ENSURE MEDICARE HOME HEALTH IS A COMPARABLE BENEFIT UNDER MEDICARE ADVANTAGE

Home health agencies throughout the nation experience numerous difficulties in their efforts to serve patients enrolled in private plans under Medicare. Since Congress reconstituted private coverage under the Medicare Advantage (MA) program and created stronger incentives for beneficiaries to migrate to private plans under the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (MMA), enrollment has grown significantly. The tensions between home health agencies and MA plans have also grown.

Historically the main problems that home health agencies have faced in providing services to Medicare private plan enrollees have included: time-consuming requirements for pre-approval of services, approval of services on a single visit or limited number of visits basis, per visit payment levels set below the cost of care delivery, and failure of Medicare systems to maintain timely records on beneficiaries' enrollment status.

In recent years new issues have emerged, including: inconsistencies between the home health benefit provided under fee-for-service (FFS) Medicare and MA, confusion on the part of beneficiaries regarding how FFS and MA home health coverage differs, charges of exorbitant copays by MA plans, limited provider appeal rights, and payment levels to MA plans set at levels far in excess of the costs incurred by Medicare for services to FFS beneficiaries. To address these troubling developments, Congress should:

REQUIRE MEDICARE ADVANTAGE PLANS TO PROVIDE A HOME HEALTH BENEFIT FULLY EQUIVALENT TO ORIGINAL MEDICARE. Under FFS Medicare, home health is delivered as an episode-based service paid on a prospective basis. Agencies serve as care managers and providers of services with the responsibility to achieve positive patient outcomes. Most MA plans have not transformed the home health benefits they provide in a similar way; instead, they approve home health services on a visit by visit basis. All this occurs despite the fact that, under law, MA plans are required to provide, at a minimum, benefits equal to those provided under the fee-for-service program. Congress should require that MA plans provide an episodic, care management home health services benefit.

PROVIDE ACCESS TO MEDICARE ADVANTAGE ENROLLMENT INFORMATION/ ESTABLISH PROVIDER ‘HOLD HARMLESS’. Unless a client provides accurate information to the agency, home health agencies often have no way of knowing on a timely basis if a patient is enrolled in a MA plan. If an agency is provided inaccurate information by a beneficiary, Medicare information sources rarely reflect current beneficiary enrollment information until two or three months after MA enrollment has become effective. It is frequently the case that a home health agency will provide care in good faith, only to find out when a claim is rejected that the patient was enrolled in a MA plan. Rarely will a MA plan agree to cover the cost of the care delivered since it was not "pre-approved" by the plan. To correct this situation, several steps should be taken. First, Congress should require MA plans to furnish immediate notification to providers and suppliers that are actively caring for an individual that the individual has become enrolled in the plan. Second, Congress should establish a “hold harmless” that ensures direct Medicare payment (and concomitant reduction in MA payments to plans) to providers who in good faith give needed care to MA enrollees before notification is received. Finally, Congress should require CMS to upgrade the timeliness of enrollment information sources and make the information available on a nationwide basis.
ENSURE PATIENTS RIGHTS AND ‘TRUTH IN COVERAGE’ IN MANAGED CARE PLANS. Many enrollees are unaware that MA plans may offer less generous coverage for certain basic Medicare benefits than are available under FFS, and may charge higher copays, as well. Plans fail to disclose this important information to prospective enrollees. Congress should establish MA plan “truth in coverage” requirements that include consumer education provisions that ensure consumers understand the cost sharing requirements and other limitations on home health services under managed care plans; potential MA beneficiaries should be given clear explanations of how plan requirements for copayments and accessibility of home health benefits will differ from traditional Medicare.

RESTRICT EXORBITANT COST-SHARING IN MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS/PROHIBIT HOME HEALTH COPAYS. Under MA private fee-for-service (PFFS), if the plan has established a network of service providers, it is permitted to charge higher copayments for services delivered by non-network providers. Plans have been approved by the Centers for Medicare & Medicaid Services that charge as much as a 50% copay on services delivered by non-network providers. Congress should either rescind the ability of PFFS plans to restrict access to services/supplies through selected networks or establish reasonable limits on beneficiary cost-sharing. On a related issue, many PFFS and HMO-type MA plans offer benefit packages that include a copay for home health services, despite the fact that Congress eliminated copays on home health services in order to encourage use of this more cost-effective service. Congress should prohibit MA plans from imposing copays on Medicare home health services.

ESTABLISH PROVIDER APPEAL RIGHTS IN MEDICARE ADVANTAGE. Under the rules governing MA, enrollees have detailed and extensive rights of appeal regarding any adverse decision related to the coverage of an item or service by the plan. These rights essentially mirror the rights afforded Medicare FFS beneficiaries. However, neither network nor non-network providers of service have stated appeal rights beyond those specified by the contract or by state law. 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 FFS, 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. Congress should amend the Medicare law relating to MA plans to network and non-network providers of services with administrative appeals rights comparable to those existing under the Medicare FFS program.

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. During the 1990s studies concluded that Medicare private plan-participating home health patients received less visits and had less positive outcomes than their FFS counterparts. Since that time there have been a number of changes that have affected the provision of care. Under FFS, agencies serve as care managers and providers of services with the responsibility to achieve positive patient outcomes, while the home health benefit under MA is, for the most part, still provided on a visit by visit basis. Data from old studies is no longer applicable to the Medicare home health benefit. Congress should authorize and fund study of variations in the use of services and outcomes between MA and FFS clients. The beneficiary groups studied should be risk adjusted in order that a true comparison of treatments and outcomes can be made.

LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER FEE-FOR-SERVICE. Congress created options under Medicare for beneficiaries to enroll in private health plans in hopes of reducing Medicare’s financial outlays. Recent studies indicate that MA plan payments average 112 to 120% of the costs incurred by Medicare for FFS enrollees. Despite these excessive payments, many MA plans charge higher cost sharing for some basic Medicare benefits, and pay providers substantially less than the FFS program for the services they provide. Given concerns that the Medicare program may not be sufficiently funded to meet its financial obligations as the baby-boom generation retires, Congress should limit payments to MA plans to the cost of care under FFS.

For more information, please contact the National Association for Home Care & Hospice
Government Affairs Department, 202-547-7424 (04/07)