academy of Medicine, during the PHE some 60 to 75 percent of clinicians have reported symptoms of exhaustion, depression, sleep disorders and PTSD. Dzau also noted that about 20 percent of health care workers have quit during the PHE, and four out of five who remain say that staff shortages have affected their ability to work safely and to satisfy patient needs. Employers in the health care sector have struggled to provide appropriate support to emotionally and physically overburdened health care workers. In early 2022, the House of Representatives and the U.S. Senate approved H.R. 1667, the Dr. Lorna Breen Health Care Provider Protection Act, which establishes grants and requires other activities to improve mental and behavioral health among health care providers. The legislation was named for an emergency room physician who

committed suicide while serving on the frontlines of the COVID-19 PHE at New York Presbyterian Hospital.

RECOMMENDATION: The growing healthcare workforce shortage is reaching crisis proportions, and demands a comprehensive, cross-sector approach to ensure that the nation's health care needs can be successfully met. Congress can play a significant role in addressing this challenge in the following ways:

- Congress should support initiatives that fund and enhance well-being and behavioral health services programs for health care workers.
- Congress should fund grant programs and loan forgiveness for education of 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 and/or where high demand is anticipated.
- 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.
- 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, including funding to ensure that nursing school faculty are paid competitive rates that attract quality candidates.
- Congress should support immigration reform efforts that improve the flow of clinicians and direct care workers into this country and that allow for qualified individuals to remain in the U.S.
- In efforts to address concerns about the influx of immigrants to this country the Administration and Congress should examine potential policy changes thoroughly to ensure that they do not inadvertently diminish access to care for some of our nation's most vulnerable citizens.
- 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.

PREVENT VIOLENCE AGAINST HOME CARE WORKERS

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

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

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

- Make physical violence directed toward home care workers (including volunteers and individuals providing services under contract, such as those delivering medical equipment and supplies) providing federally-funded care through programs such as Medicare, Medicaid, TRICARE, and Veterans health programs, a federal-level felony with appropriate classification of the felony dependent upon the degree of violence.
- Establish a grant program to provide for the development of educational programs for local and state police regarding the role that they can play in protecting home care workers.
- Ensure reimbursement for home care services to allow for pass-through financing for any reasonable and necessary security measures required to protect home care workers and to maintain continued access to services for home care beneficiaries.
- Direct the U.S. Department of Health and Human Services and the Civil Rights Division of the U.S. Department of Justice to establish a model standard for suspension of services in geographic areas which may be temporarily subject to increased risk of violence and strengthen the rights of agencies to discontinue cases that pose a threat to workers. This standard would allow for suspension of services without risk of allegations of noncompliance with various civil rights laws.

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

Since workplace violence presents a health and safety concern, the Occupational Safety and Health Administration (OSHA) is properly positioned to develop model standards for risk management. In 2016 OSHA issued "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers," which address risk management in a variety of health

care settings, including the home. The OSHA guidelines are discretionary in nature and would, if mandated, increase the cost of the delivery of services. To maximize protections of home care workers various federal programs that finance home care services should adjust their rates of reimbursement to cover the cost of implementing such worker protections. More recently, OSHA announced plans to hold a Workplace Violence Roundtable in early 2023 to discuss a potential standard for the prevention of workplace violence in the healthcare and social assistance fields. During 2019, Representative Joe Courtney (D-CT) introduced H.R. 1309, The Workplace Violence Prevention for Health Care and Social Service Workers Act, which would require the Occupational Safety and Health Administration (OSHA), within a year of enactment of the legislation, to issue an interim final rule establishing a standard under which each covered employer (including home health and hospice organizations) must develop a Workplace Violence Prevention Plan and take other action to address relevant hazards specific to the workplace. The legislation contains a thorough delineation of the standard that OSHA would be required to issue; if OSHA fails to issue the standard within the given time frame, the standard laid out in the legislation would automatically be in force. The legislation was reintroduced in early 2021 as H.R. 1195, and was approved by the House of Representatives in April 2021, but no Senate action was taken. While the rationale behind H.R. 1195 is sound and the home care and hospice industry support the legislation's intent, the legislation in its current form raises concerns, as implementing such a sweeping standard as an interim final rule does not allow needed opportunity for public consideration of the details of the standard and appropriate input on its impact.

During the 117th Congress, Rep. Madeleine Dean (D-PA) introduced the Safety from Violence for Healthcare Employees Act (SAVE Act, H.R. 7961), which would establish a new criminal offense for knowingly assaulting or intimidating hospital personnel during the performance of their official duties in a manner that interferes with their performance of the duties or limits their ability to perform the duties. The legislation also authorizes grants to reduce the incidence of violence at hospitals, including violence or intimidation against hospital personnel in the performance of their duties. Ideally, future iterations of this legislation would include healthcare personnel, volunteers, and contracted support in other sectors, including home care and hospice.

The occurrence of violence against home care workers may result in discriminatory treatment of geographic areas by home care providers attempting to avoid danger. It is not unusual for a home care provider to suspend services temporarily in geographic areas when violence arises. This suspension may affect a home, apartment building, housing complex, or an entire neighborhood and disproportionately impacts low income and minority populations. In order to protect health care providers from allegations of discrimination, Congress should require the appropriate federal authorities to establish standards to which home care providers can refer in making determinations on suspension of service as a last resort to protect home care workers.

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

ISSUE: At times, media attention has focused on the unacceptable, but few, cases of abuse of home care clients, fueling consumer anxiety and industry concern about the need for better consumer protections. Although any incidence of abuse is unacceptable, cases of consumer abuse in home care are extremely rare, and tend to occur under independent provider programs rather than an agency model. The overwhelming majority of home care workers perform their duties with compassion, skill 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.

The 2008 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. In subsequent Congresses legislation was introduced to require criminal background checks for long term care workers. 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.

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.

Twenty-five states participated in the National Background Check Program, which entered its ninth and final phase in 2018. A 2019 Department of Health and Human Services Office of the Inspector General (OIG) report found that across eight states participating in the pilot (all of which finished participation by 2016) nearly 80,000 individuals were excluded from eligibility for employment based on the background check program, but also found that some states did not implement all program requirements, some due to state legislative constraints.

In late 2020, the OIG issued a final report recommending that CMS continue to implement OIG's prior recommendation that the agency take appropriate actions to encourage States to obtain the necessary legislative authority to fully implement program requirements. Further, the OIG recommended that CMS assist participating states to address the challenge of coordinating between state-level departments and require participating states to consistently submit data that allow for CMS and each state to calculate determinations of ineligibility. CMS concurred with both of the OIG's recommendations.

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 the purpose 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.

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

ISSUE: Medicare home health and hospice payments have historically been adjusted to reflect varying wage levels across the nation through the application of a wage index. However, the wage index that has been utilized by the Centers for Medicare & Medicaid Services (CMS) has been based upon wages reported by hospitals across the nation. This index is derived from data that explicitly excludes any home health or hospice services costs. An attempt some years back to create and utilize a home health-specific wage index failed due to the lack of reliable wage data.

While home health and hospice payment rates are adjusted for wage variability through application of a hospital wage index, the index utilized and its manner of application is significantly distinct from that utilized for hospital 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, while Congress has established specific wage index criteria for certain geographic locations, 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. In 2021, the Medicare Payment Advisory Commission (MedPAC) noted that 67 percent of Inpatient Prospective Payment System (IPPS) hospitals received at least one wage index adjustment during 2022 (<https://www.medpac.gov/wp-content/uploads/2021/11/wage-index-medpac-oct-2021.pdf>).

Finally, to the extent that the home health PPS case-mix adjuster is not sufficiently sensitive, agencies are not 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 that are paid at prospectively-set rates. During 2022, MedPAC once again discussed the need for reforms to Medicare’s wage index system and outlined specific goals and principles for development of an alternative wage index, including that the new wage index method should:

- Use cross-industry, occupation-level wage data, weighted by sector-specific occupational weights
- Account for county-level variation in relative wages and smooth wage indexes

across adjacent counties

- Have no exceptions.

The Patient Protection and Affordable Care Act provided for comprehensive reform of the Medicare hospital wage index system taking into account MedPAC's 2007 recommendations (PPACA Section 3137). This provision required 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 recommended the use of Commuting Based Wage Index (CBWI) that sets wage index values using the commuting patterns of hospital workers. The consulting group that developed 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."

Despite identification of methods that could be used to adapt the CBWI for home health and hospice, the report recognized noted significant 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." CMS has not moved forward with any wage index reforms.

In late 2018, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued an in-depth report, "Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments" identifying problems with the wage index system and recommending, among other actions, stepped-up oversight and comprehensive reform of the system.

During 2022, the Centers for Medicare & Medicaid Services (CMS) took action to limit the negative impact that routine wage index changes can have on various Medicare provider types by imposing a permanent 5 percent cap on reductions in wage index values from one year to the next. While this change will protect providers from dramatic, unanticipated reductions in payments due to wage index changes from year to year, it does not address some of the basic inequities of existing wage index policies.

RECOMMENDATION: Congress should authorize Medicare to implement and apply a wage index model in line with the system recommended by MedPAC as soon as possible and one that provides 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. Finally, Congress should extend to all providers protections that ensure that no entity's wage index falls below the rural wage index value in that state.

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

III. ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE

PROVIDE REIMBURSEMENT FOR TELEHEALTH SERVICES IN THE HOME HEALTH BENEFIT

ISSUE: The essence of home health is care delivered in person, in the patient's home, as conceived in 1965 as part of the original Medicare law. In the more than 50 years since that landmark legislation was enacted, developments in technology and medical practice have changed the way health care professionals approach care delivery. These developments have led to new best practices and new telehealth tools greatly enhancing treatment options in patient care.

However, with the advent of these technologies, Congress has not acted to modernize the home health benefit to leverage the full array of tools available that hold positive impact for outcomes, patient satisfaction, and optimization of care delivery. Under current law, home health agencies (HHAs) are permitted to utilize telehealth technologies in their care delivery, but those services are not considered reimbursable. The limited number of providers with the means to incorporate telehealth into their practice have done so and found it to be of great value to their patients, though not all providers possess the resources to do so.

In 2019, as part of their annual rulemaking, the Centers for Medicare & Medicaid Services (CMS) permitted HHAs to include telehealth related expenses on their cost reports, an important step indicating recognition of the value and cost of telehealth in home health, though falling short of meaningful action towards providing reimbursement for those services.

In March of 2020, as part of CMS's response to the COVID-19 pandemic, CMS through an interim final rule announced that telehealth visits could be included on the home health plan of care, though they would not be allowed to substitute for an in-person visit and would not be billable. CMS made this standard a permanent one in its CY 2021 payment rule. As part of the CY2023 home health payment rule, CMS required that, effective January 1, 2023, HHAs may begin voluntarily reporting new telecommunications G-codes on HH claims with HH periods of care that start on or after January 1, 2023. On July 1, 2023, reporting of these new codes will become mandatory with HH periods of care that start on or after July 1, 2023.

The recent relief efforts by Congress and CMS to accommodate the demands of the COVID-19 pandemic include significant expansions of Medicare coverage of telehealth services. However, these changes did not incorporate payment for telehealth services under the home health benefit. Telehealth has been part of the tools employed by HHAs for two decades. HHAs can use telehealth for evaluation and assessment of a patient's condition, teaching and training of self-care and rehabilitative activities, wound care, direct therapy services, medication management, and more. During 2020, as part of the CARES Act, Congress instructed CMS to encourage HHAs to utilize telehealth.

In October of 2020, Senators Susan Collins (R-ME) and Ben Cardin (D-MD) were joined by Representatives Roger Marshall (R-KS), Terri Sewell (D-AL), Mike Thompson (D-CA), and Jodey Arrington (R-TX) in introducing the Home Health Emergency Access to Telehealth (HEAT) Act, S. 4854/H.R. 8677. This legislation would allow for CMS to issue a waiver providing for reimbursement for telehealth within the home health benefit. This would be dependent upon declaration of a public health emergency. CMS would be tasked with devising the payment methodology and visit equivalency between an in-person visit and a telehealth visit. Following the sharing of concerns from Congressional staff, safety guardrails were incorporated into the legislative text to ensure that patients would receive the benefit as intended while maintaining the in-person nature of home health. These include patient consent

to telehealth and a cap of 50% on visits occurring via telehealth. Despite NAHC Advocacy efforts, the Congress did not act on the HEAT Act in their end-of-year COVID-19 relief legislation.

The HEAT Act was reintroduced as S. 1309/H.R. 3371 early in the 117th Congress.

RECOMMENDATION: Congress should enact the HEAT Act into law.

RATIONALE: The coronavirus pandemic highlighted the need for modernization of several aspects of the Medicare home health benefit. In this case, utilization of telehealth to limit the risk of viral transmission, maximize utilization of personal protective equipment, and optimize staff resources that are stretched thin due to the pandemic is only prudent and logical. That same value exists in a post-pandemic setting as telehealth used appropriately in conjunction with in-person visits can provide meaningful efficiencies in the delivery of care along with improvement in care quality.

ENABLE EFFECTIVE USE OF TELEHOMECARE AND EMERGING TECHNOLOGIES UNDER MEDICARE AND MEDICAID

ISSUE: Telehomecare is the use of technologies for goals of 1.) early detection and intervention of a potential health crisis, and 2.) empowerment of the patient for self-management through the collection and exchange of clinical information from a home residence to a home health/hospice 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.

The VA has broadly deployed a range of remote patient monitoring (RPM) technologies and conducted various studies showing improved chronic disease management, cost savings, and reduced hospital admissions and emergency department (ED) visits as the result. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology. Unfortunately, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid.. Restrictive federal Medicaid and Medicare telehomecare guidelines are barriers to more widespread adoption of telehealth.

Despite numerous attempts over the last decade, Congress has authorized very limited coverage expansion for telehealth services in Medicare. During the 115th Congress, S. 870, introduced by Senator Hatch as the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, was incorporated into the Bipartisan Budget Act of 2018. Among the enacted provisions were several that expanded the ability of MA plans and Accountable Care Organizations (ACOs) to offer telehealth services.

In response to the COVID-19 public health emergency, Congress waived the originating site and geographical limitations to allow patients to receive technology-based visits in their homes. Congress and CMS further permitted use of telecommunications equipment to conduct the home health and hospice face-to-face encounters. CMS also clarified that telecommunications technologies could be used to conduct home health and hospice visits that are specified on a patient's plan of care provided the purpose of the visit can be met using such technologies and the services are reasonable and necessary. CMS also permitted hospices to bill for attending physician telehealth visits. As part of its 2022 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS require reporting of technology-based visits on home health and hospice claims. In late 2022, Congress enacted legislation that provides for an extension of the existing PHE-related telehealth flexibilities for home health and hospice related to completion of the face-to-face requirements through the end of 2024. CMS also, as part of its CY2023 home health payment rule mandated that home health agencies report visits using telecommunications technologies on claims on a mandatory basis beginning July 1, 2023. However, CMS does not currently collect data on technology-based visits on hospice claims, so there is no means for determining the volume of visits that are provided in that manner, nor is it possible to determine whether use of technology-based visits have any impact on the quality of care provided.

Before the COVID-19 PHE the health care sector experienced personnel shortages that were exacerbated by the PHE. It is anticipated that problems recruiting qualified staff will only become more severe as the baby boom cohort ages and develops care needs. Use of technology-based interactions, where appropriate, allow health care providers to more efficiently utilize staff and more effectively meet care needs.

Limitation on coverage of telehomecare in federal health care programs is not the only barrier to broader use of this care delivery mode. Many rural areas across the United States – the very areas that could most benefit from use of telehomecare technologies -- do not have Internet access sufficient to enable its use. The Administration, Congress, states, and carriers must take action to address this serious deficiency.

At the same time, the technology sector is rapidly developing other valuable new technologies, many of which will help to promote aging in place, while others may provide sufficient advance warning of potential changes in health status that they could reduce acute exacerbations of serious health conditions. These hold great promise for more effectively addressing health care needs of community-based senior citizens. Technologies for use in the delivery of home health and hospice care are increasingly being recognized as essential tools for an industry challenged by an exponential growth in the number of patients over 65 with chronic disease, a shortage of skilled professionals to handle the increased senior population and by diminished reimbursement formulas. Through the effective use of such technologies the overarching goals of keeping patients safely at home and reducing emergent and acute care spending can be realized.

RECOMMENDATION: Congress should: 1.) Establish telehomecare services as distinct benefits within the scope of federal Medicare and Medicaid coverage to include all present forms of telehealth services. As part of these benefits, Congress should allow sufficient flexibility to adopt coverage of emerging technologies, and to allow costs associated with them for cost reporting purposes; 2.) Clarify that telehomecare qualifies as a covered service and permit visit equivalency under the Medicare home health and hospice benefits (including under MA); 3.) Authorize the home as an originating site for telehealth services by physicians under section §1834(m)(3)(C) and provide greater flexibility for the use of RPM services; 4.) Ensure that all health care providers, including HHAs and hospices (especially those in rural areas with limited availability of health care/clinical providers), have access to appropriate bandwidth so that they may take full advantage of technology appropriate for the care of homebound patients; 5.) Hold cellular carriers accountable to incentives provided by states to expand broadband to rural regions; 6.) Direct CMS' Centers for Medicare & Medicaid Innovation (CMMI) to study the impact that early adoption of technology has had on access to care and reductions in overall health care costs, as well as to develop demonstration projects that identify the impact that coverage of various technologies can have on care utilization by patients who would otherwise be high utilizers of care; 7.) Direct CMS to collect information on technology-based visits on hospice claims; and 8.) Create a payment structure for the coverage of RPM within the home health benefit in addition to the standard PDGM payment. Registered nurses would be responsible for the oversight of the benefit consistent with similar responsibilities in hospitals and other institutional settings.

RATIONALE: Absent the initiation of technology-related flexibilities during the COVID-19 PHE, scores of home health and hospice patients would have been denied vital home care

services. These flexibilities dramatically increased awareness of the appropriateness of using telecommunications technologies to deliver services to patients under home health and hospice. 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. More specifically, the use of telehealth technologies in both urban and rural areas would help defray additional transportation cost and travel time and also improve the utilization of scarce nurses and therapists. With telehomecare a single clinician is able to care/case manage a larger number of patients than under the traditional in-person visit model. Given the growing financial constraints on agencies -- especially in rural settings -- 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, and emerging technologies.

Telehomecare technologies loom even more critical in light of the findings of research related to the increasing shortage of RNs. Researchers project that one million RNs will retire by 2020: a departure of a large cohort of experienced and seasoned RNs. The number of nurses leaving the work force each year has grown steadily from 40,000 in 2010 to nearly 80,000 by 2020. High nurse retirement and turnover rates will continue to affect access to health care. One study found that, on average, RNs change jobs every six months. Telehomecare technologies can make every RN more efficient and effective in providing high quality care to a larger number of patients. Relative to RPM, many home health agencies provide RPM despite the lack of coverage for it under the home health benefit. These agencies cite improved patient care and patient satisfaction as justification for footing the expense for the technology and staff hours necessary. RPM also poses the benefit of positioning home health agencies for quicker interventions should the need arise, avoiding costly and unnecessary hospitalizations.

Studies have repeatedly demonstrated the efficacy of RPM in reducing avoidable hospitalization while providing clear guidance relative to resource utilization and triaging by acuity within notable staffing shortages. Additionally, [RPM reduces readmissions for patients with COVID-19](#) and provides scalable capabilities for providers to monitor patients within their home environment. Home health-specific studies have long revealed the cost savings to the Medicare program through reductions in acute and emergent care when RPM was integrated into the home health plan of care. A Centura study reinforced this finding: “Results from the program show that 30-day rehospitalizations related to congestive heart failure, chronic obstructive pulmonary failure, and diabetes were reduced by 62 percent, and rehospitalization rates for patients receiving telehealth home care (6.3 percent) were significantly lower than those for traditional home care patients (18 percent). Emergency department use decreased from 283 visits in the year preceding the study to 21 visits during the year-long study.”

INCENTIVIZE HOME HEALTH AND HOSPICE INTEROPERABILITY AND ESTABLISH STANDARDS TO FACILITATE DATA EXCHANGE WITH HOSPITALS, PHYSICIANS AND OTHER PROVIDER TYPES

ISSUE: Home health agencies (HHAs) and hospices operate in increasingly complex regulatory environments that demand the use of sophisticated technological solutions to manage patient care, report claims data, track quality metrics, and coordinate care with other providers. The Medicare home health prospective payment system and changes to hospice requirements, including revisions to the payment system and reporting of additional data on claims, have required a wholesale revision in agencies' billing, documentation, data collection and data utilization. With a more recent focus on the collection and measurement of the quality of care, and a broader shift towards value-based care models that require seamless data sharing across provider types, advancements in technology coupled with the challenges of collecting data and maintaining up-to-date systems will increase the responsibilities of HHAs and hospices to respond to data management trends.

While a vast majority of HHAs and hospices currently use electronic fiscal billing software systems, the transition to adopt more dynamic electronic health record (EHR) systems has been challenging and administratively costly. The purchase and maintenance of multi-purpose clinically and financially integrated systems requires a significant capital investment. Without federal incentives, HHAs and hospices have had to justify their business decisions to utilize EHRs, Point of Care (POC) technologies, and other vertically integrated technology solutions by achieving improved efficiencies. HHAs and hospices that invest in health IT have also reported improvements in their ability to capture patient information at the point of care, send and retrieve health information, improve care coordination, improve the quality and safety of care and make more responsive clinical decisions. Robust IT and data-sharing capabilities have been especially important during the COVID-19 public health emergency response, with better-connected HHAs and hospices able to more quickly and easily gather, analyze, and transmit important health information, including infection and/or vaccination status.

Over the past decade, advances in the adoption and use of health IT in health care have correlated with the federal government's prioritizing the use of certified EHR systems by hospital and physicians through the CMS Medicare and Medicaid EHR Incentive programs. While the vast majority of hospitals and office-based physicians use EHRs, the interoperable exchange of health information remains a problem for providers across the continuum of care, and especially for providers such as HHAs and hospice that lack data standards that would allow their EHR systems to easily connect and share information with the systems of other health care organizations. In many cases, the delivery of quality home care, including home health and hospice services, relies on the collaboration and exchange of health information across the continuum of care with physician practices, hospitals, and long-term post-acute care (LTPAC) providers such as skilled nursing facilities and rehabilitation hospitals. It is critical that standards

be developed that will govern and facilitate interoperable data sharing between home-based care providers and other types of health care entities, especially physician practices and hospitals, who often possess important patient information that can and should inform any home-based care plan. Especially if HHAs and hospices are expected to participate more fully in the shift towards value-based care models that require interoperable care coordination across providers, there must be a formalized set of standards that put them on a level data-sharing playing field. Therefore, we believe it is imperative that policymakers consider home health care agencies and hospice providers as vital partners in the overarching pursuit of interoperable health information exchange across the continuum of care. The interoperable exchange of health information, including with and from home health agencies and hospice providers, is a necessary goal to achieve the overarching goal of person-centric longitudinal coordination of care.

Congress has attempted to address the lack of interoperable exchange of health information in laws targeted at physicians and federal partners to develop health IT standards and solutions to promote health information exchange. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. No. 114–10, Section 106(b)(1)(C)), Congress declared it a national objective to achieve widespread exchange of health information through interoperable certified electronic health record (EHR) technology nationwide by December 31, 2018. The 21st Century Cures Act (Cures Act), (P.L. No. 114-255) signed into law in December 2016, calls on the Office of the National Coordinator (ONC) to work with federal partners, including the National Institute of Standards and Technology (NIST), and the healthcare and health information technology (health IT) industries to provide interoperability for all. The Secretary of Health and Human Services (HHS) through the Office of the National Coordinator for Health Information Technology (ONC) has initiated next generation EHR certification programs – such as the “2015 Edition” modular certification – that support patient care, patient participation in care delivery, and electronic exchange of interoperable health information. While these include some criteria for long term care and post-acute providers, they do not fully address the full array of data and other informational elements that are relevant to the specific care setting.

Most recently, in early 2022, the ONC finalized the establishment of the Trusted Exchange Framework and Common Agreement (TEFCA) that would enable Health Information Networks (HINs) that operate locally, regionally, or nationally to exchange health information. While development of these standards and structures are essential first steps in achieving meaningful exchange of vital health information, the full promise of interoperability will remain elusive until and unless providers across the continuum are able to secure and share information that reflects the unique role that they play in patient care. To achieve this goal, we must ensure that certification standards clearly define and adequately support the information exchange needs of community-based providers.

RECOMMENDATION: Congress and the Administration must extend their efforts to encourage the interoperable exchange of health information to all sectors of providers – including HHAs and hospices – and take the following additional actions:

- 1) Since widespread adoption and use of certified EHRs by HHAs and hospices remains unfulfilled, HHS and Congress should consider providing financial assistance to HHAs and hospices to encourage the adoption of certified EHRs, especially for providers that have limited capital for investments in technology solutions. This monetary support could include incentives such as small business loans, tax incentives, and grants from

- the Medicare and Medicaid programs;
- 2) Congress should fully fund the Office of the National Coordinator for Health Information Technology (ONC) to support public and private efforts to develop interoperability data standards that will enable HHAs and hospices to seamlessly and efficiently exchange information with provider types across the continuum of care, with a priority focus on physician practices and hospitals; and
 - 3) Congress should require that ONC review and revise existing Health IT Certification Criteria to fully address health information exchange needs of home care and hospice providers and develop a plan for applying the revised standards for certification eligibility to products serving these settings. The plan could include a phased-in approach that prioritizes the incorporation of the required information elements over time.

RATIONALE: In order for HHAs and hospices to participate in nationwide interoperable health information exchange, these smaller providers require financial assistance to adopt and use next generation EHR systems as well as maintain memberships in newly formed health information networks. HHAs and hospices need to be able to meet the demands to improve quality of care standards with the use of vertically integrated EHR systems and supportive technologies. These next generation systems will also enable HHAs and hospices to exchange health information with physicians, hospitals, other provider, patients and caregivers and play a more central role in Medicare and new care delivery models.

ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR CENTER- BASED CARE FOR TECHNOLOGY-DEPENDENT CHILDREN

ISSUE: Technology-dependent children, those who rely on medical equipment such as mechanical ventilation or feeding tubes for daily care at home, are among the sickest and most vulnerable subset of children with complex chronic conditions. An estimated 600,000 children in the United States are technology dependent and live at home, and are cared for primarily by their parents. Medicaid waiver programs that provide funds for providing home and community-based services for technology-dependent children have not been sufficient to meet the demand for the delivery of care in non-institutional health care settings. The 2176 waiver program, often called the Katie Beckett Waiver program that gained popularity in the 1980s, enables severely disabled children to be cared for at home and receive ongoing long-term care that is financed by Medicaid. However, even with the addition of Medicaid waiver services to provide home health and personal care benefits at home, additional resources are required to provide families means to care for technology-dependent children.

At the same time, center-based care for technology-dependent children has developed in the United States as a means to provide relief to family caregivers; an opportunity for the technology-dependent child to avoid “institutionalization” at home; and as a means of meeting the medical and rehabilitative needs of the child. Center-based care provides a supplement to direct family services, allowing caregiving of technologically dependent children to receive care in a community-based location while still residing in their own home. However, Medicaid does not cover center-based care consistently across the nation.

RECOMMENDATION: Congress should pass legislation requiring mandatory Medicaid coverage of center-based care for technology-dependent children at day care centers. Medicaid administrators should also recognize the health and economic advantages of serving technology-dependent children in center-based care programs. In addition, more trained caregivers, better coordination of services, and improvements in the design of home-medical devices would all help to improve the lives of families with technology dependent children.

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

COVER APPROPRIATE HEALTH ASSESSMENT TECHNOLOGIES UNDER MEDICARE

ISSUE: Computer and smartphone-based health assessment applications (mHealth)—tools used by consumers and their nonprofessional caregivers to manage health issues either outside of formal medical settings or in collaboration with their health care providers—allow the disabled and infirm to gain increased access to health care professionals and self-care management techniques while coping with acute and chronic illnesses. Individuals with diabetes, hypertension, COPD, and other chronic illnesses are their own primary care managers, at no cost to the health care system except when self-monitoring falls short of its capabilities. Health applications that combine high-quality information with interactive components for self-assessment, decision support, or behavior change have the potential to reduce cost while maintaining the same or achieving better quality of care. Providing patients and their caregivers easy access to health assessment technologies that make them less dependent on the health care system could reduce health care costs dramatically. The development of more dynamic health assessment applications that provide continuous personal health monitoring and individualized feedback should improve quality of life for people with chronic health conditions and support their care in the community. Currently, Personal Health Records (PHRs) and cloud-based monitoring technologies have interactive components, such as an “ask the doctor service” (via secure email consultation), wearable technologies for fitness, aging-in-place technologies, real-time monitoring, self-tests, online forms, and mobile health applications are evolving rapidly.

Through the use of mHealth and new technologies driven by artificial intelligence, individuals are able to better self-monitor and obtain necessary insights as to when to contact professional health care providers. However, these technologies are not covered under the Medicare benefit since it does not neatly fit within the benefit structure as “durable medical equipment” or otherwise.

RECOMMENDATION: Congress should consider solutions that provide Medicare coverage for medically-appropriate mHealth technologies and support the availability and development of health assessment applications for use in the home. Congress should also consider the value of self-reported health information and consider funding studies to measure its impact on improving the quality of care, patient satisfaction and increasing patient self-care.

RATIONALE: mHealth monitoring technologies can engage consumers to make better health care decisions, serve as a supplementary educational resource and help to prevent acute exacerbations of an individual’s condition, thereby preventing or delaying costlier health care measures.

**IV. ENSURE APPROPRIATE PAYMENT POLICY AND
REGULATION OF HOME CARE AND HOSPICE WHILE
EASING THE PAPERWORK BURDEN AND DUPLICATIVE
STATE AND FEDERAL REQUIREMENTS**

A. MEDICARE COVERAGE, ACCESS AND ELIGIBILITY

ESTABLISH AN EQUITABLE HOME INFUSION THERAPY BENEFIT

BACKGROUND: The 21st Century Cures Act (Act) included a provision that called for the development of new home infusion therapy benefit under Medicare Part B. The benefit would provide professional services for beneficiaries receiving home infusion therapy through a pump that is an item of Durable Medical equipment (DME). Medicare covers certain infusion drugs under Part B when the drug requires infusion by a pump. These drugs include chemotherapy, inotropic medications, certain pain medications, immunoglobulin therapy, and anti-fungal medications.

The Act defines a qualified home infusion therapy supplier as a pharmacy, physician, or other provider licensed by the state where services are provided. Home health care and hospice providers are eligible to be accredited as home infusion therapy suppliers.

The new benefit includes the professional service, such as nursing services, under a physician established plan of care that is periodically reviewed; training and education on infusion therapy, medications, disease management, and care of vascular access sites; remote monitoring; and 24/7 availability by the supplier. CMS would permit remote monitoring to be follow-up telephone calls or on-site visits. CMS proposes payment for home infusion therapy to be a single payment for the day the nurse is in the home and the drug is infused.

Full implementation of the home infusion therapy benefit will begin in 2021, once the benefit becomes a permanent program; beneficiaries will not be able to receive Part B home infusion therapy services under the home health benefit. Beneficiaries will only be able to receive the services through a home infusion therapy supplier.

The 2018 Bipartisan Budget Act (BiBA) included a provision that provides payment for home infusion therapy services, under the new benefit, during a transitional period (2019-2020) to select providers. Only licensed pharmacies enrolled as a DME supplier will be eligible to offer the benefit to beneficiaries during the transitional period.

In the final rule for the 2019 Home Health Proposed Payment System rate update rule, CMS indicated, in a response to comments, that home health agencies (HHAs) would not be permitted to provide infusion therapy for Part B drugs beginning January 1, 2019, when the transitional period begins: “Home infusion therapy is excluded from the Medicare home health benefit, and separately payable, beginning January 1, 2019.”

CMS ultimately agreed to permit HHAs to provide the professional services associated with Part B infusion drugs during 2019 and 2020 transitional period. However, since certain pharmacies are also eligible to provide the professional services, HHAs will need to coordinate services with home infusion suppliers.

RECOMMENDATIONS: Congress should work with CMS, the home health industry, and the home infusion industry to establish a more equitable home infusion benefit that takes into account the concerns of all stakeholders.

RATIONALE: NAHC has serious concerns with CMS' proposal since it fails to recognize how home infusion therapy is currently provided to eligible beneficiaries under the home health benefit.

Currently, a beneficiary may receive home infusion therapy by combining the DME benefit for the pump, supplies and covered infusion drug with the skilled professional services covered under the home health benefit. The DME supplier bills Part B DME for the supplies, pump and infusion drugs, while the HHA bills Medicare for the professional services under the home health benefit.

If the home infusion therapy benefit is implemented as proposed, HHAs will not be able to bill for the professional services associated with the new benefit for home infusion therapy under the home health benefit, rather, this service will need to be provided and billed by a home infusion therapy supplier under Medicare Part B, whether or not the home infusion therapy supplier is also the Medicare certified HHA. This benefit structure disadvantages beneficiaries in terms of cost to the beneficiary, restricting entitled benefits, and fragmenting care.

Eligible beneficiaries are able to receive the professional services associated with infusion therapy under the home health benefit without incurring out of pocket costs. The new Part B home infusion therapy benefit will require 20 % beneficiary co-pay for the professional services that are otherwise covered in full under the home health benefit.

Additionally, some beneficiaries could see limitations in eligibility for home health services. For example, if a beneficiary is otherwise eligible for home health services and the only needed skilled service is nursing for infusion therapy, but also needs a dependent home health service(s)(occupational therapy, home care aide, social worker), the beneficiary will be precluded from receiving the other support services under the home health benefit. The qualifying service for Medicare home health services will be shifted to the home infusion therapy supplier. The home infusion therapy supplier will not be eligible to provide the support services nor will the beneficiary be eligible to receive the services under the home health benefit. Therefore, the beneficiary will be forced to go without the needed support services or pay for the care privately.

Furthermore, the proposal for the home infusion therapy benefit and the home health benefit to run concurrently could require two distinct service providers in the home under separate plans of care during the same spell of illness. For example, a beneficiary that requires skilled nursing for wound care and infusion services could potentially be required to receive skilled nursing for the wound care from the home health agency and receive skilled nursing for the infusion from the home infusion therapy supplier. This fragmentation of care poses a clear risk to the quality of care provided to the beneficiary. Additionally, the burden of coordinating care to assure beneficiary safety will be the responsibility of the home health agency since home health agencies are required to coordinate all care provided to patients under the HHCoPs.

PRESERVE THE PUBLIC NATURE OF THE MEDICARE PROGRAM

ISSUE: The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (P.L. 108-173) intensified the trend of recent years to encourage greater participation by Medicare beneficiaries in private insurance plans. Many members of Congress have considered proposals that reduce federal responsibilities and further encourage private plan participation. During the 112th and 113th Congresses, efforts were made to transition Medicare from a public insurance program to a premium support model or “voucher” program where beneficiaries receive capped assistance to use towards a private insurance plan of their choice. Other proposals to reform Medicare include creating a Medicare exchange comprised of approved private insurance plans and the traditional Medicare plan serving as choices beneficiaries may select from. Beneficiaries would then receive “premium support” determined by income levels to use towards the exchange plan of their choice.

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

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

Defined Benefits

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

Coverage

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

Affordability

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

Program Administration

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

Quality Assurance

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

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

ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES

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

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

Recent data indicates that Medicare margins for home health agencies are quickly declining as the numerous years of rate cuts take their toll. In addition, new regulatory-driven costs are being incurred by home health agencies with more expected in future years.

On November 23, 2013, The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule that sets Medicare home health payment rates based on a formula that ostensibly relates to the average cost of care. With this approach, CMS reduces base episode payment rates by the full 14% allowed under PPACA through a 4-year phase in of the rate changes. In addition, CMS limits the increases in per visit payment rates to 3.5% despite a finding that average costs of these visits is as much as 133% of the rates. 78 Fed. Reg. 72256 (December 2, 2013).

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

Legislation was introduced in the 113th Congress to address the concerns with rate rebasing. The Medicare Home Health Rebasing Relief and Reassessment Act, HR 4625, would suspend the rebasing rule for 12 months and require that CMS reassess the rule and submit a report to Congress on alternative rebasing methods, including methods offered by stakeholders. The SAVE Medicare Home Health Act of 2014, HR 5110, proposed repeal of the 2015-2017 Medicare home health rebasing payment cuts, but would have offset the cost of repeal by requiring an equivalent level of home health payment cuts in 2019-2024 and establish home health value-based purchasing program in 2019 that would put 17-28% of a home health agency’s Medicare payments at risk. These bills were not reintroduced in the 114th Congress, and have not yet been introduced in the 115th.

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

zero percent. Further, MedPAC seeks rate rebasing that reduces rates to a zero percent average margin. Such a rebasing result would further diminish access to care throughout the United States.

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

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

MAKE PERMANENT THE ADD-ON FOR SERVICES TO RURAL PATIENTS; ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS

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

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

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

The health reform legislation passed in 2010, the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148), reinstated a 3 percent differential payment for home health services delivered to residents of rural areas. Under the legislation the “add-on” payment became effective for visits ending on or after April 1, 2010, and before January 1, 2016. The rural add-on was extended to the end of 2017 in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R.2/Pub Law No: 114-10). The Preserve Access to Rural Home Health Services Act (S. 353) would extend the rural add-on to the end of 2022. Congress did not take action to extend the rural add-on before it expired at the end of 2017.

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act (BBA) of 2018 (P.L. 115-123). This law included the extension of the rural add-on, but will also work to

phase out its existence over a five year timeline while simultaneously targeting its provision to certain geographic areas. Under this new law, all services provided in rural areas will continue to receive the three percent add-on for calendar year 2018. Starting in 2019, the add-on will be applied in three different groups. In the first, services provided in frontier areas (defined as six persons or fewer per square mile) will see an increase to four percent for 2019, followed by three percent in 2020, two percent in 2021, and one percent in 2022. Providers that fall into the highest 25 percent of counties nationwide based on home health utilization per 100 Medicare beneficiaries would be reimbursed one and a half percent for 2019, and one half percent for 2020. For all other eligible claims that do not fit into the prior two categories, providers will receive three percent in 2019, two percent in 2020, and one percent in 2021. The Consolidated Appropriations Act, 2023 (P.L. 117-328) provided a one-year extension of the 1% add-on for services provided in frontier areas.

Additionally, the BBA called for a study to be performed by the Office of the Inspector General within the Department of Health and Human Services to analyze home health claims and home health utilization by county, and for recommendations by the Inspector General based upon the analysis.

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

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

OPPOSE IMPOSITION OF COPAYMENTS TO ACCESS MEDICARE HOME HEALTH SERVICES

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

The National Commission on Fiscal Responsibility and Reform (2010) (the “Bowles-Simpson plan”) recommended a uniform 20 percent copay for all Medicare services, including home health care. This would amount to a \$600 copay to access an episode of home health care. The Congressional Budget Office (CBO) put forth a 10 percent home health copay (\$300 per episode) as one of its budget options for deficit reduction, a proposal that received support from the Republican Study Committee. The Medicare Payment Advisory Commission (MedPAC) recommended a home health copay (as much as \$150 per episode) for episodes not preceded by a hospital or nursing home stay. From 2011 - 2017, the President’s budget proposals have included a \$100 home health copay for episodes not preceded by a hospital or nursing home stay, beginning in 2019 for newly eligible Medicare beneficiaries.

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

RATIONALE: Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall. The Urban Institute’s Health Policy Center found that home health copays “...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays.”^{xii} Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.^{xiii} The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copayment. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, “may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long term.”^{xiv} According

^{xi} Congressional Record, October 5, 1972, p. 33939.

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

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

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

to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years.^{xv}

- Copayments are an inefficient and regressive “sick tax” that would fall most heavily on the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries. About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.^{xvi} Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.^{xvii} The Commonwealth Fund cautioned that “cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs.”^{xviii}
- **Most people with Medicare cannot afford to pay more.** In 2013, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes below \$23,500.^{xix} On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.^{xx}
- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (\$11,412 for singles, \$15,372 for couples) and non-housing assets below just \$6,940 for singles and \$10,410 for couples. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.^{xxi}
- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and skilled nursing facility care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated \$470 billion a year in unpaid care to their loved ones, and too frequently having to cut their work hours or quit their jobs.^{xxii}
- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary,

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

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

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

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

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

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

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

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

that beneficiaries are homebound and meet other stringent standards. There is scant evidence of overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.^{xxiii}

- **Home health copayments would shift costs on to states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.
- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 23 percent of Medicare beneficiaries have Medigap coverage. For the 26 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.^{xxiv} The 30 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.^{xxv}
- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill.

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

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

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

ANY RESTRUCTURING OF MEDICARE COST SHARING SHOULD NOT CREATE BARRIERS TO ACCESS HOME HEALTH 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 then-Speaker of the House Paul Ryan in 2016 would have instituted 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. Congress should reject any legislative proposals that establish limits on Medigap insurance. Medicare beneficiaries should be able to purchase supplemental insurance to cover co-pays and deductibles without any limitation.

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 must incorporate consideration of this fact. Medigap insurance should not be restricted as beneficiaries should have the right to protect themselves against the cost of health care.

ENACT A HOMEBOUND DEFINITION THAT ENSURES ACCESS AND ELIGIBILITY FOR NEEDED HOME HEALTH SERVICES

ISSUE: Under existing Medicare policy an individual receiving home health care services must be “homebound.” Homebound is defined as having “a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices...or the assistance of another person.” According to the longstanding Medicare policy, if a person leaves their home, “absences must be infrequent or for periods of relatively short duration,” unless for medical purposes. Congress and the Administration have expressed an interest in redefining the eligibility criteria needed to be considered homebound under the Medicare home health benefit. Congress rejected this proposal. Instead, under the Balanced Budget Act of 1997, the Secretary of Health and Human Services was required to study the criteria for determining an individual’s homebound status. The study, in essence, recommended no changes to the current definition of homebound.

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

Section 702 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) required the Secretary of Health and Human Services to conduct a two-year demonstration project where beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. The Secretary was required to select three states – one state in each of the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. The states chosen were Massachusetts, Missouri, and Colorado.

After completion of the demonstration, the Secretary reported that participation in the program was very low because of the agencies’ fear of losing money on costlier patients; agency difficulties enrolling Medicaid-eligible beneficiaries who did not wish to switch services; agency estimates that they would be paid less for care under the Medicare benefit; agencies’ concerns that potential enrollees would not benefit from the program; and unduly restrictive eligibility requirements. The demonstration failed to produce sufficient data to make recommendations regarding changes to the homebound definition. In 2013 the Long Term Care Commission recommended eliminating the homebound restriction.

Included in the Home Health Payment Innovation Act of 2018 (S. 3545) was a provision allowing for the waiver of the homebound requirement in the Medicare program in Medicare Shared Savings programs or Medicare Advantage plans. This bill was referred to the Senate Finance Committee but did not receive further consideration. This bill was reintroduced in 2019, in the 116th congress as S. 433/H.R. 2573 under the same title.

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

additional administrative burdens on home care providers beyond documentation of the beneficiary's functional and clinical status.

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

ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR THOSE RECEIVING ADULT DAY CARE

ISSUE: Home care, along with other health care services, has evolved in response to technological and economic changes. With these advances has come the opportunity for deinstitutionalization of many patients who would otherwise require hospital or nursing home care. At the same time, adult day care has developed in this country as a means to provide respite to family caregivers, an opportunity for the elderly patient to avoid “institutionalization” at home, and as a means of meeting social and health-related needs of the patient.

During 2000, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the 106th Congress provided clarification of the homebound definition under the Medicare home health benefit. This clarification allows Medicare home health patients regular absences from the home for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program. An evaluation of this amendment and its effect on the cost and access to Medicare home health services was conducted by the General Accounting Office (GAO), which found that the recent changes to the homebound definition will have “little effect on costs and access” to home health services (“Medicare Home Health: Clarifying the Homebound Definition is Likely to Have Little Effect on Costs and Access,” GAO-01-555R, 4/26/2002).

Section 703 of the Medicare Prescription Drug, Improvement, and Modernization Act (H.R.1; Public Law 108-173), passed by Congress in 2003, required the Secretary of HHS to establish a three-year demonstration project in not more than five states, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary’s home. The agencies chosen to participate are Aurora Visiting Nurse Association, Milwaukee, Wisconsin; Doctor’s Care Home Health, McAllen, Texas; Landmark Home Health Care Services, Allison Park, Pennsylvania; Metropolitan Jewish Health System, Brooklyn, New York; and Neighborly Care Network, St. Petersburg, Florida.

Phase I included case studies to assess the implementation, interviews with beneficiaries and home health agencies, and an analysis of beneficiary characteristics and services provided by selected demonstration sites to enrolled beneficiaries. Phase II, which ran through September 2009, focused on selection and matching of control patients and an analysis of the use and cost of home health services among both demonstration site beneficiaries and the control patients. An evaluation and report on the demonstration project by CMS failed to show savings or improvements in quality of care, but did show high rates of satisfaction among beneficiaries participating in the demonstration project.

Legislation, the Medicare Adult Day Care Services Act, was introduced in the 109th, 111th, 112th, 113th, 114th, and 115th Congresses which would permit Medicare home health services to be provided at adult day centers if the center becomes Medicare- certified. Most recently it was introduced in the 116th Congress as H.R. 4063.

RECOMMENDATION: Congress should pass legislation amending the Medicare home health services benefit to allow for coverage of “home health services” provided to “homebound” patients at adult day centers. Reimbursement for services provided at adult day centers should be set at levels sufficient to achieve access. Congress should require that adult day centers offering home

health services meet national standards established by Medicare for adult day facilities. In cases where these centers provide home health services, they should be required to meet the Medicare home health Conditions of Participation and be a Medicare-certified home health agency. Medicare payments for home health services should be disbursed to certified home health agencies, not to adult day facilities. Home health agencies should be allowed to provide adult day facility services either by being certified providers of licensed medical adult day facility services or under arrangement with a licensed certified medical adult day facility.

RATIONALE: The Medicare program could better serve the interests of beneficiaries by allowing coverage of home health services provided by home health agencies at adult day centers. This would enable patients to socialize outside the home, which would improve their mental health.

MAKE SOCIAL WORK SERVICES QUALIFYING SERVICES FOR MEDICARE HOME HEALTH

ISSUE: The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) eliminated occupational therapy as a basis for initial entitlement to home health benefits (although physical or speech therapy alone continue as a basis for entitlement). Once eligible for home health services, patients may, however, continue to receive occupational therapy even if other skilled services are no longer required. Additionally, medical social work services can only be provided after the opening of a case by a qualifying service and must be terminated prior to the closing of the qualifying service. This results in fractured services to patients due to social work's delayed entrance into a case and premature or unplanned termination.

RECOMMENDATION: Congress should allow medical social services to be deemed as a qualifying service for purposes of establishing home health eligibility.

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

A small number of Medicare patients need only medical social work and no other skilled service.

Medical social work can prevent institutionalization by decreasing the social and economic problems that have a negative impact on a patient's response to treatment and increase the patient's ability to remain at home. Medical social work can also reduce the number of visits for other home care services by strengthening the family and other support systems. In addition, medical social work services can mitigate crises that otherwise lead to rehospitalization through long-term planning and crisis management.

B. MEDICARE PAYMENT METHODOLOGY

END APPLICATION OF MEDICARE SEQUESTRATION

ISSUE: As part of the Budget Control Act of 2011, Congress called for mandatory, across the board spending cuts at the federal level. For Medicare, this meant a 2% reduction in provider reimbursements beginning in April 2013 and ending in Fiscal Year 2021. In the time since the expiration was pushed back to 2023 by the Bipartisan Budget Act of 2023, then to 2025 by the Bipartisan Budget Act of 2015, then 2027 by the Bipartisan Budget Act of 2018, and then to 2029 through the Bipartisan Budget Act of 2019, and finally to 2031 by the *Protecting Medicare and American Farmers from Sequester Cuts Act*

With the onset of the COVID-19 pandemic the Congress elected to suspend Medicare sequestration from May 1, 2020 – December 31, 2020 as part of the CARES Act (P.L. 116-136) as a means of providing financial relief to Medicare providers as they encountered decreased patient volumes and increased expenses resulting from the coronavirus. However, to offset the expense of the suspension, Congress extended the expiration timeline to 2030. As part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), Congress continued the suspension of sequestration from December 31, 2020 – March 31, 2021. Congress further extended full sequestration relief until April, 2022, followed by a 1% relief from April 1, 2022 – June 30, 2022. as part of the *Protecting Medicare and American Farmers from Sequester Cuts Act*, passed at the end of 2021. The Consolidated Appropriations Act, 2023 (P.L. 117-328) extended through 2032.

RECOMMENDATION: Congress should act to end the practice of Medicare sequestration. From its origin it served as a penalty paid by health care providers for the Congress's inability to square the federal budget. Continuing to extend the termination date has proven to be a budgeting gimmick to use provider reimbursements to fund other aspects of the government.

RATIONALE: In recent years home health providers have faced several cuts to their reimbursement rates, including sequestration, rate rebasing, behavioral assumption-based rate cuts as included in the PDGM payment model, as well as potential reductions for providers in the nine value-based purchasing states. In addition, providers serving rural areas continue to see rural add-on percentages decrease on that programs march to obsolescence.

Similarly, hospice providers have withstood significant cuts, starting with market basket cuts and the productivity adjustment imposed by the Affordable Care Act beginning in 2010, the sequester, and dramatic increases in costly administrative obligations, including a significant expansion of data collected through the hospice cost report, burdensome requirements related to the Notice of Election timely filing requirements, and, most recently, the addition of the Election Statement Addendum requirements. The Addendum requirement was imposed in the midst of the COVID-19 pandemic, which has significantly added to implementation challenges. Finally, hospices are anticipating significant changes to the hospice survey process and imposition of new survey requirements as the result of enactment of the Consolidated Appropriations Act of 2021; these will further strain hospice capabilities.

These ever-present cuts continue to threaten business viability as many providers scrape by on minimal profit margins. Some already operate in the red. Suspension of sequestration during

the COVID-19 pandemic proved effective and beneficial in injecting financial resources to providers truly in need.

ENSURE THAT MEDICARE HOME HEALTH PAYMENT MODEL REVISIONS PROVIDE FAIR AND REASONABLE REIMBURSEMENT TO MAINTAIN ACCESS TO CARE

ISSUE: The Medicare home health benefit is an essential part of Medicare as it is the primary means by which beneficiaries can receive care in the location of their choice. As with other health care sectors, adequate reimbursement is essential for the providers of care to deliver high quality services. Since the inception of Medicare, the home health benefit payment, model has changed multiple times. On occasion, the changes were not well conceived nor well implemented leading to the closure of providers with consequential loss of service access for beneficiaries.

Until 2000, home health agencies (HHAs) were paid on a “reasonable cost” basis with payment determined using per visit cost limits related to each specific discipline of care. In October 2000, Medicare instituted the Home Health Prospective Payment System (HHPPS) that paid for services on the basis of a 60-day episode of care with a base rate that was adjusted under a case mix model reflecting various patient characteristics. The HHPPS model continued the further adjustment of payment rates based on the patient’s geographic location with annual inflation updates consistent with a Market Basket Index (MBI). The HHPPS model was modified on an incremental basis over the years with changes in the case mix adjuster, reduction in rates related to congressional mandated cuts to the MBI, the rebasing of the base payment rate and other modifications that affected payment levels.

In 2017, CMS proposed to replace HHPPS with the Home Health Groupings Model (HHGM). HHGM retained some of the basic structure of HHPPS, but would have fully replaced the case mix adjuster with a system that relied on different measures of patient characteristics. For example, HHGM eliminated the application of a Utilization Domain that increased payment based on the number of therapy visits in an episode. Further, it would have used a 30-day payment unit. CMS did not finalize its proposed HHGM.

The Bipartisan Budget Act (BBA) of 2018 mandated that Medicare establish and implement budget neutral payment model reforms in the home health benefit beginning 2019. The reforms must include a “30-day unit of service” using a case mix adjustment model that does not rely on the volume of therapy services to determine the payment amount and based on a model designed with stakeholder inputs including a Technical Expert Panel (TEP) that fully evaluates and advises on the options available. The BBA also set the MBI for 2020 at 1.5%. While the BBA included elements that help maintain access to home health services, there are adjustments that need to be made to fully preserve care access.

For CMS’s 2019 HHPPS update they included an overhaul of the model similar to the HHGM model, but rebranded as the Patient-Driven Groupings Model (PDGM). In accounting for the budget neutrality requirements from the BBA, CMS called for a reduction in base payment rates on the basis of assumptions of provider behavior in response to the new PDGM model. These assumptions equated to upcoding, documenting additional diagnoses, and a decrease in Low-Utilization Payment Adjustments with a simultaneous increase in full episodic payments. In the proposed rule these assumptions totaled up to a 6.42% cut. The final rule maintained the same assumptions but did not equate to a specific percentage.

As a remedy to these assumptions, legislation, S. 3458/H.R. 6932, was introduced in both chambers of Congress eliminating CMS’s ability to make assumptions in determining reimbursement rates. In place of assumptions, CMS would be required to utilize “observed

evidence” as the standard for altering rates. A second bill, the Home Health Payment Innovation Act (S. 3545), was introduced in the Senate as well. In addition to the elimination of assumption-based changes in favor of an observed evidence standard, the legislation also provided the opportunity for the waiver of the Medicare homebound requirement for Medicare Shared Savings Programs, such as Accountable Care Organizations, and Medicare Advantage plans. Introduced late in the 115th Congress, these bills did not receive consideration in either chamber. In the 116th Congress the legislation was introduced as S. 433/H.R. 2573.

In the 2020 rule making process, CMS proposed increasing the behavior assumption-based cut from the previous year’s 6.42% to 8.01%. In their final rule, following intense advocacy efforts led by NAHC, CMS finalized the cut at 4.36%. CMS rationalized the reduced cut to the base payment rate by citing and agreeing with public comments questioning the frequency of behavior changes in the first year of PDGM. During CY 2021 rule making, CMS proposed and finalized continuation of the 4.36% behavioral assumption rate cut despite NAHC’s continued pleas to not do so. In CY2022 rulemaking CMS stated, “CY 2020 30-day base payment rate was approximately 6 percent higher than it should have been, and would require temporary retrospective adjustments for CY 2020 and subsequent years until a permanent prospective adjustment could be implemented in future rulemaking.”

In addition to concerns about assumption-based rate reductions, there are potential unintended consequences that could result from the PDGM model. In particular, there are concerns of patient access to care being adversely impacted. With the elimination of therapy utilization as a payment determinant, as required by the BBA, there are concerns that the Medicare Home Health benefit may not be fully realized as intended. While it was advisable to remove a utilization domain from reimbursement calculations that was ripe for both under and over utilization, the methodology for replacement creates unease for how therapy may be utilized in the new PDGM model. This will need to be closely monitored to ensure that beneficiaries are receiving the benefit to its full extent.

For CY2023 rulemaking CMS finalized a negative 6.85% budget neutrality adjustment (authorized in BBA 2018), phasing it in over a two-year period of 3.925% increments citing potential provider instability if the full cut was effectuated in 2023. Further, CMS called for temporary cuts totaling \$2 billion in overpayments from 2020 and 2021. Legislation, the Preserving Access to Home Health Act (S. 4605/H.R. 8581), was introduced in the 117th Congress seeking to delay the budget neutrality cuts temporarily freezing payment rates while also calling for added transparency by CMS in their rulemaking.

RECOMMENDATION: Congress should amend the BBA as follows:

- Clarify the budget neutrality requirement to permit rate adjustments only after there is evidenced based establishment of actual utilization behavior changes that do not reflect changes in the nature of patients served
 - Remove CMS authority to reduce payment rates based on assumptions of provider behavior.
 - Tighten requirements that provide for transparency in the CMS regulatory process
- In addition, Congress should mandate that CMS adhere to the following principles in constructing any new payment model:
1. The transition to any new payment model must be fully budget-neutral in relation to the existing payment model.

2. Any new model should not include system changes that incentivize or encourage behavioral changes that are counter to the provision of necessary and timely care.
3. Payment models should provide reasonable and sufficient reimbursement such that the entire scope of the home health benefit is covered.
4. Payment amounts should be based on patient characteristics and clinical needs, not the level of service utilization in order to avoid improper financial incentives to provide unnecessary care.
5. The payment model should operate consistently with other aspects in service delivery.
6. All stakeholders should be given sufficient time to implement any changes in operations that are needed with a new payment system to avoid unintended consequences that could affect patients and service continuity.
7. Significant changes in payment models should be fully tested and validated through such means as a demonstration program prior full application.

RATIONALE: Payment models affect provider behavior. Improper incentives or disincentives in a payment model will lead to an improper outcome in services. Inadequate payment will result in inadequate services. A payment model that does not reflect the full scope of the home health benefit will leave portions of the Medicare patient population disenfranchised from home health services. A careful and deliberative construction of a payment model is essential. That comes about through the benefit of inclusiveness in the construct deliberations, not by excluding stakeholders.

REFINE MEDICARE HOME HEALTH PPS OUTLIER PAYMENT

ISSUE: The Balanced Budget Act of 1997 (BBA) required implementation of a home health prospective payment system (PPS), including designation of 5 percent of anticipated expenditures for “outlier” patients – those patients whose care is particularly costly to agencies. In implementing this mandate, the Centers for Medicare & Medicaid Services (CMS) created an outlier payment methodology that includes shared losses with the provider of services through the use of an eligibility threshold and percentage payment on costs above that eligibility threshold. CMS could alter the “fixed dollar loss ratio (FDL)” for any future year based on the level of spending for outlier payments in the previous year to keep overall outlier spending in check. If spending for outlier cases was high in a given year, CMS could increase the FDL ratio so that fewer outlier payments would be issued in the following year.

In the first few years of PPS, only a portion of the outlier budget (between 2 and 3 percent) was actually spent. At the same time, there was strong evidence that certain long term and high-cost home health patients were no longer being served in the home care setting, but instead were receiving care in skilled nursing facilities.

Subsequently, overall outlier spending increased significantly, due primarily to anomalous claim practices in the Miami-Dade, Florida area, where outlier spending jumped to over \$300 million in 2005. In the rest of the nation, outlier spending totaled approximately \$350 million overall in the same year. This anomaly was ignored initially by CMS, despite its awareness of the matter and the instigation of enforcement activities to put a stop to abusive outlier claims.

As part of health reform legislation approved in 2009, the House of Representatives included a series of swift, deep, across-the-board cuts to home health; if enacted, these cuts would have threatened the financial viability of numerous home health agencies throughout the nation and, in turn, access to vital services for elderly and infirm Medicare beneficiaries. As an alternative to these deep cuts, the home health industry recommended that Congress address outlier abuses through reduction of the overall annual home health outlier budget to 2.5 percent of program outlays and imposition of an agency-specific outlier limit of 10 percent of Medicare payments. The industry proposal was included in the final health reform legislation approved by the Senate and ultimately signed into law (Public Law 111-148) by President Obama on March 23, 2010. The outlier provisions became effective January 1, 2011. CMS further modified the outlier eligibility standards by way of regulation in CY 2017. That change considers the amount of time in patient visits rather than the number of visits alone.

RECOMMENDATION: Congress should monitor implementation of the new outlier limitations to ensure that past abuses of the payment system are eliminated, while ensuring that beneficiaries who are legitimate “outliers” continue to have access to needed services, and the agencies that serve them are appropriately compensated.

RATIONALE: The original outlier payment methodology was established based upon speculation and assumptions that have not proven accurate. Actions taken by the Congress as part of P.L. 111-148 as part of the Calendar Year 2017 payment rule, have helped to ensure that outlier payments are targeted appropriately. However, close monitoring of these significant changes to the outlier policies must be monitored to ensure that beneficiaries – and the agencies that serve them – are protected.

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

ISSUE: The latest trend in health care payment policy revolves around paying providers based on the quality of care they provide and the success of their treatment patterns. “Pay for performance” (P4P) systems acknowledge financial remuneration as one of the strongest incentives available; they can be designed to reward providers based on use of certain processes of care, outcomes of care, or patient satisfaction. Incentive payments can be designed in a variety of ways – for example, payers could impose a “withhold” of a certain amount on each patient until such time as performance can be assessed or payers could receive an additional payment if it is found that they have relatively high performance standing. While P4P has been used by private payers and on a limited basis in Medicare, it is now gaining the attention of federal policymakers. The Medicare Payment Advisory Commission (MedPAC) has recommended application of a “pay for performance” system for home health and other Medicare provider payments. Starting in 2008, Medicare began a two-year P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in overall health care spending. Data on savings during 2008 was analyzed during 2009, and 2009 data was analyzed in 2010. CMS announced that it shared more than \$15 million in savings with 166 home health agencies based on their performance during the first year of the Medicare Home Health Pay for Performance demonstration. Another \$15 million in savings was shared with the agencies in 2010.

In the 2015 HHPPS rate rulemaking, CMS initiated a value-based purchasing pilot program in 9 states on a mandatory basis which will withhold 3-8% of payments to fund an incentive pool. NAHC raised concerns about the size of the incentive pool, which contrasts with the 2% withhold that is the maximum allowed for hospitals and skilled nursing facilities under their VBP efforts. NAHC also expressed concerns with the absence of information on the VBP measures that would be employed along with the incentive distribution model. The pilot is currently under way.

The Chairman of the House Ways and Means Committee, Kevin Brady (R-TX), introduced the Medicare Post-Acute Care Value-Based Purchasing Act of 2015 (H.R.3298) which would replace the separate VBP programs put forth by CMS with a single VBP program for all post-acute providers. It would also withhold 3-8% to fund an incentive pool and rely on a single performance measure based on average spending per patient.

During negotiations with Congressional leaders in 2017 and 2018, the expansion of VBP has been discussed as a possible pay-for to offset the costs of other NAHC priorities. The Centers for Medicare and Medicaid Services have attributed the current 9 state VBP demonstration program as generating \$378 million in savings. Extrapolating this rate of savings across all 50 states could be estimated at an approximate \$2 billion in savings.

RECOMMENDATION: Congress should monitor the progress of the ongoing value-based purchasing pilots and use the findings to guide its consideration of value-based payment for Medicare home health services. Any project in this area must:

- Be developed in conjunction with provider stakeholders;
- Be tested as a pilot program prior to full-fledged implementation;
- Be fair in its assessment of the quality of care provided to home health patients and incorporate pending OASIS changes, as well as a mix of multiple process and outcome measures;
- Refrain from negatively affecting patient access to care;
- Be consistent with the home health PPS and appropriately risk-adjusted;
- Limit any expansion of data collection requirements and fully reimburses agencies for the costs of any additional data collection requirements that are imposed;
- Only reward agencies for care elements over which they have some control;
- Reward high scoring agencies as well as those that demonstrate improvement for the dynamic value of home health services to the entire Medicare program;
- Not pose cash flow difficulties for agencies, with the incentive pool not to exceed 2 percent of home health payments; and
- Allow the Secretary of Health & Human Services sufficient discretion to delay application of value-based purchasing if implementation concerns arise.

RATIONALE: CMS has developed refinements to the existing PPS for home health; however, it may be another year or two before the impact of these refinements are known. It takes time for providers to adapt to changes in payment and treatment methods. Further, a number of factors beyond a home health agency's control can affect patient outcomes – including patient compliance with self-care regimens or the absence or presence of a responsible caregiver in the home. Development and application of any value-based purchasing model must be approached very cautiously to ensure that incentives are properly and fairly crafted.

REFORM ANNUAL MEDICARE INFLATION UPDATE CALCULATION METHOD

ISSUE: Home health and hospice service payment rates under Medicare are annually updated by a market basket index (MBI). The Centers for Medicare & Medicaid Services (CMS) uses the Hospital MBI as the basis for updates to hospice payments and uses a home health-specific MBI to update home health payments. The MBI is intended to reflect changes in the cost of the delivery of services from the previous year. However, the MBI relies on cost input proxies and a weighting of the inputs that reflect cost report experiences from several years in the past. Beginning in with fiscal year 2006, in accordance with section 404 of Public Law 108–173, CMS established a frequency for rebasing the hospital MBI every four years. Such routine updates are not utilized for home health; instead, on an irregular basis, Medicare reexamines the inputs, proxies, and respective weights assigned to the home health inputs. In the 2008 home health payment rate regulation, Medicare updated the base year for determining the MBI to 2003 using filed, but not audited, cost reports. In that rulemaking, Medicare noted the call from home health care to reweight the MBI on a more frequent basis, but made no commitment to do so.

The current formula for calculating the MBI for home health has resulted in inflation updates that are lower than the updates calculated for hospital and outpatient services despite the similarities in cost factors in providing the services. For example, in 2018, the hospital update was 2.7 percent as compared to a 2.5 percent update for home health services. It is believed that the current MBIs do not adequately take into account transportation, clinical professional, technology, and drug-related costs (among others) that make up the changing costs in home health services. Part of the problem is explained in Medicare’s use of unaudited cost report data that is notoriously unreliable.

Further, the forecasting system employed by Medicare to trend cost changes into succeeding years has often underestimated the increase in costs. For example, the 2005 and 2006 forecast for transportation costs showed a minimal increase that fell far short of reality when gas prices soared. Similarly, the 2009 forecast on staff salaries shows that hospital and nursing home staff salaries will increase at a significantly higher rate than in home health services despite the fact that similar staff are employed by these providers.

Another flaw in the MBI calculation is that it does not address new regulatory costs associated with implementation of legislative and regulatory changes. For example, in 2012 home health agencies had higher administrative costs due to the physician face-to-face encounter rule as well as new rules requiring compliance plans, intensified provider screening, and PECOS enrollment for physicians ordering home health services.

At various intervals when CMS rebases and re-weights the home health MBI there are clear indications that significant changes had occurred since the last time a similar change occurred.

RECOMMENDATION: Congress should require CMS to rebase and re-weight the home health MBI at least every three years, along with an analysis as to the appropriateness of the price inputs used in the MBI calculation. In addition, Congress should require that Medicare utilize audited cost report data and more than a single forecasting system in estimating succeeding year costs. Finally, Congress should require CMS to incorporate a forecasting model for new regulatory costs into the MBI updates.

RATIONALE: Home health is changing rapidly in terms of the patients served and the elements

of service to the patients. Technology-based care has grown in use as part of home health services. At the same time, normal costs such as transportation have increased much beyond the projections by the Medicare program. Additionally, costly regulatory burdens continue to be imposed on both home health and hospice providers. Finally, various Medicare providers all compete in the same labor marketplace for nurses, therapists, and aides. As such the variation in the inflation updates relative to labor should never be significant. The MBI is the mechanism by which the changes in costs and prices are reflected in payment rates; every effort should be made to ensure that it reflects those costs and prices and on a timely basis.

REJECT RISK-SHARING UNDER HOME HEALTH PPS

ISSUE: A prospective payment system (PPS) for Medicare home health services was implemented on October 1, 2000. Under the system, certified home health agencies are given a single payment for delivery of needed home health services during a 60-day episode of care. The episode payment is adjusted to account for the patient's care needs (case-mix) and for labor costs in the particular geographical area. During the first year of the PPS, payments were further adjusted for "budget neutrality" so that total annual projected outlays would not exceed what would have been spent if the pre-PPS payment methodology remained in place. As part of the transition to the Patient Driven Groupings Model (PDGM) implemented in January 2020 the episode of care was decreased to 30 days. The certification period was maintained at 60 days.

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

In a September 2000 report (GAO/HEHS-00-176) reviewing the decline in home health service use in recent years and implications for payment policy, the then-General Accounting Office (GAO) commented that home health PPS will "need to be evaluated and refined periodically and that utilization monitoring and medical review of claims will be critical to ensuring that HHAs [home health agencies] do not stint on care or provide unnecessary services..." and that "PPS should be modified to incorporate a risk-sharing arrangement, which would limit aggregate HHA Medicare gains or losses."

In a February 2004 report to Congress on home health payments, GAO expressed the belief that payments for home health services under Medicare exceed agencies' costs and reiterated its recommendation for a risk sharing payment system for home health.

The Medicare Payment Advisory Commission (MedPAC) has also examined risk-sharing as a potential element for consideration as part of the home health PPS. At the same time, MedPAC, Congress, and CMS have indicated a keen interest in and worked to develop value-based payment under which higher quality care would be rewarded with bonus payments, and lower quality care would result in lower reimbursements.

In January 2010, MedPAC Commissioners approved a recommendation that Congress should direct the Secretary of Health and Human Services (HHS) to modify home health payment to protect beneficiaries from "stinting" on care and included risk corridors and blended cost/PPS payments among the approaches that HHS should consider.

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

RATIONALE: The home health PPS case-mix adjustment system has limited ability to account for variation in agency resource use. Despite the fact that overall average Medicare financial margins calculated by MedPAC appear to be relatively high, there are dramatic ranges among agencies and various areas of the country. Reductions in market basket inflation updates in recent years have further strained agencies financially. Further, CMS has finalized regulatory cuts in the home health base payment rate every year since 2008. As a result there is widespread concern that

existing payment levels will fall short of many agencies' actual expenditures in serving patients. There is no type of risk sharing under either the hospital or skilled nursing facility PPS. Such an adjustment would help to perpetuate the complexities and incentives of cost-based reimbursement. Finally, the potential imposition of performance-based payment under Medicare and the myriad of changes such a system will require would advise against further complication of the home health PPS with risk-adjusted payment. Consideration of any type of risk-sharing system at this time, most particularly if it is based on an individual case basis, could cause great harm to agencies and the patients they serve.

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

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

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

The Center for Medicare and Medicaid Innovation (CMMI) initiated a four-model Bundled Payments for Care Improvement (BPCI) initiative in 2013. Models 2 and 3 included post-acute care services. Model 2 BPCI includes a patient’s hospitalization, physician services, and post-acute care for 30, 60, or 90 days. Model 3 BPCI is focused on post-acute care services provided 30, 60, or 90 days following an inpatient stay, but does not include the inpatient stay in the bundled payment. The BPCI initiative was extended until September 30, 2018 for model 2, 3, and 4 awardees who chose to extend their period of performance.

CMS initiated a lower joint replacement bundling pilot program on April 1, 2016. It included a risk sharing payment model involving all post-acute services, physician services, re-hospitalizations, hospice and other ancillary services provided to patients discharged from an inpatient setting over a 60-day post hospital period of time. Initially the pilot was to operate in 67 hospital service areas but the number was reduced to 34 areas and made voluntary in 33 of those 34 areas effective January 1, 2018.

Congress has supported bundling initiatives. In past Congresses, The proposed Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2015 would have bundled all post-acute care services. In recent years the White House budget has included significant Medicare spending reductions achieved through post-acute care bundling.

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

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

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

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

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

OPPOSE THE INSTITUTION OF UNTARGETED MEDICARE HOME HEALTH PRIOR AUTHORIZATION OR PRECLAIM REVIEWS

ISSUE: The Centers for Medicare and Medicaid Services (CMS) had instituted a system of pre-claim review in Medicare home health services. This demonstration project requires pre-claim reviews for home health in Illinois, Florida, Michigan, Texas, and Massachusetts. CMS justified this action by claiming that those states have high incidence of fraud and abuse in Medicare home health services. In addition, the FY 2017 federal budget proposed by the White House includes the allowance of the unspecified use of prior authorization systems in Medicare for a ten year reduction in Medicare spending of \$75 million.

The home health pre-claim review project was initiated on August 3, 2016 in Illinois. It proved to be highly costly with inconsistent decisions issued by Medicare. Further, while it demonstrated that HHAs have correctable documentation it did not uncover any fraud or abuse of Medicare. The demonstration was put on pause in March of 2017. CMS is looking at ways to improve the program, but further details, including when it might be revived, have been scarce.

In July of 2018, the CMS released a Paperwork Reduction Act notice revitalizing the pre-claim review demonstration program under a rebranded name, the Review Choice Demonstration Program (RCD). Similar to PCR, RCD offers providers the choice between a pre-claim review or a post-claim review. Home Health Agencies have the option to opt out of both, but will be subject to a 25% reimbursement reduction. The CMS announcement called for RCD to operate in five states: Illinois, Texas, North Carolina, Ohio, and Florida. The RCD proposal was finalized by CMS in April of 2019. Illinois was the first state subject to RCD in June, followed by Ohio in late September. Texas was scheduled to begin in December 2019, followed by Florida and North Carolina in March of 2020. At NAHC's and other stakeholders urging CMS announced RCD would be delayed in Texas until March 2020, and Florida and North Carolina in May of 2020. This was to alleviate the simultaneous burden of RCD and the Patient Driven Groupings Model (PDGM) going live in the same time frame. RCD poses significant costs for all parties and could present barriers to the timely and effective use of home health services. CMS estimates that the costs associated with performing review for home health services under the revised demonstration would be approximately \$392.9 million over the 5-year demonstration period.

Included in the President's Fiscal Year 2019 budget was a call to "expand prior authorization to additional Medicare fee-for-service items at high risk of fraud, waste, and abuse." The projected savings were not significant to enumerate within the budget.

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

RATIONALE: Prior authorization/ pre-claim review is an extraordinary action that triggers

significant costs for all parties and establishes barriers to the timely and effective use of home health services. Past trials of prior authorization in Medicare home health services have shown that it has negligible impact on program abuse.

C. MEDICARE ADVANTAGE

ENSURE ADEQUATE REIMBURSEMENT FROM MEDICARE ADVANTAGE PLANS FOR HOME HEALTH SERVICES

ISSUE: Home Health Agencies continue to experience financial difficulties tied directly to the increasing number of patients served by agencies that are covered under Medicare Advantage (MA) plans. Many of the MA plans reimburse agencies on a per-visit basis rather than on an episodic payment model as Fee- for-Service Medicare. The per-visit rates typically do not cover the full cost of care for a visit. The average rate per-visit is estimated to be about 75 % of the Medicare Fee-for-Service home health low utilization payment adjustment (LUPA) rate.

Where MA plans do reimburse agencies on the Medicare Fee-for-Service episodic rate, agencies report significant increases in claim reviews by the plans with subsequent claim denials. The denials tend to be for very technical reasons; reasons for which the Medicare Administrative Contractors have not denied home health claims. To compound the problem, network providers in an MA plan are not provided the same appeals rights as in the Medicare Fee-for-Service program. The appeals process is established by the MA plan which gives the plan an unfair advantage in any appeals decision.

Low reimbursement rates coupled with the unfair appeals process within the MA plans results in agencies having to depend on Fee-for-Service Medicare to subsidize MA plan reimbursement.

With more Medicare beneficiaries enrolled in MA plans and the MA plan market saturation increasing, HHAs are out leveraged in their ability to negotiate fair rates for services. This imbalance is largely due to CMS' limited oversight on MA plans' regarding provider relations and the flexibility in benefit packages MA plans are now permitted to offer their enrollees. MA plans may offer its members supplemental benefits that include services, such as, transportation, adaptive equipment for the home and home support services. Additionally, CMS is proposing to lift the restricting of telehealth services to only beneficiaries in rural areas and to permit the originating site for telehealth services to include the beneficiary's home.

RECOMMENDATIONS: Congress Should:

- Require that MA plans reimburse home health providers in an episodic manner consistent with the prospective payment system in traditional Medicare.
- Monitor for, and intervene, when MA plans show a pattern of inappropriate claim denials for home health services.
- Require the MA plans provide the same appeal rights to network providers as the Medicare Fee- for-Service program.
- Apply the same benefit flexibilities in Fee-for-Service Medicare as permitted by the MA plans

RATIONALE: Medicare Advantage plans have played an increasingly larger role in the Medicare program over the past decade. According to the [Kaiser Family Foundation](#), more than 24 million Medicare beneficiaries (36%) were enrolled in Medicare Advantage plans in 2020. Enrollment in Medicare Advantage plans has grown every year since 2010 and is anticipated to continue to attract enrollment for Medicare beneficiaries. CMS continues to set policies that favor the MA plans'

ability to offer innovative benefit packages to enrollees but has done nothing to ensure the providers of services are able to negotiate with MA plans for fair rate structures and appeals.

ESTABLISH PROVIDER APPEAL RIGHTS IN MEDICARE ADVANTAGE

ISSUE: Under the rules governing Medicare Advantage (MA), plan enrollees have detailed and extensive rights of appeal regarding any adverse decision related to the coverage of an item or service by the MA plan. These rights essentially mirror the rights afforded Medicare fee-for-service beneficiaries. However, neither network nor non-network providers of service have stated appeal rights. In some instances, an aggrieved provider may have grievance and appeal rights under a contract with the MA plan. In other instances, a dissatisfied provider may be able to pursue a complaint under state law authority. The absence of an administrative appeal system for providers in MA plans is in stark contrast to the system of appeals available under the Medicare fee-for-service program, where providers have full appeal rights comparable to Medicare beneficiaries. The absence of provider appeal authority in MA plans results in lost revenues to providers who deliver care to MA enrollees in good faith and later receive claim denials.

RECOMMENDATION: Congress should amend the Medicare law relating to MA plans to provider network and non-network providers of services with administrative appeals rights comparable to those existing under the Medicare fee-for-service program. Congress should also prohibit any retribution by Medicare Advantage plans against providers of services that utilize these administrative appeals rights.

RATIONALE: MA plans have expanded enrollment in recent years thereby taking a more significant role in the business of home health services. Home health agencies raise concerns that the MA plans tend to deny authorization for necessary services and to prematurely terminate coverage. The providers may continue care because of their concern for patient safety and clinical outcomes without MA plan coverage. Providers of services under MA plans are impacted by these claim denials and reimbursement disputes. The most efficient system to address these disputes is the administrative appeals process available under the Medicare fee-for-service program. Medicare beneficiaries under the MA program and beneficiaries and providers under the fee-for-service program can access that appeal system.

LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER TRADITIONAL MEDICARE

ISSUE: At various times since the early 1980s Congress has legislated changes designed to provide financial incentives for private insurers to create plans to replace the Medicare fee-for-service (FFS) benefit package. Most frequently these changes were made in hopes that private coverage under Medicare or “privatization” would result in savings for the program.

Numerous studies in recent years have raised concerns that the Medicare program is paying substantially more – about 14 percent on average -- for care for Medicare Advantage (MA) enrollees than for “traditional” fee-for-service (FFS) Medicare beneficiaries. The findings contrast sharply with the stated goals of creating incentives for private plans to enroll Medicare beneficiaries -- to save money by privatizing what was established as a health care entitlement program for seniors and disabled individuals.

Studies by the Medicare Payment Advisory Commission and the Congressional Budget Office support the Commonwealth findings, and indicate that significant gaps between average care costs for traditional FFS Medicare and MA beneficiaries exist, resulting in tens of billions of dollars in additional expenditures to private plans. Further, a late 2008 study by the Government Accountability Office found that, due to higher calculations on the part of plans relative to their 2006 costs, MA plans earned higher profits.

As part of health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) phased down payments to plans over four years (Fiscal Years 2012-2016) to the average plan bid in the bid area; it also begins a program of quality bonus payments for MA plans.

RECOMMENDATION: Congress should ensure Medicare reimbursement to private plans is consistent with the costs borne by the program for comparable traditional FFS beneficiaries. Congress should also require stronger oversight of plans’ estimates of costs to ensure that Medicare is not inadvertently overpaying plans.

RATIONALE: Study findings clearly indicate that privatizing the Medicare benefit is not an effective way to save money and, given the poor financial state of the Medicare trust funds, Congress should take steps to ensure that the Medicare program is not spending more than it needs to for care.

RESTRICT EXORBITANT COST-SHARING IN MEDICARE PRIVATE FEE-FOR-SERVICE PLANS

ISSUE: Medicare Part C, otherwise known as Medicare Advantage (MA), includes an option for a “Private Fee-for-Service” (PFFS) plan that is intended to mirror the original Medicare program. These plans are provided through private health insurance companies in many parts of the country. In the last two years, enrollment in this type of Advantage plan has grown to nearly one million Medicare beneficiaries.

Generally, these plans allow enrollees to choose any provider of services, supplies, or equipment that is qualified under the original Medicare program. However, the “Medicare Prescription Drug, Improvement and Modernization Act” (P.L. 108-173) contains a provision that allows Medicare Advantage PFFS plans to establish provider/supplier networks as an alternative to open access that was previously available to enrollees. While this provision requires that the plans allow enrollees to receive benefits through any qualified Medicare provider/supplier, it allows the plans to establish a higher cost-sharing obligation to select non-network providers/suppliers.

The Centers for Medicare & Medicaid Services (CMS) has approved PFFS plans that require enrollees to pay as much as a 50 percent copayment for out-of-network services/supplies. In doing so, a central feature of the PFFS plans -- open access-- is virtually eliminated. However, CMS also has undertaken an analysis of PFFS and other MA plan beneficiary cost sharing with a particular focus on home health services coinsurance. While the outcome of the CMS effort is not yet known, the study may indicate a new hesitancy to allowing nearly unfettered plan activity in restructuring beneficiary cost sharing in comparison to traditional Medicare.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, section 3202, provides limitations on the variation in beneficiary cost-sharing in comparison to traditional Medicare. However, the limitation directly applies only to certain services that include chemotherapy, renal dialysis, and skilled nursing care. Home health is not specifically included in the restriction, but the Secretary of Health and Human Services (HHS) is authorized to expand the scope of the limitation.

In 2010, CMS proposed restricting MA plans from charging any cost sharing on home health services. While CMS recognized that the PPACA provision does not directly authorize a home health cost sharing ban, CMS believes it has broad-based discretionary authority to promulgate such restriction. CMS withdrew this proposed rule.

RECOMMENDATION: Congress should either rescind the MMA provision that allows for PFFS plans to restrict access to services/supplies through selected networks or establish reasonable limits on cost-sharing obligations for non-network services. Congress also should prohibit a Medicare Advantage PFFS plan from imposing any level of coinsurance on home health services. Alternatively, Congress should support the Secretary of HHS in proposing to ban home health services copayments/coinsurance in MA plans. Congress should also specifically expand the restriction in section 3202 of PPACA to include a ban on home health services cost-sharing.

RATIONALE: If the Medicare Advantage private fee-for-service plan is to be a true alternative to the original Medicare program, it must not be allowed to impose significant financial barriers to open access to qualified providers/suppliers. Such limitations already exist in other Medicare Advantage plans such as health maintenance organizations and preferred provider organizations.

To allow the private fee-for-service plans to operate in a comparable manner effectively eliminates an intended option under Medicare Advantage.

REQUIRE MEDICARE ADVANTAGE PLANS TO PROVIDE A HOME HEALTH BENEFIT FULLY EQUIVALENT TO ORIGINAL MEDICARE

ISSUE: With the Balanced Budget Act of 1997 (BBA 97), Congress required that the original Medicare home health benefit be transformed from a per-visit, cost-based reimbursement benefit to an episodic service benefit, with payment based upon a prospective payment rate. With its initiation in October 2000, this reformed benefit dramatically altered the delivery of home health services to Medicare beneficiaries. Home health agencies were transformed from entities that delivered procedure-oriented visits of services to care managers and providers of services with the responsibility to achieve positive patient outcomes. In managing the individual's care in the home for 60- day episodes, home health agencies use both traditional disciplines of care along with new telehealth technologies, preventive services, and wellness services to manage the whole patient. Accordingly, the transition to a prospective payment system is much more than changing the reimbursement methodology.

Most Medicare Advantage plans have not adopted the reformed home health benefit. Instead, plans continue to deliver a visit-based home health services benefit, failing to provide the episodic care management service that is now provided to enrollees in the original Medicare plan. Those plans that have adopted the Medicare episodic reimbursement model have done so only through intense negotiations with network providers. For enrollees of plans that do not provide an episodic home health benefit, the result is restricted access to home health services and, more importantly, barriers to clinical stability, rehabilitation, and care coordination.

RECOMMENDATION: Congress should specifically mandate that all Medicare Advantage plans provide an episodic, care management home health services benefit and prohibit continuation of the antiquated home health benefit currently provided by most Medicare Advantage plans. At a minimum, Congress should order a study reviewing home health claims under Medicare Advantage for adherence to the home health benefit as exists in traditional Medicare.

RATIONALE: Significant clinical gains have been afforded to Medicare beneficiaries receiving home health services under original Medicare that do not occur in Medicare Advantage plans because of the continued focus on a per-visit benefit structure.

RESTRICT PASSIVE ENROLLMENT OF DUAL ELIGIBLES IN MEDICARE ADVANTAGE PLANS

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

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

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

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

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

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

PROVIDE ACCESS TO MEDICARE ADVANTAGE ENROLLMENT INFORMATION/ESTABLISH A PROVIDER “HOLD HARMLESS”

ISSUE: Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have become firmly established as a means for providing health insurance coverage for a significant portion of the U.S. population. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) provided new financial support for Medicare HMOs, PPOs, and other private plans under the Medicare Advantage (MA) program; as the result, in 2011, about 25 percent of Medicare beneficiaries were enrolled in private plans under Medicare. That percentage has grown to 30 in more recent years. Many newly-enrolled patients, however, fail to understand that enrollment in an HMO/PPO or other private plan may prohibit their being cared for by their chosen care providers, and may result in copayments in excess of those assessed under traditional Medicare.

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

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

The Centers for Medicare & Medicaid Services (CMS) has established a nationwide data base, known as the Common Working File (CWF), which contains information on the enrollment status of Medicare beneficiaries. CWF contains MA enrollment information only after data is transferred periodically from the separate MA enrollment database. As a result, the CWF is far from up-to-date, making the information unreliable.

RECOMMENDATION: To resolve this issue, Congress should:

- Require MA plans to determine any health services enrollees receive from other providers and furnish those providers with immediate notification of the MA enrollment;
- “Hold harmless” providers who in good faith provide needed care to MA enrollees before this notification is received through direct Medicare payment and concomitant reductions in MA payments; and
- Require CMS to upgrade the timeliness of information contained in the CWF and to make this information available on a nationwide basis.

RATIONALE: Medicare-certified home health agencies need timely enrollment information to avoid retroactive coverage denials. Despite providers’ best efforts to determine MA plan enrollment, information available from patients and families is frequently inadequate and unreliable. This is particularly a problem with MA enrollees who do not fully understand the implications of MA enrollment and fail to accurately explain their status to home health agencies. Since the cost of care provided to an MA plan enrollee by a “fee-for-service” home health agency is the enrollee’s liability, protections are necessary for both the enrollee and the provider.

D. MEDICAID AND MEDICARE ADMINISTRATION

ENSURE TIMELY HEARINGS AND DECISIONS BY MEDICARE ADMINISTRATIVE LAW JUDGES

ISSUE: Medicare law requires that providers and beneficiaries have a right to a hearing before and decision from an Administrative Law Judge (ALJ) within 90 days of request. If the decision is not rendered consistent with that standard, the appellant can accelerate the appeal to the next level. The right of an accelerated appeal has value, but it falls short of the right of a face-to-face hearing before an ALJ.

ALJ appeals are significantly backlogged with an expected delay of, minimally, two to three years before matters are scheduled and heard. Efforts by the Office of Medicare Hearings and Appeals have been useful, but only a small part of the backlogged cases has been resolved, with thousands of additional appeals filed each week.

Legislation has been proposed that would add resources to the ALJ hearing budget, provide alternative resolution processes, and permit Medicare to establish parameters for settlement of pending appeals. S.2368 -- The Audit & Appeals Fairness, Integrity, and Reforms in Medicare (AFIRM) Act of 2015 had bipartisan support, but was not considered by the full Senate prior to the close of the 114th Congress although the Congress did appropriate a small increase in funding for appeals. The AFIRM Act was reintroduced in 2019 by Senators Chuck Grassley (R-IA) and Ron Wyden (D-OR). In September of 2018, Congress appropriated \$182 million to the office of Medicare Hearings and Appeals (OMHA) for fiscal year 2019 with the goal of applying it to clear the backlog of approximately 500,000 appealed claims. In 2019 another \$182 million was appropriated for fiscal year 2020. This trend continued in 2021 with nearly \$192 million allocated to OMHA for fiscal year 2021 in the Consolidated Appropriations Act, 2021, P.L. 116-260. In early 2018, CMS launched a Low Volume Appeals (LVA) Initiative under which eligible providers whose appeals are validated can receive payments equal to 62 percent of the net Medicare approved amount. Additionally, CMS also announced plans to expand its Settlement Conference Facilitation Process, which is applicable to larger appeals, beginning in April 2018.

The Department of Health and Human Services (HHS) has reported that the pending Medicare appeals backlog has dropped to 417,000 as of the end of the fourth quarter of 2018, down from 886,000 in 2015. In November of 2018, a federal judge ordered HHS to clear the remaining backlog by 2022.

RECOMMENDATION: Congress should enact reforms to the audit and appeals process that:

1. Limits audits to circumstances where there is reliable evidence to believe that a provider has submitted ineligible, non-covered claims.
2. Reforms the appeals process that precedes the ALJ level in order to make it more productive and worthwhile as ALJ reversals indicate a high level of erroneous claim denials and inaccurate administrative appeal decisions.
3. Establishes alternative dispute resolution processes to expedite final decisions on appeals.
4. Establishes criteria for the application of class settlements in situations where similar or identical claim denials have been issued to one or more providers.
5. Adds sufficient ALJ staff resources to process all backlogged appeals.
6. Suspends any recovery of alleged overpayments until the conclusion of all appeal rights

with no accrual of interest. Interest should be limited to matters where the appeal is frivolous.

RATIONALE: Justice delayed is justice denied. As of the end of 2015, nearly 900,000 appeals remain backlogged awaiting ALJ review with only 60 ALJs available with a capacity of 1000 appeals per year each. While CMS is to be commended for initiating the LVA Initiative and for its plans to expand the Settlement Conference Facilitation Process, these efforts may not fully address concerns over the long term, particularly in light of expanded contractor review efforts.

PROVIDE ACCESS TO MEDICAID ENROLLMENT INFORMATION

ISSUE: Medicaid reform efforts may alter eligibility standards for the Medicaid program. Following the 2010 health care reforms, Medicaid enrollment dramatically increased. According to the Kaiser Family Foundation, as of 2019, [nearly 15 million people](#) were enrolled in the expansion group. At the same time, standards for determining Medicaid eligibility create a high potential for individuals to be frequently enrolled, terminated, and re-enrolled. This fluctuation in beneficiary status makes it difficult for Medicaid home health and hospice providers to accurately determine a beneficiary's eligibility status.

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

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

ALLOW FEDERAL JUDICIAL REVIEW OF STATE MEDICAID PROGRAM COMPLIANCE WITH FEDERAL MEDICAID LAW

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

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

In 2015, the US Supreme Court issued a ruling in another case involving the jurisdiction of federal courts to adjudicate challenges to state Medicaid rate setting. This matter involved the Idaho Medicaid program that is subject to the same Court of Appeals rulings as California Medicaid. The Supreme Court reversed the Court of Appeals. As a result, there does not appear to be any route to a federal judicial challenge to a state's Medicaid rate setting by providers of services or Medicaid beneficiary.

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

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

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

are available under federal law and should not be constrained in their efforts to secure such.

STRENGTHEN REQUIREMENTS FOR PUBLICATION OF POLICY CHANGES BY CMS

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

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

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

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

ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

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

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

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

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

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

- Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.
- Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.
- Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate or erroneous enforcement action by those charged with protecting Medicaid.
- Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements unrelated to the provision of high quality care.
- The establishment of a Joint Program Integrity Advisory Council that includes representatives from state Medicaid programs, CMS, home care providers and Medicaid recipients. The Advisory Council is intended to help increase awareness of program integrity weaknesses and to recommend solutions.
- Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

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

ESTABLISH REASONABLE STANDARDS FOR ELECTRONIC VISIT VERIFICATION

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

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

In 2015, two legislative proposals were issued in the House and Senate respectively. H.R. 2446 would require state Medicaid programs to use electronic visit verification for home care services, including “home health services.” The bill did not mandate the use of any particular system, but instead requires states to take into consideration efficiencies and accuracies in establishing the state-specific requirements. If a state fails to require EVV, the state is financially penalized with a reduction in the federal share of Medicaid costs. S. 2416, Verifying Electronically the Receipt of In-Home Care For Individuals Act or the VERIFI Act, also required the use of EVV, but differ from the House bill in that the requirements also apply to Medicare home health services.

On December 13, 2016, President Obama signed the 21st Century Cures Act (CURES) (P.L. 114-255) into law. Section 12006 of the legislation included an Electronic Visit Verification (EVV) System requirement for personal care services and home health services under Medicaid. CURES directs states to collect visit verification data from Medicaid personal care services and home health providers and electronically track the exact date of service, start and end time of service, service provider, recipient of service, type of service and location of service. EVV is required to be in place by 2019 for personal care services and 2023 for home health services. Each state is responsible implementing EVV as long as the systems meet minimum functionality requirements as defined by the law.

In June 2018 Congressman Guthrie introduced a bill, H.R. 6042, that would delay the implementation date of EVV by one year to January 2020 when the reduced Federal Medical Assistance Percentage reduction penalty takes effect. This bill was signed by the President (P.L. 115-222) on July 30th, 2018.

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

hours count.

RATIONALE: EVV can be of great value in protecting the integrity of government reimbursed home care programs. However, not all programs are alike with program-specific risks that are addressed by EVV. Further, flexibility in EVV requirements for providers creates the opportunity for the development of the best EVV system to fit the program-specific needs.

E. REGULATORY BURDENS/PAPERWORK

REFORM MEDICARE HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

ISSUE: Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) establishes as a condition of payment for home health services coverage under Medicare that a patient have a face-to-face encounter with the physician who certifies the need for home health services. The encounter also can be provided by certain non-physician practitioners, such as physician assistants and nurse practitioners. While Section 6407 allows the encounter to occur through the use of telehealth, the law extremely limits that option by referencing Medicare telehealth coverage requirements that rule out services in a patient's home.

While the intention behind section 6407 was to gain greater physician involvement in ordering home health services, some physicians resisted the requirement and the documentation standards that Medicare included in the implementing rule. Under the original rule, a physician was required to document clinical findings with respect to the patient's need for home health services and explain how those clinical findings support Medicare coverage for prescribed care, the so-called "physician narrative."

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

The implementation of the face-to-face encounter rule led to great confusion among physicians, home health agencies, and other parties involved. This was evident in 2013 when even the Medicare Administrative Contractors (MACs) were confused as they stepped up medical review of home health face to face requirements and again in 2015 when the MACs implemented a "probe and educate" directive from CMS. Medicare has tried to mitigate the confusion through various communications, but the requirements remain difficult to understand and apply.

NAHC filed a lawsuit in June 2014 challenging the imposition of the "narrative" requirement and its application in claims reviews. Subsequently, CMS rescinded the narrative requirement effective January 1, 2015, but the narrative requirement remained in place for all claims between April 2011 and December 31, 2014.

The Federal district court issued its decision on November 3, 2015, finding that CMS had the authority to require a physician narrative to comply with the face-to-face encounter requirements. However, the court also concluded that CMS did not have the authority to second-guess the physician and reject a narrative as insufficient. In place of the narrative, CMS required that physicians have sufficient documentation in their own files to support the certification of a patient's homebound status and skilled care need. Through a provision of the Bipartisan Budget Act (BBA) of 2018 it became acceptable for the physician to incorporate documentation from the home health agency record into the physician's record for the patient and use that documentation to support the certification.

. Despite this change, issues remain because while CMS will consider the HHA record if it is incorporated into the physician record it will not consider the HHA record in conjunction with the physician's record if the HHA record remains separate from the physician record, even though CMS has that option. The BBA as signed into law states that "the Secretary may use documentation

in the medical record of the home health agency as supporting material, as appropriate to the case involved.” This simply codifies current practice. For real change to be realized, a firmer directive for CMS needs to be mandated. This can be achieved by changing “may” to “shall” in the previously quoted sentence.

Both under the original standard requiring a physician narrative as well as the new standard on documentation, the HHA is not in control of the documentation yet suffers the risk of a payment denial. Further, the subjectively technical requirements on documentation pose the likelihood of claim denials on patients who are, in fact, homebound and in need of skilled care.

In late March 2020, in response to the COVID-19 Public Health Emergency (PHE), CMS granted flexibilities allowing the home health face-to-face encounter to be conducted using two-way audio/visual communication. Under the Consolidated Appropriations Act of 2023 Congress authorized extensions of telehealth flexibilities related to the PHE through the end of 2024, which will permit HHAs to continue using telecommunications technologies to conduct the home health F2F. While this flexibility has been extremely helpful, it has become clear that in a number of cases two-way audio/visual interacts are not available, either due to limitations on patients’ ability to use technology or limited access to broadband. For this reason, it is believed that Congress and CMS should further extend the face-to-face flexibilities to allow for use of audio-only interactions, as well.

RECOMMENDATION: Congress should:

- Reform the face-to-face provision and devise more constructive ways to secure physician involvement in home health care.
- Clarify certification requirements included in the BBA by requiring CMS to jointly consider the physicians patient record along with the home health agency’s record when determining claim status. These two records in concert give a full and detailed look at the patient’s condition and need for home health services.
- Revise PPACA section 6407 to remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications and audio-only interactions.
- Establish exceptions to the face-to-face requirements for patients who have been recently discharged from an inpatient setting (for example, in the past two weeks) and have developed a need for home health services, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.
- Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency.
- Provide an efficient and economical process for resolving past-denied claims through settlement or otherwise that takes into consideration appeal reversal rates, the amounts in controversy and the cost of the appeal process.

RATIONALE: The purpose of the face-to-face requirement was to enhance physician

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

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

REQUIRE MULTI-STATE RECIPROCITY IN MEDICARE SURVEY CONTRACTS

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

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

RATIONALE: Medicare is a national program with uniform conditions of participation throughout all states. The failure to require reciprocity agreements can deprive residents of one state the availability of home health services centered in a neighboring state. These services are often centered in a metropolitan region that borders on another state.

ALLOW FLEXIBILITY IN THE DELIVERY OF HOME HEALTH SERVICES UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

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

In Section 3131 of the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress mandated that Medicare home health services payment rates be rebased effective 2014. However, the congressional mandate did not provide detailed, prescribed rebasing standards that ensure fair consideration of the costs of all the services provided to Medicare patients in the course of a covered episode of care.

CMS has allowed home health agencies (HHAs) to utilize the PPS payments to deliver modalities and disciplines of care beyond the items and services listed in the statutory benefit if those items and services are needed by the patient. However, CMS excludes the cost of any of those items and services from any rate analysis. The PPACA does not correct this deficiency. Further, CMS maintains no specific quality assurance standards relative to these items and services.

RECOMMENDATION: Congress should specifically authorize HHAs to utilize PPS payments in a flexible manner in order to achieve quality of care and efficiencies without adverse consequences relative to payment, coverage, and compliance with the conditions of participation. Further, Congress should require that CMS include all items and services provided to patients in the course of a covered episode of care in any quality standards or payment rate analysis. In addition, Congress should direct the Medicare Payment Advisory Commission (MedPAC) to include consideration of the cost of all clinical services when evaluating payment rates for home health services.

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

FULLY REIMBURSE OASIS COSTS, STREAMLINE OASIS REQUIREMENTS, AND CONDUCT RESEARCH ON OASIS VALIDITY

ISSUE: The Centers for Medicare & Medicaid Services (CMS) requires home health agencies to submit patient data using the Outcome and Assessment Information Set (OASIS). In addition to the ongoing agency expenses related to telephone, computer hardware, editing and auditing data entry and supplies, these requirements add considerably to the amount of time clinicians must spend on paperwork related to cases.

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

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

There has been only limited research conducted on the validity and reliability of the OASIS items. Following implementation of OASIS, the Center for Home Care Policy & Research of the VNS of New York conducted an in-depth study in this area and found that in real-world application of OASIS, many of the data items scored low in reliability tests. Of particular concern were their findings of low reliability for the instrumental activities of daily living (IADLs), functional status in the 14 days prior to the episode, and prognosis.

RECOMMENDATION: Congress should provide for reimbursement of the full costs agencies incur with respect to OASIS. OASIS data collection and submission requirements should be limited to Medicare patients. The number of OASIS items and frequency of assessments should be limited to only those necessary to determine appropriate reimbursement and patient care outcomes. Congress should direct CMS to conduct in-depth study of the reliability and validity of OASIS items on a regular basis. The recognition of the full cost of OASIS should occur in all levels of episodic payment.

RATIONALE: OASIS can be a valuable tool that, over time and with appropriate changes, could greatly enhance the delivery of home care services. However, requiring OASIS data collection and submission for non-Medicare patients constitutes an unfunded mandate. Initial assessment of OASIS requirements reflected significant increased burden on agencies and staff; regular revisions to the instrument will impose further obligations and costs. OASIS requirements should impose as few administrative and financial burdens as possible upon already severely strained home health agencies. OASIS items should be used to measure quality and alter payment ONLY after their validity and reliability have been proved.

INCREASE FLEXIBILITY IN THE APPLICATION OF THE HOME HEALTH CONDITIONS OF PARTICIPATION

ISSUE: The Centers for Medicare & Medicaid Services (CMS) requires the application of all of the Medicare Home Health Conditions of Participation (CoP) to all patients served by the Medicare-certified agency regardless of payer source or type of services provided. These requirements increase the cost of services to all payers. Yet, only one CoP, supervision of home health aides, has been written to provide flexibility in application based on service needs. Application of another condition, the Outcome and Assessment Information Set (OASIS) requirement, varies depending on payer and need for skilled care. The application of OASIS to non-Medicare/Medicaid patients was suspended under the 2003 Medicare reform legislation. As part of the calendar year 2023 home health payment rule, CMS ended the suspension of OASIS data collection on non-Medicare/non-Medicaid HHA patients. HHAs will be required to conduct OASIS assessments and submit related data beginning July 1, 2025, with a phase-in period that will run from January 1 through June 30, 2025.

The Secretary's Advisory Committee on Regulatory Reform adopted a recommendation to apply certain other Medicare Home Health CoP to Medicare patients only. The Government Accountability Office (GAO) has been charged with the responsibility to evaluate a more flexible application of the home care CoP.

CMS issued significant revisions to the Conditions of Participation in 2017 that became effective January 13, 2018. These revisions bring some new flexibility, but the structure continues an inflexible architecture for home health agencies in a number of areas, including staffing. No change was made in applying the CoPs to non-Medicare patients.

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

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

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

- It is not necessary for physicians to review and sign the plan of care for medically stable persons receiving health promotion and personal care services according to state nurse practice acts.
- Physician order requirements were designed for legal authority to provide care and control of utilization. Nursing and therapy practice acts now recognize all but invasive procedures as independent aspects of practice, so orders are not usually required for legal coverage. A physician order with the intent of controlling utilization is a payer issue, not an operations or practice issue. If a payer wants to require this and assume the costs thereof, it should be a condition of payment.

- Patients' medication monitoring should be the responsibility of physicians and pharmacists when home health patients require only therapy, medical social work, or aide services.
- OASIS data collection and reporting is not covered by most payers. Medicaid payments do not cover the cost of care in most states before the added burden of OASIS. Further, the Medicaid population can differ significantly from the Medicare population, thereby limiting the usefulness of OASIS for such cases.

ENSURE ACCESS TO HOME CARE AND FULL FEDERAL FUNDING IN ANY PROPOSALS TO REQUIRE MEDICAL DIRECTORS IN HOME HEALTH AGENCIES

ISSUE: On a periodic basis policymakers or oversight bodies (such as the Office of the Inspector General at the Department of Health and Human Services) discuss the potential for requiring home health agencies to employ a medical director to oversee quality of care, regulatory compliance and accountability for patient care. Ideally, medical directors could help bridge communication gaps between a home care agency and a physician's office, and help implement the most appropriate clinical services while helping to clarify the status of homebound patients. Several concerns must be addressed however, before consideration is given to mandating such a requirement. First, Medicare home health agencies are already under extraordinary financial strain due to the effects of many regulatory burdens and changes in reimbursement. The additional -- and potentially substantial -- costs of a medical director simply could not be borne under the current payment system and would need to be fully funded by the Medicare program as a pass-through. Second, many physicians have very limited understanding of home care and the medical regulations. Third, agencies in many rural and underserved areas may find it particularly difficult to recruit any medical director, much less a medical director with adequate knowledge of the Medicare home health benefit. Severe access problems would result if home health agencies were not able to meet this requirement.

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

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

MODERNIZE MEDICARE HOME HEALTH AGENCY “ONE SERVICE DIRECTLY” STANDARD

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

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

In 2014, CMS proposed revisions to the Conditions of Participation. However, it did not propose any changes to the “one service directly” requirement, nor was it addressed in the final version of the revised Conditions of Participation that became effective January 13, 2018. Other Medicare providers have the flexibility to staff services with their choice of employees or contractors provided quality of care systems are in place. No adverse consequences have been reported.

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

RATIONALE: The existing core services requirements for home health agency participation in Medicare are a proxy for establishing quality assurance in the provision of care. Medicare maintains an outdated and unfounded belief that an employed caregiver is more capable of providing high quality services to patients than a contracted caregiver under appropriate supervision and oversight. Quality of care should not be assured through employment label status but through outcome-oriented operations.

LIMIT ADMINISTRATIVE BURDENS ON HOME HEALTH AGENCIES

ISSUE: Through the years, the Centers for Medicare and Medicaid Services (CMS) and other federal agencies have imposed an increasing number of regulatory requirements on home health agencies, many of which have significantly increased agency costs and added to agency staffs' workloads. Among these are requirements associated with OASIS, advance beneficiary notices, 15-minute increment billing, and others. Some of these requirements are ill conceived, unnecessary, duplicative, and burdensome. In analyzing the "paperwork" costs, CMS limits its calculations to the time needed to physically complete the form rather than the full costs involved. Additional costs, including those related to the deliberative process of decision-making, patient assessment, notice delivery, and maintenance of records are not considered in evaluating burdens and considering alternatives.

In cases where requirements are reasonable, they may be ill timed considering all of the other adjustments and adaptations home health agencies are in the process of making. Recent examples include when CMS implemented a new patient notice process that, when added to existing notice requirements, requires home health agencies to provide up to six different notices, potentially at multiple points when Medicare coverage or service is to be reduced or terminated. The new Conditions of Participation also include extensive changes that will increase paperwork burdens. The cost of this process takes valuable resources away from patient care.

The 2010 and 2015 standards for face-to-face encounter requirements and therapy care planning are additional regulatory actions that have significant adverse financial consequences that may far outweigh the intended benefits of the rules. Both lead to paperwork burdens for the vast majority of providers and offer no program integrity protections.

During 2017 CMS proposed a six-state home health pre-claim review program under which 100% of claims and associated documentation would be reviewed in advance of payment. The program was started in Illinois and created such upheaval that it was suspended. During 2018 CMS announced plans to reinstate the home health pre-claim review program with minor refinements, despite the fact that improper payment rates for home health agencies dropped by approximately 15 percent in the year ending June 30, 2018, and an additional 5.5 percent in the subsequent year, indicating that imposition of such a burdensome and costly program may not be needed. In 2019 CMS instituted a slightly modified program for home health pre-claim review under the name of Review Choices Demonstration (RCD) in Illinois and Ohio. Texas was added in early 2020, and North Carolina and Florida were added later that year under a "phased in" plan as a response to the COVID-19 public health emergency. CMS recognized the burden created by RCD by instituting the phased-in approach under which home health agencies were permitted to forego pre-claim review, but indicated at the time that the claims could still be subject to post-payment review at a later date. Given the threat of post-payment review, many agencies opted to continue 100 percent pre-claim review instead of subjecting their operations to the threat of post-payment review at some time in the future. In this case, the administrative burden on agencies during the phased-in approach of RCD could have been significantly reduced if CMS had not maintained the threat of post-payment review during the course of a pandemic.

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

agencies. Congress should disapprove imposition of any duplicative, unnecessary, or overly burdensome requirements.

RATIONALE: Home health agencies are currently instituting an overwhelming number of administrative changes. Many of these changes are costly and significantly increase the workloads of already strained agency staffs, affecting the ability of agencies to retain staff and continue to provide high-quality, appropriate care. Regulatory burdens must be more closely monitored to ensure the continued viability of agencies nationwide.

OPPOSE USER FEES FOR MEDICARE AND MEDICAID ADMINISTRATIVE ACTIVITIES

ISSUE: Presidential budget proposals have included a recommendation that would require all health facilities, including home health agencies and hospices, to pay a user fee sufficient to cover the costs associated with administrative activities (such as routine surveys to ensure compliance with quality-of-care requirements) under the Medicare and Medicaid programs.

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

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

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

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

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

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

PROHIBIT USE OF SAMPLING AUDITS

ISSUE: Medicare’s program integrity contractors have used sampling techniques to audit home health agency claims and are authorized to do so as part of expanded program integrity efforts. When utilized, sampling has proven itself a devastating device with a high risk of error. Any errors in the sampling process are multiplied, possibly placing the home health agency at risk of financial collapse. A single claim denial can result in tens of thousands of dollars of payment disallowances. In one notable case, the contractor reviewed just 32 claims and extrapolated the results of the review to demand over \$14 million as an overpayment. The appeals process is an inadequate protection against erroneous denials since it can take several years to resolve a single claim denial and recovery of any alleged overpayment begins 30 days after the Reconsideration decision is issued.

As a result of erroneous sample determinations, agencies have been forced into bankruptcy and are no longer available to provide services to Medicare patients in their community. Some agencies survive, but only after protracted and expensive administrative appeals that establish that, generally, Medicare’s determinations were erroneous.

Legislation enacted by Congress in 2003 restricted the use of claims audits, but did not ban sampling. The Medicare Modernization Act of 2003 prohibits the recovery of alleged overpayments that have been calculated through sampling or otherwise through the reconsideration step in the appeal process only. In addition, the legislation limits overpayment extrapolation through sampling unless the Secretary determines that there are sustained or high levels of payment error, or education efforts have failed to correct payment error. The legislation also permits “consent settlement” sampling and full sampling where there are patterns of serious noncompliance. These reforms are helpful, but not sufficient to protect against the devastation caused by inaccurate sampling methodologies and their underlying decisions

Sampling causes great harm to Medicare patients and the home care providers who serve them for the following reasons:

- Recoupment before full appeal: Intermediaries using sampling require alleged overpayments to be refunded before the provider can exercise their full appeal rights. These recoupments can be huge and can threaten the very survival of the provider. The section 935 of MMA protections against recovery prior to appeal apply only through the first two stages of appeal.
- Access to care reduced: Historically, the fear of erroneous Medicare coverage denials has led some providers to limit availability of services to certain Medicare patients. Sample adjudication magnifies this “chilling effect” many felt.
- Claims process compromised: The coverage determination process, which requires individualized review of claims, is rendered meaningless through retrospective review of only a sample of claims. With sampling authority, the Medicare program has no incentive to issue accurate and fair determinations in advance of payment.
- Loss of third-party payment: Since the great majority of the claims on which sample adjudication is based cannot be identified, providers of services have no way of securing payment from alternative sources of payment, such as Medigap policies, which may be liable.

RECOMMENDATION: Congress should prohibit the use of sampling to audit Medicare home health and hospice bills and clarify the current law to require individual coverage determinations.

Alternatively, Congress should guarantee that a provider has a right to challenge whether sampling should be applied to it prior to its use or prior to the recovery of any alleged overpayment.

RATIONALE: At the foundation of the coverage determination process is the recognition that individualized decisions are necessary because each home health care patient presents unique health care needs. Sampling is in direct conflict with that principle. Such an action, when done incorrectly or inappropriately, leads to the demise of essential health care services in the affected area of that provider.

F. PROTECTIONS FOR CONSUMERS, PROVIDERS AND CAREGIVERS

PROMOTE MEDICARE-MEDICAID COORDINATION

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

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

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

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

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

RECOMMENDATION: In addition to prohibiting individual claims-based "Medicare maximization," Congress should require that state Medicaid programs:

- Utilize the most cost effective method for recovering payment for dually eligible patients.
- Consider the development of a system of claims review that does not require individual claims submissions and appeals. Medicare and Medicaid claims submission should be combined with initial billing to Medicare and a transfer billing of remaining non-covered care to the respective state Medicaid program.

- Recoup incorrect payments from the Medicare program rather than the provider. No recovery should take place against a provider until after third party (Medicare's) liability is established.
- Work with CMS on implementation of pilot programs that incorporate the above recommendations for dually eligible beneficiaries' coverage decisions on a nationwide basis.
- Establish clear coverage standards for Medicare and Medicaid that differentiate between the Medicare responsibilities in an episode of care and the Medicaid coverage obligations for additional services.

RATIONALE: While home health agencies make the best effort to determine whether a patient is covered under Medicare prior to submission of a claim to Medicaid, incorrect Medicaid payments have occurred. However, the use of an individual appeals system represents a costly, burdensome process for all parties concerned including the provider of care, the Medicaid program, and Medicare. Strengthened rules and better enforcement would allow CMS to maintain improved oversight over state programs and to minimize the overall cost experienced by all parties. If the model demonstration programs are adopted nationwide, most of the burden of states' efforts to maximize Medicare will be eliminated.

SUPPORT ADEQUATE FUNDING OF MEDICARE ADMINISTRATIVE ACTIVITIES

ISSUE: The Centers for Medicare & Medicaid Services (CMS) has restricted or delayed administrative functions based on the claim of funding priorities. For example, CMS has stalled or suspended the processing of changes in provider ownership because of a lack of sufficient funding available for contractor services. In addition, CMS has essentially suspended the certification of new home health agencies in a number of states because of insufficient administrative financing. This has forced prospective home health agencies to purchase Medicare certification by using private accrediting bodies rather than publicly financed survey and certification processes. At a time when home health agencies and hospices are undergoing corporate and ownership changes, consolidating or expanding operations, these administrative barriers can paralyze the business side of a significant health care sector.

Numerous statutory and regulatory changes to Medicare have taxed CMS's ability to meet ongoing administrative requirements. That means that pre-existing responsibilities are likely to be met only if sufficient additional administrative funding is provided.

RECOMMENDATION: Congress should adequately fund all CMS administrative functions regarding home health services and hospice care and establish performance standards for those functions.

RATIONALE: Medicare is not simply a health insurance payment program. It drives the business structure of many health care providers. Inadequate financing of CMS administrative functions is a problem that leads to higher cost for providers and restricts the improvements that are underway in the business of health care.

PROHIBIT SUSPENSION OF PAYMENT IN SUSPECTED OVERPAYMENT CASES

ISSUE: In 2004-2005, new Medicare contractors, Program Safeguard Contractors (PSCs), began a series of home health services claim reviews. In some cases, less than a dozen claims were subject to the reviews. The PSCs issued preliminary finding to the home health agencies indicating that they had determined that the claims might not meet Medicare coverage standards. In addition, as a result of these preliminary findings, the PSCs suspended all Medicare payments to these providers based on the allegation that the agency may have been overpaid. The PSCs continued this practiced through 2008.

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

The Patient Protection and Affordable Care Act of 2010 (PPACA), Section 6402, permits Medicare and Medicaid to establish standards for the suspension of payments when overpayments/fraud is suspected. CMS issued an interim final rule in early 2011 that implements this provision in a manner that limits any reasonable due process for providers of services, allowing unchecked and unappealable determinations to suspend payment based simply on a “reliable evidence” of abusive conduct. 76 F.R. 5862 (February 2, 2011).

CMS also issued a set of “alternative sanctions” that can be imposed on home health agencies that allegedly violate a Medicare Condition of Participation. These sanctions include the power to suspend payments. 42 CFR 488.820.

RECOMMENDATION: Congress should amend the law to include suspected overpayments that are the basis for payment suspension within the protections afforded under Section 935 of MMA. The amendment should extend to the provider of services the right to pursue a “redetermination” and “reconsideration” of the preliminary decision that the claims may not be covered under Medicare prior to the suspension of payment. Alternatively, Medicare should be prohibited from suspending payment at an amount greater than the claims involved in the preliminary review. Finally, Congress should require that Medicare issue formal coverage determinations within 30 days of any finding that a provider is suspected to have been overpaid. Extended suspensions of payment due to suspected, but not established, overpayments should be prohibited in the absence of evidence of fraud.

Any decision of Medicare or its contractors that could trigger a payment suspension should be fully subject to review and appeal before any suspension can take effect. For example, if the suspension is based on an allegation that there is “reliable evidence of an overpayment,” the affected provider should have a right to challenge that allegation in advance of any punitive measure such as payment suspension.

RATIONALE: The suspension of payment usually represents the end of the provider’s opportunity to stay in business. It is unfair to provide less protection against wrongful

governmental action in situations of suspected overpayments than where Medicare has issued a formal determination that a provider has been overpaid.

REFORM STANDARDS FOR HEALTH CARE SERVICES LIABILITY

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

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

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

ALLOW PROVIDER APPEALS PRIOR TO SANCTIONING FOR SURVEY AND CERTIFICATION DEFICIENCIES

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

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

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

With implementation of the Medicare reforms contained in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, the impact of deficiencies became increasingly serious whether or not they lead to program termination recommendations. Home health agencies with conditional deficiencies are barred from performing home health aide training; surveyor reports of deficiencies are available to the public through inquiries to home health hotlines; and intermediate sanctions, including civil monetary penalties, may be levied against agencies for certain deficiencies. As part of the Consolidated Appropriations Act of 2021 (P.L. 116-260), Congress enacted sweeping hospice survey reforms that expanded the types of remedies that CMS may invoke in response to hospice condition-level deficiencies and created a Special Focus program for poor performing hospices. These changes comparably increased the risk of survey deficiencies for hospice agencies.

Finally, the need for a formal provider appeals process is highlighted in the case of CSM Home Health Services. CSM was terminated from the Medicare program after three federal surveys found alleged noncompliance with the COP. The termination took effect in July 1996. CSM appealed to an ALJ who reversed the termination on October 25, 1996. Medicare appealed the ALJ decision. The appellate level agreed with the ALJ and reinstated CSM in an August 1997 decision. Since July 1996, however, CSM had been prohibited from serving Medicare patients. By the time the appeal was resolved, it was too late for CSM's business to resume as it was bankrupt. The CSM travesty has been repeated several times since 1996 with other HHAs desperately attempting to survive the provider participation appeals process with no Medicare

revenue for two to three years.

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

In addition, the legislation requires the Secretary to develop a “process to expedite proceedings” in termination cases. This change will not affect the timing of appeal rights that begin only after termination. CMS is currently considering the establishment of an alternative dispute resolution process to address survey deficiencies. Such a process had been previously used with nursing facilities.

Beginning on July 1, 2013, the need for pre-sanction appeals rights is heightened as new “intermediate sanctions” take effect under a rule promulgated by CMS in late 2012. While CMS allows the postponement of collecting any civil money penalties until all appeals are exhausted, the penalties continue to accrue with interest. Non-monetary sanctions are not postponed. As of July 1, 2015, CMS also established an “Informal Dispute Resolution” (IDR) process that can be used to resolve deficiency allegations that underlie intermediate sanctions.

In 2016, HHAs were hit with 129 sanctions including 79 monetary sanctions as high as \$10,000 a day.

RECOMMENDATION: Congress should enact legislation establishing formal appeals procedures for deficiencies issued during Medicare surveys regardless of whether or not the deficiencies lead to a recommendation for a sanction or termination from program participation. This legislation should allow for suspension of the termination and sanction processes pending appeal of deficiencies and should include provisions that would allow continued operations and protect the agency’s reputation while the deficiencies are under review. For example, agencies should be able to continue to provide services and public notices of deficiencies and issuance of information regarding deficiencies subject to appeal should be suspended until the issuance of a final ruling.

RATIONALE: Agencies should not be penalized for deficiencies that do not actually exist. The Medicare program does not adequately protect providers through appeals procedures. There already are processes in place that provide expedited termination authority for situations where patients are potentially placed in life-threatening situations. The recommended provision strikes a balance between protecting consumers’ and providers’ rights.

REINSTATE THE PRESUMPTIVE STATUS FOR HOME HEALTH WAIVER OF LIABILITY

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

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

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

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

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

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

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

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

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

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

particularly important. In the absence of waiver presumption, agencies will have no recourse but to reject clients when coverage is questionable.

PERMIT SUITS AND AUTHORIZE PUNITIVE DAMAGES AGAINST MEDICARE CONTRACTORS FOR BAD FAITH DECISIONS

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

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

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

REINFORCE BENEFICIARY DUE PROCESS RIGHTS

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

With the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA), Congress mandated the implementation of an expedited determination and appeal process. The rule issued by the Centers for Medicare & Medicaid Services (CMS) allows for an expedited review in the following circumstances: a) where a home health agency has determined that a patient does not meet the conditions for payment of home health service; and b) where a home health agency has determined that a patient no longer requires home health services; and c) where a home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's physician. However, the rule fails to protect providers from financial losses and inadequately protects Medicare beneficiaries where there is no physician order for care. Further, the process does not have prospective effect, limiting the care under review to that which was provided prior to the appeal.

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

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

RATIONALE: This recommendation reflects the experience of the Medicare program in its many prospective payment systems in use with various health care providers. While Congress instituted significant improvements through the mandated expedited determination process, the weaknesses that remain should be addressed.

PRESERVE INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES

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

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

The Medicare Modernization Act (MMA) of 2003 required the Secretary of HHS and the Commissioner of Social Security to develop a plan by April 1, 2004, to transfer the Medicare ALJ function from the Social Security Administration to HHS. ALJ functions were transferred to HHS as of October 2005. To preserve the independence of the ALJs, the MMA required the Secretary to place the ALJs in an administrative office that is organizationally and functionally separate from CMS. The ALJs are required to report to, and be under the general supervision of the Secretary, not the Administrator of CMS.

RECOMMENDATION: Congress should block any CMS effort to interfere with the independence of the ALJs through oversight, indoctrination, or otherwise.

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

IMPROVE ACCESS TO JUDICIAL REVIEW FOR MEDICARE CLAIMS

ISSUE: The Medicare program currently operates an elaborate and extensive administrative appeals system for coverage disputes. At the same time, an administrative appeals process is available for review of reimbursement disputes that come about through audits of home health agencies by Medicare Administrative Contractors (MACs). Federal court rulings indicate that providers of services may be required to utilize these administrative appeals to resolve broad-based complaints regarding reimbursement policy actions by Medicare. For example, in *NHPCO v. Leavitt*, the court held that hospices must individually exhaust all administrative appeal remedies before the court can hear a challenge to the Medicare rule eliminating the Budget Neutrality Adjustment Factor for all hospices. The administrative systems ultimately provide for a right of judicial review, but only after exhaustion of administrative remedies. The U.S. Supreme Court, in *Illinois Long Term Care Council v. Shalala*, ruled that exhaustion of all administrative remedies under Medicare is a prerequisite in almost all instances to jurisdiction in federal court.

Where the controversy involves a widespread practice or a policy interpretation, administrative review may not only postpone a global resolution of the issue, but may also prevent such resolution. A favorable administrative ruling cannot be appealed nor does it set a precedent. The Centers for Medicare and Medicaid Services (CMS) has generally followed a policy of non-acquiescence to administrative rulings it does not approve of, thereby leading to multiple administrative appeals on the same issue without any programmatic correction of the controversy. If providers and beneficiaries were allowed to pursue such issues in federal court without needing to resort to administrative remedies, an injunction issued by the court on behalf of a class of providers or beneficiaries would allow for resolution of the issue globally.

Through legislative and regulatory reforms in 2003-2005, including the Medicare Modernization Act of 2003, an expedited right of judicial review where there are no material issues of fact in dispute and the validity of a law or regulation is the only dispute that exists. This right applies to payment and provider agreement determinations, but not reimbursement disputes. Process-related issues are also not addressed.

In 2014, NAHC filed a lawsuit challenging the validity of the Medicare face-to-face physician encounter rule requirement for a physician narrative along with its implementation and oversight by CMS. The federal court permitted the prosecution of the claim regarding the validity of the rule, but dismissed the claims related to its administration, requiring an exhaustion of individual claims' administrative appeals.

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

RATIONALE: Where issues involving significant segments of Medicare operation are to be reviewed, the current administrative appeals process presents a costly and unnecessary burden. Requiring exhaustion of administrative remedies for matters of potentially widespread impact could lead to inconsistent operations within the Medicare program. Claimants that are successful within the administrative process are made whole.

For those providers who have neither the resources nor ability to access the appeals process, an illegal payment denial or disallowance of cost becomes final. Systemic reform of errors in practice or policy at CMS or its contractors can come about only through class action judicial review.

ALLOW APPROPRIATE AND EXPEDITED JUDICIAL REVIEW OF MEDICARE REIMBURSEMENT POLICY DISPUTES

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

In addition, the Balanced Budget Act of 1997 (BBA) prohibited judicial review of any decisions by CMS relative to the creation and implementation of the home health prospective payment system (PPS). This leaves CMS with unfettered discretion and forces Congress to micromanage CMS through ongoing oversight. The recent case mix creep adjustment as part of the PPS reforms is a clear example of arbitrary rulemaking that may go un-reviewed by federal courts. NAHC filed a lawsuit in 2009 challenging CMS's evaluation of changes in case mix coding weights. Among the claims, the lawsuit argued that CMS switch its rationale for the adjustment between the proposed and final rule giving no opportunity for public review. The federal court dismissed the case holding that the individual providers of care had to exhaust administrative review prior to litigation in court. To do so, providers, individually or in small groups, would need to pursue administrative appeals. Such an approach is inefficient and impractical thereby insulating CMS from real review.

The current expedited judicial review authority allows a party to bypass some of the administrative appeal steps, but it still requires a party to wait for a Notice of Program Reimbursement (NPR) before proceeding. In a typical reimbursement dispute the NPR is issued only months after the close of a provider's Medicare cost report year. This means that the impact of a disputed rule will continue for several years before judicial review of its validity is available.

This roadblock to judicial review also impacts hospice. An example is the case, *NHPCO v. Leavitt*, where the court held that hospices must individually exhaust all administrative appeal remedies before the court can hear a challenge to the Medicare rule eliminating the Budget Neutrality Adjustment Factor for all hospices.

RECOMMENDATION: Congress should enact legislation that would create an expedited route to judicial review where the basis of the action is a challenge to the validity of a Medicare reimbursement policy, including the home health PPS and any hospice payment policy. Judicial review should be available where the claim is collateral to a direct claim for payment and the provider of services faces irreparable harm without judicial intervention. The review should allow for nationwide relief rather than a ruling that affects only the named parties to the litigation. Also, that review should be available immediately after Medicare issues a Final Rule rather than needing to wait through the entire cost report year and NPR process.

RATIONALE: The current system allows CMS to develop home health services and hospice reimbursement policy without subjecting it to public or judicial oversight and in a manner which

dissuades home health agencies and hospices from incurring costs which may actually be allowable under the Medicare program. Further, it allows CMS to establish PPS and hospice policy which is counter to the mandates of Congress. An expedited judicial review under these limited circumstances would allow for program wide resolution of disputes, thereby reducing the number of individual disputes that have to be resolved through the administrative process.

ENSURE AND ENFORCE BENEFICIARY CHOICE IN ALL FEDERAL HEALTH CARE PROGRAMS

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

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

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

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

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

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

ENSURE PATIENTS' RIGHTS AND "TRUTH IN COVERAGE" IN MANAGED CARE PLANS

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

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

The increased emphasis on managed care as a means of cost containment has caused concerns about quality and access among consumers and providers, who fear that increased reliance on managed care will exacerbate the problems experienced to date. Despite significant attention to the need for patients' rights legislation to address managed care abuses beginning in the 107th Congress, Congress has been unable to successfully complete action on such a measure. There are wide disagreements over the circumstances and extent to which managed care enrollees should be allowed to sue their managed care plans. Patients' rights legislation is expected to remain a major issue for members of Congress and the Administration.

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

- The patient's physician loses control of the patient's care;
- Managed care plans create strong financial incentives to deny services, and some plans have illegally denied home care services to patients who need them;
- Patients whose care needs can be both expensive and lengthy are especially vulnerable under managed care plans that seek primarily to control costs;
- When plans fail to achieve sustained cost savings, and many payers have found that promised savings were experienced only as a one-time phenomenon, benefits are reduced or eliminated altogether;
- Patients are sometimes illegally denied home care services and must sue insurers to get the care they need and deserve;
- Managed care organizations have sometimes engaged in unfair competitive practices and heavy-handed bargaining in negotiating referrals to home care agencies;
- Consumers resent their lost freedom of choice in what can seem like a third-party bureaucracy designed to deprive them of care;
- Unwarranted interference with the caregiving process and excessive paperwork have been continuing problems;
- The potential for fraud and abuse increases under managed care when plans pursue cost savings at the expense of quality and access;
- In the long run, managed care can reduce quality of care by curbing the development and use of new medical technology; and
- Consumers are not told about copay requirement and other limitations on the provision of

home health service in the managed care plans. During 2007, Rep. Pete Stark (D-Calif.), chair of the House Ways & Means Health Subcommittee, introduced legislation that would address one specific element of concern that relates to the Medicare Advantage program – that of private plans charging more in the way of beneficiary coinsurance for services than are charged under the traditional Medicare program. In 2010 the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) included a provision forbidding higher copays in Medicare Advantage plans for certain services but did not specify home health care.

RECOMMENDATION: Managed care is not a panacea for controlling costs and ensuring access to appropriate services. If utilized, managed care plans should be designed carefully so that the pursuit of least costly care does not jeopardize quality of care or access to necessary services. Managed care plans should include mechanisms to preserve consumer choice, ensure easy access to needed services, require and enforce quality assurance standards for all providers, ensure payment rates that recognize the costs associated with high-quality care, allow individuals to challenge adverse decisions, promote fair marketing practices, and provide appropriate consumer education. To secure many of these goals, a national patient bill of rights should be enacted.

Congress should pass plan “truth in coverage” requirements that include consumer education provisions to ensure consumers understand the cost-sharing requirements and other limitations on home health services under managed care plans. Medicare Advantage plans should be prohibited from charging beneficiary cost sharing in excess of that charged under the traditional Medicare program, including a prohibition against any home health copayments. Beneficiaries should be given clear explanations of how accessibility of Medicare Advantage home health benefits will differ from under traditional Medicare.

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

PROTECT CONSUMERS FROM ERRONEOUS SERVICE AND COVERAGE DETERMINATIONS

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

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

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

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

- Allow federal court review of all disputed MCO determinations regardless of payer.
- Establish an office of a health plan ombudsman within each state with responsibility to provide oversight of health plan operations and advocacy on behalf of consumers. This office should resolve disputes informally and refer consumers to necessary advocacy resources when appropriate.
- Require that the Department of Labor consult with the Department of Health and Human Services in establishing the standards of operation for the review offices within states.
- Require that claims review be performed only by personnel with expertise in the area of concern, not limiting such expertise to physician reviewers, but including all disciplines of service.
- Amend the Employee Retirement Income Security Act to provide for rights of action under state law for damages as related to principles of equity, including but not limited to, promissory estoppel, bad faith, and unjust enrichment.

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

PROTECT PATIENTS' FREEDOM TO CHOOSE IN MANAGED CARE PLANS

ISSUE: There has been a growing shift toward use of managed care plans in the Medicaid program and in spite of recently decreased payment rates for Medicare managed care under the Medicare Advantage program, beneficiary enrollment in Medicare-managed care plans has increased significantly.

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

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

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

The Medicare Advantage program known as the Private Fee-for-Service plan allows enrollees to utilize any Medicare participating provider of services and receive the identical benefit available under traditional Medicare. This approach has worked well for Medicare beneficiaries who wish to choose a particular provider of care. However, the Medicare Modernization Act of 2003 allows these plans to limit patient choice through the imposition of copayments where the plan develops a network of providers. Further, the availability of the PFFS plans was reduced dramatically in 2010 when new federal rules took effect requiring the plans to maintain network providers in addition to the allowed freedom of choice.

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

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

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

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

RATIONALE: An “any qualified provider” provision helps protect patients from the increasingly common trend in MCOs of frequently changing contract providers as the MCO bargains for ever-

lower provider rates. The "any qualified provider" provision also helps ensure that patients are not forced to choose a new provider with every renegotiation. Restricting a patient's freedom to choose violates the spirit of the Medicare and Medicaid programs and should not be permitted in any health plan.

PROHIBIT GAG RULES IN MANAGED CARE CONTRACTS

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

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

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

MODIFY PREEMPTION PROVISION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

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

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

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

AMEND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT TO REQUIRE DIRECT PROVIDER APPEAL RIGHTS

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

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

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

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

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

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

AUTHORIZE PUNITIVE DAMAGES LAWSUITS FOR BAD FAITH INSURANCE DECISIONS

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

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

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

G. PRIVATE INSURANCE

REQUIRE COVERAGE OF HOME HEALTH CARE AND HOSPICE AS ESSENTIAL HEALTH INSURANCE BENEFITS

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

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

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

RATIONALE: All Americans should have access to home care and hospice coverage in their health insurance. Home health has proven to be effective in reducing health care expenditures by reducing hospitalizations, shortening hospital stays, and serving as an alternative to costly post-acute inpatients stays. In addition, cost savings are realized at the end of life through the delivery of hospice services. Failure to include home health and hospice coverage will result in increased costs and fewer options to enrollees. Furthermore, failure to include home health and hospice benefits is inconsistent with the Administration's focus on home and community-based services and could be in violation of the American with Disabilities Act (ADA).

H. STUDIES

CONDUCT IN-DEPTH STUDY OF VARIATION IN HOME HEALTH SERVICE USE AND OUTCOMES IN MEDICARE MANAGED CARE AS COMPARED TO THE FEE-FOR-SERVICE SECTOR

ISSUE: [39 percent of Medicare's 62 million beneficiaries](#) were enrolled in Medicare Advantage (MA) health maintenance organizations (HMOs) and other types of private plans as of 2020. In certain areas of the country, home health agencies are experiencing significant change in terms of the proportion of their Medicare clients that have chosen to enroll in Advantage plans. MA plans pay in a variety of ways, including on a per-visit basis; most do not reimburse agencies their full costs of providing care. Many home care agencies experience financial hardship in ensuring that their managed care patients the same level of care as they provide their fee-for-service clients.

Under traditional Medicare, quality of care provided to home health beneficiaries has continued to improve. However, in recent years the Medicare Payment Advisory Commission (MedPAC) has studied Medicare's private plans and found that the care quality MA HMOs that entered the market before 2004 has improved somewhat; however, the quality of care from newer plans has not. Further, even greater concerns surround Medicare Private Fee-for-Service (PFFS) plans, which have been the fastest growing segment of private coverage in recent years, because they do not employ care coordination as part of their coverage.

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

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

PROTECT PATIENT ACCESS TO CARE AND PAYMENT RATE NEUTRALITY IN A SITE-NEUTRAL POST-ACUTE CARE PROSPECTIVE PAYMENT SYSTEM

ISSUE: Over the past ten years, Congress and the Medicare Payment Advisory Committee (MedPAC) have studied and evaluated the viability of moving towards a site-neutral post-acute care payment system. The effort started in 2008 with the post-acute care payment reform demonstration (PAC-PRD). This congressionally-mandated program was designed to evaluate patients following their discharge from acute hospitals in the four PAC settings utilizing a standardized data collection process.

In building on the PAC-PRD, the MedPAC has studied a shift towards a site-neutral, or unified post-acute care prospective payment system (PAC-PPS) whereby parity would be brought to reimbursements across the four PAC settings -- home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Congress and MedPAC's motivation in developing a unified PAC PPS is driven by vastly different reimbursement structures and profit margins across the four settings. Additionally, MedPAC states that the current systems provide disincentives to providing care to certain patient types and groups depending on their presenting condition.

Further, in 2014, President Obama signed into law the Improving Medicare Post-Acute Care Transformation (IMPACT) Act (P.L. 113-185). A provision in this legislation called for MedPAC to present to Congress a report on a unified PAC PPS utilizing data from the PAC-PRD that reimburses based on patient characteristics rather than the patient treatment setting. Additionally, MedPAC was directed to report on the impact related to such a shift.

As a broad outline for a site-neutral payment system, a uniformed unit would be defined (i.e. the number of days that makes up a "stay"). A base payment rate would coincide with this unit, to then be adjusted for local wage indices, and then again by a case-mix assessment, and potentially other adjustors, as well. Two outlier adjustments would also apply -- one for higher than expected costs, and one for low utilization, similar to what is currently in place. Unique to HHAs' would be another adjustor bringing down the reimbursement rate compared to the other three PAC settings. MedPAC justifies this by pointing to HHAs lack of infrastructure overhead that institutional settings must maintain.

President Trump's Fiscal Year 2019 budget called for implementing a unified post-acute care prospective payment system from which a deficit reduction of approximately \$80 billion will be generated over 10 years. The President's Fiscal Year 2020 budget contained a similar proposal, though with updated figures of \$101 billion in savings over a 10 year window.

RECOMMENDATION: Congress should closely monitor all developments related to a unified PAC PPS ensuring strong patient access to care. Careful study and modeling needs to be performed on the payment adjustor HHAs would be subject to. If Congress chooses to move to a site-neutral payment system, it should be implemented as a demonstration program or on a limited roll-out to protect against widespread unintended consequences. Any payment reform must be payment rate neutral, rather than budget neutral. A budget neutral plan holds the potential to unjustly favor one sector at the expense of another. Home health is a vital service that should not be discouraged in a site-neutral system.

RATIONALE: As the number of citizens achieving Medicare eligibility continues to expand, it is vital that precious financial resources be directed to the most effective and efficient settings of care. Home health has been shown to be not only the preferred care setting, but also to be the most effective in particular cases relative to outcomes and cost- efficiency. Any unified PAC payment system should neither discourage such efficiencies, nor reduce patient choice. An excessive adjustor threatens to cut reimbursement, forcing HHAs out of business and diminishing patient options for care.

I. QUALITY AND INTEGRITY OF CARE

EVALUATE USE AND ACCURACY OF HOME HEALTH COMPARE

ISSUE: The Centers for Medicare & Medicaid Services established a web-based information tool for consumers to aid in their selection of a home health agency for themselves or a loved one. This tool also can be used by health care professionals such as hospital discharge planners and managed care organizations. “Home Health Compare” provides a listing of Medicare-participating home health agencies and the geographic area that they serve. It also offers information regarding the performance of the agencies in terms of certain patient outcomes. The home care community was an avid supporter of Home Health Compare prior to its inauguration several years ago. However, it is unknown as to how much this tool is actually used to guide parties in the recommendation or selection of a home health agency. Further, there have been some questions raised regarding the accuracy and relevance of the information contained in Home Health Compare. A core problem is a weak risk adjustment model used when comparing agencies serving widely differing patients and the use of a limited data set on adverse patient events such as re-hospitalizations.

CMS has extended the use of Home Health Care Compare data in its Star rating system for home health agencies. CMS has selected a portion of the Compare data to support the system that presents consumers with a simpler comparison rating model. As such, the reliability of the Compare data is more important than ever. One central weakness in the Star rating system is that it uses measures that focus on improvement in patient function while a large portion of the home health patient population are not candidates for functional improvement. The Star ratings do not evaluate an agency’s performance in maintaining function or slowing the deterioration of function. That weakness is compounded by a design flaw that rates agencies on a bell curve, leading to most agencies rated at a 3 Star. Unlike consumer-known star ratings where objective criteria allow the service or good to be objectively rated, the CMS Star model forces a proportion of agencies into each of the 9 levels of ratings.

In 2016, CMS added a new, separate Star rating that is focused on patient satisfaction survey data. No changes have been made in the system framework that eliminate or mitigate the problems and concerns that have existed since the outset of the Star ratings.

RECOMMENDATION: Congress should support and expand the OIG study into the use and accuracy of Home Health Compare. The study should focus primarily on the validity of Home Health Compare and then on whether and how Home Health Compare is used to select a home health agency, guide hospital discharge planners, and influence Medicare Advantage plans in their contracting for services. Further study should be done on the validity and usefulness of the Star rating systems.

RATIONALE: Conceptually, Home Health Compare is a valuable tool for consumers and health care professionals. However, no tool is of value unless it is accurately composed and effectively used. The proposed study will help gain understanding as to how Home Health Compare can be used and improved for maximum beneficial use.

ENACT MEDICARE HOME HEALTH AND HOSPICE PROGRAM INTEGRITY MEASURES

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

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

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

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

- Requiring federal enforcement authorities to prioritize oversight and enforcement on matters that have high dollar impact while establishing sensible corrective measures to address providers with minor errors and omissions.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services or hospice care.
- Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.
- The establishment of a Joint Program Integrity Advisory Council that works in partnership with federal and state programs to prevent and resolve systemic programmatic weaknesses that waste health care resources.
- Development and authorization of an industry-directed enforcement entity working in conjunction with federal and state authorities.
- Establishment of targeted payment safeguards that utilize modern techniques and tools, directed towards abusive utilization of services and payment as necessary and appropriate.
- Explore options for “certifying” providers for compliance with technical billing requirements to reduce audit burdens.
- Monitor the impact of Targeted Probe and Educate (TPE) for its impact on home health and hospice providers and the home health and hospice benefits.

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

ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

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

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

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

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

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

hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.

- Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.
- Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.
- Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicaid.
- Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality care.
- The establishment of a Joint Program Integrity Advisory Council that includes representatives from state Medicaid programs, CMS, home care providers and Medicaid recipients. The Advisory Council is intended to help increase awareness of program integrity weaknesses and to recommend solutions.
- Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

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

**V. ENSURE A CENTRAL ROLE FOR HOME CARE
RELATIVE TO WELLNESS AND PREVENTION OF
DISEASE**

ALLOW HOME CARE AGENCIES TO SERVE AS CASE MANAGERS IN FEDERALLY-FUNDED PROGRAMS

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

External case managers who are responsible for fiscal management are often inadequately qualified and frequently see too little of clients to deal with their problems on a timely and informed basis. While an external or independent case manager was suggested as a means to contain costs as part of H.R. 2342 and S. 1179, the Medicare Chronic Care Improvement Act of 2003, it can be quite costly to implement and is unnecessary where case management is already available from a home health agency.

The Patient Protection and Affordable Care Act, P.L. 111-148, (PPACA) included numerous components that utilize case management services as part of the overall care benefits of various programs. For example, case management is an integral part of post- partum depression programs (PPACA section 2952), the patient-centered medical home pilot (section 3502), and community-based collaborative care networks (section 10333). Case management is also central to the program establishing incentives for state Medicaid programs to offer home care as an alternative to nursing home care (PPACA section 10202). In that program, the states must provide “conflict-free” case management services. This program has the potential to leave providers of home care services outside of the opportunity to also provide the case management services.

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

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

CREATE A NUTRITIONAL SERVICES HOME HEALTH BENEFIT

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

About 3.5 million Medicare beneficiaries received home care services in 2015 according to the Medicare Payment Advisory Committee (MedPAC). Patients who receive home care services have a high prevalence of malnutrition and need some type of nutrition service (Rebovich et al., 1990). Malnutrition can be a risk for early non-elective hospital readmission.

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

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

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

During 2000, the National Academy of Sciences Institute of Medicare (IoM) submitted a report to Congress entitled, "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population" (IoM, 2000). This report

summarizes conditions that were identified as requiring a nutritional professional within the home setting. The conditions identified are listed below.

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

RECOMMENDATION: Congress should amend the Medicare home health benefit to create a nutritional services benefit and include in the calculation of the PPS episodic rate the services of nutritional professionals. Congress should also amend the home health benefit to include the recommendations of the National Academy of Sciences mentioned above.

RATIONALE: Patients seen in the home care setting are often the most frail, undernourished group of elders within the health care system. Because these patients are homebound, they do not have the ability to use nutrition services that may be available in other ambulatory settings. Beneficiaries who are unable to maintain adequate nutritional status are more likely to experience adverse outcomes, including premature hospital readmission, functional compromise, comorbidities and mortality.

**VI. ENSURE THE AVAILABILITY OF HOSPICE AND
PALLIATIVE CARE FOR ALL AMERICANS NEAR THE END
OF LIFE**

REJECT EFFORTS TO REDUCE THE HOSPICE AGGREGATE CAP

BACKGROUND: At the time the Medicare hospice benefit was enacted by legislation in 1982 it was expected to serve primarily terminally ill cancer patients. For its time the benefit and payment structure were extremely innovative – hospice providers were paid prospectively set rates to provide an array of services based on patient care needs. When creating the Medicare hospice benefit, congressional advocates included provision in statute for a Hospice Aggregate Cap (Cap) to meet budget reconciliation requirements and ensure that establishing a hospice benefit would be cost-neutral in the aggregate as compared with what otherwise would have been spent. While the Cap was originally intended to provide for variation in costs among different regions of the country, subsequent legislation imposed a flat national Cap of \$6500, with provision for an annual update. The \$6500 value was roughly equivalent, at the time, to the cost of providing care to hospice cancer patients in the final 40 days of life (the average length of stay for hospice patients cared for under the hospice demonstration). Substitution of a flat rate has resulted in inequities, particularly for areas of the country with high labor costs. The Cap is applied in the aggregate on a hospice-by-hospice basis, but a “lifetime limit” equal to the value of the Cap follows the patient while on hospice care.

The hospice population currently served under the program varies significantly from that served in hospice’s early years. Due to a variety of health care advances and other factors, cancer now represents the principle diagnosis for less than 30% of hospice patients. Most patients have a non-cancer diagnosis, as well as multiple comorbidities, that contribute to the determination that they are terminally ill with a prognosis of six months or less. In keeping with these changed patient characteristics, the average length of stay on hospice care has increased to about 90 days. A significant proportion of hospice patients are on care for more limited length of time prior to death. Despite these changes over recent decades, the Cap mechanism has remained, for the most part, unchanged. The approximately 14% of hospices that exceed the cap return self-calculated overpayments within five months of the end of the cap year.

During late 2019, the Medicare Payment Advisory Commission (MedPAC) conducted discussions on potential reforms of the hospice Cap. As part of these sessions, staff provided findings from a simulation under which they estimated the impact of wage-adjusting the hospice Cap and, at the same time, cutting the overall Cap value by 20%. While MedPAC staff provided no analytical rationale for cutting the Cap by 20%, they indicated that taking such action would alter incentives for hospice providers to accept patients onto service for longer lengths of stay. The combined impact of the two changes would roughly double the percent of hospices that exceed the aggregate Cap (from 12.7 to roughly 26%). In January 2020 MedPAC voted to include the two policy changes (wage indexing and reducing the Cap by 20%) as part of its March 2020 report containing Medicare payment recommendations to Congress. In January 2021 MedPAC once again approved these recommendations, and did so again in January 2022.

RECOMMENDATION: Congress should reject MedPAC’s recommended Cap cut of 20%. Congress should consider wage adjusting the Cap to address wage variation and make this change on a budget-neutral basis. The cap calculation should be based on the wage index connected to the location of the hospice provider in order to ensure ease of cap calculation and monitoring of cap status. Since applying a wage adjuster will have a significant redistributive impact, wage adjustment of the Cap should be phased in over time to minimize the potential impact on access to

care and to allow the most negatively impacted areas of the country to adjust. Finally, Congress should limit variation in the wage index applicable to the Cap (creating a “floor” and a “ceiling”) so as to protect hospice providers from the significant swings that can accompany wage index changes from year to year to ensure the Cap value remains more consistent.

RATIONALE: Analysis of factors linked to over-cap hospices conducted during 2020 by Dobson DaVanzo for the National Association for Home Care & Hospice (NAHC) found that while a number of factors that appear to impact cap status are beyond an established hospice’s control, provision of services to non-cancer patients (including those with neurological conditions and heart and circulatory system diseases) has the most significant impact on a hospice’s potential for exceeding the hospice cap, and that reducing the cap by 20% increases the degree to which care of non-cancer patients impacts cap status. For example, under the MedPAC proposal, a 10% increase in services to patients with neurological disorders increases the chances that a hospice will exceed the aggregate cap by 11% (nearly double what is the case under existing cap policy). Based on these findings, a cut to the hospice cap will create a strong incentive for hospices to avoid admitting these patients onto service and may lead to significant care access problems for these types of patients. MedPAC’s recommended cut of 20% to the hospice Cap represents a crude attempt to change hospice financial incentives and fails to take into consideration the many factors that contribute to variations in patient care needs. These factors include a more complex patient population for whom establishing an accurate six-month prognosis can be challenging, as well as greater variation in patient mix and size of individual hospice provider.

MedPAC’s underlying concern for long length of stay associated with higher margins also fails to fully consider budget neutral payment changes (such as building on CMS’ previous payment reform work by creating an additional payment “tier” to Routine Home Care (RHC) to better address high-cost, short-stay patients) within the payment system that could shift resources to ensure that hospices are more adequately reimbursed for the costs of care when patients first enter hospice and for patients with very short lengths of stay.

Absent full analysis of the Cap, a deep cut to the Cap value is a blunt instrument for changing provider incentives and fails to address other changes -- such as a further refinement to the payment system (including potential creation of an additional, budget-neutral RHC payment tier) that would shift resources in order to more appropriately reimburse variation in patient care needs — that may be indicated.

SAFEGUARD THE INTEGRITY OF THE HOSPICE BENEFIT AS PART OF EFFORTS TO TEST COVERAGE OF HOSPICE UNDER THE MEDICARE ADVANTAGE BENEFIT PACKAGE

ISSUE: The hospice benefit was the first bundled benefit package authorized under Medicare. Since its inception, the Medicare hospice benefit has been excluded from the Medicare private plan (Medicare Advantage-MA) benefit package and in 1997, as part of the Balanced Budget Act, Congress established in statute that hospice is carved out of the Medicare managed care benefits package. In 2014, the Medicare Payment Advisory Commission (MedPAC) recommended that hospice coverage be incorporated as part of the MA benefit package. MedPAC's rationale was 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.

In December 2015 the Bipartisan Chronic Care Working Group of the Senate Finance Committee issued a Policy Options Document that suggested MA plans should be required to include hospice as part of the MA benefit package. The working group's proposal elicited significant concerns about the impact of this potential change on hospice patients and the integrity of the hospice benefit. As a result, when chronic care legislation authored by the Working Group (S. 870 -- the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017) was introduced in April 2017, it did not propose inclusion of hospice as part of the MA benefit package.

During January 2019, the Centers for Medicare & Medicaid Services (CMS) announced plans to test inclusion of hospice under MA as part of its Value-Based Insurance Design model for four years starting in CY2021. In CY 2021, nine MA organizations participated in the VBID hospice model with 52 individual plans. For CY 2022, 13 MA organizations are participating with 115 plans.

Under the model, MA plans are required to offer advance care planning (ACP) services to all enrollees, palliative care services (described by CMS as “largely medical services” already available under Parts A and B of Medicare) for patients not yet eligible for hospice or who choose not to elect hospice care, and concurrent care (expected to be time-limited) to assist with the transition to hospice care. Concurrent care will be offered only to patients choosing an in-network provider, and plans are encouraged to provide patient consultations to explain the benefit limitations of selecting an out-of-network hospice. Plans may not increase their bids to address the costs of palliative or concurrent care.

Plans are also permitted to offer a hospice- and beneficiary-specific set of supplemental benefits, access to which can be limited to a specific dollar value as well as to patients based on their choice of an in-network hospice provider. While the model requires that the “full” hospice benefit be provided, it also places a heavy emphasis on management by the MA plan and on

utilization controls. CMS and plans will have the ultimate authority for determining whether services are “unrelated” to the terminal condition and related conditions, rather than the hospice physician. Further, plans are permitted to implement “program integrity safeguards”, suggestions for which include requiring prepayment review of drugs ordered by out-of-network hospices and prepayment review to address long lengths of stay (more than 180 days).

CMS initially signaled plans for potential bonus payments in later years of the model for those plans that reduce spending outside of hospice while patients are on service (unrelated services), reduce long lengths of stay (over 180 days), reduce the frequency of very short lengths of stay (less than 7 days), and reduce live discharges from hospice followed by hospitalization or death. Plans will cover services provided by all hospices in an area for the first two years of the model. In the third year of the program, plans will be subject to a network adequacy standard that was initially expected to be as low as one hospice per county, although CMS has more recently indicated it is seeking input on how to establish an appropriate network adequacy standard.

Inclusion of hospice as part of the MA benefit package raises significant concerns for hospice providers and beneficiary advocates; among them are the following:

- The success of MA has been largely due to imposition of utilization controls. Bringing coverage of end-of-life care under this model runs counter to the hospice model, which emphasizes team-based, patient-centered care;
- Medicare beneficiaries enrolled in MA who elect hospice will no longer have a choice of the hospice provider that will care for them in their final days of life;
- Many hospices provide additional services beyond the scope of the hospice benefit (such as massage, music, and other therapies) because these services have been shown to improve the quality of life for many patients on hospice. Continuing availability of these services may be at risk if MA payment rates do not adequately compensate the hospice;
- 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 hospice relative to whether a patient does or does not meet Medicare’s eligibility requirements;
- The hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the palliation and management of the terminal illness and related conditions, and hospice medical personnel have extensive experience in making determinations of what diagnoses and treatments are related and unrelated to the terminal diagnosis. However, under the model, these decisions are superseded by the MA plan, and may be driven by an MA plan’s financial incentives to shift responsibility for unrelated services to the hospice provider.
- The lack of clear and consistent requirements in the model guidance around the breadth, depth, and scope of the required non-hospice palliative care component, as well as the “transitional concurrent care” flexibility. Neither of these elements of the model are well-defined, which is resulting in a wide variation in how MA plans implement them. This lack of standardization can result in the disparate provision of this important upstream care depending on which plan a beneficiary is a member of.
- The onerous administrative burden placed on hospices in the model that are required to submit claims and report data to both the various MA plans their patients are members of, as well as to their regular MACs. This “double-submission” is time-consuming and increases rather than diminishes provider burden.

Anecdotal evidence from many hospice providers that have participated in year one of the

model suggests that MA plans are indeed finding ways to reduce payment to hospices, either through securing negotiated rates lower than the FFS per diem amounts, and/or establishing processes or policies that make it harder for hospices to get paid for things like the Service-Intensity Add-On (SIA) payment or the transitional concurrent care services.

There are also significant concerns that CMS' plans for evaluation of the model are not sufficient to ensure that the model will not negatively impact the integrity and scope of the hospice benefit.

RECOMMENDATION: The CMS guidance for the VBID hospice model and the experience of many hospices that participated in the demo's first implementation year have done little to allay concerns around bringing hospice under MA. It is incumbent on CMS and other policymakers to ensure that the model addresses concerns regarding patient freedom of choice, addresses perverse incentives that will contribute to patient steering and could lead to reductions in services for hospice patients, and ensures that plans for a thorough and transparent evaluation of the impact of the model have been developed. As part of its efforts to monitor the model, CMS must ensure that MA plans report all patient visits and services in a comprehensive manner so that service utilization can be compared with hospice care under fee-for-service. CMS should also be required to publicly share model data in a more timely and transparent fashion, so that hospices and other stakeholders can more accurately assess the impact the demo is having in real-time. Further, CMS must be required to expand the quality measures it uses as part of the model to include a focus on the percent of patients that die in hospice care. Finally, CMS must ensure full transparency around the benchmarks to be used for each measure and evaluate all outcomes of the model against the experience of MA patients outside the model who elect hospice care and patients enrolled in hospice under fee-for-service, as well as provide Congress with annual updates on the model.

As part of the demonstration, CMS should test alternative models, including:

- Allowing MA plans to cover all services (including services unrelated to the terminal illness and related conditions) except hospice services; and
- Creating an end-of-life services bundle that provides hospices the opportunity to manage all care needs once a patient enrolls in hospice care.

Finally, given the breadth of concerns regarding the demonstration model, Congress should prohibit CMS' expansion of MA coverage of hospice services outside of the VBID demonstration model on its own motion. Any consideration of expansion of the model must be contingent upon assurance that the model has demonstrated improved access to, and quality of hospice care and that MA coverage of hospice services has not impacted the scope of the hospice benefit negatively.

Congress should also urge the Administration to focus on addressing areas that hold the greatest potential for improvement in end-of-life care, including:

- Creation of a robust set of cross-setting end-of-life care measures that can be utilized under original Medicare and MA to assess quality of care, adequacy of care coordination and transitions, and patient/family satisfaction;
- Education of stakeholders (plans, hospices, and patients) around the interaction of MA and hospice care coverage to reduce existing confusion and exploration of potential MA coverage modifications, such as the transfer of non-related care at the end of life to MA plans, to reduce coverage complexity and increase plan responsibility;
- Examining findings from existing innovation models, such as the Medicare Care Choices Model (MCCM) and the Direct Contracting High-Needs Track models for useful lessons on appropriate support of advanced illness ways to provide a smoother transition to hospice care where appropriate; and

- Thorough analysis of the impact of developments in end-of-life care and recent changes to the MA benefit package (including the allowance of palliative care as a MA supplemental benefit) on utilization of hospice care.

RATIONALE: The Medicare hospice benefit was created to respond to the broad array of care needs that patients and families experience in the final months and days of life. While use of hospice was limited in its early days, the benefit has now become the foundation for the nation's end-of-life care system. The greatest challenges to hospice at this time are ensuring that patients enter service in sufficient time to fully reap the benefit that hospice has to offer and maintaining the integrity of the existing benefit.

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, and patients must retain the right to determine what level of care to pursue and under what provider's care.

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, the Centers for Medicare & Medicaid Services' (CMS) activation of advance care planning codes under Medicare Part B, and the massive increase in demand created by the COVID-19 emergency for pain and symptom management and sensitive serious illness communication -- 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 guidelines for palliative care teams (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)

According to the American Academy of Hospice and Palliative Medicine, over the next 20 years the demand for palliative care will grow by more than 20 percent, while over the same time the palliative physician workforce will grow by only 1 percent. This falls far short of the anticipated 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 2019 Reps. Elliott Engel (D-NY), Tom Reed (R-NY) and others reintroduced the Palliative Care and Hospice Education and Training Act (PCHETA) – H.R. 647 -- to 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. PCHETA was passed by the House of Representatives on October 28, 2019. Companion legislation was introduced by Sen. Tammy Baldwin (D-WI) as S. 2080. Both bills enjoy widespread bipartisan support.

On a related note, in June 2019, and again in September 2021, Sens. Jacky Rosen (D-NV) and Lisa Murkowski (R-AK) introduced S. 1921, the *Provider Training in Palliative Care Act*, which would allow participants in the National Health Service Corps (NHSC) program to defer their obligated service in order to receive training in palliative care services. The NHSC is a HRSA-administered program that provides grants and loan-repayment incentives to medical providers who choose to practice in certain rural and underserved areas. By removing barriers to NHSC enrollees' ability to pursue palliative training, the bill would help address the especially severe hospice and palliative

care worker shortage in these already short-staffed communities.

Congressional and CMS oversight of Graduate Medical Education (GME) is another policy area in need of updates in order to meet the growing need for more hospice and palliative care professionals. Despite the fact that the majority of patients receiving palliative care and hospice services are Medicare beneficiaries, Medicare does not invest in the training of hospice and palliative medicine (HPM) physicians. Because the Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots—before HPM was formally recognized as a medical subspecialty by the American Board of Medical Specialties—specialty training in HPM is entirely dependent on private-sector philanthropy or institutional support. Given the instability of such funding, this is not a sustainable or rational way to train our nation’s HPM physicians.

RECOMMENDATION: Congress should enact legislation along the lines of the Palliative Care and Hospice Education and Training Act and provide appropriations to implement the legislative proposal. Congress should also enact The Provider Training in Palliative Care Act, to help to better address need in underserved areas. Additionally, Congress should expand GME funding for hospice and palliative medicine, develop innovative models for GME financing, including considering all payers of health care services as sources of funds, and consider revising the current hospital-based GME financing system to reflect changes in health care delivery towards non-acute, home and community-based settings.

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 legislation to support an increased supply of well-trained palliative care practitioners is essential to meeting the care needs of the nation’s aging population and individuals with advanced and terminal illness.

ESTABLISH NEW HOME-AND COMMUNITY-BASED PALLIATIVE CARE DELIVERY AND PAYMENT MODELS TO ADDRESS THE NEEDS OF SERIOUSLY-ILL MEDICARE AND MEDICAID PATIENTS

ISSUE: Most Americans will now experience a substantial period of living with serious illness, mostly progressive and life-limiting. An estimated 45 million Americans are living with one or more chronic conditions that limit personal function and are likely to worsen rather than get better. According to the Institute of Medicine, although representing only 14 percent of the population, these seriously-ill persons account for 56 percent of all health care expenditures. While many of these individuals may eventually elect the Medicare hospice benefit, many others may never choose to receive hospice care, and for those who ultimately will, there can be a substantial amount of time before election where there remains a great need for the kinds of supportive services that high-quality home-and-community-based palliative care provides.

Palliative care is interdisciplinary patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering of all kinds. It is appropriate at any age and any stage in a serious illness, and involves addressing physical, intellectual, emotional, social, and spiritual needs. Despite the proven impact it has on patient and family wellbeing, and its ability to reduce health care spending associated with unnecessary acute care utilization, the lack of a predictable and sustainable payment mechanism has limited community-based palliative care's development and reach across the country and within the Medicare and Medicaid programs. As the population continues to age and people live longer with serious and chronic illnesses, we need more congressional support for innovative delivery and financing models that leverage home-based care providers' expertise to increase access to and the quality of community-based palliative care.

Over the last decade, there have been a small handful of legislative efforts to better define and support development of home-and community-based care models for people with serious illness. In 2013, Senators Mark Warner (D-VA) and Johnny Isakson (R-GA) introduced *The Care Planning Act*, which called for a demonstration of an advanced illness coordination services demonstration that would deliver wrap-around, home-based services to beneficiaries who need assistance with two or more progressive, disease-related activities of daily living. The bill was reintroduced in 2015, and again in 2017, after being slightly modified and given the new name *The Patient Choice and Quality Care Act of 2017* (PCQCA). PCQCA was also introduced in 2017 in the US House of Representatives by Rep. Earl Blumenauer (D-OR-3) and Rep. David Roe (R-TN-1). In 2016, Senators Sheldon Whitehouse (D-RI) and Elizabeth Warren (D-MA) introduced the *Removing Barriers to Person-Centered Care Act*, which would establish a pilot program to test a new payment model that promotes better coordination between health care and social service providers and places greater emphasis on the needs and preferences of Medicare beneficiaries with advanced and serious illnesses. The bill was reintroduced by Senator Whitehouse in 2019. Finally, in 2021, Senator Jacky Rosen, founder of the Senate's Comprehensive Care Caucus, introduced the *Expanding Access to Palliative Care Act*, another bill that calls for the creation and testing of a comprehensive community-based palliative care demonstration run out of the Center for Medicare and Medicaid Innovation (CMMI).

While containing important differences, all of these bills would require CMMI to develop models that would better standardize what high-quality serious and advanced illness care looks

like, and address the gaps in care that those living with serious illness who are not in hospice face in having their pain and symptom management, communication, care coordination, and functional needs addressed. Importantly, each bill would allow many types of providers to participate in these models, as long as they are qualified and experienced in delivering palliative or advanced illness management services. Hospices and home health agencies are uniquely positioned for success under these models, given their expertise in serving chronically and seriously-ill patients and families in their own homes and communities.

In addition to congressional efforts to advance new models of serious illness care, CMS and CMMI have independently pursued models to try to address the needs of this population. For example, the Medicare Care Choices Model (MCCM), which concluded at the end of 2021, tested a kind of concurrent hospice-curative care model and payment structure that should inform new palliative models going forward. Similarly, 2019's Primary Care First-Seriously Ill Population (PCF-SIP) model, which was designed but cancelled before implementation, represented CMMI's first dedicated effort focused on the seriously-ill, non-hospice patient population. The "carve-in" of hospice care into Medicare Advantage as part of CMMI's broader Value-Based Insurance Design (VBID) demonstration also requires participants to offer palliative care upstream of hospice. While they represent early efforts to more broadly scale community-based palliative care, none of these announced models to-date have fully addressed the need for the type of standardization and adequate financial support that high-quality community-based palliative care programs need to spread widely. Notable limitations include both MCCM's restrictions on patient and provider eligibility, and the VBID carve-in's lack of any formal definition about what exactly its required palliative care component should entail in terms of services offered, eligible providers, or payment structures. CMMI must continue to pursue such models and model strategies that will address the gaps in care for the non-hospice seriously-ill population. There is a need both for a standalone sustainable payment and delivery model for targeted community-based palliative care interventions, as well as for policies that thread core palliative care principles and services throughout any care models that impact people with complex chronic and serious illness.

RECOMMENDATION: Congress should pass legislation that requires the creation and testing of home-and-community-based delivery and payment models that address the palliative and supportive needs of the seriously-ill population, and guarantee that qualified home care organizations of all types and sizes, including hospices, home health agencies, and personal care providers, are able to participate in the demonstrations. The failure of past Administrations to put forward a comprehensive solution to address the needs of seriously-ill patients and families has left the health care system ill-prepared to meet the large and growing demand for palliative and supportive services. The *Patient Choice and Quality Care Act of 2017*, the *Removing Barriers to Person-Centered Care Act of 2019*, and 2021's *Expanding Access to Palliative Care Act* all provide viable options for congressional action focused on scaling and spreading palliative care to every community in the country.

RATIONALE: As the country ages and more and more people live longer with more serious illness, there will be an ever-growing demand for the person-and-family-centered, interdisciplinary team-based care that high-quality community-based palliative care provides. However, our current fee-for-service health care payment system presents huge barriers to palliative care growth and standardization.

orically, most hospice and home health agencies have had to cobble together various revenue streams to fund palliative care services, often at a loss. These sources include Medicare Part B payment for physician, nurse practitioner (NP), psychologist and limited situations of Licensed Clinical Social Worker (LCSW) services, home health reimbursement, or concurrent hospice care reimbursement available through Medicaid for pediatric patients or via demonstration projects. Unfortunately, these sources rarely cover the full cost of providing palliative care services. As a result, often seek out alternative sources of funding to supplement traditional payment streams. These additional sources of funding include: grants, philanthropy, commercial insurance contracts, arrangements with hospitals or health systems, arrangements with ACO's or other bundled payment payers, or private pay (concierge) models.

The heterogeneity of the funding landscape for palliative care, and the lack of a dedicated, sustainable, government-based funding source, have been the greatest barriers to the model's wider adoption. Additionally, certain patient eligibility requirements of the existing Medicare home health and hospice benefits limit who can access the kinds of palliative care services that might be delivered under these models. In home health, the requirement that an individual be homebound effectively disqualifies a large number of people who may be seriously ill but still relatively mobile. For hospice, the 6-month prognosis requirement leaves out many people with advanced illness who may not yet be terminally ill but are still in great need of supportive palliative services. In order to build the workforce and design the programs necessary to meet the soaring palliative needs of patients and families, we need Congress to allocate funding to test new models of care.

ENSURE ACCESSIBILITY AND PROMOTE USE OF ADVANCE CARE PLANNING COUNSELING, ADVANCE DIRECTIVES, AND OTHER ADVANCE CARE PLANNING DOCUMENTS.

ISSUE: Advance care planning (ACP) is an ongoing conversation that involves shared decision making to clarify and document an individual's wishes, preferences, and goals regarding future medical care. This comprehensive process, which ideally should involve a patient's loved ones and relevant health care providers, is critically important to ensuring individuals receive the medical care they want in the event they lose the capacity to make their own decisions. ACP is an important component of the kinds of new care models we need focused on people with serious illness. If performed longitudinally and in a manner that encourages iterative discussion as opposed to a once-off "check-box" approach, ACP can help ease a seriously ill patient and their family along the care continuum journey, from the time of a diagnosis all the way to death. Despite being supported by policymakers and healthcare leaders, ACP amongst the general population remains low.

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) activated those advance care planning codes under the Medicare Part B physician fee schedule. In conjunction with activation of the codes, CMS 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.

Since the codes first became available to bill, the number of claims has grown steadily each year. While there were 17,000 beneficiaries with advance care claims in 2017, the number increased to just under 120,000 per month in 2019. However, the prevalence of advance care planning remains low. According to a 2021 Health Affairs study, fewer than 7.5% of beneficiaries in 2019 who experienced a recent onset of certain conditions that would indicate they would benefit from an ACP conversation or those who died within the year had an advance care planning claim. A number of barriers to greater ACP utilization in Medicare have been identified, including lack of knowledge and/or comfort level amongst providers in having these sensitive conversations, limits on the types of providers who can bill for them, concerns around burdening patients with unexpected charges, lack of incentives to signal the importance of their use in billing, and concerns about increasing workflow burden.

In recent years, serious illness care champions in Congress have introduced legislation that aims to improve advance care planning's effectiveness and reach. In 2017, a bipartisan, bicameral group of advanced illness policy leaders, including Senators Mark Warner (D-VA) and Johnny Isakson (R-GA) and Representatives Earl Blumenauer (D-OR) and Phil Roe (R-TN) introduced the *Patient Choice and Quality Care Act of 2017* which includes the following advance care planning-related provisions:

- Permit qualified clinical social workers to provide advance care planning services under Medicare Part B
- Remove all patient cost-sharing obligations for advance care planning services under Medicare Part B

- Require inclusion of information in the Medicare & You Handbook about advance directives, planning services, planning tools, and portable treatment orders.
- Require development of standards for including completed advance care planning documents within a patient's electronic health record.
- Ensure advance directive portability by requiring that an advance directive validly executed in one state may be given effect in a different state.
- Direct the Comptroller General to study the use, portability, and electronic storage of advance directives
- Require Medicare providers and entities to document plans made during a stay of care
- Fund a broad awareness campaign to educate providers and the public on issues related to advance care planning and advanced illness.

In 2016 and then again in late 2020, Sen. Richard Blumenthal (D-CT) introduced the *Compassionate Care Act* to promote advance care planning and end of life care. Among other provisions, the bill's advance care planning elements include:

- Establishing guidelines for advance care planning between health providers and patients
- Launching a national public awareness campaign that would encourage patients and providers to make end-of-life plans
- Requiring the development of education resources for providers to engage with patients to develop advance care education resources
- Allowing a permanent expansion of the COVID-19 pandemic-related flexibility that allows Medicare advance care planning to be delivered using telehealth
- Facilitating a study on a national advanced care planning registry that would allow patients to transfer their advanced directives from state to state.

RECOMMENDATION: Congress should expand opportunities for advance care planning activities, including ensuring that all appropriate disciplines (including clinical social workers) are able to be reimbursed to perform such services, removing cost-sharing under Medicare for advance care planning, ensuring advance care directive reciprocity across states, mandating the development of standards for advance care plan inclusion in and portability across electronic health records, and supporting a broad public awareness campaign. Congress should look to legislative proposals like the *Patient Choice and Quality Care Act* and the *Compassionate Care Act* to help guide their efforts.

RATIONALE: Patient-and-family-centered care requires that patient values and preferences are known and are authentic and informed, as well as are accessible by the individual's care team. Advance care planning (ACP) is one tool to enable patients (and/or their legal representative or next-of-kin) to determine their values and goals and document them in a way which facilitates care that aligns with what matters to the patient. Despite much progress in developing policies to support and expand awareness and access to advance care planning, much work remains to be done to optimize these conversations and support health care providers (including home-based care organizations and practitioners) in their efforts to learn about and implement advance care planning in diverse settings in a way that is sustainable and reduces administrative or logistical burden.

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 wherever possible to target program integrity efforts toward “bad actors” rather than toward imposing costly across-the-board requirements on compliant hospice programs
- Explore options for “certifying” providers for compliance with technical billing requirements to reduce audit burdens
- Examine any available findings related to the Patient Protection and Affordable Care Act (PPACA) provisions directing CMS to review care of hospice providers that have high proportions of long-stay patients and take appropriate next steps
- 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
- Monitor the impact of the Targeted Probe and Educate Program for its impact on hospice programs and the hospice benefit
- 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.

OVERSEE THE IMPACT OF HOSPICE PAYMENT REFORM

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 (MedPAC) reports 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 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 90 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 more recently. 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 represents roughly 98 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.

Public Law 111-148, the Affordable Care Act, also included a productivity adjustment to the annual market basket inflation update beginning in FY2013 and reduced the market basket index by 0.3 points in FY2013 through 2019. The Medicare Access and CHIP Reauthorization Act of 2015 limited the hospice update for FY2018 to 1 percent.

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. CMS also significantly revised the hospice cost reporting requirements to gather more detailed information related to hospice costs by level of care. 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 reforms to payments for RHC under hospice that sets out two payment rates -- a higher rate (\$186.83 for January 1 through September 30, 2016) for days one through 60 of hospice care and a lower rate (\$146.83) for days 61 and over. Despite a break in service, unless a patient is off hospice care for more than 60 days, the “count of days” for purposes of determining the appropriate RHC rate includes previous hospice service days. CMS also created a Service Intensity Add-on (SIA) applicable to in-person RN and Social Worker visits that are provided during the final seven days of life. The SIA is payable at the hourly rate for Continuous Home Care (CHC, paid at \$39.37 in FY2016) for up to four hours per day. CMS was required to make the payment system changes budget neutral in the first year of application. Given that provision of RN and Social Worker visits in the payment changes may result in future behavioral changes connected to visits in the last week of life, CMS applies an annual budget neutrality adjustment to account for changes in SIA utilization. Both CMS and the Medicare Payment Advisory Commission (MedPAC) have conducted analyses of the impact of the new

payment structure for RHC and have found that the changes have had a modest redistributive effect.

In 2019, CMS released analyses of cost report and claims data estimating that hospices (on average) receive higher payments for RHC than the costs they incur delivering such care, and (conversely) costs incurred for delivery of General Inpatient (GIP), Inpatient Respite (IRC) and Continuous Home Care (CHC) are significantly higher than payment rates. In response to these findings, CMS proposed and finalized rebasing of GIP, IRC and CHC to reflect costs they estimated in their analysis, and reduced payments for RHC by a sufficient amount to cover the rebasing costs for the higher levels of care. While the proposal drew some supportive comments from the industry, it also drew significant criticisms; some specific concerns related to the quality of the data that was used to arrive at the rates, the overall impact on hospice operations and the perverse incentives that might be created under the changes.

In late 2020, MedPAC held discussions regarding further action that could be taken to reform the hospice payment system based on continuing concerns regarding relatively high financial margins (upwards of 13% in 2019) and care patterns that include long lengths of stay and high live discharge rates. MedPAC identified two key areas for continuing research in this area:

- Hospice aggregate level of payments, which MedPAC believes substantially exceeds overall costs, while margins vary widely by length of stay
- Outlier utilization patterns among some hospice providers that raise program integrity concerns

To address long lengths of stay, MedPAC staff indicated that future research could explore a site-neutral payment adjustment for long stays using the Medicare home health per-visit payment as a benchmark, with some additional payment to address some of the differences in services (such as durable medical equipment and medications).

Relative to utilization patterns, MedPAC indicated that an area of research could include whether providers with longer lengths of stays differ from others in terms of the comprehensiveness and intensity of care provided, and whether some type of compliance threshold might be utilized. Examples of compliance thresholds include the 60% rule for inpatient rehabilitation facilities and the 50% rule for long-term care hospitals.

It is anticipated that MedPAC will continue its work in this area as part of future discussions.

RECOMMENDATION: Congress must closely monitor the impact of the payment reform changes that have already been implemented by CMS to ensure that recent 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. Looking forward, Congress must ensure that CMS does not overstep its charge to refine the hospice payment system by implementing changes like rebasing of RHC to costs or reduced payments for care provided to NF residents that could go far beyond the payment refinement sought by the Affordable Care Act.

In the meantime, Congress should reject any reductions in the annual hospice updates, the aggregate cap reduction, or other changes that will impact hospice outlays. Any payment reforms going forward should reflect a measured approach and 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 initial payment reforms implemented by CMS in 2016 have had a modest impact on the distribution of payments within the hospice program, but the impact of the payment changes to levels of care implemented in FY2020 are not yet known. Some hospice providers report that despite the 2016 changes to the RHC payment methodology they are still not adequately compensated for costs they incur providing RHC to short-stay patients. Given the potential disruption that can result from payment changes, care must be taken to guard against disruption to the availability or quality of this most humane service for America's terminally ill patients and their families, and that hospice remains a benefit available to all at the hour of greatest need – the final stage of life.

ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: Section 3132(a) of the Patient Protection and Affordable Care Act (PPACA -- Public Law 111-148), enacted in March 2010, requires that the Centers for Medicare & Medicaid Services (CMS) develop Medicare hospice payment system reforms, and contains hospice payment cuts - including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013 and a 0.3 percentage point reduction to the annual market basket update for FY2013 through FY2019. In addition to the PPACA reductions, CMS has, over seven years, phased out the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index. As the result of these cuts and imposition of the Budget Control Act's 2 percent across-the-board sequester, hospice payments for FY2016 were 12 percent LESS than they would otherwise have been. The sequester is 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. Hospice payment amounts increased by 2.1 percent for FY2017 but were limited to 1 percent for FY2018 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

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 referenced additional unspecified, budget- neutral hospice policy changes. No action was taken to implement these proposals and they have not been included in subsequent proposed budgets.

Over recent years the Medicare Payment Advisory Commission (MedPAC) has recommended to Congress that the statutorily-mandated market basket update be frozen or significantly reduced. As part of March 2020 recommendation to Congress, MedPAC recommended a market basket freeze for FY2021 payments. It reiterated this position in March 2021, once again recommending a freeze on hospice payments applicable to FY2022. It is expected that MedPAC will once again put forward a recommendation to freeze payments in its March 2022 Report to Congress.

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 payment policies, giving close consideration to their potential impact on access to high quality hospice services. 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, and until it can be ascertained that data gathered through various sources (including claims and cost reports) accurately represent the costs of providing hospice care.

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. 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. FY2018 payment updates were limited to 1 percent under MACRA. FY2019 payment updates increased by 1.8 percent. Hospice payments are further reduced by the 2 percent sequester, which is scheduled to remain in place into 2031, due to recent cancellation of the sequester on a temporary basis in response to the COVID-19 public health emergency.
- 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, including the recent addition of time-intensive Election Statement and Election Statement Addendum requirements. The impact of the COVID-19 public health emergency has also created significant financial strains on hospice organizations. MedPAC projects an average Medicare margin of 13 percent for 2022. This estimate excludes costs related to volunteer, bereavement, and other non-reimbursable services, which would further reduce margin calculations by as much as 1.6 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 regulatory burdens.
- 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 continue to report losses under the system. Further, hospices nationwide are reporting later referrals to hospice, which increases overall costs of care.
- The impact of the FY2020 rebasing of General Inpatient, Inpatient Respite, and Continuous Home Care and attendance reductions to Routine Home Care payments are not yet known.
- 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 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.

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

ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS

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, historically neither RHCs nor FQHCs were permitted to bill for visits provided by center physicians for hospice attending physician services. This created a disincentive for RHCs and FQHCs to provide these services, resulting in a greater burden for rural hospices. In recent Congresses legislation was introduced by Sen. Shelly Moore Capito (R-WV) as S. 1190 and Rep. Ron Kind (D-WI) as H.R. 2594 to address this inequity (the *Rural Access to Hospice Act*). This legislation was enacted as part of a 2020 year-end legislative package (Public Law 126-260).

Despite passage of the *Rural Access to Hospice Act*, many barriers remain for rural and frontier-area hospices. Scope-of-practice limitations for certain provider types hinder many rural hospices' ability to maximize staff time and efficiency and serve patients in as timely a manner as possible. For example, under existing hospice law, neither NPs nor PAs may certify a patient as eligible for hospice services and PAs may not conduct the face-to-face encounter. Additionally, while the Bipartisan Budget Act of 2018 gave PAs the authority to serve as hospice attending physicians, there are still unnecessary limitations on their scope under this role. Specifically, hospices are only allowed to accept medication orders from PAs acting as attending physicians if the PA is not employed/contracted by the hospice.

RECOMMENDATION: Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas. Congress should enact legislation to allow NPs and PAs to certify patients for hospice care if this does not conflict with state law, and allow PAs to conduct the hospice face-to-face encounter, as well as allow hospices to accept medication orders from Physician Assistants (PAs) when the PA is not the patient's attending physician and is employed/contracted by the hospice.

RATIONALE: While Congress has taken an important step in enacting *The Rural Access to Hospice Act*, problems for rural hospice providers persist. 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.

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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 frequently do not have up-to-date information related to a patient's history on hospice care to allow a hospice to establish with absolute certainty whether a face-to-face encounter is required. A hospice may take a patient onto service only to discover sometime later (once Medicare systems are updated) that a face-to-face encounter was required. These hospices are technically not permitted to 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.
- Outside of the federally declared COVID-19 public health emergency, hospices may not utilize telehealth services to meet the face-to-face requirement.

In early 2011, CMS modified requirements so that under well-documented "exceptional circumstances" (for example, a hospice is unable to schedule a timely face-to-face prior to beginning needed services for a newly readmitted hospice patient or a hospice is not aware that a patient requires a face-to-face encounter because CMS' data systems do not contain adequate information) hospices are given an additional two days within which to complete the face-to-face.

Subsequently, the National Association for Home Care & Hospice (NAHC) has heard from

hospice providers that have not been permitted an “exceptional circumstances” exception because the circumstances of the late face-to-face did not precisely meet the examples provided in the CMS Benefit Policy Manual.

During the 114th Congress, Rep. Tom Reed (R-NY) introduced H.R. 2208, The Hospice Commitment to Accurate and Relevant Encounters Act (Hospice CARE Act). The legislation would permit hospices to utilize physician assistants (PAs) and other clinicians for completion of the face-to-face encounter. Additionally, under CMS’ “exceptional circumstances” provision, the legislation would give hospices seven days from the beginning of the benefit period within which to complete the encounter. The legislation was not subsequently reintroduced.

In late 2019, the CONNECT for Health Act was introduced, and was reintroduced again amidst the COVID-19 pandemic in 2021 (S. 1512/H.R. 2903). Among its numerous provisions to support increased use of technology by Medicare-participating providers, its sponsors included a provision which would allow hospice providers to use telehealth for performing the face-to-face encounter when recertifying a hospice beneficiary’s eligibility. In such circumstances the originating site requirement for telehealth eligibility would not apply, meaning the recertification could be conducted via telehealth from the beneficiary’s home. Tied to this would be a study to be conducted by the Government Accountability Office (GAO) within three years of enactment that would evaluate the number and percentage of telehealth re-certifications performed, as well as the appropriateness of hospice care for beneficiaries recertified via telehealth.

In response to the COVID-19 public health emergency (PHE), the CARES Act (Public Law 116-136) permitted hospices to use telecommunications technologies to conduct the hospice face-to-face encounter during the PHE. Throughout 2021, NAHC heard overwhelmingly from hospices that the ability to perform the face-to-face encounter using telehealth during the COVID-19 public health emergency has been beneficial to patients, families, and the hospices themselves. Hospices report that all the required information needed for a face-to-face recertification can be obtained virtually, in a manner that is more comfortable and safe for the patient in a post-COVID-19 world. The change has also allowed for joint face-to-face encounter visits for many hospices, including the primary hospice case managing RN and the NP/physician, which has improved communication about patient’s history and supported the NP/physician assessment at the visit. Critically, allowing the face-to-face encounter to be performed via telehealth will also help address workforce shortage challenges by freeing up physician/NP time that was otherwise spent traveling to patient to perform the F2F. This is especially important for patients and families in rural and underserved communities.

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. Further, in cases where two-way audio-visual connections cannot be established, use of audio-only technologies should be permitted provided the hospice is able to establish continuing eligibility for services via this method. 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 information indicating 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.

ALLOW NPs AND PAs TO CERTIFY/RECERTIFY PATIENTS FOR MEDICARE HOSPICE SERVICES

ISSUE: Under current law, neither nurse practitioners (NPs) nor physician assistants (PAs) are permitted to certify/recertify patients for Medicare hospice services, although NPs and PAs can now certify for Medicare home health services as a result of 2020's CARES Act. NPs are also currently permitted under Medicare to order skilled nursing facility care if working in collaboration with a physician.

RECOMMENDATION: Congress should enact legislation that authorizes 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 advance 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.

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 the effectiveness of 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. As an example of the unintended consequences on seriously-ill patients of the well-meaning effort to reduce illicit or unnecessary opioid prescribing and use, a major 2021 study found that between 2007 and 2017, the proportion of cancer patients near the end of life who filled one or more opioid prescriptions declined from 42% to about 35%. The proportion who received long-acting opioids, which are most effective for treating severe cancer-related pain, declined from 18% to about 11%.

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.

REJECT ANY EFFORT TO IMPOSE ADDITIONAL BENEFICIARY COST SHARING FOR MEDICARE HOSPICE SERVICES

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.

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.

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.

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.

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.

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.

VII. FACT SHEETS ON HOME CARE

HOME CARE AND HOSPICE LEGISLATION 2022

Consolidated Appropriations Act, 2022 (P.L. 117-103)

SEC. 301. REMOVING GEOGRAPHIC REQUIREMENTS AND EXPANDING ORIGINATING SITES FOR TELEHEALTH SERVICES. – Extended the waiver for allowing the home to serve as an originating site for telehealth services for 151 days post COVID-19 Public Health Emergency cessation.

SEC. 306. USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD. – Extended hospice face-to-face recertification eligibility for 151 days post COVID-19 Public Health Emergency cessation.

Consolidated Appropriations Act, 2023 (P.L. 117-328)

- Delayed PAYGO cut (across the board 4% cut) to 2025

Section 4113. Advancing telehealth beyond COVID-19. - Extends all of the Medicare telehealth flexibilities that were extended in the Consolidated Appropriations Act, 2022, through December 31, 2024.

Section 4121. Coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program. - Allows hospices to include marriage and family therapists (MFTs) and/or mental health counselors (MHCs) as part of the hospice interdisciplinary team (IDT), in lieu of a social worker

Section 4137. Extension of certain home health rural add-on payments. - Extends, for one year through December 31, 2023, the 1 percent add-on payment provided to certain home health agencies that furnish services in counties with a low population density.

Section 4142. Increasing transparency for home health payments under the Medicare program. - Requires HHS to provide publicly available information on the simulation of 60-day episodes under the Medicare home health prospective payment system in effect prior to the Patient Driven Groupings Model. This section also requires HHS to use a public forum to engage with home health stakeholders on the Medicare home health payment rate development within 90 days of enactment.

Section 4162. Extension of adjustment to calculation of hospice cap amount under Medicare. - Extends, by one year, the change to the annual updates to the hospice aggregate cap made in the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 and applies the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers (CPI-U) to the hospice aggregate cap through 2032.

Section 4163. Medicare direct spending reductions. - Extends the mandatory Medicare payment reductions under sequestration for the first 6 months of fiscal year 2032, while revising Medicare sequestration percentages to 2 percent for fiscal year 2030 and fiscal year 2031.

Section 5114. Extension of Money Follows the Person Rebalancing demonstration. - Extends funding for the Medicaid Money Follows the Person Rebalancing Demonstration program at \$450 million per year through fiscal year 2027.

Section 5115. Extension of Medicaid protections against spousal impoverishment for recipients of home and community-based services. - Extends protections against spousal impoverishment for Medicaid recipients of home and community-based services through fiscal year 2027.

Section 5131. Transitioning from Medicaid FMAP increase requirements. - Provides funding for transitioning Medicaid from the 6.2% enhanced FMAP (not HCBS specific)

- Quarter ending 3/31/23 — 6.2%
- Quarter ending 6/3/23 — 5.0%
- Quarter ending 9/30/23 — 2.5%
- Quarter ending 12/31/23 — 1.5%

HOME CARE AND HOSPICE LEGISLATION 2021

Lifespan Respite Care Reauthorization Act of 2020 (Public Law 116-324) - Reauthorizes through FY2024 and revises the Lifespan Respite Care Program, which supports state lifespan respite care services.

American Rescue Plan Act of 2021 (Public Law 117-2)

SEC. 9817. ADDITIONAL SUPPORT FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES DURING THE COVID-19 EMERGENCY - The ARP provides for a 10% increase for one year starting on April 1st, 2021 to the Federal Medical Assistance Program (FMAP), the federal share of Medicaid, specifically for HCBS. These funds can be applied towards: Home Health Care services, Personal care services, PACE services, HCBS Services, Case Management services, Rehab services

SEC. 1150C. FUNDING FOR PROVIDERS RELATING TO COVID-19 - \$8.5 billion in provider relief funds specifically for rural providers.

Sec. 2301. Funding for COVID-19 vaccine activities at the Centers for Disease Control and Prevention - \$12.2 billion for increased vaccine supplies and distribution capacity designed to speed up vaccine administration.

PPP Extension Act of 2021 (Public Law – 117-6) - Extended the Paycheck Protection Program, established to support small businesses in response to COVID-19 (i.e., coronavirus disease 2019), through June 30, 2021.

To prevent across-the-board direct spending cuts, and for other purposes (Public Law 117 – 7) - Continued to exempt Medicare from sequestration until December 31, 2021.

Protecting Medicare and American Farmers from Sequester Cuts Act (Public Law 117 – 71) - Continued to exempt Medicare from sequestration until March 31, 2022, while providing a 1% relief from sequestration from April 1, 200 – June 30, 2022.

HOME CARE AND HOSPICE LEGISLATION 2020

Coronavirus Aid, Relief, and Economic Security Act or the CARES Act (Public Law 116-136)

Summary of Hospice-specific Provision

SEC. 3706. USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD. Section 1814(a)(7)(D)(i) of the Social Security Act is amended such that during the public health emergency, for purposes of hospice care recertification under Medicare, physicians and nurse practitioners may fulfill the requirement for a face-to-face encounter with the hospice patient via telehealth.

Summary of Home Health-specific Provisions

Sec. 3707 ENCOURAGING USE OF TELECOMMUNICATIONS SYSTEMS FOR HOME HEALTH SERVICES FURNISHED DURING EMERGENCY PERIOD. Directs the Secretary of HHS to consider ways to encourage use of telecommunication systems, including remote patient monitoring, consistent with the plan of care for the individual.

Sec. 3708 IMPROVING CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES. Provides authorization to nurse practitioners, physician assistants, and clinical nurse specialists to certify a Medicare beneficiaries eligibility for home health services.

SEC. 3709. ADJUSTMENT OF SEQUESTRATION. Temporary suspends Medicare sequestration May 1, 2020 – December 31, 2020.

Summary of Other Relevant Provisions

SEC. 3811. EXTENSION OF THE MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION PROGRAM. Extended the Money Follows the Person Program through November 30, 2020.

SEC. 3812. EXTENSION OF SPOUSAL IMPOVERISHMENT PROTECTIONS. Extended protections against spousal impoverishment for recipients of Medicaid home and community-based services through November 30, 2020.

SEC. 1102. PAYCHECK PROTECTION PROGRAM. Created the Paycheck Protection Program with an initial funding of \$350 billion. This was designed to provide small businesses with eight weeks of cash flow assistance through federal loans which would be forgiven should certain parameters be met. Additional funding of \$340 billion was provided by the Paycheck Protection Program and Health Care Enhancement Act in April 2020, and another \$285 billion in the Consolidated Appropriations Act in December 2020.

Consolidated Appropriations Act, 2021 (Public Law 116-260)

Summary of Home Health-specific Provisions

Division N, SEC. 102. EXTENSION OF TEMPORARY SUSPENSION OF MEDICARE SEQUESTRATION. Provides further suspension of Medicare sequestration through March 31, 2021.

Division CC, SEC. 115. PERMITTING OCCUPATIONAL THERAPISTS TO CONDUCT THE INITIAL ASSESSMENT VISIT AND COMPLETE THE COMPREHENSIVE ASSESSMENT WITH RESPECT TO CERTAIN REHABILITATION SERVICES FOR HOME HEALTH AGENCIES UNDER THE MEDICARE PROGRAM. Allows occupational therapists to conduct initial patient assessment in home health.

Summary of Other Relevant Provisions

Division CC, SEC. 105. EXTENDING THE INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM UNDER THE MEDICARE PROGRAM. Further extends the Independence at Home program for three additional years.

Division CC, SEC. 204. EXTENSION OF MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION. Extends the Medicaid Money Follows the Person program through September 2023.

Division CC, SEC. 205. EXTENSION OF SPOUSAL IMPOVERISHMENT PROTECTIONS. Extends protections against spousal impoverishments for Medicaid HCBS recipients through September 2023.

Summary of Hospice-specific Provisions

132: Medicare payment for certain Federally Qualified Health Center and Rural Health Clinic services furnished to hospice patients (HR 2594). This section allows Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to furnish and bill for hospice attending physician services when RHC and FQHC patients become terminally ill and elect the hospice benefit beginning January 1, 2022. As a result, Medicare beneficiaries will continue to receive hospice-related care from their known provider.

Section 404: Adjusting calculation of hospice cap amount under Medicare. This section extends the change to the annual updates to the hospice aggregate cap made in the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 and applies the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers (CPI-U) to the hospice aggregate cap for fiscal years 2026 through 2030.

Section 407: Establishing hospice program survey and enforcement procedures under the Medicare program (HR 5821). This section makes changes to the Medicare hospice survey and certification process to improve consistency and oversight, allowing the Secretary to use

intermediate remedies to enforce compliance with hospice requirements and extending the requirement that hospices be surveyed no less frequently than once every 36 months. It also creates a new Special Focus Facility Program for poor-performing hospice providers, who will be surveyed not less frequently than once every six months. It increases the penalty for hospices not reporting quality data to the Secretary from two to four percentage points, beginning in fiscal year 2024.

Detailed summary of hospice survey reforms:

<p>Survey Frequency</p> <ul style="list-style-type: none"> • Makes routine hospice surveys permanent • routine survey frequency established at no less than once every 36 months
<p>Transparency</p> <ul style="list-style-type: none"> • Authorizes public release of surveys conducted by Accrediting Organizations (AOs) • States/AOs must submit timely survey/certification information in form specified by HHS • Information shall include any inspection reports, enforcement actions, and other information as determined by HHS; For AO surveys conducted on/after 10/2021, form 2567 must be part of information submitted • Beginning not later than 10/2022, HHS shall publish survey/certification information online in a manner that is “prominent, easily accessible, readily understandable, and searchable”; info shall be updated in a timely manner
<p>Survey Consistency</p> <p>Each state and HHS shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors</p>
<p>Survey Teams</p> <p>For surveys conducted on/after 10/2021 by more than one person must be conducted by a multi-disciplinary team (including RN)</p>
<p>Conflicts of Interest</p> <p>State surveyors may not survey programs by which they have been employed/acted as consultant in previous 2 years (or in which surveyor has personal or familial financial interest), beginning 10/2021</p>
<p>Surveyor Training</p> <ul style="list-style-type: none"> • No later than 10/2021, HHS shall provide for comprehensive training for state, Federal, and AO surveyors, including training related to review of written plans of care • No one may serve as a member of a survey team unless they have completed a training and testing program approved by HHS
<p>Special Focus Program</p> <p>HHS shall conduct a special focus program for enforcement of requirements for those hospices that have substantially failed to meet requirements; special focus surveys shall be conducted not less than once every 6 months</p>

Enforcement

Instances of IJ: HHS must take immediate action to remove the jeopardy and correct deficiencies using temporary management or terminate the program. HHS may also provide for one or more of the other remedies (payment suspension, CMPs, temporary management)

Instances of Non-IJ: In such cases in lieu of termination, HHS may impose additional remedies for a period not to exceed 6 months; if program is still not in compliance, HHS shall terminate

Penalty for previous non-compliance

If HHS determines a hospice is in compliance but had been out of compliance for a previous period, HHS may impose CMP for the days for which the program was not in compliance

Option to continue payments for an out of compliance hospice for a period of not longer than 6 months if:

- Survey agency finds it more appropriate to take alternative action to termination
- Hospice has submitted plan and timetable for corrective action that is approved by HHS
- Program agrees to repay Federal payments during such period if corrective action is not taken in accordance with the agreed-upon plan of correction
- HHS shall establish guidelines for approval of corrective action

Remedies

- Not later than 10/2022, HHS shall develop and implement a range of remedies to address circumstances of concern identified for enforcement (see above) along with procedures for appealing determinations relating to imposition of such remedies
- Not later than 10/2022, HHS shall develop and implement specific procedures and conditions for applying new remedies (including amounts of fines and severity of each remedy). Procedures must reflect incrementally more severe fines for repeated or uncorrected deficiencies.
- Specific remedies (these are in addition to State/Federal sanctions and shall not limit other available remedies):
 - CMPs not to exceed \$10,000 per day
 - Any portion of CMPs collected may be used to support activities that benefit individuals receiving hospice care, including education and training programs for hospices to ensure compliance
 - Prospective payment suspension
 - Suspension of payment shall terminate upon findings of substantial compliance with all requirements
 - Temporary management
 - Shall not be terminated until HHS determines program has management capability to ensure continued compliance

Funds for Hospice Program Improvements

HHS may provide for use collected CMPs to support activities that benefit hospice patients, including education and training to ensure hospice compliance

<p>Funding</p> <p>Transfers \$10 million annually (beginning 10/2022) from Trust Fund to conduct hospice surveys (and continues IMPACT Act funding)</p>
<p>Toll Free Hotline</p> <p>State/local agency must maintain toll-free hotline to take public inquiries, provide information and take complaints; must maintain up-to-date information about hospice survey performance; eff. for agreements entered into on/after one year following enactment</p>
<p>Quality Reporting</p> <p>Increase penalty for failure to meet HQRP requirements beginning with FY2024 payment year (from 2% to 4%)</p>
<p>GAO Report</p> <p>Not later than 36 months following enactment, GAO shall submit to key congressional committees an analysis of the effects of the new remedies, including the frequency of application of such remedies and the impact on access to, and quality of, hospice care.</p>

HOME CARE AND HOSPICE LEGISLATION 2018

BIPARTISAN BUDGET ACT OF 2018 (H.R. 1892, P.L. 115-123). On February 9, 2018, President Trump signed into law the Bipartisan Budget Act, a large appropriations measure providing funding for the federal government. Multiple provisions affecting the Medicare home health and hospice benefits were also included.

The legislation includes several provisions that have impact on home care and hospice. These include:

Section 30101: Medicare Sequester. Extension of across-the-board 2 percentage point Medicare sequestration for an additional two years, now set to expire in April 2028.

Section 50208. Extension of the Home Health Rural Add-on. In addressing the rural add-on, the BBA works to phase out and target its application over the ensuing five years. For Calendar year 2018, the Medicare Home Health Rural Add-on is extended at a rate of three percent. In CY 2019, services provided in counties qualifying as “frontier” (defined as six or fewer individuals per square mile) will see an increase to a four percent add-on. Services provided in the highest quartile of counties, based on number of home health episodes per 100 eligible beneficiaries, will see the add-on decrease to one and a half percent. All other eligible episodes will receive three percent. In CY 2020, frontier counties will drop to three percent, the highest quartile counties will drop to one half percent, and all others will receive two percent. In CY 2021, frontier areas will receive two percent, all other eligible counties will receive one percent. In 2022, frontier areas will receive a one percent add-on. No other claims will be eligible.

Additionally, the Office of the Inspector General is to conduct a review of the Medicare home health benefit by county and provide recommendations based upon this analysis.

Sec. 50301. Independence at Home. Extends the Independence at Home (IAH) Demonstration Program for an additional two years and 5,000 more participants. This demonstration program intends to provide comprehensive primary care in the home, particularly targeted towards Medicare beneficiaries suffering from multiple chronic conditions. IAH has proven successful, saving over \$10 million in its second year of operation.

Section 50323. Increasing Convenience for Medicare Advantage Enrollees Through Telehealth. Starting in 2020, Medicare Advantage plans may offer additional telehealth services as supplemental benefits that are available under part B, and are identified as clinically appropriate when a medical practitioner is not in the same area as the plan enrollee.

Section 50324. Providing Accountable Care Organizations the Ability to Expand the Use of Telehealth. In 2020, beneficiaries’ homes will qualify as an originating site for Accountable Care Organization purposes.

Section 50342. GAO Study and Report on Longitudinal Comprehensive Care Planning Services Under Medicare Part B. Requires the Comptroller General of the Government Accountability Office (GAO) to conduct a study on the establishment under part B of the Medicare program under title XVIII of the Social Security Act of a payment code for a visit for longitudinal

comprehensive care planning services within 18 months of enactment.

Section 51001. Home Health Payment Reform. Beginning in 2020, the Secretary of HHS is directed to implement a prospective payment system for home health services based on a 30-day unit of service. The new payment system must be budget neutral in the first year of implementation but budget neutrality may take into account behavioral changes anticipated to occur as the result of the policy change. The Secretary is further directed, for 2020 and subsequent years, to eliminate the use of therapy thresholds in case mix adjustment factors for calculating home health payments. Additionally, the BBA called for the convening of at least one Technical Expert Panel (TEP). The TEP's purpose is to make recommendations on the current home health prospective payment system, the home health groupings model, and alternative models.

Section 51002. Information to Satisfy Documentation of Medicare Eligibility for Home Health Services. This provision of the BBA sought to address the onerous face-to-face/physician documentation certification. However, in a change from standalone legislation that had already been introduced (H.R. 2663), the Home Health Documentation and Program Improvement Act, the final version lacks the firm mandate needed for a meaningful remedy. As signed into law, the BBA language stated “the Secretary may use documentation in the medical record of the home health agency as supporting material.” This essentially codified current practice by allowing CMS the option to review the home health record when determining claim status, which they already have the authority to do. A proper fix would be substituting “shall” in for “may” which would provide the firm mandate that CMS will be required to review the agency's patient record in conjunction with the physician's version.

Section 51006: Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients. Beginning January 1, 2019, permits physician assistants (PAs) to serve as attending physicians for hospice patients.

Section 52001. Repeal of the Independent Payment Advisory Board. This committee was called for in the Patient Protection and Affordable Care Act. Its intent was to make implement savings measures in the Medicare program should certain expense thresholds be met. The 15 member board was never formed, and the thresholds were never met. However, it has been a controversial issue since its creation as its efforts would become law independent of the Congress. Congress could only negate their cuts through alternatives that save an equal amount of money. This section repeals the IPAB.

Section 53109: Hospital transfer policy for early discharges to hospice care. Effective October 1, 2018, requires that the Secretary of HHS consider certain short-stay hospital patients that, following discharge, are admitted to hospice, as a “transfers” for purposes of hospital payment. Requires the Medicare Payment Advisory Commission (MedPAC) to evaluate the impact of the hospital to hospice transfer policy and provide a preliminary report to Congress no later than March 15, 2020, and a final report by March 15, 2021.

HOME CARE AND HOSPICE LEGISLATION 2016

21st Century Cures Act of 2016 (H.R. 6, P.L. 114-255). December 13, 2016, President Barack Obama signed into law the 21st Century Cures Act, a sweeping piece of legislation providing new programs and funding for health maladies and innovation, including medical devices, access to new drugs, cancer and Alzheimer's treatment, opioid addiction and more.

The legislation includes several provisions that have impact on home care. These include:

- A required report on the expanded use of telehealth services and the barriers to such technology in Medicare.
- New Medicare coverage of home infusion therapy.
- Mandatory use of Electronic Visit Verification in Medicaid personal care and home health services.
- Application of moratoria based on the site of services rather than the location of the provider.

There are several other provisions that can have indirect impact on home care. These include standards for issuance of Local Coverage Determinations by Medicare contractors, monitoring of terminated Medicaid providers, and the publication of a Medicare fee-for-service provider directory.

HOME CARE AND HOSPICE LEGISLATION 2015

The Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2, P.L. 114-10) replaced the Medicare physician payment formula known as the Sustainable Growth Rate (SGR) with a new payment methodology. The cost of the legislation was partially offset by setting the annual payment rate update for post-acute (including home health) and hospice providers at 1 percent in 2018. This represents an estimated 1 percentage point reduction from what would otherwise have been the update.

It included a provision that extended the Medicare rural add-on payment for home health agencies for two years (to the end of 2017). It also contained a modification to home health surety bond requirements, setting the bond minimum at \$50,000 and allowing Medicare to scale the bond value above \$50,000 commensurate with a home health agency's volume of Medicare revenue. CMS has taken no action to implement the bond requirement. Lastly, MACRA extended Medicare sequestration by two additional years.

HOME CARE AND HOSPICE LEGISLATION 2013/14

The Consolidated Appropriations Act of 2014 (H.R. 3547; Pub. Law No: 113-76 (1-17-2014)) extended the 2 percent sequester payment cut for all Medicare providers through 2023. The Medicare physician payment formula “fix” was extended to March 31, 2014 to prevent a cut in physician payments. In March 2014, the physician payment fix was extended again to March 31, 2015. Home health and hospice were spared from any payment cuts to help offset the cost of the temporary physician payment fixes.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (H.R. 4994; P.L.113-185) requires that 1) post-acute providers (PAC) report standardized patient assessment data, data on quality measures, and data on resource use and other measures; 2) the data be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare outcomes; and 3) PAC assessment instruments applicable to PAC providers be modified for the submission of standardized patient assessment data and comparison of assessment data across all such providers.

The IMPACT Act requires CMS to survey hospices at least as frequently as every 36 months for the next 10 years. It also corrects a legislative drafting error that has prevented implementation of the Affordable Care Act provision requiring medical review of hospices with a high proportion of long-stay patients. The legislation also modifies the annual update for the hospice aggregate cap; beginning with the 2016 cap year the aggregate cap will be updated by the net market basket update for that year, rather than by the BLS medical expenditure category of the Consumer Price Index for all Urban Consumers -- the CPI-M(U), as has historically been the case.

HOME CARE LEGISLATION 2012

The American Taxpayer Relief Act (ATRA) of 2012 (H.R. 8; P.L. 112-240) extended the Medicare physician payment formula “fix” to the end of 2013 to prevent a cut in physician payments. Medicare payments to hospitals and some other Medicare providers were cut to help offset the cost of the physician fix. Home health and hospice were again spared.

The sequester cuts scheduled for January 2, 2013 were delayed by the ATRA until March 1, 2013; the 2 percent Medicare payment cut under the sequester was delayed until April 1, 2013.

HOME CARE LEGISLATION 2011

On August 2, 2011, at the conclusion of an intensive effort by Congress and the Administration to negotiate a deficit reduction package and raise the debt ceiling, Congress passed the Budget Control Act of 2011 (S. 365/P.L. 112-25). In the Act Congress mandated certain percentage cuts in federal spending (known as a “sequester”) sufficient to achieve \$1.2 trillion in savings over 10 years. Under Section 302 Medicare provider payments, including payments for home health and hospice, will be cut by 2 percent beginning in 2013 as part of the sequester.

At the conclusion of 2011 and early 2012 Congress worked to extend a payroll tax cut, unemployment insurance, and a Medicare physician payment “fix” through the end of 2012 (Middle Class Tax Relief and Job Creation Act (H.R. 3630/P.L. 112-96)). Medicare hospital and nursing home payments were cut to help offset the costs of these provisions; home health and hospice were spared.

HOSPICE LEGISLATION 2011

Chronological Summary of Health Care Reform Provisions Affecting Hospice Care (Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148))

2010

Medicaid/CHIP Pediatric Hospice. Medicaid or CHIP-eligible children may receive hospice services without forgoing other services to which they are entitled under Medicaid/CHIP. (Sec. 2302)

2010 or later

Medicare Hospice Concurrent Care Demonstration. Three-year demonstration program would allow hospice patients to concurrently receive all other Medicare-covered services. This demonstration is required to be budget neutral and expected to improve patient care, quality of life and cost-effectiveness. (Sec. 3140)

January 1, 2011

Continued Eligibility for Medicare Hospice Services. The Secretary of HHS must require a hospice physician or advanced practice nurse to determine, through a face-to-face encounter, a patient's continued hospice eligibility prior to the 180th day recertification, and for each certification thereafter, and attest that such a visit took place. In the case of hospice programs for which the number of patient stays in excess of 180 days meet a certain threshold (as determined by the Secretary), stays in excess of 180 days must be reviewed by CMS or its contractors for medical necessity. (Sec. 3132(b))

January 1, 2011

Additional Data Collection from Medicare Hospice Programs. Requires the Secretary of HHS to collect additional data and information to be used for payment system revisions. (Section 3132(a))

October 1, 2012

Medicare Market Basket Update Reductions (applicable for FY 2013 through 2019)/Productivity Adjustments. The Secretary of HHS must, beginning with Fiscal Year 2013, impose annually a productivity adjustment (reduction roughly estimated at 1 percent) to the market basket inflation update. Additionally, for FYs 2013 through 2019, the hospice market basket update would be reduced by an additional 0.3 percentage point. However, for FY2014 through 2019, if growth in the previous year's insured population does not exceed 5 percent, no 0.3 percent reduction is imposed in that year. (Sec. 3401(g); HCERA Sec. 10319(f))

October 1, 2012

Publication of Quality Measures. By October 1, 2012 The Secretary of HHS must publish quality measures for reporting by hospices in FY2014. The measures would cover all dimensions of quality as well as efficiency of care. (Sec. 3004(c))

October 1, 2013

Medicare Payment Revisions. Effective no earlier than October 1, 2013, payment system revisions for hospice services will be implemented on a budget-neutral basis. (Sec. 3132(a))

October 1, 2013

Reporting of Quality Measures. Hospice programs must begin to report quality measures; failure to do so would result in a 2.0 percentage point cut in the annual Medicare market basket update. (Sec. 3004(c))

January 1, 2016

Pilot Testing of Pay-for-Performance. No later than this date, the Secretary of HHS is required to establish a pilot program to test value-based purchasing under hospice. (HCERA Sec. 10326)

Other Provisions of Interest

2010

Criminal Background Check Pilot Program Expansion. Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of hospice care. (Sec. 6201)

2010 or later

Advancing Research and Treatment for Pain Care Management. Pending appropriations, the Secretary of HHS shall convene a Conference on Pain in conjunction with the Institute of Medicine. The Director of NIH is encouraged to engage in an aggressive program of pain research through the Pain Consortium. The Secretary of HHS shall establish no later than one year after enactment an Interagency Pain Research Coordinating Committee. The Secretary may make awards of grants, cooperative agreements, and contracts to hospices and other entities for the development and implementation of programs to provide education and training to health care professionals in pain care. (Sec. 4305)

2010-2012

Grants for Postpartum Depression Services. Allows the Secretary of HHS to establish under the Material and Child Health Services Block Grant projects to provide services to individuals with a postpartum condition and their families. Definition of “eligible entities” to receive grants includes hospices. (Sec. 2952(b))

2010

Compliance and Penalties. Requires background screening and credentialing of provider and supplier owners and managers; requires compliance plans; provides authority to the Secretary of HHS to impose a temporary moratorium on new providers. (Sec. 6401)

2014

Independent Payment Advisory Board. Establishes an Independent Payment Advisory Board (IPAB) to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending is expected to exceed a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, IPAB proposals

will take effect unless Congress passes an alternative measure that achieves the same level of savings. IPAB would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. IPAB would be prohibited from recommending payment reductions for providers during a year in which those providers' market basket updates are scheduled for reduction beyond the annual productivity adjustment. (Sec. 3403)

HOME CARE LEGISLATION 2010

Chronological Summary of Health Care Reform Provisions Affecting Home Care (Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148))

January 1, 2010

(Proposed extension to January 1, 2011 by regulation)

Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare; Sec. 10605 of Manager's Amendment. Certain other providers permitted to conduct face to face encounter for home health services.

Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement.

January 1, 2010

Sec. 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.

Physician must maintain and provide access to documentation on Medicare home health referrals if requested. Home health agencies must maintain and provide access to documentation of certification of Medicare home health services if requested.

April 1, 2010

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(c). Application of the Medicare Rural Home Health Add-on Policy.

3% rural add-on for episodes and visits ending on or after April 1, 2010, and before January 1, 2016.

July 1, 2010 (regulation out July 6)

Sec. 6405 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals; Sec. 10604 of Manager's Amendment. Technical Correction to Section 6405.

Medicare enrolled physician requirement regarding care plan certification

September 30, 2010

Sec. 5101. National Health Care Workforce Commission.

Establishes commission to review health care workforce and projected workforce needs.

October 1, 2010

Sec. 2401. Community First Choice Option.

Expanded Medicaid home care through agencies and self-directed care.

October 1, 2010

Sec. 2402. Removal of barriers to Home and Community based Services.

Expanded rebalancing requirements and waiver authority and removal of restrictions on waivers.

October 1, 2010

Sec. 2403. Money Follows the Person Rebalancing Demonstration.

Extension through September 2016.

2010

Sec. 6401. Provider Screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers.

2010

Sec. 3502. Establish Community Health Teams to Support Patient-Centered Medical Home.

Grants to community-based interdisciplinary, interprofessional teams to support primary care practices; includes chronic care management.

2010

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of home care.

2010 - 2014

Sec. 4201. Community Transformation Grants

Competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and develop a stronger evidence-base of effective prevention programming. Authorized appropriations for 2010 – 2014.

2010

Sec. 10501. National Diabetes Prevention Program

Grants to entities determined by the Secretary for community-based diabetes prevention programs.

2010 - 2014

Sec. 4202. Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries

Grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to

provide public health community interventions, screenings, and clinical referrals for individuals between 55 and 64.

2010

Sec. 4204. Demonstration Program to Improve Immunization Coverage.

Demonstration program awarding grants to states to improve the provision of recommended immunizations through the use of evidence-based, population-based interventions for high-risk populations.

2010 - 2015

Sec. 2951. Grants for Early Childhood Home Visitation.

Grants to states to establish quantifiable and measurable 3- and 5-year benchmarks to demonstrate improvements in maternal and newborn health, prevention of child injuries and abuse, improvements in family economic self-sufficiency and school readiness/achievement, and improvements in coordination and referrals between other community resources.

2010 (authorized for five years, with option of additional five years)

Sec. 2601. Medicaid Waiver Demonstration Projects for Dual Eligibles.

Medicaid waivers for coordinating care for dual eligible beneficiaries.

January 1, 2011

Sec. 2703. Health Homes for Chronically Ill Patients

Planning grants to states to develop a new state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least a serious and persistent mental health condition to select a designated provider (could include a home health agency), a team of healthcare professionals operating with such a provider, or a health team as the individual's health home for purposes of providing the individual with health home services. States taking up option provided with 90 percent of FMAP for two years for home health related services, including care management, care coordination, and health promotion.

January 1, 2011

Sec. 3021. Establish a Center for Medicare and Medicaid Innovation within CMS.

Opportunities for chronic care and other initiatives includes funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (xiv). Telehealth advancement opportunities through new CMS Innovations Center but no guarantee.

January 1, 2011

Sec. 3026. Community Based Transitions Program

Funding for hospitals with high admission rates and community-based organizations that improve care transition services for high-risk Medicare beneficiaries. (\$500 million total.)

January 1, 2011

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(b). Program Specific Outlier Cap.

Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%.

January 1, 2011

Sec. 3401 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.; Sec. 10319 of Manager's Amendment. Revisions to market basket adjustments.

Reduce home health market basket update by 1 percentage point in 2011, 2012, and 2013.

October 1, 2011

Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.

Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011.

2011 (enroll)

2016 (coverage begins)

Sec. 8001. Community Living Assistance Services and Supports Act (CLASS Act).

Establish voluntary national home and community-based long term care insurance program. Beneficiaries vest after 5 years paying premiums.

January 1, 2012

Sec. 3024. Independence at Home demonstration program.

Tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams.

January 1, 2012 – December 31, 2016

Sec. 2704. Bundled Payments Medicaid.

Medicaid demonstration project in 8 states to pay bundled payments to hospitals for episodes of care that include hospitalizations.

January 1, 2012

Sec. 3022. Accountable Care Organizations.

Establishes a shared savings program that rewards Accountable Care Organizations (ACO) that take responsibility for the costs and quality of care. ACO's may include groups of health care providers.

October 1, 2012

Sec. 3025. Hospital Readmissions and Reductions Program.

Reduce hospital payments for readmissions.

January 1, 2013

Sec. 3023. National Pilot Program on Payment Bundling.

Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013, for a period of five years. Before

January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending.

January 1, 2014

Sec. 3131. Payment Adjustment for Home Health Care; Sec. 10315 of Manager's Amendment. Revisions to Home Health Provisions.

Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year.

January 1, 2014 – December 31, 2018

Sec. 2404. Protection for Recipients of Home and Community Based Services Against Spousal Impoverishment.

Spousal impoverishment protection for home care eligibility.

January 1, 2014

Sec. 1513. Shared Responsibility for Employers.

Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) Exempt employers with 50 or fewer employees from any of the above penalties.

January 1, 2014

Sec. 10108. Free Choice Vouchers.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

January 15, 2014

Sec. 3403. Independent Medicare Advisory Board; Sec. 10320 of Manager's Amendment.

Expansion of the Scope of, and additional improvements to, the Independent Medicare Advisory Board.

Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

March 1, 2014

Sec. 3131(d). Study and Report on the Developments of the Home Health Payment Reforms In Order to Ensure Access to Care and Quality Services.

By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality.

March 1, 2014

Sec. 10315 (b). Revisions to Home Health Care Provisions.

HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.

2014

Sec. 1302. Essential Health Benefits Requirements

Secretary shall define essential health benefits with respect to any health plan; provides for notice and opportunity for public comment.

January 1, 2015

Sec. 3131(2)(B). MedPAC Study and Report.

MedPAC shall report by Jan. 1, 2015, on impact of rebasing.

January 1, 2015

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015.

January 1, 2015

Sec. 10315 (b) Revisions to Home Health Care Provisions.

Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) \$500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

HOME HEALTH LEGISLATION 2009-2010

Patient Protection and Affordable Care Act (H.R. 3590: Public Law No. 111-148)

MEDICARE HOME HEALTH PAYMENT ADJUSTMENTS

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(b). Program Specific Outlier Cap.

Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%.

Sec. 3131(c). Application of the Medicare Rural Home Health Add-on Policy.

3% rural add-on for episodes and visits ending on or after April 1, 2010, and before January 1, 2016.

Sec. 3401 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.; Sec. 10319 of Manager's Amendment. Revisions to market basket adjustments.

Reduce home health market basket update by 1 percentage point in 2011, 2012, and 2013.

Sec. 3131. Payment Adjustment for Home Health Care; Sec. 10315 of Manager's Amendment. Revisions to Home Health Provisions.

Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year.

Sec. 3131(2)(B). MedPAC Study and Report.

MedPAC shall report by Jan. 1, 2015, on impact of rebasing.

Sec. 3131(d). Study and Report on the Developments of the Home Health Payment Reforms In Order to Ensure Access to Care and Quality Services.

By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality.

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015.

Sec. 3025. Hospital Readmissions and Reductions Program.

Reduce hospital payments for readmissions.

Sec. 3023. National Pilot Program on Payment Bundling.

Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013, for a period of five years. Before January

1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending.

Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.

Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011.

Sec. 10315 of Manager’s Amendment. Revisions to Home Health Care Provisions.

Sec. 10315(b).

HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.

Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) \$500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

Sec. 3403. Independent Medicare Advisory Board; Sec. 10320 of Manager’s Amendment. Expansion of the Scope of, and additional improvements to, the Independent Medicare Advisory Board.

Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

INNOVATIONS IN HEALTH CARE/PRIVATE LONG TERM CARE INSURANCE PROGRAM (CLASS)

Sec. 3021. Establish a Center for Medicare and Medicaid Innovation within CMS.

Opportunities for chronic care and other initiatives funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (xiv). Telehealth advancement opportunities through new CMS Innovations Center but no guarantee.

Sec. 3024. Independence at Home demonstration program.

Tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams.

Sec. 8001. Community Living Assistance Services and Supports Act (CLASS Act).

Establish voluntary national home and community-based long term care insurance program. Beneficiaries vest after 5 years paying premiums.

PROGRAM INTEGRITY

Sec. 6401. Provider Screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers.

Sec. 6405 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals; Sec. 10604 of Manager's Amendment. Technical Correction to Section 6405.

Medicare enrolled physician requirement regarding care plan certification

Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare; Sec. 10605 of Manager's Amendment. Certain other providers permitted to conduct face to face encounter for home health services.

Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement.

Sec. 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.

Physician must maintain and provide access to documentation on Medicare home health referrals if requested. Home health agencies must maintain and provide access to documentation of certification of Medicare home health services if requested.

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of home health care.

MEDICAID HOME AND COMMUNITY-BASED SERVICES EXPANSIONS

Sec. 2401. Community First Choice Option. Expanded Medicaid home care through agencies and self-directed care. (Effective October 1, 2011).

Sec. 2402. Removal of barriers to Home and Community based Services. Expanded rebalancing requirements and waiver authority and removal of restrictions on waivers.

Sec. 2403. Money Follows the Person Rebalancing Demonstration.

Extension through September 2016.

Sec. 2404. Protection for Recipients of Home and Community Based Services Against Spousal Impoverishment.

Spousal impoverishment protection for home care eligibility. (Effective 2014-2019)

EMPLOYER REQUIREMENTS

Sec. 1513. Shared Responsibility for Employers.

Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014)

Exempt employers with 50 or fewer employees from any of the above penalties.

Sec. 10108 of Manager's Amendment. Free Choice Vouchers.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

HOSPICE LEGISLATION 2009-2010

Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148)

Section 3132(a). Additional Data Collection from Medicare Hospice Programs.

Requires the Secretary of HHS to collect additional data and information to be used for payment system revisions. January 1, 2011

Sec. 3132(b). Continued Eligibility for Medicare Hospice Services.

The Secretary of HHS must require a hospice physician or advanced practice nurse to determine, through a face-to-face encounter, a patient's continued hospice eligibility prior to the 180th day recertification, and for each certification thereafter, and attest that such a visit took place. In the case of hospice programs for which the number of patient stays in excess of 180 days meet a certain threshold (as determined by the Secretary), stays in excess of 180 days must be reviewed by CMS or its contractors for medical necessity. Effective date: January 1, 2011

Sec. 3401(g); HCERA Sec. 10319(f). Medicare Market Basket Update Reductions (applicable for FY 2013 through 2019)/Productivity Adjustments.

The Secretary of HHS must, beginning with Fiscal Year 2013, impose annually a productivity adjustment (reduction roughly estimated at 1 percent) to the market basket inflation update. Additionally, for FYs 2013 through 2019, the hospice market basket update would be reduced by an additional 0.3 percentage point. However, for FY2014 through 2019, if growth in the previous year's insured population does not exceed 5 percent, no 0.3 percent reduction is imposed in that year. Effective date: October 1, 2012

Sec. 3004(c). Publication of Quality Measures.

By October 1, 2012, The Secretary of HHS must publish quality measures for reporting by hospices in FY2014. The measures would cover all dimensions of quality as well as efficiency of care. Effective date: October 1, 2012

Sec. 3132(a). Medicare Payment Revisions.

Effective no earlier than October 1, 2013, payment system revisions for hospice services will be implemented on a budget-neutral basis. Effective date: October 1, 2013

Sec. 3004(c). Reporting of Quality Measures.

Hospice programs must begin to report quality measures; failure to do so would result in a 2.0 percentage point cut in the annual Medicare market basket update. Effective date: October 1, 2013

HCERA Sec. 10326. Pilot Testing of Pay-for-Performance.

The Secretary of HHS is required to establish a pilot program to test value-based purchasing under hospice. Effective date: January 1, 2016

Sec. 2302. Medicaid/CHIP Pediatric Hospice.

Medicaid or CHIP-eligible children may receive hospice services without forgoing other services to which they are entitled under Medicaid/CHIP.

Sec. 3140. Medicare Hospice Concurrent Care Demonstration.

Three-year demonstration program would allow hospice patients to concurrently receive all other Medicare-covered services. This demonstration is required to be budget neutral and expected to improve patient care, quality of life and cost-effectiveness.

Sec. 6201. Criminal Background Check Pilot Program Expansion.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of hospice care.

Sec. 3403. Independent Payment Advisory Board.

Establishes an Independent Payment Advisory Board (IPAB) to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending is expected to exceed a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, IPAB proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. IPAB would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. IPAB would be prohibited from recommending payment reductions for providers during a year in which those providers' market basket updates are scheduled for reduction beyond the annual productivity adjustment.

Sec. 4305. Advancing Research and Treatment for Pain Care Management.

Pending appropriations, the Secretary of HHS shall convene a Conference on Pain in conjunction with the Institute of Medicine. The Director of NIH is encouraged to engage in an aggressive program of pain research through the Pain Consortium. The Secretary of HHS shall establish no later than one year after enactment an Interagency Pain Research Coordinating Committee. The Secretary may make awards of grants, cooperative agreements, and contracts to hospices and other entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

Sec. 2952(b). Grants for Postpartum Depression Services.

Allows the Secretary of HHS to establish under the Material and Child Health Services Block Grant projects to provide services to individuals with a postpartum condition and their families. Definition of "eligible entities" to receive grants includes hospices.

Sec. 6401. Compliance and Penalties.

Requires background screening and credentialing of provider and supplier owners and managers; requires compliance plans; provides authority to the Secretary of HHS to impose a temporary moratorium on new providers.

HOME HEALTH LEGISLATION 2008

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (H.R. 6331; Public Law No: 110-275)

H.R. 6331 contained a number of provisions of interest to home care and hospice providers. Most importantly, the legislation preserved full inflation updates for home health and hospice by rejecting the President's proposed five year freeze in home health payments and three year freeze in hospice payments. It reduced payments to Medicare Advantage plans to help fund several Medicare provisions, including blocking scheduled physician payment cuts.

Following is a summary of the sections in the bill of most interest to home care and hospice providers.

Sec. 123. Demonstration project on community health integration models. Establishes a demonstration project to allow states to test new ways to better coordinate hospital, nursing home, home health and other critical health care services in rural areas.

Sec. 141. Extension of exceptions process for therapy caps. Extends the exceptions process for therapy limits through December 31, 2009.

Sec. 150. MedPAC study and report on improving chronic care demonstration programs. Requires the MedPAC to examine the possibility of using a standing network of providers to test innovative approaches to care coordination and other chronic care delivered to the Medicare patient population.

Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program. Imposes an 18-month delay to Round 1 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Acquisition Program (CAP), with a corresponding 18-24 month delay of Round 2 and subsequent applications of the program. Also modifies and improves the CAP to ensure a fair bidding process and to protect beneficiaries. Pays for this delay with a reduction in the payment rates for items included in the CAP.

Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans. Changes requirements for private fee-for-service (PFFS) plans in counties where there are two or more non-PFFS plans (either an HMO or PPO). In these counties, PFFS plans could no longer "deem" providers into the plan. Instead, beginning in 2011, they would have to form provider networks.

Secs. 168-169. MedPAC studies. Directs MedPAC to study how comparable measures of performance and patient experience can be collected and reported in the MA and PFFS programs. Also directs MedPAC to study alternative payment formulas for MA plans.

Sec. 187. OIG report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare. Directs the Office of Inspector General to report, within two years, on the extent to which Medicare providers follow

the rules regarding discrimination against beneficiaries with limited English proficiency and the Culturally and Linguistically Appropriate Services Standards, and requires the Secretary to correct and deficiencies.

HOME HEALTH LEGISLATION 2007

On December 19, 2007, as one of the last acts of the first session of the 110th Congress, the House and Senate passed the “Medicare, Medicaid and SCHIP Extension Act of 2007” (S. 2499, P.L. 110-173). Unable to reach agreement on a wide range of Medicare and Medicaid issues, Congressional leaders cobbled together a pared down package of Medicare and Medicaid provisions designed primarily to prevent a 10 percent reduction in physician payments under Medicare through June 30, 2008, and extend some expiring Medicare and Medicaid programs.

The home health and hospice community successfully defeated legislative proposals by the President to freeze home health payments for five years and cut the hospice inflation update. The House passed the “The Children's Health and Medicare Protection Act of 2007” (H.R. 3162) that would have frozen Medicare home health payments for one year and reinstated the 5 percent rural add on for two years. The Senate rejected the House bill.

S. 2499 did not contain any provisions directly impacting home health and hospice. Of interest to some home health providers was Section 105 of the legislation that extended the exceptions process for the caps on outpatient therapy services through June 30, 2008 (cap does not apply to therapy services provided under the Medicare home health benefit).

In the final days of 2007, Congress passed the fiscal year 2008 omnibus appropriations bill (Public Law No: 110-161) that contained more than \$20 million in funding for telehealth and health information technology (HIT) programs. The spending bill, which contained \$555 billion overall, included approximately \$6 million for telehealth projects funded through the Office for the Advancement of Telehealth housed in the U.S. Department of Health and Human Services. An additional \$17.7 million for telehealth and HIT projects was included at the request of individual Members of Congress for special projects within their home states and districts.

HOME HEALTH LEGISLATION 2006

On December 9, 2006, as one of the last acts of the 109th Congress, the House and Senate passed the “Tax Relief and Health Care Act of 2006” (H.R. 6111; Public Law No: 109-432). This legislation includes several provisions affecting the Medicare and Medicaid programs, as well as a number of other health care items that may of interest to home health and hospice providers.

Division B: Medicare and Other Health Provisions - Medicare Improvements and Extension Act of 2006 –

Title I: Medicare Improved Quality and Provider Payments

Section 103: Directs the Comptroller General to report to Congress on the costs for home hemodialysis treatment and patient training for both home hemodialysis and peritoneal dialysis.

Section 111: Deems Medicare provider number 29-1511 to be a multiple location of Medicare provider number 29-1500, for purposes of calculating the hospice aggregate payment cap for 2004, 2005, and 2006 for a hospice program for care provided between November 1, 2003, and December 27, 2005.

Title II: Medicare Beneficiary Protections

Section 201: Amends SSA title XVIII to extend through 2007 the exceptions process for Medicare therapy caps.

Section 204: Directs the Secretary to establish under SSA title XVIII a medical home demonstration project to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations. Requires such project to provide that: (1) care management fees are paid to persons performing services as personal physicians; and (2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

Title III: Medicare Program Integrity Efforts

Section 301: Amends SSA title XVIII to make a total of \$3.5 billion available to the MA Regional Plan Stabilization Fund for expenditures between January 1, 2012, and December 31, 2013.

Section 302: Requires the Secretary, under the Medicare Integrity Program, to enter into contracts with recovery audit contractors to identify underpayments and overpayments and recoup overpayments for all services for which payment is made under Medicare part A (Hospital Insurance) or Medicare part B (Supplementary Medical Insurance).

Requires the Secretary to enter into such contracts in a manner so as to provide for activities in all states under such a contract by January 1, 2010.

Section 303: Makes appropriations to the Health Care Fraud and Abuse Control Account for FY2007-FY2010 and ensuing fiscal years.

Provides funding for the same period for the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the Medicare and Medicaid programs. Makes appropriations for the same period for the Federal Bureau of Investigation to cover the costs of the administration and operation of the health care fraud and abuse control program.

Section 304: Directs the Secretary to make certain funds transfers from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Centers

for Medicare and Medicaid Services Program Management Account for this title and titles I and II of this division for FY2007-FY2008.

Title IV: Medicaid and Other Health Provisions

Section 403: Amends SSA title XIX (Medicaid) to revise the formula for determining the existence, between January 1, 2008, and October 1, 2001, of an indirect guarantee to hold taxpayers harmless for any portion of the costs of a broad-based health care related tax, which would require reduction in the computation of state Medicaid expenditures when determining the amount of federal payments to be made to the state. (This reduction is a function of a certain limitation on the use of provider-specific taxes to obtain federal financial participation under Medicaid.)

Section 405: Revises requirements for: (1) continued application of regular Medicaid cost-sharing rules for individuals with family income not exceeding 100% of the poverty line; and (2) cost-sharing rules applicable to disabled children provided medical assistance under the eligibility category added by the Family Opportunity Act.

Waives citizenship or nationality documentation requirements for an individual declaring to be a U.S. citizen or national who is receiving disability insurance benefits under SSA title II (Old-Age, Survivors, and Disability Insurance Benefits) (OASDI).

Title IV: Other Provisions

Section 405: Authorized appropriation and directs the Secretary of Health and Human Services to conduct a study on establishing a uniform national database on elder abuse.

HOME HEALTH LEGISLATION 2005

THE DEFICIT REDUCTION ACT OF 2005 (S. 1932; PL 109 -171)

On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the “Byrd Rule.” The amended agreement passed the Senate on December 21, 2005, and was returned to the House for further action. On February 1, 2005, the House agreed to the Senate amendment by a vote of 216 to 214. S. 1932 was signed into law (Public Law 109-171) on February 8, 2006, by President Bush.

TITLE V -- MEDICARE

Subtitle A – Provisions Relating to Part A

Section 5008. Post-Acute Care Payment Reform Demonstration Program.

The Secretary of the Department of Health and Human Services is required to establish a three-year demonstration program to assess the costs and outcomes across different post-acute care sites by January 1, 2008.

Subtitle B – Provisions Relating to Part B

Section 5101. Beneficiary Ownership of Certain Durable Medical Equipment (DME).

Requires the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a 13-month rental period, but retains a beneficiary option for purchasing power-driven wheelchairs when initially furnished. Automatic payment to the suppliers every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier’s or manufacturer’s warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006.

Provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36-month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier’s or manufacturer’s warranty) will be made if the Secretary determines them to be reasonable and necessary. This provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36 month period begins January 1, 2006.

Section 5107. Revisions to Payments for Therapy Services.

Does not extend the moratorium, however, the Secretary is required to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on behalf of the enrollee, may request an exception from the physical therapy and occupational

therapy caps. The individual may obtain an exception if the provision of services is determined medically necessary. If the Secretary does not make a decision on a request within 10 business days of receipt, the Secretary is deemed to have found the services medically necessary. The Secretary is required to waive such provisions of law and regulations (including those related to the Paperwork Reduction Act) as are necessary to implement these amendments on a timely basis. The amendments may be implemented by program instruction or otherwise. The legislation specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process). It also requires the Secretary, by July 1, 2006, to implement clinically appropriate code edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

Subtitle C – Provisions Relating to Parts A and B

Section 5201. Home Health Payments.

Eliminates the update for home health payments in 2006. It also extends the 5% additional payment for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007. Starting in 2007, home health agencies will submit to the Secretary health care quality data in a form, manner, and time period specified by the Secretary. In 2007 and subsequent years, a home health agency that does not submit the required quality data will receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. Directs the Secretary to design procedures for making the data available to the public. The Medicare Payment Advisory Commission is directed to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, determining thresholds, the size of value-based payments, sources of funds, and the relationship of payments and improvements in health care quality.

Section 5202. Revision of Period For Providing Payment for Claims that are not Submitted Electronically.

Directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95% of all “clean” claims within 29-30 days of receipt for paper claims.

Section 5203. Time Frame for Part A and B Payments.

Delays Medicare Part A and B payments by nine days. Claims that would otherwise be paid on September 22, 2006, through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.

Section 5204. Increase in Medicare Integrity Program Funding.

Increases Medicare Integrity Program funding \$100 million for fiscal year 2006. As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust

Fund. Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP).

TITLE VI – MEDICAID

Chapter 2 – Long-Term Care Under Medicaid

Subchapter A – Reform of Asset Transfer Rules

Section 6011. Lengthening Look-Back Period; Change in Beginning Date for Period of Ineligibility.

Section 6011(a). Amends section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual after enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply. Therefore states will now be required to delay Medicaid eligibility as specified above for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a “look-back date.” The beginning date for the period of ineligibility will change from the date of the asset transfer to the date of application for Medicaid. The section identifies hardship exceptions in certain cases.

Section 6012. Disclosure and Treatment of Annuities.

Amends Section 1917 of the Social Security Act and requires individuals applying for Medicaid-covered LTC services, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Also amends Section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity be treated as a disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named in the second position after the community spouse or minor or disabled child and such spouse or a representative of the such child does not dispose of any such remainder for less than fair market value. Includes annuities purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services in the definition of annuities that are subject to asset transfer rules.

Section 6014. Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity.

Amends Section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$500,000. A state may elect, without regard to Medicaid’s requirements concerning state wideness and comparability, to substitute an amount that exceed \$500,000 but does not exceed \$750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000. The Secretary establishes a process for waiving this provision in the case of a demonstrated hardship. Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act)

lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home. The provision applies to individuals who are determined eligible for Medicaid nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Section 6015. Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts.

Amends Section 1919(c)(5) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. Also amends Section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination to the extent that: (A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care; (B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and (C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

Section 6016. Additional Reforms of Medicaid Asset Transfer Rules.

Section 6016(a). Amends Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period with respect to the disposal of assets.

Section 6016(b). Amends Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

Section 6016(c). Amends Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender. In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding

balance due as of the date of the individual's application for certain Medicaid long-term care services.

Section 6016(d). Amends Section 1917(c)(1) of the Social Security Act by adding a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

Subchapter B – Expanded Access to Certain Benefits –

Section 6021. Expansion of State Long-Term Care Partnership Program.

Amends Section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing Medicaid long-term care (LTC) insurance partnership programs not allow consumer protection standards to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a LTC policy (including a certificate issued under a group insurance contract), if the following requirements are met:

- (I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a LTC insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;
- (II) The policy is a qualified LTC insurance policy (meeting specifications defined in Section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;
- (III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000);
- (IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection;
- (V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a LTC insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of LTC;
- (VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of

the partnership programs. These regulations shall specify the type and format of the data and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved.

The Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTC insurance policies under qualified state LTC insurance partnerships to a secure, centralized electronic query and report generating mechanism that state, the Secretary, and other federal agencies can access.

Chapter 3 – Eliminating Fraud, Waste, and Abuse in Medicaid

Section 6031. Encouraging the Enactment of State False Claims Acts.

Requires that if a state has in effect a law relating to false or fraudulent claims that meets requirements specified in the bill, the FMAP, with respect to any amounts recovered under a state action brought under such a law, is decreased by 10 percentage points. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Section 6032. Employee Education about False Claims Recovery.

Requires a state to provide that any entity that receives annual Medicaid payments of at least \$5 million, as a condition of receiving such payments, must: (1) establish written policies for all employees (and any contractor or agent) of the entity that provide detailed information on state and federal false claims laws and whistle-blower protections under such laws, (2) include in such written policies detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Section 6034. Medicaid Integrity Program.

Establishes a Medicaid Integrity Program, under which the Secretary of HHS shall enter into contracts with eligible entities to carry out its activities, including review of the actions of individuals or entities, audit of claims for payment, identification of overpayments, and education with respect to payment integrity and quality of care. Appropriations for the program total \$5 million in FY2006, \$50 million in each of FY2007 and FY2008, and \$75 million in each fiscal year thereafter (with a mandated increase of 100 employees whose duties consist solely of protecting the integrity of the Medicaid program). States are required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program. In each of FY2006-2010, \$25 million is appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). Also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program. The Medi-Medi program data match project analyzes

claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation. It is primarily supported by “wedge” funds from the Health Care Fraud and Abuse Control Account (HCFAC) within the federal Hospital Insurance (Medicare Part A) trust funds. In addition to HCFAC appropriations for the Medicare Integrity Program, the Medi-Medi Program is appropriated \$12 million in FY2006, \$24 million in FY2007, \$36 million in FY2008, \$48 million in FY2009, and \$60 million in FY2010 and each fiscal year thereafter.

Section 6035. Enhancing Third Party Identification and Payment

Substitutes the term “managed care organization” for “health maintenance organization” and amends the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include self-insured plans, pharmacy benefit managers, and other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It also amends that section to include these entities in the list of health insurers that states must prohibit from taking an individual’s Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual. Requires a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring third parties to provide, upon request of the state, information to determine health insurance coverage (in a manner prescribed by the Secretary) and to cooperate with payment and recovery efforts by Medicaid.

The provision is effective January 1, 2006, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Chapter 4 – Flexibility in Cost Sharing and Benefits

Section 6041. State Option For Alternative Medicaid Premiums and Cost Sharing.

Section 6041(a). Allows the states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service. Premiums and cost-sharing provisions in current law for workers with disabilities are not affected. For individuals in families with income between 100 and 150% Federal Poverty Level (FPL): (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.

Exempts premiums for the following groups: (1) mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in medical institutions who

are required to pay for costs of care all but a minimal amount of their income for personal needs, and (5) women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional groups from premiums.

Cost-sharing is not permitted for: (1) services provided to mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided to terminally ill individuals receiving Medicaid hospice services; (5) services provided to individuals in medical institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; (7) family planning services and supplies, and (8) services to women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional individuals or services from service-related cost-sharing.

Section 6041(b). Beginning with 2006, the Secretary is required to increase nominal amounts for service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

Chapter 6 – Other Provisions

Subchapter A – Family Opportunity Act

Section 6063.

Establishes a five year demonstration project in which up to 10 states could provide a broad range of home- and community-based services (HCBS) to children who would otherwise require services in a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child's functional level, and the cost-effectiveness of providing these types of services as an alternative to psychiatric residential treatment services. The projects must follow the existing requirements of the HCBS waiver, and be budget neutral. \$218 million has been appropriated for FY2007-FY2011 to carry out the demonstration. The funds available for this demonstration total: \$21 million in FY2007; \$37 million in FY2008; \$49 million in FY2009, \$53 million in FY2010; and \$57 million in FY2011.

Section 6071. Money Follows the Person Demonstration

Authorizes the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions by relocating individuals from institutions into the community, (2) expand the state's capacity to provide home and community-based long-term care services for individuals who choose to transition into the community; and (3) to ensure that procedures are in place to provide quality assurance and continuous quality improvement, that is at least comparable to other Medicaid home and community-based services.

States awarded a demonstration would receive additional federal funding for the costs of home

and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community based long-term care program.

Individuals may participate in the demonstration if they meet the following criteria: (1) they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); (2) they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); (3) they are receiving Medicaid benefits for the services in this facility; (4) they will continue to require the level of care of the facility but for the provision of HCBS services. After relocating into the community, the individual must reside in one of the following: a home owned or leased by the individual or his/her family; an apartment with an individual lease in which the individual (or family) has domain and control over the space; or a community-based residential setting where no more than four unrelated individuals reside.

\$250 million is appropriated for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; \$300 million in FY2008; \$350 million in FY2009; \$400 million in FY2010; and \$450 million in FY2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years, through September 30, 2011.

Section 6086. Expanded Access to Home and Community-Based Services for the Elderly and Disabled.

Establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve and would not include an individual's room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR. States that offer this new benefit must establish needs based criteria to determine an individual's eligibility for HCBS services, and the specific HCBS the individual will receive. The state must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision. The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

For this new benefit, a state may allow an individual or the individual's representative to receive

self-directed home and community-based services. If the state permits self-direction, there must be an assessment of the needs, capabilities and preferences of the individual. There must also be a service plan developed jointly with the individual that is approved by the state. The service plan must specify the services to be self-directed, identify the method of self-direction, specify the roles of various parties, and, if offered by the state, an individualized budget for the value of the services and supports to be self-directed. The provision of home and community-based services must meet state and federal guidelines for quality assurance. The state must also establish standards for the conduct of the independent evaluation and assessment to safeguard against conflict of interest.

Section 6087. Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling).

Allows a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The state must ensure that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and to assure financial accountability for funds expended for these services.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for state wideeness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Individuals participating in such services would be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services. At the election of the state, a participant is be allowed to (1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

The approved self-directed services plan developed under option must meet the following requirements: (1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual's plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant's capacity to engage in activities that promote community life; respects the

participant's preferences, choices and abilities; and involves families, and professionals in the planning or delivery of services or supports as desired or required by the participant.

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual's resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity is reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50 %, though certain activities may be eligible for 75 % reimbursement). This provision becomes effective on January 1, 2007.

Labor, Health and Human Services, and Education
Fiscal Year 2006 Appropriations
Public Law 109-149

On December 30, 2005, President Bush signed into law H.R. 3010, the "Department of Health, Labor, and Human Services, and Education, and Related Agencies Appropriations Act, 2006." H.R. 3010 includes funding for telehealth. Specifically, it provides \$3,000,000 to the Office of the Advancement of Telehealth to carry out programs and activities under the Health Care Safety Net Amendments of 2002 (Public Law 107-251). Of that amount, \$1,500,000 can be used to fund telehealth resource centers that provide assistance with respect to technical, legal, regulatory service delivery or other related barriers to the development of telehealth technologies. The Congress urged the Department of Health and Human Services' Health Resources and Services Administration (HRSA) department to place a high priority on the needs of rural States with populations of less than 1,500,000 individuals in the awarding and geographical placement of the telehealth resource grants. \$750,000 will be used for network grants and demonstration or pilot projects for telehomecare and another \$750,000 will be used for grants to carry out the licensure provisions in Section 102 of Public Law 107-251.

HOME HEALTH LEGISLATION 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (HR 1; PL 108-173)

HOME CARE

Section 421-One-year increase for home health services furnished in a rural area.

Provides a one-year, five percent additional payment for home health services furnished in a rural area. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004, and before April 1, 2005.

Section 701-Update in home health services.

Changes the time frame for the home health inflation update from the federal fiscal year to a calendar year basis beginning with 2004. Home health agency payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points.

Section 702-Demonstration project to clarify the definition of homebound.

The Secretary is required to conduct a two-year demonstration project under which beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare.

The Secretary is required to select three states in the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. Up to 15,000 beneficiaries can participate. The demonstration is required to begin within six months of enactment. Within one year of completing the demonstration, the Secretary is required to report to Congress recommendations and findings regarding the demonstration and its impact on the Medicare program. The provision is effective upon enactment.

Section 703-Demonstration project for medical adult day care services.

Requires the Secretary to establish a three-year demonstration project in not more than five states that license or certify providers of medical adult day care services, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Payment for the episode will equal 95 percent of the amount that would otherwise apply, subject to budget neutrality provisions. The agency or facility is prohibited from charging the beneficiary separately for the medical adult day care services. Participation of up to 15,000 Medicare beneficiaries is on a voluntary basis.

When selecting participants, the Secretary is required to give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior two-year period.

The Secretary is required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than six months after completion of the demonstration. The provision

is effective upon enactment.

Section 704-Temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients.

Suspends the requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients until the Secretary (1) reports to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies, and then (2) publishes final regulations regarding the collection and use of OASIS. The provision does not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

Section 705-Medicare Payment Advisory Commission (MedPAC) study on Medicare margins of home health agencies.

The conference agreement requires MedPAC to study payment margins of home health agencies paid under the Medicare home health prospective payment system, using cost reports filed by agencies. The study is required to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies. MedPAC is required to submit a report to Congress on the study within two years of enactment.

Section 953-GAO report on flexibility in applying home health Conditions of Participation to patients who are not Medicare beneficiaries.

Requires the GAO to report to Congress on the implications if the Medicare conditions of participation for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries. The report is due no later than six month after enactment.

Section 307-Pilot program for national and state background checks on direct patient access employees of long-term care facilities and providers.

Requires the Secretary to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long-term care providers, including nursing homes, home health agencies, hospices, long-term care hospitals, and other entities (except for those paid through a self-directed arrangement). Funding in each of fiscal years 2005 and 2006 is set at \$25 million.

How Will the Medicare Reform Bill Affect Home Health Payments?			
Episodes Between	Ending	National Avg. Episode Rate	National Avg. Rural Rate
Oct 1, 2002-Sept 30, 2003		\$2159.39	\$2159.39 (as of 4/1/03)

Oct 1, 2003-Mar 31, 2004	\$2230.65	\$2230.65
Apr 1, 2004-Dec 31, 2004	\$2213.37	\$2324.04

For episodes ending on or after October 1, 2003, but before April 1, 2004, there is a 3.3% market basket index (inflation) increase.

The Medicare reform bill mandates that inflation increases be made on a calendar year basis. Also, for episodes ending on or after April 1, 2004, but before January 1, 2005, the 3.3% market basket index inflation increase will be reduced by 0.8%. Rates for calendar year 2005 and 2006 will be increased by market basket minus 0.8%. The legislation provides a 5% rural add-on for episodes ending between April 1, 2004-March 31, 2005.

HOME HEALTH LEGISLATION 2002

The 2002 legislative session began with passage by the House of legislation that would eliminate the 15% cut in home health payments (implemented on October 1, 2002), extend the 10% rural add on until January 2005, create a new hospice consultation benefit, eliminate the OASIS requirement for non-Medicare/non-Medicaid patients, and provide many regulatory reforms. Similar legislation was introduced by the Chair and Ranking Member of the Senate Finance Committee. However, passage of this legislation fell victim to partisan gridlock over the creation of a prescription drug benefit. The Administration, senior groups, and some in Congress insisted that relief for Medicare providers should not be granted unless Congress first created a prescription drug benefit, but Congress could not agree on the size and structure of such a benefit.

The following legislation that could help alleviate the widespread shortage of home health nurses was signed into law. An effort will be made in 2003 to obtain an appropriation of funds to implement the new law.

Nurse Reinvestment Act (H.R. 3487, P.L. 107-205)

Title I: Nurse Recruitment

Section 101 – Defines “health care facility” to include home health agencies and hospice programs.

Section 102 – Permits the Secretary of HHS to make grants to support State and local advertising campaigns to promote the nursing profession.

Section 103 – Expands eligibility for the nursing loan repayment program to include service at any health care facility with a critical shortage of nurses. Restricts service to nonprofits after FY 2007. Provides nursing scholarships in exchange for two years of nursing services at facilities with a critical shortage of nurses.

Title II: Nurse Retention

Section 201 – Authorizes the Secretary of HHS to award grants or contracts to schools of nursing or health care facilities to expand nursing education and practice opportunities and creation of career ladders.

Section 202 – Directs Secretary to award grants for geriatric care training programs.

Section 203 – Authorizes establishment of student loan program to increase the number of qualified nursing faculty and provides loan forgiveness in exchange for service on nursing faculty.

Section 204 – Requires GAO report on national variations in nursing shortages; differences in nurse hiring practices between profit and nonprofit private entities because of the inclusion of for-profit private entities in the loan repayment program; and whether the scholarship program

increases applications to nursing schools.

HOME HEALTH LEGISLATION 2001

The 2001 legislative session got off to a promising start, with early progress on a number of health care and home health priorities. However, the events of September 11, 2001, shifted the congressional focus dramatically. As a result, most pending legislation affecting health care providers took a back seat until the start of the 2002 legislative session. The following pieces of legislation that impact home health and hospice providers were signed into law:

The National Defense Authorization Act for Fiscal Year 2002 (P.L. 107-107)

Title VII: Health Care Provisions - Subtitle A: TRICARE Program Improvements - Amends the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to direct the Secretary to establish a sub-acute care benefits program for the same types of health care authorized under CHAMPUS. Requires such program to include a uniform skilled nursing facility benefit and a home health care benefit as provided under title XVIII (Medicare) of the Social Security Act.

Administrative Simplification Compliance Act (P.L. 107-105)

SEC. 2. Extension of Deadline for Covered Entities Submitting Compliance Plans -- Extends by one year the deadlines for compliance by health care providers, health plans other than small health plans, and health care clearinghouses with the standards for electronic health care transactions and code sets adopted under part C (Administrative Simplification) of title XI of the Social Security Act (SSA) by the Secretary of Health and Human Services only if, before the current deadline, such entity submits to the Secretary a plan for compliance with such standards.

HOME HEALTH LEGISLATION 2000

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT (H.R. 4577, incorporated into P.L. 106-554)

Title V, Subtitle A – Home Health Services

Section 501 – 1-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits to Home Health Services

The 15 percent reduction in payment rates scheduled for October 1, 2001, is delayed until October 1, 2002.

The Comptroller General of the General Accounting Office (GAO) (rather than the Secretary of Health and Human Services) would be required to submit a report by April 1, 2002, analyzing the need for the 15 percent or other reduction.

Additionally, if the Secretary of HHS determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary of HHS may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Section 502 – Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001

The provision would modify the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, would apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates would be increased by 2.2 percent for 60-day episodes ending in that time period.

Section 503 -- Temporary Two-Month Periodic Interim Payment Extension

The provision would provide for a one-time payment to home health agencies that were receiving periodic interim payments as of September 30, 2000, equal to four times the last two-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts would be included in the agency's last settled cost report before implementation of the PPS. This payment will be made by CMS as soon as is "practicable."

Section 504 -- Use of Telehealth in Delivery of Home Health Services

This provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment. Moreover, nothing in this provision shall be construed as waiving the physician certification requirement for payment for home health services, whether or not such certification is provided by telephone.

Section 505 -- Study on Costs to Home Health Agencies of Purchasing Non-routine Medical Supplies

The provision would require that, not later than August 15, 2001, the Comptroller General of the GAO shall submit to Congress a report regarding the variation in prices home health agencies pay for non-routine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary of HHS would be required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

Section 506 -- Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas

The provision would clarify that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary would be authorized to include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status.

Not later than January 1, 2002, the Comptroller General would be required to submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas and to make recommendations on whether national standards for supervision would be appropriate in assuring quality.

Section 507 -- Clarification of the Homebound Definition under the Medicare Home Health Benefit

The provision clarifies that the need for adult day care for a patient's plan of treatment does not preclude appropriate coverage for home health care for other medical conditions. The provision also clarifies the ability of homebound beneficiaries to attend religious services without being disqualified from receiving home health benefits.

In addition, the Comptroller General will conduct a study on the effect of the provision "on the cost of and access to home health services" under Medicare. A report on the study will be presented to Congress no later than 1 year after enactment.

Section 508 -- Temporary Increase for Home Health Services Furnished in a Rural Area

For home health services furnished in certain rural areas during the two-year period beginning April 1, 2001, Medicare payments are increased by 10 percent, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase would not be included in determining subsequent payments.

Title V, Subtitle C – Changes in Medicare Coverage and Appeals Process**Section 521 -- Revisions to Medicare Appeals Process**

Provides that an expedited determination would be available for a beneficiary who received notice:

1. that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely place the beneficiary's health at risk; or
- 2.

that the provider plans to discharge the beneficiary.

New steps are instituted in the appeals process by implementing a "redetermination," an expedited

in-house review by the regional home health intermediaries. The redetermination would be required to be completed within 30 days of a beneficiary's request.

The Secretary would enter into three-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations, thereby replacing the current intermediary reviewers with an outside body of reviewers.

Title III, Subtitle C -- Hospice Care

Section 321 -- Five Percent Increase in Payment Base

The provision would increase, effective April 1, 2001, the base Medicare daily payment rates for hospice care for fiscal year (FY) 2001 by 5 percentage points over the rates otherwise in effect. This increase would continue to apply after fiscal year 2001. The temporary increase in payment rates provided in BBRA 99 for FY 2001 and FY 2002 (.5 percent and .75 percent, respectively) would not be affected. In addition, the hospice wage index for Wichita, Kansas' metropolitan statistical area for FY 2000 would be adjusted.

Section 322 -- Clarification of Physician Certification

Effective for certifications of terminal illness made on or after the date of enactment, the provision would modify current law to specify that the physician's or hospice medical director's certification of terminal illness would be based on his/her clinical judgment regarding the normal course of the individual's illness. The Secretary would be required to study and report to Congress within two years of enactment on the appropriateness of certification of terminally ill individuals and the effect of this provision on such certification.

Section 323 -- MedPAC Report on Access to, and Use of, Hospice Benefit

The provision would require MedPAC to examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences in utilization rates. The provision would require a report on the study to be submitted to Congress 18 months after enactment.

Title IV, Subtitle C -- Other Services

Section 425 -- Full Update for Durable Medical Equipment (DME)

The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update would equal the full increase in the CPI-U for the 12 months the previous June. The provision specifies that, for the period January 1, 2001, through June 30, 2000, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28 percent.

Older Americans Act Amendments of 2000 (H.R. 782, incorporated into P.L. 106-501)

Title III -- Amendments to Title III of the Older Americans Act of 1965

Section 310 – Consumer Contributions and Waivers

Authorizes a state to implement cost sharing by recipients for all services, with specified exceptions, provided for in the Act. Requires cost sharing to be on a sliding scale based solely on individual income and the cost of delivering services.

Provides for waivers of cost sharing requirements upon demonstrations by area agencies that: (1) a significant proportion of recipients in the area have incomes below the threshold established in state policy; or (2) cost sharing would be an unreasonable administrative or financial burden.

Allows solicitations of voluntary contributions for services provided under the Act.

Requires states and area agencies to develop plans to ensure that the participation of low-income older individuals receiving services will not decrease with the implementation of cost sharing.

Directs the Assistant Secretary to take corrective action to assure that services are provided to all older individuals without regard to cost sharing criteria if there is a disparate impact upon low-income or minority older individuals in any state or region regarding provision of services.

Authorizes the Assistant Secretary, subject to certain requirements, to waive any of the following provisions of the Act with respect to a state: (1) specified statewide uniformity requirements under title III; (2) area or state plan requirements; (3) restrictions on the amount that may be transferred between supportive and nutrition services programs; and (4) a requirement that certain amounts of a state allotment be used for the provision of services with respect to states that reduce expenditures under a state plan.

Not later than 1 year after enactment, and annually thereafter, the Assistant Secretary of the Administration on Aging will conduct a comprehensive evaluation of the practices for cost-sharing to determine its impact on participation rates with particular attention to low-income and minority older Americans and older Americans living in rural areas. If the Assistant Secretary finds a disparate impact on any of these groups, the Assistant Secretary shall take “corrective action” to assure that such groups fully participate in OAA programs.

Section 314 – In-home Services and Additional Assistance

Repeals provisions of the Act regarding: (1) in-home services for frail older individuals; (2) additional assistance for special needs of older individuals; and (3) supportive activities for caretakers who provide in-home services to frail older individuals.

Section 316 – National Family Caregiver Support Program

Establishes a three-year grant program for: (1) support services for family caregivers (including grandparents and older relatives) and development and testing of innovative approaches to sustaining the efforts of families and other informal caregivers of older individuals; and (2) activities of national significance to promote quality and continuous improvement in the support provided to family and other informal caregivers of older individuals through program evaluation, training, technical assistance, and research.

The Assistant Secretary of the Administration on Aging shall evaluate the effectiveness of these grant programs and disseminate this report to the states so that useful approaches can be identified and incorporated into the program.

Title VI – Amendments to Title VI of the Older Americans Act of 1965

Section 604 – General Provisions

Establishes a Native American caregiver support program.

Title VII – Amendments to Title VII of the Older Americans Act of 1965

Section 704 – State Long-Term Care Ombudsman Program

Revises the provisions regarding the State Long-Term Care Ombudsman program.

Section 707 – Native Americans Programs

Authorizes appropriations for Native American elder rights and protection program.

HOME HEALTH LEGISLATION 1999

MEDICARE, MEDICAID, AND SCHIPP REFINEMENT ACT OF 1999 (H.R.3426, incorporated into P.L. 106-113)

Title III, Subtitle A -- Home Health Services

Section 301 -- Adjustment to Reflect Administrative Costs Not Included in the Interim Payment System; GAO Report on Costs of Compliance with OASIS Data Collection Requirements.

The bill provides that a home health agency be paid \$10 to defray the costs of OASIS for each beneficiary served by the agency during the agency's cost reporting period beginning in fiscal year 2000.

This provision mandates that Medicare pay the agency 50 percent of the estimated aggregate amount payable to the agency by April 1, 2000. The balance is payable when the cost reports are settled.

The General Accounting Office (GAO) is required to submit a study to Congress no later than 180 days after enactment of the Act which includes an assessment of the costs incurred by agencies in complying with OASIS and an analysis of the effect of OASIS on patient privacy.

Section 302 -- Delay in Application of 15 Percent Reduction in Payment Rates for Home Health Services Until One Year After Implementation of Prospective Payment System.

The 15 percent reduction in payment rates scheduled for October 1, 2000, is delayed for one year after implementation of the prospective payment system.

Not later than six months after the date the Secretary of HHS implements PPS, the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction or any reduction in PPS payment amounts.

Section 303 -- Increase in Per Beneficiary Limits

The per beneficiary limits under the interim payment system are increased by 2 percent for those agencies with per beneficiary limits below the national median. Effective for cost reporting periods beginning during or after fiscal year 2000.

Section 304 -- Clarification of Surety Bond Requirements.

This provision limits the surety bond requirement to four years, or in the case of a change of ownership or control, an additional period determined by the Secretary but not to exceed four years from the change of ownership or control.

The surety bonds are set at the lesser of \$50,000 or 10 percent of Medicare and Medicaid payments to the agency. One bond shall satisfy the requirement for both Medicare and Medicaid.

Section 305 -- Refinement of Home Health Agency Consolidated Billing.

This provision eliminates the requirement that home health agencies bill for durable medical equipment.

Section 306 -- Technical Amendment Clarifying Applicable Market Basket Increase for PPS.

This provision makes clear that scheduled reductions in market basket adjustments for home health agencies shall take place in "2002 and 2003," rather than "2002 or 2003."

Title I, Subtitle D – Hospice

Section 131 – Temporary Increase in Payment for Hospice Care

For each of fiscal years 2001 and 2002, hospice payment rates (otherwise in effect for those years) are increased by 0.5 percent and 0.75 percent, respectively.

Section 132 – Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care

Requires the General Accounting Office to conduct a study on the feasibility and advisability of updating the hospice rates and certain capped payment amounts, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. The report and recommendation are to be submitted to Congress within 1 year of enactment.

Title I, Subtitle C – Other Services

Section 223 – Implementation of the Inherent Reasonableness (IR) Authority

The Secretary is prohibited from using inherent reasonableness authority until after (1) the GAO releases a report regarding the Secretary's recent use of the authority; and (2) the Secretary has published a notice of final rulemaking in the Federal Register that responds to the GAO report and to comments received in response to the Secretary's interim final regulation published January 7, 1998. In promulgating the final regulation, the Secretary is required to (1) reevaluate the appropriateness of the criteria included in the interim regulation for identifying payments which are excessive or deficient; and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority.

Section 228 – Temporary Increase in Payment Amount for Durable Medical Equipment (DME) and Oxygen

Provides temporary adjustments to the DME fee schedule payments equaling 0.3 percent in FY 2001 and 0.6 percent in FY 2002. The Secretary is prohibited from including the additional payments for FY 2001 and 2002 in updates for future years.

Section 229 – Studies and Reports

Directs MedPAC to conduct a comprehensive study to review the regulatory burdens placed on all classes of health care providers under Parts A and B of the Medicare program. The purpose of the study is to determine the costs these burdens impose on the nation's health care system and the impact on patients and providers, and their ability to deliver cost-effective quality care to Medicare beneficiaries.

THE VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT (P.L. 106-117)

PRIVATE

Section 101 -- Requirement to Provide Extended Care Services

Creates a four-year plan requiring the Department of Veteran Affairs (VA) to provide extended care services to veterans needing it for a service-connected disability and to any veteran who is 70 percent disabled by service-related injuries.

Requires the Secretary to provide community-based primary care, adult day health care, respite care, palliative and end-of-life care, and home health aide visits to enrolled veterans. Respite care would be furnished in the patient's home or in a VA facility.

At the end of four years Congress will determine whether these provisions should be eliminated, expanded or left intact. In the event that these provisions were to expire, veterans would continue to be eligible for such services under existing law. A copayment will be developed and assessed by the VA.

Section 102 -- Pilot Programs Relating to Long-Term Care

Directs VA to carry out three long-term care pilot programs over a three-year period. The goal of these pilot programs is to determine the effectiveness of different models of providing all-inclusive care with the aim of reducing the use of hospital and nursing home care. Each model would be carried out in two VA regions designated by the Secretary. The pilots would provide a comprehensive array of services to include institutional and non-institutional long-term care services, and appropriate case-management.

Under one pilot model, VA would provide long-term care services directly through VA staff and facilities. A second model would employ a mix of VA provided care and care provided under cooperative arrangements with other service providers (who VA reimburses exclusively by providing in-kind services). Under a third model, VA would serve as a case-manager to ensure that veterans receive needed long-term care services through arrangements with non-VA entities. VA would collect data relevant to such programs and, after the completion of the program, provide Congress a report describing the services provided.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2000 (P.L. 106-65, SECTION 703); THE DEPARTMENT OF DEFENSE APPROPRIATIONS ACT FOR FISCAL YEAR 2000 (P.L. 106-79, SECTION 8118)

These two provisions reject the Department of Defense policy that limits the duration and scope of home health services provided to disabled individuals. These provisions provide that members and retired members of the military services and their dependents have access to all medically necessary home health services through the health care system of the military services regardless of the health care status of the individual seeking care.

HOME HEALTH LEGISLATION 1998

Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 1999 (P.L. 105-277)

Interim Payment System

Section 5010—Increase in per beneficiary limits (PBL) and per visit payment limits for payment for home health services.

Per Beneficiary Limits (PBLs)

Agencies with a 12-month cost reporting period ending in fiscal year 1994 whose PBLs are below the national median have their PBLs increased by 1/3 of the difference between their PBL and the national median.

Agencies without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, have their PBLs increased from 98 percent to 100 percent of the national median.

Agencies whose first cost reporting period begins during or after fiscal year 1999 receive as their PBL 75 percent of the national median.

Per Visit Limits

Per visit limits are increased from 105 percent of the national median to 106 percent of the national median.

15 percent Reduction in Payment Limits

The automatic 15 percent reduction in home health payment limits is delayed until October 1, 2000, for all agencies.

Prospective Payment

Implementation of a prospective payment system is delayed until October 1, 2000, for all agencies.

Periodic Interim Payment (PIP)

PIP is extended until October 1, 2000.

Change in Home Health Market Basket Increase

The home health market basket is reduced by 1.1 percentage points for fiscal year 2000 through FY2003.

Criminal Background Checks

Section 124—A nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of records regarding an applicant for employment if the employment position is involved in direct patient care.

Centers for Medicare and Medicaid Services—Program Management

\$2,000,000 of the funds available for research, demonstration, and evaluation activities is available to continue demonstration projects on Medicaid coverage of community-based attendant care

services for people with disabilities which ensure maximum control by the consumer to select and manage their attendant care services.

HOME HEALTH LEGISLATION 1997

Balanced Budget Act of 1997 (P.L. 105-33)

Commissions

Section 4019 -- Community Nursing Demonstration Projects.

The Community Nursing Organization Demonstration Projects, which test a prepaid, capitated, nurse-managed system of care, are extended for an additional period of two years. Fraud and Abuse Provisions

Section 4021 -- National Bipartisan Commission on the Future of Medicare.

The bill establishes a new Commission to make recommendations to Congress concerning the long-term financial condition of the Medicare program. The Commission, which will begin work in December 1997 and file its recommendations by March 1, 1999, will also examine the impact of chronic care on the Medicare program. This part of the Commission's mandate is expected to include making recommendations related to chronic home care needs of the elderly and disabled populations.

The Commission will be composed of 17 members. Four Commissioners will be appointed by the President. Six will be appointed by the Majority Leader of the Senate, and six by the Speaker of the House. An additional Commissioner will serve as Chair and will be appointed jointly by the President, the Senate Majority Leader, and the Speaker.

This Commission is expected to be composed of Members of Congress and the Administration.

Section 4022 -- Medicare Payment Advisory Commission.

The BBA abolishes the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) and consolidates their work into one new group, called the Medicare Payment Advisory Commission.

This Commission will serve as an advisory body to Congress in all areas of Medicare payment and coverage policies, including payment policies under Parts A and B, the Medicare Choice program, and access and quality of care issues.

The Commission will be composed of 15 members, appointed by the Comptroller General of the GAO. A majority of the members must be non-providers.

Fraud and Abuse

Section 4301 -- Permanent Exclusion for Those Convicted of Three Health Care-related Crimes.

The bill establishes a new "three strikes and you're out" policy for providers convicted of three healthcare-related crimes. Under this provision, the penalty for a health care provider found guilty of defrauding any federal health program for a second time would be increased from a five-year exclusion to a 10-year exclusion. A third conviction would trigger a mandatory lifelong exclusion from participation in federal health programs.

Section 4302 -- Authority to Refuse to Enter into Medicare Agreements with Individuals or Entities Convicted of Felonies.

The budget package gives the Secretary of HHS the authority to exclude from participation any

health provider convicted of a felony. This section takes effect on date of enactment.

Section 4303 -- Exclusion of Entity Controlled by Family Member of a Sanctioned Individual.

Effective beginning 45 days after date of enactment, the bill authorizes the Secretary of HHS to prohibit an entity owned or controlled by an immediate family member of an excluded individual from participation from any federal healthcare program.

Section 4304 -- Imposition of Civil Monetary Penalties.

Effective on date of enactment, this provision adds a new civil monetary penalty for cases in which a person who contracts with an excluded provider knows or should have known that the provider was excluded from participation in a federal health care program.

Section 4311 -- Improving Information to Medicare Beneficiaries.

This provision requires that each explanation of benefit (EOB) form contain HHS' toll-free number to report fraud and abuse. Moreover, under this provision, a beneficiary will be given 30 days to request an itemized bill for Medicare services from the appropriate carrier or fiscal intermediary.

Section 4312 -- Disclosure of Information and Surety Bonds.

Effective January 1, 1998, this provision requires home health agencies to post a \$50,000 bond to participate in the Medicare program. The provision also mandates that home health agencies disclose identification of all officers, directors, physicians, and principal partners owning five percent or more of the agency. Durable medical equipment suppliers are also subject to the disclosure and surety bond requirements.

Section 4313 -- Provision of Certain Identification Numbers.

Under this provision, within 90 days of filing the disclosure report on ownership interest, Medicare providers are required to supply HHS with both the employer identification number and Social Security numbers for each person or entity with an ownership interest. In addition, health care providers who have at least a five-percent ownership interest in a contractor or subcontractor must disclose their employer identification numbers and Social Security numbers. HHS will then forward these numbers to both the Social Security Commission and the Department of the Treasury for verification.

Section 4314 -- Advisory Opinions Regarding Certain Physician Self-referral.

This provision allows providers to request written advisory opinions from HHS concerning whether an arrangement violates the prohibition against physician self-referrals (known as "Stark I and II"). These opinions will be binding on both HHS and the requesting party.

Section 4315 -- Replacement of Reasonable Charge Methodology with Fee Schedules.

Under this provision, the Secretary of HHS is authorized to implement a statewide or other area wide fee schedule for payment of specified items and services paid on a reasonable charge basis. The specified items and services are medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral and enteral nutrients, equipment and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine.

Section 4316 -- Application of Inherent Reasonableness to all Part B Services Other than

Physician Services.

This provision requires the Secretary of HHS to promulgate regulations describing the factors to be used in determining cases in which application of payment rules under Part B result in the determination of an amount that is not inherently reasonable. The regulations, however, cannot increase or decrease payment amounts by more than 15 percent from the preceding year for a particular item or service.

Section 4317 -- Requirement to Furnish Diagnostic Information.

This provision requires health providers to furnish diagnostic information to non-physician practitioners when ordering specified items or services furnished by such providers. This requirement would apply to diagnostic x-rays, diagnostic lab tests, durable medical equipment, prosthetic devices, braces, and artificial limbs.

Section 4318 -- Report by GAO on Operation of Fraud and Abuse Control Program.

This provision requires the General Accounting Office to report on the operation of the new Medicare fraud and abuse control program by no later than June 1, 1998.

Section 4319 -- Competitive Bidding Demonstration Project.

This provision requires the Secretary of HHS to establish competitive acquisition areas for Part B services. The Secretary could establish different competitive acquisition areas for different classes of items and services. The areas would be chosen based on availability and accessibility of entities able to furnish items and services and probable savings to be realized.

Section 4320 -- Prohibiting Unnecessary and Wasteful Medicare Payments for Certain Items.

This provision specifies that reasonable costs do not include costs for entertainment, gifts, costs for fines and penalties under federal or state law, or certain educational expenses for spouses or dependents of providers, their employees or contractors. Moreover, personal use of motor vehicles is specified as a non-reimbursable charge under Medicare.

Section 4321 -- Nondiscrimination in Post-Hospital Referral to Home Health Agencies.

This provision requires that hospitals, as part of their discharge planning process, provide a list of all home health agencies that serve the area in which the patient resides and who request to be listed by the hospital as available. In addition, the legislation requires hospitals to maintain and disclose information to the Secretary of HHS on referrals made to entities in which that hospital has a financial interest. This information must include the nature of the hospital's financial relationship to the provider, the number of individuals discharged from the hospital who required that provider's type of services, and the percentage of these individuals who received services from the hospital-based provider.

Section 4407 -- Hospital Transfers.

Effective for discharges occurring on or after October 1, 1998, the current law that applies to transfers from one PPS hospital to another PPS hospital would be extended, for patients within a specified group of 10 diagnostic related groups (DRG), to transfers from a PPS hospital to a PPS-exempt hospital or unit, skilled nursing facility, or home health care. Under this policy hospitals will be paid on a per-diem basis, rather than receiving the full DRG payment, for patients in the specified DRGs who are transferred after short hospital stays. The provider receiving the patient

would be paid under its own Medicare payment policy.

Hospice Provisions

Section 4441 -- Payments for Hospice Services and Data Collection.

For each of FY 98 through FY 2002, payment updates will be the market-basket percentage increase minus one percentage point. Hospice providers will also be required to submit to the Secretary of HHS such data as the Secretary determines is necessary regarding the costs of providing hospice care for each fiscal year, beginning with FY 99.

Section 4442 -- Payments for Home Hospice Care Based on Location Where Care is Furnished.

Beginning with cost-reporting periods starting on or after October 1, 1997, hospice claims for services furnished in an individual's home must be submitted on the basis of the geographic location at which the service is furnished, rather than the location of the billing office.

Section 4443 -- Hospice Benefit Periods.

The final bill restructures the hospice benefit periods to include two 90-day periods, followed by an unlimited number of subsequent periods of 60 days each. This provision is effective for benefits provided on or after date of enactment.

Section 4444 -- Items and Services Included in Hospice Payment.

The bill amends the current definition of hospice care to include the existing enumerated services as well as any other item or service that is specified in the patient's plan of care and which Medicare may pay for. This provision is effective for benefits provided on or after date of enactment.

Section 4445 -- Contracting with Independent Physicians or Physician Groups for Hospice Care.

The bill deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services. This provision is effective upon date of enactment.

Section 4446 -- Waiver of Certain Staffing Requirements for Hospice Care Programs in Non-urbanized Areas.

The bill allows the Secretary of HHS to waive requirements with regard to hospices having to provide certain services as long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech language pathology services and dietary counseling. This provision is effective upon date of enactment.

Section 4447 -- Limitation on Liability of Beneficiaries for Certain Hospice Coverage Denials.

This provision, which is effective for benefits provided on or after the date of enactment, extends the limitation of liability protection to determinations that an individual is not terminally ill.

Home Health Payment Reform

Section 4601 -- Recapturing Savings from Home Health Freeze.

The budget bill recaptures the savings resulting from the freeze of the home health cost limits included in the 1993 budget by eliminating consideration of any cost increases that occurred between July 1, 1994, and July 1, 1996, when updating future cost limits.

Section 4602 -- Interim Payments for Home Health.

The budget bill establishes a new interim payment plan for home health services for FY 98 and FY 99. Beginning October 1, 1997, home care agencies will be paid the lesser of their actual, allowable costs; the per-visit cost limits reduced to 105 percent of the national median; or a new blended agency-specific per-beneficiary annual limit, applied to the agency's unduplicated census count of Medicare patients.

Section 4602(c) -- Blend.

The blended per-beneficiary limit will be calculated based 75 percent on 98 percent of the agency's own costs per beneficiary and 25 percent on 98 percent of census-region data. These calculations will be made using cost reports for cost-reporting periods ending in FY 94 including non-routine medical supplies, and updated by the home health market-basket index. The per-beneficiary limits for new providers and those providers without a 12-month cost-reporting period ending in FY 94 would be equal to the median of limits for all home health agencies. The Secretary of HHS will establish by April 1, 1998, the per-beneficiary limits that will be effective for FY 98.

Section 4603 -- Home Health Prospective Payment.

A prospective payment system (PPS) for home health must be designed and implemented by October 1, 1999. The reimbursement system is not defined other than stating that it must consider an appropriate unit of service and number of visits with potential changes in the mix of services provided. Certain elements of the system would not be subject to administrative or judicial review. The Secretary of HHS is also required to reduce cost limits and per-beneficiary limits in effect on September 30, 1999, by 15 percent, regardless of whether PPS is ready to be implemented on October 1, 1999. Periodic interim payments (PIP) would also be eliminated on October 1, 1999.

Additional Home Health Provisions

Section 4604 -- Site of Service.

Effective for cost reporting periods beginning on or after October 1, 1997, home health payments will be based on the location where the home health service is furnished, rather than the location of the billing office. Additional Home Health Related Provisions.

Section 4611 -- A to B Shift.

The bill gradually transfers from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's three-day stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in over a period of six years, beginning on January 1, 1998. For 1998, 1/6 of the payments that would have been made under Part A, prior to this change, are transferred into Part B. For 1999, 2/6; for 2000, 3/6; for 2001, 4/6; for 2002, 5/6; and for 2003, 6/6. In addition, the Medicare Part B premium would also be recalculated to reflect the increase attributable to the transfer. This increase would be phased in over a period of seven years, between 1998 and 2004. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by

two-sevenths of the extra costs; for 2000, three-sevenths; for 2001 four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.

Part A, beginning January 1, 1998, will cover only post institutional home health services for up to 100 visits during a home health spell of illness, except for those individuals with Part A coverage only who would be covered for services without regard to the shift.

Post institutional home health services are defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least three days, initiated within 14 days after discharge, or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge.

A home health spell of illness is defined as a period of consecutive days beginning with the first day that the individual receives post institutional home health services and ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospice or rural primary care hospital nor an inpatient of a skilled nursing facility, nor is receiving home health care.

Claims administration for transferred visits would continue to be done by Part A fiscal intermediaries (FIs).

The threshold for hearings before an administrative law judge on disputed claims would be \$100 for home health services under Part B, consistent with the threshold for Part A home health claims. NAHC was successful in gaining the provisions that provide for seamless administration of the home care benefit by fiscal intermediaries, ensure access to home care for individuals with Part A coverage only, and provide consistent appeals protections.

Section 4612 -- Part-time/Intermittent Standard.

This provision clarifies the part-time/intermittent standards for the home care benefit and conforms to current regulatory practice.

Section 4613 -- Homebound Standard.

The budget bill directs the Secretary of HHS to conduct a study of the criteria that should be applied, as well as the method for applying such criteria, in the determination of whether an individual is homebound for the purpose of qualifying for home health services. The bill requires the Secretary of HHS to report back recommendations to Congress by October 1, 1998.

Section 4614 -- Normative Standards.

The Secretary of HHS is authorized to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines that the Secretary shall establish by regulation." This provision allows the Medicare program to utilize norms of care for limiting coverage to individuals.

Section 4615 -- Venipuncture.

The bill revises the definition of skilled home health services, effective six months after the date of enactment, to specifically exclude venipuncture (blood drawing) as a qualifying service for the Medicare home care benefit.

Section 4616 -- Reports to Congress Regarding Home Health Cost Containment.

The bill requires the Secretary of HHS to submit to the appropriate Congressional committees by October 1, 1997, an estimate of projected Medicare expenditures for home health services for each

of FY 1998 through FY 2002. Each year, if actual expenditures exceed the estimates, the Secretary of HHS shall make recommendations to Congress regarding beneficiary copayments or other methods to reduce the growth in expenditures.

Section 4743 -- Medicaid Home and Community-based Waivers.

The bill eliminates the requirement of prior institutionalization with respect to habilitation services furnished under a Medicaid waiver for home and community-based services.

HOME HEALTH LEGISLATION 1996

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191)

This legislation addresses portability and continuity of coverage issues in private health insurance coverage. It limits the ability of insurers to restrict beneficiaries on the basis of a pre-existing condition, and guarantees renewal of coverage to groups and individuals as long as they have paid their premiums.

Title III, Subtitle C -- Tax-Related Health Provisions; Long-Term Care Services and Contracts

This section makes changes in the tax code establishing certain incentives for the purchase of private long-term care insurance policies. Benefits under long-term care policies will be tax free and eligible long-term care premiums along with qualified long-term care services, including home care, will be treated as medical expenses for the purpose of the itemized medical expenses deduction.

Section 232 -- Penalty for False Certification for Home Health Service

This section establishes a new civil monetary penalty for physicians who falsely certify that a beneficiary meets all of Medicare's requirements to receive home health care. The amount of this penalty will be equal to three times the amount of payments for the home health services provided or \$5,000, whichever is greater.

OMNIBUS APPROPRIATIONS ACT OF 1996 (P.L. 104-134)

Section 516 -- Survey and Certification of Medicare Providers

This section increases the time between home health recertifications from once every 12 months to once every 36 months. The legislation also expands The Centers for Medicare and Medicaid Services' (CMS's) deeming authority. These provisions were designed to provide CMS the budget flexibility to begin to alleviate the backlog of initial certifications and avoid the need to implement user fees as a way to finance traditional CMS functions.

OMNIBUS CONSOLIDATION APPROPRIATIONS ACT OF 1997 (P.L. 104-208)

Title II -- Department of Health and Human Services

This title earmarks \$158 million for survey and certification activities in fiscal year (FY) 1996. This amount represents an additional \$10 million increase for survey and certification activities over fiscal year FY 1996 levels.

HOME HEALTH LEGISLATION 1995

Although Congress passed the Balanced Budget Act of 1995, H.R. 2491, which contained sweeping changes in the structure of Medicare and Medicaid, the legislation was vetoed by the President. H.R. 2491 contained important changes in the home care benefit, the most significant of which was the inclusion of a prospective payment system for home care.

HOME HEALTH LEGISLATION 1994

Congress did not pass any home health legislation in 1994. The primary reason was the absence of a reconciliation bill, which is the usual vehicle for home health amendments. And although there are sometimes significant items in the Labor/HHS appropriations bill, that was not the case in 1994. Much of the legislation that would have affected home health care was focused on the larger issue of health care reform. But the 103rd Congress adjourned without passing any elements of reform legislation.

HOME HEALTH LEGISLATION 1993

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (P.L. 103-66)

Section 13564 — Reduction in payments for home health services.

This section essentially freezes the home health cost limits for two years. On July 8, 1993, new cost limits were published in the Federal Register that apply to cost report periods beginning from July 1, 1993, through June 30, 1994. The new legislation provides for the continued use of these same limits until the cost caps are updated effective with cost reporting periods beginning on and after July 1, 1996. In addition, the wage index that applies to a home health agency during its July 1993-June 1994 cost reporting period will also be continued for the following two reporting periods. It is intended that the new cost limits will apply over the period of the freeze with as little change as possible (except for reductions necessitated by the elimination of the hospital add-on). The legislation provides that the amount of any cost limits exception that may be granted cannot exceed what would have been allowed if the cost limits had not been frozen.

Section 13564(b) — Elimination of Hospital Add-On.

This section eliminates the hospital add-on effective with reporting periods beginning October 1, 1993. Thus, hospital-based home health agencies will be able to continue to use the add-on for at least the balance of their current reporting period and until they begin a reporting period that begins on or after October 1, 1993.

Section 13504 — Reductions in Payments for Hospice Services.

This section changes the inflation factor that is used to update hospice payments each October. Instead of using the hospital market basket (HMB) as the measure of inflation, this section provides for the use of the following update factors: October 1993, HMB minus 2.0 percent; October 1994, HMB minus 1.5 percent; October 1995, HMB minus 1.5 percent; October 1996, HMB minus 0.5 percent. In October 1997, Medicare would resume using the full HMB in updating the hospice payment rates.

Section 13601 — Medicaid personal care mandate.

This section repeals the mandate requiring personal care services to be covered under states' Medicaid programs. The mandate was to have gone into effect on October 1, 1994.

Section 13567 — Extension of social HMO demonstrations.

This section extends the social health maintenance organizations (SHMO) demonstrations for an additional two years. These demonstrations, which provide health and long-term care on a capitated basis, are presently authorized to continue through 1995.

Section 13552 — Extension of Alzheimer's disease demonstration projects.

This section extends for one more year and \$3 million the Alzheimer's disease demonstrations that had been authorized for \$40 million for three years in OBRA-86 (P.L. 99-509, Section 9342) and extended for two years and \$15 million by OBRA-90 (P.L. 101-508, Section 4164(a)(2)). The demonstration projects were designed to determine the cost and effectiveness of providing comprehensive services including home- and community-based services to Medicare beneficiaries

with Alzheimer's disease or related disorders.

Section 13568 — Timing of claims payments.

This section modified requirements for claims payments by establishing separate payment floors for claims submitted electronically and otherwise, and extended the time limit for processing clean claims before interest must be paid. The change in timing for claims processing conforms to earlier modifications brought about indirectly through the appropriations bill, which became effective in October 1992. Under these standards, no Medicare claim that is submitted on paper can be paid any earlier than the 27th day after submission. For electronic billers, the payment floor is 14 days. This section also gives CMS 30 days to process clean claims or begin making interest payments; the previous standard was 24 days.

Section 13562 — Ban on physician ownership and referral.

This section extends the self-referral ban that exists under Medicare law that prohibits physicians or immediate family members with a financial relationship with clinical laboratories from referring Medicare patients to those entities. The self-referral ban is extended to other designated health services that include home care, clinical laboratory services, physical therapy services, occupational therapy services, radiology or other diagnostic services, radiation therapy, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.

The extended ban on self-referrals is subject to numerous exceptions including the in-office ancillary services exemption that applies to all the designated health services except durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies.

Additionally, exceptions relating to compensation arrangements include rentals of office space and equipment, employment relationships, and personal services arrangements, among others designed in a manner comparable to those set under the current anti-kickback safe harbor regulations.

The bill provides an effective date of January 1, 1995, to allow physicians and their immediate families sufficient time to sever ownership or compensation arrangements. It should be noted that the legislation does not ban ownership and compensation, it only affects the ability of a physician to refer Medicare patients with a prohibited ownership or financial relationship exists.

HOME HEALTH LEGISLATION 1992

Congress did not pass a budget reconciliation bill in 1992 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in Labor/HHS Appropriations Act, which was signed into law on October 6, 1992. In addition, Congress reauthorized the Older Americans Act.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-394)

Prohibit Postpayment Claims Sampling—Language was included in both the Senate and House reports on Labor/HHS Appropriations that denounced the Centers for Medicare and Medicaid Services use of sampling in postpayment review of Medicare claims and directed CMS to stop the practice (S.Rept. 102-397, pp. 164-5; H.Rept. 102-708, p. 110). The appropriations conferees viewed the report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of \$149 million for survey and certification activities.

Encouragement of Electronic Claims Transmissions—In an effort to encourage providers to transmit Medicare claims to contractors electronically, Congress established a payment floor of 14 days for electronically transmitted claims and a payment floor of 27 days for claims submitted on paper.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received \$300 million for FY93 appropriations. Of that amount, \$185 million was directed toward emergency assistance grants to high-impact cities.

In-Home Services to Frail Elderly—Congress appropriated \$7 million for in-home services for the frail elderly under the Older Americans Act (Title III-D).

Home Health Demonstration Projects—Congress did not include further funding for the Health Care Services in the Home Demonstration program, which is a demonstration program being conducted under the Health Resources and Services Administration in Hawaii, South Carolina, North Carolina, Mississippi and Utah. Senate report language stated the unobligated FY92 funds were "expected to allow current grantees to complete this demonstration in FY93" (S.Rept. 102-397, p. 42).

OSHA Seat Belt, Driver Safety Regulations—Congress directed the Occupational Safety and Health Administration (OSHA) to reconsider its proposed rules on seat belt use and driver awareness education, which were published July 12, 1990. Congress expressed particular concern about the impact of the regulations on employers and about the imposition of sanctions against

employers who have made a good faith effort to comply with the standards (H.Rept. 102-974, p. 49).

OLDER AMERICANS ACT AMENDMENTS OF 1992 (P.L. 102-375)

Reauthorizes the Older Americans Act through 1995, and requires: that the National Academy of Sciences' Institute of Medicine conduct a study on home care quality; that providers of in-home services promote the rights of the frail elderly individuals who receive such services; that a White House Conference on Aging be held no later than December 31, 1994; that the National Center for Health Statistics conduct studies on demographic information related to paraprofessionals working in the home and nursing home settings; and that the Department of Labor conduct a study on employment conditions of in-home and nursing home paraprofessionals.

The Act also includes provisions related to case management of services funded under the OAA. The bill provides a comprehensive definition of case management services for OAA purposes. It also requires that OAA case management services not duplicate such services provided through other federal and state programs, that they be coordinated with services provided through other federal and state programs, and that such services be provided by a public agency or a nonprofit private agency that does not provide other OAA services under Title III of the Act. An exception to the service-provision limitation is included for nonprofit private agencies located in rural areas that obtain a waiver.

HOME HEALTH LEGISLATION 1991

Congress did not pass a budget reconciliation bill in 1991 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in the 1991 Labor/HHS appropriations bill.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-170)

Prohibit Postpayment Claims Sampling—Language originating in the Senate Report of the Labor/HHS appropriations bill denounced the Centers for Medicare and Medicaid Services' use of sampling in postpayment reviews of Medicare claims (S.Rept. 102-104, p. 172). The appropriations conferees viewed the Senate report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of \$150 million for survey and certification activities.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received \$280 million for FY92 appropriations, an increase of \$59.4 million over the previous year.

Home Health Demonstrations Grants—A \$2.9 million appropriation was approved to continue for two years the Health Care in the Home Demonstrations program, under the Health Resources and Services Administration. These demonstrations have been underway for the past three years in Hawaii, South Carolina, North Carolina, Mississippi and Utah.

Home Health Care and Alzheimer's Disease Pilot Grants—A \$4 million appropriation was approved for 10 state pilot projects to provide home care and other services to individual with Alzheimer's disease. The pilots were authorized by P.L. 101-557, § 102.

NATIONAL DEFENSE AUTHORIZATION ACT (P.L. 102-190)

Section 702(a)—Creates a new hospice benefit for active military and their families either in military hospitals or under CHAMPUS. Hospice care may be provided in facilities of the uniformed services to a terminally ill patient who chooses to receive hospice care rather than continuing hospitalization or other health care services for treatment of the patient's terminal illness.

Section 702(b)—Allows hospices to contract with CHAMPUS to provide hospice services. The reimbursement is to be determined by the Secretary of Defense.

HOME HEALTH LEGISLATION 1990

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (P.L. 101-508)

MEDICARE

Section 4207(d)—Home Health Wage Index: The conference agreement includes a provision which permanently reinstates the use of the hospital wage index for determining home health agency cost limits, with a transition period to the 1988 hospital wage index for cost reporting periods beginning on or after July 1, 1991.

For home health agency reporting periods that begin between July 1, 1991, and June 30, 1992, the wage index would be based two-thirds on the 1982 wage index now in use and one-third on the new index. For the 12-month period beginning July 1, 1992, the blend would be based on one-third of the 1982 index and two-thirds of the 1988 index. For cost reporting periods beginning on or after July 1, 1993, the 1988 wage index, or any later version that may be in effect, would be used.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) had included a provision which required the Secretary of Health and Human Services (HHS) to continue to use the hospital wage index until the cost reporting period beginning on or after July 1, 1991.

Sections 4207(b)(3) and 4008(a)(2)—Waiver of Liability: The waiver of liability presumptive status as applied to medical and technical denials will be extended for five years, through December 31, 1995, for home health agencies. The waiver for hospices was also extended for five years.

The waiver for home health and hospice providers was scheduled to expire on November 1, 1990.

Section 4207(h)—Prohibition of User Fees for Survey and Certification: This provision prohibits HHS from imposing, or requiring states to impose, on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvement Amendments of 1988) a fee to offset the costs of surveys to certify compliance with the conditions of participation under Medicare Part A or B.

Sections 4207(j) and 4801(a)—Home Care Aide Requirements: The conference agreement includes an amendment which would make any home care agency ineligible to train and test home care aides if, within the previous two years, the agency: (1) is found to be out of compliance with training and testing standards; (2) has been subjected to a partial or extended survey; (3) has been assessed a monetary penalty of \$5,000 or more for deficiencies relating to quality of care; or (4) has been subject to suspension of payment or temporary management for noncompliance.

The conference agreement also includes an amendment which would permanently bar agencies from training and testing home care aides if, between October 1, 1988, and September 30, 1990, the agency: (1) was terminated from the Medicare program; (2) was assessed a civil monetary penalty of \$5,000 or more for deficiencies relating to quality of care; (3) was subject to suspension of payment or temporary management for noncompliance; or (4) pursuant to state action was closed or required to transfer patients.

Section 4006—Hospice 210-Day Limit: This amendment eliminates the 210-day cap on the Medicare hospice benefit and allows for unlimited days of coverage. This amendment would be effective for services furnished on or after January 1, 1990.

This amendment will not change the requirement that a patient have a prognosis of six months or less to live, nor does it change the aggregate cap which limits the amount of Medicare reimbursement a hospice can receive each year.

Section 4751—Patient Self-Determination: Effective one year after enactment, Medicare providers, including home health agencies and hospices, will be required to inform patients of their rights under state law to make decisions concerning medical care, including: (1) the right to accept or refuse medical or surgical treatment; and (2) the right to formulate advance directives recognized under state law, such as through appointment of an agent or surrogate to make health care decisions on his/her behalf (durable power of attorney) and written instructions about health care (living will).

As a condition of participation, all providers will (1) inquire whether an adult patient has formulated an advance directive, and (2) document whether an advance directive exists in the medical record. In addition, all providers, including home health agencies and hospices, will be required to provide patients with the provider's written policies concerning the implementation of advance directives.

Civil monetary penalties will be applied for noncompliance.

Section 4207(b)(2)—Prohibition on Payment Cycles: Effective upon enactment, HHS is prohibited from issuing any final regulation, instruction or policy change which is primarily intended to have the effect of slowing down claims processing or delaying the rate at which claims are paid. An existing provision expired September 30, 1990.

Section 4207(g)—Case Management Study: The budget agreement requires HHS to resume three case management demonstration projects authorized by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), but later lost when the Act was repealed. Under the demonstration projects, appropriate entities will provide case management services to Medicare beneficiaries with selected catastrophic illnesses.

Section 4207(c)—Prospective Payment Study: The conference agreement directs the Centers for Medicare and Medicaid Services (CMS) to conduct research and sets deadlines for CMS to report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. HHS is to submit a report to Congress that includes a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission is to analyze HHS' proposal and report to Congress by March 1, 1994.

In developing this proposal, HHS is to:

1. take into account the need to provide for appropriate limits on home care expenditures;
2. provide for changes in patient case mix, severity of illness, volume of cases and the development of new technologies and standards of medical practice;
3. take into consideration the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

4. take into account the varying wage-related costs among agencies; and
5. analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Section 4007—Delay in Hospice Payment Update: The conference agreement includes an amendment which would delay the update in the daily hospice payment rates from October 21 until January 1, 1991. However, hospices will receive the 5.2 percent increase in daily rates from October 1-20, then drop back to the old rates until January 1, 1991, when the increased rates will again apply.

Section 4158—Part B Payment Reductions: All payments to Medicare Part B providers will be reduced by 2 percent for services furnished on or after November 1, 1990, and on or before December 31, 1990.

Section 4153(d)—Home Health Supplies: Home health agencies who are caring for Medicare home health beneficiaries who need catheters, catheter supplies, ostomy bags and related supplies must offer to furnish these supplies directly to the beneficiary under the home health benefit. Previously, home health agencies were required to furnish ostomy supplies only, as part of OBRA-89 amendments which exempted all of these items from the "Six-Point Plan" reimbursement system.

Section 4156—Coverage of Injectable Drugs for Osteoporosis: The conference agreement includes an amendment which provides coverage under Part B for drugs, and its administration for osteoporosis. The administration of this and any drug is already covered under the home health benefit. This provision is in effect from January 1, 1991, through December 31, 1995.

MEDICAID

Section 4711—Home and Community Care as an Optional Statewide Service: This amendment would allow states to offer, under a capped program, without demonstrating budget neutrality, home or community-based services to elderly beneficiaries with the inability to perform two out of three activities of daily living. The five-year optional program is capped at \$580 million.

The legislation defines "home and community care" as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be eligible: home care aide services, chore services, personal care services, nursing care services (provided by or under the supervision of a registered nurse), training for family members, adult day health services, and in the case of individuals with chronic mental illness, day treatment and clinic services, and any other such items as HHS may approve.

Eligibility—An eligible individual is: (1) 65 years or older; (2) determined to be functionally disabled; and (3) eligible for Medicaid including, at the state's option, the "medically needy."

A state may continue to maintain its current waiver programs and choose this new option. Also a state may substitute the new option for its existing waiver program provided that it grandfathers current-program clients in the new programs. Of course, due to different eligibility rules, new beneficiaries who would have qualified under the terminated waiver program may not qualify under the new program.

Functionally Disabled—Functionally disabled individuals are defined as persons who (1) are unable to perform without substantial assistance at least two of the specified three activities of daily living (toileting, transferring and eating); or (2) have a primary or secondary diagnosis of Alzheimer's disease and are unable to perform without substantial assistance at least two of the five specified activities (bathing, dressing, toileting, transferring, and eating).

Assessments—Assessments will be based on a uniform minimum data set and assessment instrument specified by HHS.

HHS is required by July 1, 1991, to specify a minimum data set of core elements and common definitions for use in conducting the assessments and to establish guidelines for using the data set. Also by July 1, 1991, HHS is to designate one or more instruments for use by the state in conducting comprehensive functional assessments.

Appeals Procedures—Each state which elects to provide this benefit must provide for an appeal procedure for individuals adversely affected by eligibility determinations.

Periodic Review—Individuals' assessments must be reviewed and revised, as may be appropriate, not less often than once every 12 months.

Conduct of Assessments by Interdisciplinary Teams—Assessments and reviews are to be conducted by an interdisciplinary team designated by the state. These must be under contracts with public or nonpublic organizations which do not provide, directly or through an affiliate, home or community care or nursing home care.

Individual Community Care Plans (ICCP)—An ICCP is defined as a written plan which (1) is established and periodically reviewed and revised by a qualified case manager; and (2) specifies the care to be provided and indicates the individual's preference for the types and providers of services.

Qualified Case Management Entity—A qualified case management entity is defined as: (1) a nonprofit or public agency or organization which has experience in establishing, reviewing and revising care plans for the elderly and in providing case management services to the elderly; (2) is responsible for assuring that the care as specified for in the plan is being provided; (3) in the case of nonpublic agency, does not provide home or community services or nursing facility services; (4) has procedures for assuring quality case management services that include a peer review process; (5) completes the ICCP in a timely manner, and meets other standards established by HHS to assure competency.

Appeals Procedures—The legislation requires that the state provide for an appeal procedure for any individual who disagrees with the ICCP.

Minimum Requirements for Home and Community Care—Home and community care providers must meet the following requirements: (1) individuals providing the care must be competent; and (2) specify patient rights to the beneficiary (similar to current Medicare bill of rights). Minimum requirements are established for community care settings as well.

Certification—States will be responsible for certifying compliance of providers of home and community care no less frequently than once every 12 months. Periodic review of provider performance will be conducted.

Investigation of Complaints and Allegations of Abuse—States will be responsible for the investigation of complaints regarding the violation of certification requirements and allegation of individual neglect and abuse.

Disclosure of Results of Inspections and Activities—This section requires the states and HHS to make available to the public information on all surveys, reviews and certifications.

State and Secretarial Authority—Both the state and HHS will be permitted to terminate from the program and impose civil monetary penalties on home and community care providers who no longer meet the requirements.

Payment for Services—States are required to pay for home and community care at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable state and federal laws, regulations, and quality and safety standards. It further amends the Medicaid law to specify that HHS could not limit the amount of payment that may be made for home and community care.

Effective Date—This new waiver authority is available to states effective with services provided on or after July 1, 1991, without regard to whether or not final regulations have been promulgated by that date.

Section 4705—Hospice Payments: Effective as if included in OBRA-89, the conference agreement includes a retroactive provision which further clarifies that an additional amount should be paid for dual eligible nursing facility residents electing hospice under Medicaid.

Section 4717—Clarifying Effect of Hospice Election: This sections adds to the Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

Section 4746—New Jersey Respite Care Demonstration: The conference agreement extends the New Jersey respite care demonstration project through September 1992. This project was originally authorized under OBRA-86 and is designed to determine the extent to which respite services will delay or avert the need for institutional care.

Section 4741—Respite Care: The agreement clarifies that HHS has no authority to limit the number of hours of respite care that a state may offer under a budget-neutral "2176" waiver.

Section 4720—Personal Care Services: The agreement provides that, in Minnesota, for fiscal years 1991-1994, federal Medicaid matching funds are available for personal care services prescribed by a physician, provided by a qualified person, supervised by a nurse, and furnished in a home or other location; but does not include such services furnished to an inpatient or resident of a hospital or nursing home. It further requires that in fiscal year 1995 and beyond, Medicaid's

definition of home health services is to include personal care services prescribed by a physician, provided by a qualified individual, supervised by a registered nurse, and furnished in a home or other location, not including such services furnished to an inpatient or resident of a nursing facility.

Section 4744—Frail Elderly Demonstration Project Demonstrations: This section expands from 10-15, the number of demonstrations to provide health care on a capitated basis to frail elderly at risk of institutionalization.

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT OF 1990 (P.L. 101-381)

Title I—Provides for \$87.8 million in the form of grants for cities hardest hit by the AIDS crisis. The 16 eligible cities, in order of severity of need are: New York, Los Angeles, San Francisco, Houston, Washington, DC, Newark, Miami, Chicago, Philadelphia, Atlanta, San Juan, Dallas, Boston, Fort Lauderdale, San Diego, and Jersey City.

Funding under Title I of the bill, to be administered through the Health Resources Services Administration (HRSA) under the US Public Health Services, is intended to help eligible areas operate programs that enable persons with HIV disease to receive appropriate care on an outpatient and ambulatory basis.

Title I also establishes a HIV Health Services Planning Council in each state. These councils can be an existing entity with demonstrated experience in (1) planning for HIV health care services needs and (2) implementing coordinated delivery of HIV health care services within the eligible geographic area. The councils are to include representatives of other providers, including health care providers. The duties of the planning councils include the development of a comprehensive plan for the organization and delivery of health services to eligible individuals.

Title II—Provides for another \$87.8 million to states in the form of grants to promote HIV-related care through the development of HIV community-care consortia, home- and community-based care, therapeutic drug subsidies and maintenance of health insurance.

Also administered through HRSA, this title provides for direct grants to states for the provision of health care services, including home- and community-based care. Monies under this title also can be used to establish and operate HIV-care consortia in areas most affected by HIV disease. These consortia would consist of public and nonprofit private, health care and support service providers and community-based organizations operating in the areas determined to be most affected by the AIDS disease. They must agree to use the funds for the planning, development and delivery, either through direct service or through contract, of comprehensive outpatient health and support services. These services may include case management services, medical, nursing, dental, home health and hospice care and essential support services such as attendant care, home care aide, personal care, intravenous drug therapy, day or respite care, durable medical equipment, transportation and nutritional services.

The home- and community-based care must be provided pursuant to written plans of care prepared by a case management team. The case management team will include appropriate health care professionals with priority given to entities that participate in the consortia, if one exists, and to entities that provide care to low-income individuals. Co-charges for services provided under the CARE bill will be imposed on individuals according to their income. None will be assessed if the recipient's income is at or below the official poverty line.

Title III—Provides \$130 million to states for HIV testing and counseling services and another \$44.9 million to community health centers for HIV-related care, including early intervention programs.

HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990 (P.L. 101-557)

Home Health Care Demonstration Projects—Reauthorizes and expands the home health care demonstration projects first authorized in the 1987 amendments to the Older Americans Act. The grants would continue to provide skilled nursing care, and be expanded to include home care aide services, for low-income individuals who, with the availability of such assistance, can avoid institutionalization or prolonged hospitalization. Expands the number of grants available to 10.

Alzheimer's Demonstrations Projects—Provides grants to states to provide home- and community-based care, including respite care, for individuals with Alzheimer's disease or related disorders.

HOME HEALTH LEGISLATION 1989

OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (P.L. 101-239)

MEDICARE

Sections 6001 & 6101—Gramm-Rudman-Hollings Reduction: Home health agencies were subject to a 2.092 percent reduction in their Part A Medicare payments until December 31, 1989. Medicare Part B providers were subject to the 2.092 percent reduction until March 31, 1990, after which Medicare Part B providers will be subject to 1.42 percent reduction throughout the remainder of the fiscal year, October 1, 1990.

Section 6222—Home Health Wage Index: In determining home health cost limits, the wage index in use prior to July 1, 1989 (hospital wage index), will continue to be utilized until cost-reporting periods beginning on or after July 1, 1991.

Section 6112(e)—Home Health Supplies: This provision continues to include 38 ostomy and catheter supplies as home health supplies. It requires home health agencies to offer to furnish ostomy supplies to individuals who require them as part of the home health service. This is effective with respect to items supplied on or after January 1, 1990.

Section 6005—Increased Payments for Hospice Care: Medicare hospice payments will be increased by 20 percent. Payments in subsequent years will be indexed to the hospital market basket. The provision further provides that written certification for hospice care be obtained no later than eight days after care is initiated, provided a verbal order is given by the physician within two days. The effective date for the increased payments is January 1, 1990. Additionally, the provision provides for the Secretary of Health and Human Services (HHS) to conduct a study of high-cost hospice care provided to Medicare beneficiaries and to evaluate the ability of hospice programs participating in Medicare to provide this care. On the basis of this study, HHS is required to develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries. HHS to report to Congress by April 1, 1991.

Section 6214—Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims: Amends the current policy for purposes of calculating the waiver of liability presumption so that denials would be deemed final if (1) the initial denial is not appealed by the home health agency within the allotted 60-day time period; or (2) upon a reconsideration decision by the fiscal intermediary. The provision further states that HHS is to monitor the proportion of denied claims for which reconsideration is requested and report to Congress if the proportion of denials reversed upon reconsideration increases significantly. This provision is effective with determinations for quarters beginning on January 1, 1990.

Section 6224—Peer Review Organizations: This section requires that Peer Review Organizations (PRO) establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession. This is effective with contracts entered into after enactment.

Section 6204—Physician Ownership of, and Referral to, Health Care Entities: This provision will require entities to report to HHS with information concerning the entity's ownership arrangement, including the covered items and services provided by the entity and the names and all of the Medicare provider numbers of all of the physicians who are interested investors or who are immediate relatives of interested investors. HHS is to specify the form and manner of such reporting. It further specifies that such information shall be furnished not later than one year after the date of enactment. Only clinical laboratories will be subject to a general prohibition against the referral of a beneficiary to an entity which the physician, or members of his or her immediate family, are interested investors. HHS must submit to Congress, not later than 90 days after the end of each quarter, a report which provides a statistical profile (by state and type of item and service) comparing utilization of items and services by Medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest, and by Medicare beneficiaries serviced by other entities. Additionally, the General Accounting Office (GAO) is to conduct a study of ownership of hospitals and other Medicare providers by referring physicians.

Section 6218—General Accounting Office Study of Administrative Costs of the Medicare Program: GAO will be required to conduct a study of the administrative burden of Medicare regulations and program requirements on providers of services (including home health agencies), fiscal intermediaries and carriers. No later than March 31, 1990, GAO is to submit a report to Congress that includes (1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982, and (2) a comparison of the administrative burden to such entities in providing services to individuals who are not Medicare beneficiaries. For purposes of such an assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the Medicare program and costs to such entities for noncompliance with such requirements resulting from the failure of HHS to provide entities with adequate notice of changes in program requirements.

Section 6220—Amendments Relating to the Bipartisan Commission on Comprehensive Health Care: This amendment provides that the commission may also be known as the "Claude Pepper Commission," after the late Senator Claude Pepper. It also extends the deadline to March 1, 1990, for the two reports that the commission must submit to Congress.

Section 6112—Durable Medical Equipment: Fees will be frozen in 1990 and there will be no national cap on fee schedules.

MEDICAID

Section 6408(c)—Hospice Payment for Room and Board: When a hospice patient is residing in an intermediate care facility (ICF) and/or a skilled nursing facility (SNF), Medicaid will be required to pay an additional amount to take into account the room and board furnished by the facility equal to at least 95 percent of the rate that the state would have paid under the plan for facility services in that facility for that person. The effective date is for calendar quarters beginning on or after July 1, 1990.

MEDICAID ELIGIBILITY EXPANSION ITEMS

Section 6401—Phased-In Coverage of Pregnant Women and Infants up to 133 percent of the Federal Poverty Level: This section requires states (including Arizona) to offer Medicaid coverage to pregnant women and infants under one years old up to 133 percent of the federal poverty level.

Section 6401—Phased-In Mandatory Coverage of Children up to 100 percent of the Federal Poverty Level: States will be required to extend Medicaid coverage to all children born after September 30, 1990, up to age six in families with incomes below 133 percent of the federal poverty level.

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989 (P.L. 101-234)

P.L. 101-234 repeals all provisions of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), including the home care-related provisions for an IV therapy drug benefit, intermittent care, hospice care and respite care. Retained were minor and technical provisions, including the extension of the home health waiver of liability.

Enacted were several transitional provisions designed to protect some patients and providers from the abrupt termination of repealed benefits. Among those provisions were two relating to home care and hospice providers. The first extends through 1990 the full benefits of catastrophic coverage for enrollees in risk-based health maintenance organizations (HMO). Congress determined this necessary because the 1990 rates already had been adjusted for risk-based HMOs. The second transitional provision indicates that the repeal of the hospice benefit extension "shall not apply to hospice care provided during the subsequent period (described as in effect on December 31) with respect to which an election has been made before January 1, 1990."

HOME HEALTH LEGISLATION 1988

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (P.L. 100-360)

Section 426—Waiver of Liability: The favorable presumption under the waiver of liability for home health agencies and hospices is extended through October 1990. The extension applies to medical necessity denials as well as to intermittent care and homebound denials. In addition, the Secretary of Health and Human Services (HHS) is prohibited from modifying the criteria for these waivers.

Section 206—Extending Home Health Benefits: Nursing care and home care aide services may be provided seven days per week (with one or more visits per day) for up to 38 days, after which additional days of care can be provided under exceptional circumstances. There is no prior hospitalization requirement.

Section 202-203—IV Drug Therapy: Under Part B, effective for services provided after January 1, 1990, home IV antibiotic drug therapy services including nursing visits, pharmacy and related items (such as medical supplies, IV fluids, delivery and equipment) will be covered under Medicare. Other IV drugs would be covered only if the HHS Secretary determines that providers can administer them safely and effectively in a home setting. The HHS Secretary is expected to complete a review of the safety and effectiveness of home IV cancer chemotherapy drugs as soon as possible. IV drug therapy services would not be subject to the Part B deductible or coinsurance. Coverage and reimbursement for the drugs used for this service are not included in the definition of home IV drug therapy, but would be reimbursed under the Medicare Catastrophic Drug Benefit. The drug benefit deductible and coinsurance would be waived if the therapy was initiated during a hospital admission.

To be a qualified home IV drug therapy provider, an entity must meet the following standards set by HHS Secretary: (1) is capable of providing or arranging for services and items mentioned above and the drugs; (2) adheres to written protocols with respect to service provisions and (3) can assure that only trained personnel provide covered home IV drugs (and any other services for which training is required to safely provide the service); (4) maintains clinical records on all patients; (5) makes services available on a 24-hour basis; (6) coordinates services with the patient's physician; (7) conducts a quality assessment and assurance program, including drug regimen review and patient care coordination; (8) assumes responsibility for the quality of services provided by others under arrangement; (9) is licensed, or approved as meeting the requirements for licensure, if state or local law provides for licensure for home IV drug providers; (10) meets other requirements the HHS Secretary deems necessary.

There will be limitations on physician referrals to a home IV provider in cases where the doctor receives compensation from, or has an ownership interest in, the provider. The HHS Inspector General will be required to conduct a study of physician ownership of, and compensation by, other suppliers of Medicare-covered services to which they make referrals.

Reimbursement would be calculated based on whichever is the lower charge, the provider's actual charge or the fee schedule amount. The HHS Secretary would be required to establish a fee schedule through regulation before January 1, 1990, that would provide payment on a per-diem basis. In establishing the fee schedule, the HHS Secretary could consider cost information, charge

information and payment rates for similar items and services covered under Medicare. The HHS Secretary would not, however, require routine cost reports. Report language indicates that the HHS Secretary is expected to use broad flexibility in establishing a fee schedule that assures adequate access to services while preventing excessive payment.

A care plan must be developed by the physician prescribing the home IV drug therapy. In addition, through 1992, prior approval by a Peer Review Organization (PRO) would be required as a condition of payment. PROs would be required to complete review determinations within one working day of a request. To assure the validity and uniformity of PRO reviews, the conference agreement requires the HHS Secretary to establish criteria that would be used by PROs in conducting reviews with respect to the appropriateness of home IV drug therapy services.

Section 205—Respite Care: Services covered would include home care aide services (performed by aides who have successfully completed a training program approved by the HHS Secretary), personal care services and nursing services provided by a licensed professional nurse. Eighty hours per year will be covered. Care provided on any one day for less than three hours would be counted as three hours. Services must be provided under the supervision of a registered nurse, home health agency or others under arrangement with the agency.

Those eligible for respite care coverage must meet the following qualifications: (1) Medicare Part B beneficiary who is dependent on a daily basis on a primary caregiver who is living with the beneficiary and is assisting the beneficiary without compensation in performing at least two activities of daily living (ADL); (2) without this assistance could not perform these two ADLs; and (3) the covered expenses must exceed the catastrophic limit (estimated to be \$1,370 in 1990) or the newly created Medicare drug benefit deductible (\$550 in 1990).

Services would then be available to the beneficiary for a 12-month period from the date the beneficiary was determined to have incurred such expenses. If a beneficiary meets a second limit within the 12-month period, he or she would be entitled to a new 12-month period. In no situation could a beneficiary carry over hours not used in a previous 12-month eligibility period, nor could a beneficiary use more than 80 hours of care per year.

The beneficiary would be responsible for a 20 percent coinsurance even if the beneficiary's costs have exceeded the catastrophic limit; however, the 20 percent coinsurance payment would be counted toward the limit. Payment will be made on the basis of hourly rates based on reasonable costs of furnishing care.

A physician is required to certify that the beneficiary is chronically dependent during the immediate preceding three-month period. Payment will not be made unless the care is deemed reasonable and necessary. The HHS Secretary is required to take appropriate efforts to assure high quality and provide for the appropriate utilization of in-home care.

The HHS Secretary is to study and report to Congress within 18 months after enactment on the advisability of providing out-of-home services, such as adult day care centers or nursing facility services, as an alternative to in-home care. The provision applies to services furnished on or after January 1, 1990.

Section 101(1)(4)—Medicare Hospice Extension: Provides for a subsequent extension (time period not specified) beyond the 210-day limit for Medicare-certified hospice providers, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program. This provision is effective for services provided on or after January 1, 1989.

Section 427—Home Health Advisory Commission: Requires the Centers for Medicare and Medicaid Services (CMS) Administrator to appoint an 11-member Advisory Commission on Home Health Claims. The commission is to study and report to Congress within one year after enactment on the reasons for the increase in the denial rate for home health claims in 1986 and 1987, the ramifications of such increase and the need to reform the process involved in such denials. At least five of the commission members must be representatives of home health or visiting nurse agencies. The remaining six must consist of representatives of senior citizens' groups, physicians' groups and fiscal intermediaries, with no more than three of the six representing fiscal intermediaries.

Section 425—Case Management Study: The HHS Secretary must establish four demonstration projects within 12 months after enactment, under which an appropriate entity (one of which must be a PRO) agrees to provide case management services under the Medicare program to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs. The demonstration projects are to evaluate the appropriateness of, and determine the most effective approach of, providing case management services for Medicare beneficiaries with high medical bills.

The HHS Secretary is to waive limitations or restrictions on benefits necessary to conduct the demonstration. The demonstrations will be conducted for a two-year period. The HHS Secretary is to make an interim report within a year after the demonstrations begin and a final report upon completion.

Section 207—Research on Long-Term Care Services for Medicare Beneficiaries: The HHS Secretary is required to provide for research relating to the delivery and financing of long-term care services for Medicare beneficiaries. The study is to include at least the following: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care; (2) how financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and non-institutional services; (3) how beneficiaries and relatives are affected financially and other ways because the beneficiary requires or received long-term care services; (4) the quality of long-term care services (in community and custodial settings) and how the provision of such services may reduce expenditures for acute care services; and (5) the effectiveness of, and need for, state and federal consumer protections that assure adequate access to and protect the rights of beneficiaries receiving long-term care (other than in a nursing home).

The provision defines long-term care to include nursing home care, home care, community-based services and custodial care. The HHS Secretary would submit interim reports December 1990 and December 1992, with a final report due June 1994. The provision also requires the Secretary of Treasury to conduct a study of federal tax policies to promote the financing of long-term care due to Congress by November 31, 1988.

Section 401-408—U.S. Bipartisan Commission on Comprehensive Health Care: Establishes a commission to examine shortcomings in the health care delivery and financing mechanisms that limit or prevent access to all individuals of comprehensive health care, and make recommendations to Congress on federal programs, policies and financing needed to assure the availability of comprehensive health care services for all U.S. citizens.

Both the terms "comprehensive health care services" and "comprehensive long-term care services"

include home care services. The commission is to submit to Congress no later than six months after enactment a report on its findings regarding comprehensive long-term care services for the elderly and disabled. Within one year, the commission is to report to Congress on its findings regarding comprehensive health care services for the elderly, disabled and for all individuals. Both reports are to include detailed legislative initiatives.

Section 208—Study of Adult Day Care Services: Effective upon enactment, this provision requires the HHS Secretary to survey adult day care services to collect information on (1) the scope of such services; (2) the characteristics of entities providing the services; (3) licensure, certification and other quality standards applied to those providing the services; (4) their cost and financing; and (5) the characteristics of people receiving such services.

The HHS Secretary is to report to Congress within one year on recommendations for appropriate standards for Medicare adult day care services.

CHANGES FROM THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA-87, P.L. 100-203) INCLUDED IN THE MEDICARE CATASTROPHIC PROTECTION ACT OF 1988

Section 411—Data Used to Determine Home Health Agency Cost Limits: Beginning July 1, 1989 (July 1, 1988, in OBRA-87), the HHS Secretary is to utilize, for home health agencies cost limits, a wage index that is based on verified data (audited data in OBRA-87) obtained by home health agencies. The amendment will penalize agencies that refuse to provide data or deliberately provide false data.

Section 411—Home Health Prospective Payment Demonstration: The effective date for the demonstration has been changed to begin on April 1, 1989, rather than July 1, 1988.

Section 411—Training for DME Suppliers: All durable medical equipment (DME), whether provided by a home health agency or a DME supplier, must be furnished by individuals who have met training standards set by HHS. The 1987 budget reconciliation law required only home health agencies providing DME to meet the standard.

HOME HEALTH LEGISLATION 1987

OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (P.L. 100-203)

Section 4001—Gramm-Rudman-Hollings: The reduction to home health agencies under the Gramm-Rudman-Hollings sequestration was in effect only until December 31, 1987. The sequester was continued for inpatient hospital services and physician services until March 31, 1988.

Section 4024—Homebound Requirement: Clarifies that an individual does not have to be bedridden to be homebound. Includes those whose ability to leave home without assistance or supportive device is restricted due to illness. Clarifies that limitations on individuals' absences from home do not apply to absences for the purposes of medical treatment. Absences must be infrequent, of short duration and require considerable effort by the beneficiary.

Section 4032—Denials and Reconsiderations of Claims for Home Health Services: Effective with claims received on or after January 1, 1988, the intermediary must furnish the provider and beneficiary promptly with a written explanation of the denial and of the statutory and regulatory basis for the denial. Effective with claims filed on or after October 1, 1988, the HHS Secretary shall take into account, when evaluating fiscal intermediaries and carriers, whether or not they process 75 percent of reconsiderations within 60 days, and 90 percent of reconsiderations within 90 days, and the extent to which determinations are reversed on appeal.

Section 4035—Publication and Notification of Policies: No rule, requirement or other statement of policy that establishes or changes substantive legal standards governing the scope of benefits; the payment for services; or the eligibility of individuals, entities or organizations to furnish or receive services shall take effect unless it is promulgated by the HHS Secretary by regulation. The HHS Secretary shall publish in the Federal Register, not less frequently than every three months, a list of all manual instructions, interpretative rules, statements of policy and guidelines of general applicability. Effective June 1, 1988, each fiscal intermediary and carrier shall make available to the public all interpretative materials, guidelines and clarifications of policies that relate to payment for such benefits.

Section 4037—Medicare Hearing and Appeals: Hearings will be conducted by administrative law judges (ALJ) under the Social Security Administration until September 1, 1988, or upon receipt by Congress of a report regarding the administrative review hearings by the Secretary, whichever is earlier. This study, to focus on whether telephone hearings allow for a full and fair evidentiary hearing, is due six months after enactment.

Section 4039(e)—Moratorium on Home Health Prior Authorization: Prohibits the HHS Secretary from implementing a national program of voluntary or mandatory prior authorization for home health and post-hospital extended care services claims until six months after Congress receives final results of the Administration's evaluation of studies required by OBRA (1986). The report is due February 1, 1989; therefore implementation could not be prior to July 1, 1989.

Section 4026—Study of Urban/Rural HHA Cost Limits: The HHS Secretary must study and report to Congress by June 1, 1988, whether cost limits for home health agencies (HHA) located in rural and urban areas accurately reflect cost differences and the appropriateness of modifying the limits to take into account the proportions of patients from urban and rural areas.

Section 4026—Data Used to Determine HHA Cost Limits: In determining the cost limits, the HHS Secretary is required to utilize a wage index that is based on audited wage data obtained from HHAs, not hospitals. Such audited data cannot be from cost reporting periods before July 1, 1985.

Section 4027—Home Health Prospective Payment Demonstration: The HHS Secretary will provide for a demonstration project to develop, test and evaluate various methods of paying HHAs on a prospective basis. The project shall be designed in a manner to enable the HHS Secretary to evaluate the effects of various methods of prospective payments (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, as well as beneficiaries' access to quality care. An interim report is due to Congress within one year after enactment. A final report is due four years after enactment. The demonstration is to begin no later than July 1, 1988.

Section 4021—Home Care Quality:

1. Conditions of Participation—Beneficiary Rights

Informed. Beneficiaries have the right to be fully informed in advance about the care and treatment to be provided by the agency. Beneficiaries will have the right to participate in the planning of care and treatment and any changes that might occur. Family members of those judged incompetent would be consulted.

Grievances. Beneficiaries have the right to voice grievances about care without reprisals.

Confidentiality. Clinical records will be confidential to ensure appropriate release or review under federal or state law.

Property. Beneficiaries have the right to have their property treated with respect.

Informed of All Services and Any Other Services Provided by the Federal Government. Beneficiaries must be informed, orally and in writing, about all items and services to be provided, the availability and extent of coverage for those items and the costs for services for which the beneficiary is responsible. This information must be provided prior to the beneficiary's care by the agency.

Informed of Rights and Obligations. HHAs would be required to notify beneficiaries of their rights and obligations under the Medicare statute, in writing and in advance of start of service. This includes the right to be informed about Medicare costs, charges and coverage, as well as their right to appeal any denial.

2. Conditions Relating to Agency Administration

Notification of Changes in Ownership and Management. HHAs will be required to notify the state agency responsible for their licensure of changes in ownership or management of the agency. This information should be considered as part of the licensure process, in particular with regard to those decertified as part of other health care facilities, or those previously convicted of fraud.

Durable Medical Equipment and Supplies. With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment may not use any individual who does not meet minimum training standards

established by the HHS Secretary by October 1, 1988, for the demonstration and use of any such equipment.

Inclusion of Plans of Care in Records. Mandates the inclusion of plans of care in beneficiaries' records to ensure the maintenance of the most complete and accurate clinical records possible.

Compliance with Laws and Regulations and Professional Standards. Requires that all HHAs provide services in accordance with all relevant professional standards and principles.

3. Conditions Relating to Provision of Service

As a condition of participation, by January 1, 1990, non-licensed health care professionals (home care aides) will have to (a) have completed or be enrolled in and making progress towards completion of a training program that meets minimum standards and (b) must be competent to provide such services. HHAs would have to provide regular review and in-service education so as to assure competency.

The minimum standards to be established by the HHS Secretary no later than October 1, 1988, would have to include: (a) requirements regarding the content of the training curriculum, (b) minimum hours of training, (c) the qualification of training instructors and (d) the procedures by which competency is to be determined. These standards are not meant to supersede any state requirements.

The above standards may permit recognition of training programs, either within or by other agencies, so long as those agencies have not been out of compliance with all Medicare conditions of participation within the previous two years. Medicare certification—which can be awarded even when an agency has not met all participation requirements—is not sufficient to grant recognition of a program offered by the agency. Those individuals who completed a training program prior to January 1, 1989, may be deemed as completing an HHS program, if the program offered met the standards under this section at that time.

Standards for determining the level of competency should receive careful consideration by the HHS Secretary. The individual must be competent to perform only those tasks for which he or she is responsible, such as turning the patient, or transferring him or her from the bed to a wheelchair. The HHS Secretary is not precluded from allowing HHAs in the establishment of a minimum standard, as part of an HHS-approved training program, to determine on their own decisions regarding competency; however, the HHS Secretary must include specific methods (such as HHS review) for ensuring that competency determinations made by the agencies about their own aides are accurate and in compliance with HHS standards.

Section 4022(a)—Standard Survey: Each HHA shall be subject to a standard survey performed without notice and up to, but not beyond, 15 months after the previous survey. The statewide average may not exceed 12 months. The survey shall be conducted by an individual who meets minimum requirements established by the HHS Secretary not later than July 1, 1989.

Survey agencies would be allowed to survey within two months after any change in agency's ownership, management or administration. This is not mandated; however, a survey is required to be conducted when a significant number of complaints are reported to any appropriate federal, state or local agency.

The content of the survey would be based on protocol that is developed, tested and validated by

the HHS Secretary no later than January 1, 1989. The protocol must include visits to a sample number of beneficiaries in their homes. (These visits are to be used to evaluate the qualitative impact of services provided on the functional capacity, as reflected in their plans of care. Agencies do not have to demonstrate that the services provided resulted in a complete recovery of the beneficiary, but that quality care should result in the highest possible functional capacity given the restraints of the beneficiary's illness or injury.)

To ensure that individual assessments are conducted accurately and effectively, the HHS Secretary must provide for the training of federal, state and local surveyors.

Section 4022(b)—Extended Survey: Each HHA that is found, under a survey, to have provided substandard care, shall be subject to an extended survey, not later than two weeks after the completion of the standard survey. The HHS Secretary must develop protocol for an extended survey, including at a minimum, a review of the agency's compliance with all of the Medicare conditions of participation.

Section 4023—Enforcement: Decisions about enforcement would begin with the HHS Secretary's determination about the type of deficiency, based upon findings of standard, extended or partial survey, or an investigation of complaints.

Deficiency jeopardizes the health and safety. If the health and safety of beneficiaries are determined by the HHS Secretary to be immediately jeopardized, the Secretary may: (1) appoint temporary management to oversee the operation of the agency or (2) terminate the agency's certification of participation. Temporary management would remain in place until such time as the HHS Secretary determines that the agency has a management in place to comply with all relevant requirements. Termination would mean denial of all existing and new beneficiary claims. The HHS Secretary also is authorized to provide for intermediate sanctions, including civil monetary penalties.

Deficiency does not jeopardize the health and safety. When deficiencies are not found to be jeopardizing to health and safety of beneficiaries, the HHS Secretary may impose one or more intermediate sanctions for no longer than six months. If the agency still has not come into compliance in this time, certification will be terminated.

Payments may be made during this six-month period if three conditions are met: (1) the surveying agency finds it more appropriate to take alternative action rather than terminate; (2) the agency submits and the HHS Secretary approves of a plan of corrective action; and (3) the agency agrees to repay any payments received if corrective action is not taken in accordance with the plan.

The HHS Secretary has the authority to develop and implement additional sanctions (civil monetary penalties, suspensions of Medicare payments and temporary management).

Section 4025—Maintenance of Toll-Free Hotline and Investigative Unit: Surveying organizations will be required to establish and maintain a toll-free hotline for complaints and questions. They also will be required to maintain a unit to investigate complaints. Such a unit will possess enforcement authority, including data collection authority. Data collection may include survey and certification data and patient medical records, but with patient consent only.

Section 4079—Community Nursing and Ambulatory Care on Prepaid, Capitated Basis: Requires the HHS Secretary to conduct demonstrations in at least four sites of community nursing and ambulatory care services furnished on a prepaid, capitated basis. Projects would begin no later

than July 1989, and would be conducted for a period of three years. The HHS Secretary is required to report to Congress no later than January 1, 1992.

Section 4009(e)—Waiver of Inpatient Limitations for Connecticut Hospice: Provides that the existing two-year waiver from the 20-80 percent inpatient-home care day requirement is permanently waived.

Section 4039(f)—Delay in Publishing Regulations with Respect to Deeming the Status of Home Health Agencies: The HHS Secretary is prohibited from publishing earlier than six months after publication of proposed regulations, final regulations providing that an entity may be deemed a home health care agency for the purposes of Medicare on the grounds that it has been certified by a private accreditation agency.

Section 4114—Medicaid Waiver for Hospice Care for AIDS Patients: Provides, for Medicaid services only, that a hospice may be allowed to exclude days of inpatient care provided to individuals with AIDS from the days counted towards the 20 percent inpatient day limit. The HHS Secretary is required to establish procedures for making this allowance.

Section 4102—Home- and Community-Based Services for the Elderly: Establishes a new state waiver authority, separate from the existing "2176" waiver authority under the Medicaid program. Payments may be made for part or all of the cost of home- or community-based services (other than room and board), approved by the HHS Secretary, that are provided pursuant to a written plan of care to individuals 65 years or older, with respect to whom there has been a determination that institutionalization would be required in the absence of such services.

OLDER AMERICANS ACT AMENDMENTS OF 1987 (P.L. 100-175)

Section 140—Creates a new Part D of Title III, In-Home Services for Frail Elderly. Services include homemaker and home health aide, visiting and telephone reassurance, chore maintenance, in-home respite care and adult day care as a respite for families, and minor modification of homes. Frail elderly individuals are defined as those having a physical or mental disability, including Alzheimer's disease or a related disorder with neurological or organic brain dysfunction that restricts their ability to perform daily tasks or threatens their capacity to live independently.

Section 141—Creates a new Part E of Title III, Assistance for Special Needs. Activities include transportation, outreach, targeting services to those with the greatest economic or social need, long-term care ombudsman services, and other services where there is unmet need.

Section 143—Creates a new Part F of Title III, Preventive Health Services. The services include: routine health screening; group exercise programs; home injury control services, including screening of high-risk home environments and educational programs on injury protection in the home environment; nutritional counseling and educational services; screening for the prevention of depression, coordination of community mental health services, educational activities, and referral to psychiatric and psychological services; educational programs on the benefits and limitations of Medicare and various supplemental insurance coverage, including individual policy screening and health insurance-needs counseling; and counseling regarding follow up health services based on any of the services provided for above.

Section 144—Creates a new Part G of Title III, Prevention of Abuse, Neglect and Exploitation of Older Individuals.

Section 602—Establishes a two-part grant program for home care services under the Public Health Service Act. Part I, Health Care Services in the Home, provides in-home health services to help low-income individuals avoid institutionalization or prolonged hospitalization. Part II, establishes grants for in-home services for individuals with Alzheimer's disease or related disorders.

HOME HEALTH LEGISLATION 1985—1986

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272)

Section 9123—Increased payment in daily rates for hospice care; eliminated sunset provision of the program.

Section 9205—Extended presumption of waiver of liability for home health agencies.

Section 9502—Modified requirements for waiver provisions for home- and community-based care.

Section 9503—Added hospice care as an optional Medicaid benefit.

Section 9508—Revised requirements for optional targeted case management services.

Section 9520—Required HHS to establish a task force regarding alternatives to institutional care for technology-dependent children.

Section 9601—Required HHS to establish a task force on long-term health care policies.

SIXTH OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (P.L. 99-509)

Section 9315—Required HHS to restore the aggregated method of applying the home health cost limits; also required that cost limits be based on the most recent data available. Cost limits also must take into account costs of current billing and verification procedures, as appropriate. GAO is to study the relative merits of applying the cost limits on a per discipline or an aggregate basis.

Section 9305(g)—Extended presumption of waiver of liability to "technical denials" (i.e., denials because beneficiaries did not meet the homebound requirement or did not have a need for intermittent skilled care). New favorable presumption for technical denials is in addition to the existing favorable presumption for claims that are not medically necessary or are for custodial care.

Section 9305(f)—Presumption of waiver also was extended to hospices for claims denied on the basis of medical necessity.

Section 9353(e)—Extended PRO review to home health agencies. PROs will review home health services and complaints.

Section 9305(h)—HHS must develop a uniform needs assessment to evaluate an individual's functional capacity and available resources to meet those needs.

Section 9305(k)—HHS must implement four demonstration projects regarding prior and concurrent authorization for home health services.

Section 9305(a)—HHS is required to develop guidelines and standards for hospital discharge planning.

Section 9313(a)—Clarified that providers may represent Medicare beneficiaries in appeals of denied claims.

Section 9311—Maintains periodic interim payment for home health agencies while eliminating it for hospitals under prospective payment. Established deadlines for payment of "clean" Medicare claims, with interest required when deadlines are not met.

Section 9305(i)—HHS is required to include in prospective payment reports information on the adequacy of quality assurance procedures for post-hospital services.

Section 9313(b)—Allows Medicare beneficiaries to appeal denials for home health services that do not meet the homebound and intermittent care requirements.

Section 9337—Extended Part B coverage to occupational therapy services furnished by an independently practicing therapist in the therapist office or beneficiary's home.

Section 9341—Specified that national coverage determinations are not subject to review by an administrative law judge and limited judicial review. Also added carrier and judicial review of a Part B claim.

Section 9342—HHS must conduct between 5 and 10 demonstration projects to determine the cost and effectiveness of providing comprehensive services including case management, respite care and other in-home services to Medicare beneficiaries with Alzheimer's disease or related disorders.

Section 9408—Permits states to provide optional coverage of respiratory care services at home to ventilator-dependent individuals without having to provide the same amount, duration and scope of services to other Medicaid beneficiaries.

Section 9411—Extended eligibility for home- and community-based services under Medicaid waiver authority to all individuals who, but for such services, would require institutional care which could be reimbursed under Medicaid. States may target waived services to groups by illness (e.g., AIDS) or condition (e.g., chronic mental illness, ventilator dependency).

Section 9435—Clarified rules for hospice payment for individuals who are eligible for both Medicare and Medicaid.

HOME HEALTH LEGISLATION 1984

DEFICIT REDUCTION ACT OF 1984 (P.L. 98-369)

Section 2321—Established a 20 percent beneficiary deductible for durable medical equipment provided by a home health agency.

Section 2336—Permitted physicians who have a financial interest in a sole community home health agency to carry out certifications and plan of care functions for patients served by the agency under certain circumstances. Also deleted uncompensated officers or directors from the list of disqualified physicians.

Section 2343—Allowed a waiver of the hospice "core services" requirements if the hospice has shown good faith in trying to hire its own nurses.

Section 2348—Reduced period in which Medicare would pay for services provided to beneficiaries following termination of participation agreements with home health agencies or hospices.

OLDER AMERICANS ACT AMENDMENTS OF 1984 (P.L. 98-459)

Authorized funds to address the increasing demands for in-home services; required the Commissioner on Aging to establish linkages with peer review organizations to strengthen the involvement of the Administration on Aging in the development of policies relating to community-based long-term care.

INDIAN HEALTH CARE IMPROVEMENT ACT (S. 2166)

Expanded Indian Health Service facilities eligible for Medicare reimbursement to include (in addition to hospitals and skilled nursing facilities) health centers, clinics and home health services.

PAYMENT RATE FOR HOSPICE ROUTINE HOME CARE AND OTHER SERVICES (H.R. 5386)

Increased hospice payment rate for routine home care.

PREVENTIVE HEALTH SERVICE AMENDMENTS (P.L. 98-555)

Authorized grants and loans to meet initial costs of establishing and operating home health services in areas in which those services are inadequate, or not readily accessible. Funds also were approved for training programs for paraprofessionals to provide home health services.

HOME HEALTH LEGISLATION 1983

ORPHAN DRUG ACT (P.L. 97-414)

Section 6(b)—Required a report to Congress on the results of studies currently evaluating home- and community-based services.

Section 6(c)—Required analysis of results of studies on alternative reimbursement methodologies for home health services.

Section 6(d)—Required investigation of methods to stem fraud and abuse in Medicare and Medicaid home health programs; also required report to Congress.

Section 6(e)—Required demonstrations to test—(1) methods for identifying patients at risk of institutionalization who could be treated more cost effectively in a home health program, including hospitalized Medicare patients who are candidates for early discharge due to availability of home health services, and persons in the community who could avoid institutionalization if they had access to home health services; and (2) alternative reimbursement methodologies for home health agencies to determine the most cost-effective and efficient way of providing home health services, including fee schedules, prospective reimbursement and capitation payments.

HOME HEALTH LEGISLATION 1982

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (P.L. 97-248)

Section 105—Requires the HHS Secretary to issue regulations establishing a single reimbursement limit for home health agencies, based on the costs of freestanding facilities, and provided for exceptions.

Section 134—Expanded state ability to cover under Medicaid certain disabled children aged 18 or under who live at home. Provision applies to children who would have been eligible for SSI and hence Medicaid, if they had been institutionalized.

Section 122—Provided Medicare Part A coverage of hospice services.

HOME HEALTH LEGISLATION 1981

OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35)

Section 2122—Eliminated occupational therapy as a basis for initial entitlement to home health benefits.

Section 2144—Reduced Medicare reimbursement limits applied to home health agencies from the 80th to the 75th percentile, or such comparable or lower limit as the HHS Secretary may determine.

Section 2176—Provided for Medicaid waivers to provide home- and community-based services for certain individuals.

HOME HEALTH LEGISLATION 1980

OMNIBUS RECONCILIATION ACT OF 1980 (P.L. 94-499)

Section 930—Provided for coverage under Medicare of unlimited home health visits; eliminates the three-day prior hospitalization requirement for home health services under Part A; eliminates the \$60 deductible for home health services under Part B; includes the need for occupational therapy as qualifying criteria for home health benefits; allows proprietary home health agencies in states without licensure laws to participate in Medicare; eliminates the authority of HHS to establish additional standards solely on the basis of the tax status of an agency; provides authority for HHS to require bonding or the establishing of escrow accounts to the extent necessary; and requires HHS to establish regional intermediaries for home health agencies.