2012 Congressional Priorities

A unified voice for affordable, accessible, quality home care and hospice services
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The Home Care & Hospice Alliance of Maine provider members seek a number of legislative and regulatory reforms in order to more effectively address the challenges of providing access to home care and hospice services throughout the State of Maine.

I. 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 announced in a bulletin its intention to issue a regulation giving wide discretion to the states to make the final determination of what are “essential benefits” in the standardized benefit packages offered in state health insurance exchanges.

RECOMMENDATION: Congress should require that insurance companies provide a standardized benefit package that includes coverage for home health care and hospice. Any listing of “Essential Benefits” in insurance offered through state health insurance exchanges under PPACA should include home health care and hospice.

RATIONALE: All Americans should have access to home care and hospice coverage in their health insurance. According to a recent national study, home health is a benefit in 77 percent of health plans and hospice in 66 percent. Home health has proven to be effective in reducing health care expenditures by reducing hospitalizations, shortening hospital stays, and serving as an alternative to costly post-acute 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).
II. Ensure Appropriate and Adequate Reimbursement for and Access to Medicare Home Health and Hospice Services

A. Block CMS Regulatory “Case Mix Creep” Cuts and Require a New Process for Calculating Case Mix Adjustments.

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

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

CMS revised PPS, including a modified case mix adjustment model, with implementation in January 2008. The changes included an 11.75% rate reduction phased in over four years triggered by a finding that coding weights had increased beyond levels justified by changes in patient characteristics. Additional rate reductions related to changes in the average case mix weights of 3.79% occurred in 2011 and 2012. In response to the regulatory rate reductions, beginning in 2007 legislation has been introduced in both houses of Congress that would require CMS to utilize a rational and transparent process for adjusting rates under the BIPA authority. That legislation proposes detailed standards such as the use of a Technical Advisory Group, consideration of service utilization through service reviews rather than statistical assumptions, and a full public display of the data and analysis prior to the finalization of rate adjustments. This legislation was refiled in the 112th Congress (S.659). Unfortunately, the proposed legislation has not advanced. In its 2011 rulemaking, CMS promised to revisit its process for evaluating changes in case-mix weights. However, CMS did not agree to voluntarily utilize the process prescribed in the bills.

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

RECOMMENDATION: Congress should restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of the BIPA case-mix adjustment correction authority through public rulemaking. The procedural standards set out in S. 3315 should be enacted immediately and applied prospectively to any further coding weight adjustments.
RATIONALE: An intended consequence from the transition of cost reimbursement to prospective payment is stability and reasonable certainty regarding Medicare home health service payment rates. With cost reimbursement principles allowing for retroactive payment adjustments, home health agencies suffered through an environment of financial instability. PPS should operate with at least a modicum of stability of payment rates and CMS should not be allowed to arbitrarily adjust payment rates through the application of vague and ambiguous standards.

B. Establish Reasonable Standards and Timeframes 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 2011 congressional recommendations from the Medicare Payment Advisory Commission (MedPAC) advises Congress to begin rebasing in 2012 and complete it in 2013. 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.

RECOMMENDATION: Congress must closely monitor the implementation of the rate rebasing by the Centers for Medicare and Medicaid Services (CMS). Further, Congress should amend the legislation to require that the rate rebasing include all usual and customary business costs consistent with standards under the Internal Revenue Code, including telehealth services, all disciplines of caregivers, and usual business operating expenses along with needs for operating capital and operating margins.

RATIONALE: In the absence of well-defined standards for rebasing of payment rates, there is a strong risk that CMS will set rates at a single amount based solely on the average cost of an episode of care using the antiquated cost reimbursement criteria that has not been applicable to home health services since 1999. The current episode of care allows HHAs the flexibility to provide a wide range of services that do not constitute allowable costs under these outdated criteria. Further, these cost reimbursement criteria do not recognize the needs of a present day health care providers to access capital for achieving efficiencies or the need for a reasonable operating margin to meet cash flow obligations and to incentivize performance. Setting the rates simply at average cost is also in conflict with the intentions and recommendations of the Medicare Payment Advisory Council (MedPAC) that expressed the need for capital and operating margins in its deliberations.
C. Ensure Full Market Basket Updates to Medicare Home Health and Hospice.

Home Health

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

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

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

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


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

In March 2010, MedPAC again recommended elimination of the home health market basket update for 2011, as well as rebasing of rates to “reflect the average cost of providing care.” Additionally, MedPAC suggested that Congress direct the Secretary of Health and Human Services (the Secretary) to modify the home health payment system (through possible use of risk corridors and blended payments) to protect beneficiaries from “stinging or lower quality of care” in response to rebasing. MedPAC also recommended that the Secretary identify categories of patients likely to receive greatest clinical benefit from home health and develop quality outcome measures for each category of patient. Finally, MedPAC recommended that Congress direct the Secretary to review agencies that exhibit unusual patterns or claims for payment and provide authority to the Secretary to implement safeguards (including a moratorium, preauthorization requirements or suspension of prompt payment requirements) to address high risk areas.
MedPAC’s recommendations are predicated on findings of “excessive” Medicare profit margins for freestanding agencies. More comprehensive study of agency margins performed by the National Association for Home Care & Hospice has found significantly lower Medicare profit margins that virtually disappear when all payers are taken into account. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges.

In recent years, MedPAC has also expressed interest in imposition of a “productivity adjustment” which would reduce payments to Medicare providers to reflect gains in productivity.

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

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

**RECOMMENDATION:** Congress should reject any proposals to reduce the market basket inflation update or impose additional rate reductions for home health agencies. Congress should maintain its carefully crafted schedule of payment rate changes as contained in PPACA in order to secure access to continued care.

**RATIONALE:** Since legislative changes instituted in 1997 and subsequent imposition of a PPS for home health, reimbursement levels have failed to adequately cover the rising costs of providing care, including increased labor costs for home health agencies. Thousands of home health agencies closed following implementation of the 1997 Balanced Budget Act (BBA). In calendar year 2000, one million fewer beneficiaries received home health services than in calendar year (CY) 1997 and, in the first year of PPS (CY 2001), an additional 300,000 fewer beneficiaries received home health services than in CY 2000. In CY 2001, 5.5 percent of Medicare beneficiaries received home health services, compared to 6.5 percent in 1991. Recent study by MedPAC and CMS indicate that a major problem with the PPS is that the case mix adjustor in most cases does not accurately predict the costs of providing care.

Under PPS refinement regulations promulgated during 2007-2010, CMS included four years of reductions to the home health base payment rate – 2.75 percent in each of 2008, 2009, and 2010, and 3.79 percent in 2011 and 2012, for a total of over $20 billion in cuts over a ten year period. These cuts could well send the home health network into severe financial difficulties similar to those experienced after passage of the BBA. This would ill serve beneficiaries, agencies, and the Medicare program.

It is estimated that with the MedPAC proposals, well in excess of 50% of all home health agencies will be paid less than the cost of care in 2012 and there are no revenue sources to offset these losses. That means that access to care will be lost to a significant number of Medicare beneficiaries. A similar arbitrary rate-cutting effort in 1998 led to the loss of care to nearly 1.5 million home health patients, forced the closure of over
4000 home health agencies, and increased overall Medicare spending because of the expanded use of more expensive care.

Crude measures such as across-the-board reductions or freezes will only exacerbate inequities in the system, and contribute further to access concerns. Access to care continues to be a serious problem in home health, and it is anticipated that these concerns will only increase with further cuts to home health payments. Home health care is efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.

**Hospice**

**ISSUE:** The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010 as Public Law 111-148, requires the development of Medicare hospice payment system reforms along the lines recommended by the Medicare Payment Advisory Commission (MedPAC) in 2009 and again in 2010 (Section 3132(a)). Under the new law, the effective date for collection of data to begin is January 1, 2011, with system reforms in operation no earlier than October 1, 2013. P.L. 111-148 also includes interim hospice payment changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points for FY2013 through 2019, but conditions the 0.3 point market basket reductions in each of FY2014 – 2019 on growth in the health insurance-covered population exceeding 5 percent in the previous year. In 2011, MedPAC recommended to Congress that the hospice market basket update be limited to 1 percent for FY2012; this recommendation was not approved by Congress. In early 2012, it is expected that MedPAC will recommend that the FY2013 market basket update for hospice be limited to 0.5 percent.

**RECOMMENDATION:** Congress should restore the market basket update, rescind the productivity reductions authorized under P.L. 111-148, and reject any further proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by the Government Accountability Office (GAO) and MedPAC should be conducted before any cuts in reimbursement are undertaken. Also, Congress should oppose any reductions in the annual updates until such time as all payment reforms are instituted and then only after the issues are fully examined.

**RATIONALE:**

- Beginning in FY2010, the Centers for Medicare and Medicaid Services (CMS) began phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. In each year the phase out reduces scheduled annual increases by 0.6 percent. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent.
- MedPAC has projected that Medicare hospice financial margins for 2012 (without consideration of costs related to volunteer and bereavement services) will average about 5 percent; however, financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is some concern that MedPAC’s estimates may not take into full account costs associated with the face-to-face encounter requirements that went into effect Jan. 1, 2011.
- A study by Duke University showed that patients who died under the care of hospice cost the Medicare program an average of about $2,300 less compared with those who did not. In its June 2004 report on
the Medicare hospice benefit, the GAO determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursements. A cut in the market basket update would impair the ability of hospices to maintain Medicare beneficiary access to care.

- The GAO recommended that CMS should collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. It did not recommend an across-the-board cut in hospice payments. CMS is in the process of collecting such data for analysis.
- At its November 2008 and subsequent meetings, MedPAC discussed potential recommended revisions to the Medicare hospice benefit reimbursement system. There is concern about the costs of short stay patients not being fully covered under the current reimbursement system. Financial margins for hospices with shorter stay patients are generally significantly lower than those of hospices serving long-stay patients. Paying accurately for all types of patients is important to ensure access to services for all Medicare beneficiaries who want to elect hospice care and to ensure that the program is paying rates that cover providers’ costs for all types of patients.

D. Closely Oversee Revision of Hospice Benefit Payment System.

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to care for terminally ill cancer patients. The Medicare Payment Advisory Commission’s (MedPAC) June 2008 Report to the Congress stated that, although the benefit was created to care for terminally ill cancer patients, they are now a minority of MHB participants. Currently, patients with diagnoses such as Alzheimer’s disease, nonspecific debility and congestive heart failure make up the majority of Medicare’s hospice patients. Although the average length of stay (LoS) has been increasing, the more important median LoS remains at about 17 days, according to the MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. The current reimbursement structure was created by estimating the original cost of delivering routine home care (96 percent of the care given) by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project. Despite significant technological, pharmaceutical, and medical care delivery advances over the past 25 years, there has been no reimbursement adjustment to reflect the changes. The shorter LoS increases per diem costs for each patient.

In the intervening years, costs for pharmaceuticals and pharmacotherapy for symptom control and pain management have increased dramatically. The advancement in technology has resulted in increased outpatient services such as palliative radiation therapy and chemotherapy with accompanying diagnostic procedures required to monitor responses and side effects resulting in increased outpatient services costs.

MedPAC issued recommendations to the Congress for revising the hospice reimbursement system in its March 2009 Report to the Congress. It reiterated those recommendations in its 2010 Report to Congress. Those recommendations include expansion of data collection and the creation of a new payment model that reflects the variation in the costs of care over the patient’s length of hospice care.

The Centers for Medicare & Medicaid Services (CMS) began collecting numbers of visits and costs per visit for some of the services that hospices provide in July 2008. Data collection was expanded in January 2010. Collection and in-depth analysis of these and other data are essential to establishing an appropriate method for reforming payments for Medicare hospice services.
The final 2010 health care reform legislation (Public Law 111-148) requires the development of payment system reforms along the lines of the MedPAC recommendations (Section 3132(a)). Payment system reforms are authorized by P.L. 111-148 to be put in place no earlier than October 1, 2013.

Public Law 111-148, the final health reform bill, also includes some interim payment changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points in FY2013 through 2019, but makes provision to eliminate the market basket cut in each of FY2014 - 2019 if growth in the health insurance-covered population does not exceed 5 percent in the previous year.

During 2011, Sen. Ron Wyden (D-OR) and Rep. Tom Reed (R-NY) introduced companion legislation (S. 722/H.R. 3506) that includes a provision requiring that changes to the hospice payment system be studied through a 15-site demonstration project prior to nationwide implementation.

RECOMMENDATION: Congress must carefully review MedPAC’s recommendations and closely oversee CMS’ activities related to hospice payment reform to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress should support efforts by Sen. Wyden and Rep. Reed to ensure that any revisions to hospice payment are tested in the “real world” to avoid unintended consequences.

In the meantime, Congress should oppose any reductions in the annual hospice updates until all payment reforms are instituted and then only after all issues related to coverage and payment for hospice services are fully examined. Any system reforms must assure preservation of access to care, quality of care, and reasonably sufficient reimbursement rates to maintain a viable and stable delivery system.

RATIONALE: Regardless of the level of care taken when developing a new payment system, unintended consequences that have a dramatic impact on the population served may result. These consequences frequently only come to light when the system is actually tested on operating care providers. For this reason, most payment reforms under Medicare have undergone a “demonstration” phase. S. 722/H.R. 3506 would incorporate a “demonstration phase” into the hospice payment reform process to ensure that the new payment system will not have a negative impact on the delivery of high quality care in the hospice program. Congress must ensure this most humane service for America’s terminally ill patients and their families remains a benefit available at the hour of greatest need – the final stage of life.

E. Ensure Access to Hospice Care for Rural Patients.

ISSUE: Hospices are reimbursed one of four per diem rates based on the level of care provided. At least 95 percent of the care provided is in the patient’s residence. Based on the demographics in rural areas, there are naturally fewer patients needing hospice services than is the case in urban areas. As a result, rural hospices must offer the full hospice benefit at a generally higher cost per patient. The benefit was originally enacted with a per-patient cap to be calculated on an aggregate basis with the thought that some patients would require fewer resources than others, thus making those excess cap payments available to offset the costs of more resource-intensive patients. This works if a hospice has a large enough case load to balance expenses. However, if a rural hospice has several high cost patients and a relatively small patient census, there are fewer
lower cost patients to help balance expenses and keep the hospice below cap.

**RECOMMENDATION:** Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas.

**RATIONALE:** 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). 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.
ISSUE: Nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM) and physicians’ assistants (PA) are playing an increasing role in the delivery of our nation’s health care. Moreover, many state laws and regulations authorize these non-physician health professionals to complete and sign physical exam forms and other types of medical certification documents.

The federal government is also recognizing the growing role of PAs and NPs. The Balanced Budget Act of 1997 (BBA), P.L. 105-35, allows Medicare to reimburse PAs and NPs for providing physician services to Medicare patients. These physician services include surgery, consultation, and home and institutional visits. NPs and PAs can certify Medicare eligibility for skilled nursing facility services. The Centers for Medicare & Medicaid Services (CMS) now allows PAs and NPs to sign Certificates of Medical Necessity (CMNs) required to file a claim for home medical equipment under Medicare. Since 1988, CNMs have been authorized to provide maternity-related services to the relatively small population of disabled women of child bearing age who are Medicare-eligible.

Despite the expanded role of PAs and NPs in the BBA, the Centers for Medicare & Medicaid Services (CMS) continue to prohibit PAs and NPs and other non-physician health professionals from certifying home health services to Medicare beneficiaries. According to CMS, the Medicare statute requires “physician” certification on home health plans of care. Legislation has been introduced in the 112th Congresses which would permit NPs, CNSs, CNMs, and PAs to certify Medicare home health plans of care: the “Home Health Care Planning Improvement Act” (S.227; H.R.2267) and the “Craig Thomas Rural Hospital and Provider Equity Act” (S.1680). Similar legislation was introduced in the 110th and 111th Congresses.

RECOMMENDATION: Congress should enact legislation that would allow NPs, CNSs, CNMs, and PAs to certify and make changes to home health plans of treatment.

RATIONAL: NPs, CNSs, CNMs, and PAs are increasingly providing necessary medical services to Medicare beneficiaries, especially in rural and underserved areas. NPs, CNSs, CNMs, and PAs in rural or underserved areas are sometimes more familiar with particular cases than the attending physician, so allowing them to sign orders may be most appropriate. In addition, they are sometimes more readily available than physicians to expedite the processing of paperwork, ensuring that home health agencies will be reimbursed in a timely manner and that care to the beneficiary will not be interrupted. The Institute of Medicine released a study which recommends that NPs and CNSs be allowed to certify eligibility for Medicare home health services (IOM, The Future of Nursing: Leading Change, Advancing Health, October 5, 2010).
IV. Recognize Telehomecare Interactions as Bona Fide Medicare and Medicaid Services

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

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

Despite significant progress that has been made in the development and use of advanced telehomecare technologies, the absence of a uniform federal Medicaid and Medicare telehomecare guideline that provides for comprehensive reimbursement mechanisms and a uniform certification process for certifying telehealth providers, is creating barriers to more widespread adoption of telehomecare and the establishment of services employing telehomecare. Currently, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow for telehomcare technology costs to be reimbursed by Medicare.

Small inroads have been made under Medicaid as at least 13 state Medicaid programs have passed Medicaid waivers that include the reimbursement of telehomecare. Unfortunately, CMS maintains that telehealth visits do not meet the Social Security Act definition of home health services “provided on a visiting basis in a place of residence” under the Medicare program. CMS regulations (42 CFR 484.48(c)) defines a home health “visit” as “an episode of personal contact with the beneficiary by staff of the HHA [home health agency].”

Over the past few years, Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senator John Thune (R-SD) and Amy Klobuchar (D-MN) have taken up the cause and introduced the “Fostering Independence Through Technology (FITT) Act” to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare program to provide monetary incentives for HHAs to utilize home monitoring and communications technologies. In 2009, a companion bill was introduced in the House of Representatives by Rep. Tim Walz (D-MN). In 2008, and again in 2009, Representative Mike Thompson (D-CA) introduced “The Medicare Telehealth Enhancement Act” which provided a number of provisions that addressed the need for enhanced
telehealth services including, for Medicare’s purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services including home health remote monitoring, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions.

Congressional allies from both the Senate and the House also sent a letter to CMS conveying their support for the Center for Medicare & Medicaid Innovation (CMMI) created by The Affordable Care Act and recommending the FITT remote monitoring model as one of the pilot projects the CMMI should adopt to effectively test in both rural and underserved urban areas by home health care providers.

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

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

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

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

The National Commission on Fiscal Responsibility and Reform (2010) recommended a uniform 20 percent copay and a uniform overall deductible of $550 for all Medicare services combined, including home health care. In January 2011 the Medicare Payment Advisory Commission (MedPAC) voted to recommend a home health copay (as much as $150 per episode) for episodes not preceded by a hospital or nursing home stay as a means to encourage beneficiaries to control utilization of care.

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

RATIONALE: Home health cost sharing would create a significant barrier for those in need of home care and lead to increased use of more costly institutional care.

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

• A study published in the New England Journal of Medicine (“Increased Ambulatory Care Copayments and Hospitalizations among the Elderly,” January 2010) found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations. It concluded that raising cost sharing for ambulatory care among elderly patients may have adverse health consequences and increase total spending on health care. The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay.

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

• About 86 percent of home health users are age 65 or older – 70 percent age 75 or older. More than 60 percent of all users are women. Home health users are poorer on average than the Medicare population as a whole. About 43% of home health users have limitations in one or more activities of daily living, compared with 9% of beneficiaries in general. (AARP, “Home Health Copayment Would Have Negative Consequences for Medicare Beneficiaries,” 8/7/98.)

• The Commonwealth Fund cautioned lawmakers that cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate
burden on those who already face very high out-of-pocket costs. (“One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” 9/01).

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

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

• According to the AARP Public Policy institute (“Medicare Beneficiaries’ Out-of-Pocket Spending for Health Care Services, June 2009”), Medicare beneficiaries spent an average of $4,394, or 37 percent of the individual beneficiary’s income, on health care costs. The oldest and poorest beneficiaries spent more than half their incomes on health care services.

• Patients going on service for home health must pay a 20 percent copay and the Part B deductible to retain the services of a physician who can order the home health plan of care and provide care plan oversight. They must pay a copay for home medical equipment. Many home health patients will also incur the hospital deductible and copays and the skilled nursing facility copays before becoming eligible for the home health benefit.

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

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

• Since 1997, the average number of home health visits provided over a 60-day episode under Medicare has dropped from 36 to 18. Spending on a per patient basis is no greater today than in 1997. Adjusted for inflation, Medicare spends billions less on home health care today than in 1997 and serves fewer Medicare beneficiaries. The home health benefit has dropped from 8.7 percent of the Medicare program to 3.7 percent, and CMS projects that it will drop to 3.5 percent by 2020.

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

• The Balanced Budget Act of 1997 intended to reduce projected spending on home health services by $16 billion over five years. Instead, home health outlays were reduced by more than $74 billion over the same time period and Medicare spending on skilled nursing facility care increased dramatically.

• Since 1997, Medicare spending on home health care has consistently been billions below CBO projections.

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

• Although 17 percent of Medicare beneficiaries purchase Medigap coverage and 34 percent have coverage from an employer sponsored plan, there is no assurance that these plans will cover a home
health copay. (Kaiser Family Foundation, 2009) The law governing Medigap policies does not require that all models cover copays. Likewise, the 22 percent 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.

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

- About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 30 percent by MedPAC) of Medicare home health beneficiaries—who are some of the oldest, sickest, and poorest beneficiaries—are eligible for Medicaid. (e.g. Mauser and Miller, “A Profile of Home Care Users in 1992,” Health Care Financing Review, Vol. 160, Fall 1994, p. 20.) A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs.
- Even if Medicaid recipients with low incomes were exempted, a home health copay would cause more Medicare recipients to “spend down” to become eligible for Medicaid under the “medically needy” program.

**Copayments would be another federal administrative burden on providers and would increase Medicare costs.**

- Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care.
- Nurses and home care aides might be placed in the position of having to collect copays, a task for which they are unsuited. They would have to carry large sums of money, increasing their exposure to robbery and muggings. Collecting copays in a person’s home is not like a hospital or physician’s office where clerical staff can handle billing and collection.

**Hospice**

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

In recent discussion, some members of the Medicare Payment Advisory Commission (MedPAC) have suggested that it may be advisable to consider imposition of some type of copayment for Medicare hospice services. Additionally, as part of policy discussions on reform, some have advocated consolidation of Parts A and B and imposition of uniform beneficiary copayments and deductibles on all Medicare services.
**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 17 days, and 95 percent of hospice care is provided in the home. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate 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.
VI. Require Medicare Advantage Plans to Provide a Home Health Benefit and Reimbursement 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.

Medicare Advantage plans have not reformed the home health benefit in any comparable way. Most 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 traditional Medicare episodic reimbursement model have done so only through intense negotiations with network providers. Private fee-for-service plans are an exception, with many using the episodic reimbursement method used in the traditional Medicare home health program because of the deeming of such approach as compliant with federal requirements under MA. 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 and rehabilitation.

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.

RATIONALE: Medicare Advantage plans are required to provide, at a minimum, benefits equivalent to those available to enrollees under the original Medicare plan. 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.
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 care coverage toward home care. These initiatives include a “Money Follows the Person Rebalancing Demonstration” through which individuals who are residing in institutions can be provided an opportunity to receive alternative home and community-based care. The provision makes grants and enhanced federal Medicaid payments available to incentivize states to compete for an award of the demonstration program. The enhanced federal payments can range as high as 100 percent of the cost of the home care for the first 12 months. The bill provided $1.75 billion in new federal payments to support the project.

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

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

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

- Establishment of the Community First Choice Option, which allows for enhanced federal matching for community-based attendant supports and services to disabled individuals up to 150 percent of federal poverty level who require an institutional level of care;
- Extension of the Money follows the Person Rebalancing Demonstration program;
- Protections against spousal impoverishment in Medicaid home and community-based services;
- Enhanced federal matching through the State Balancing Incentive Program for select states to increase the proportion of non-institutionally-based long-term care services; and
• New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum supplemental security income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

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

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