

**Hospice Association of America
2010 Legislative Blueprint for Action**

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HOSPICE ASSOCIATION OF AMERICA

Introduction

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

The Hospice Association of America (HAA) is proactively representing its members in this new and fast-paced environment. HAA's 2010 Legislative Blueprint for Action presents a comprehensive plan for addressing major health care initiatives facing hospice providers and reflects our agenda for the 111th Congress. The Blueprint emphasizes the increasingly important role hospice plays in the continuum of health care delivery. This publication includes our members' priorities and recommendations concerning hospice care.

This document has been produced by the Hospice Association of America, a professional association representing hospices and their thousands of caregivers who provide services to America's terminally ill patients and their families. HAA hopes this document will be helpful to Congress in its deliberations in 2010 and that it will result in the enactment of legislation to preserve the Medicare Hospice Benefit and improve the quality of life for the thousands of Americans who must trust others for their care and protection.

ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: The Bush Administration's fiscal year 2009 budget proposed to cut Medicare hospice benefit payments by \$5.14 billion over five years by freezing the market basket update for three years and permanently cutting 0.65 percent from the market basket inflation updates thereafter. Fortunately, the Congress chose not to act on this proposal. The Centers for Medicare & Medicaid Services (CMS) Administrator stated that the Administration's proposed Medicare cuts mostly follow along the lines of the Medicare Payment Advisory Commission (MedPAC) recommendations. MedPAC has NOT recommended any cuts in the inflation update for hospice, although it has supported imposition of an annual reduction to adjust for productivity growth.

The final health care reform legislation requires the development of payment system reforms along the lines of the MedPAC recommendations (Section 3132(a)). The effective date for data collection to begin is January 1, 2011 with system reforms in operation 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.

RECOMMENDATION: Congress should restore reductions 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:

- A recent 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.
- MedPAC, in its November 2008 meeting discussed potential recommended revisions to the Medicare Hospice Benefit reimbursement system. There is concern about the costs of short stay patients not being covered in the current reimbursement system. 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.

PRESERVE THE BUDGET NEUTRALITY ADJUSTMENT FACTOR IN THE MEDICARE HOSPICE WAGE INDEX

ISSUE: President Bush's proposed 2009 budget included a regulatory proposal that would permanently eliminate the budget neutrality adjustment factor for the hospice wage index resulting in about a 4 percent cut in the hospice reimbursement rates each year. The anticipated savings would be \$2.29 billion over five years. The Centers for Medicare & Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) calling for comments followed by issuance of a final rule. CMS essentially ignored the comments and began a three-year phase out of the BNAF, effective November 1, 2008. As a result of passage of the American Recovery and Reinvestment Act of 2009 which postponed elimination of the BNAF until October 1, 2009, CMS must now reinstate the BNAF back to October 1, 2008. Thereafter, if Congress does not act, CMS may again begin the phase-out resulting in a hospice cut in reimbursement.

In subsequent 2009 rulemaking, CMS modified the schedule for eliminating the BNAF to phase it out over a seven year period beginning in FY2010. That phase out starts with a 10% reduction in FY2010 followed by six years of consecutive 15% reductions.

The House proposal for health care reform included a one year delay until October 1, 2010 in the start of elimination of the BNAF (H.R.3962, Section 1113). This was not included in the final health reform legislation.

RECOMMENDATION: Congress should direct CMS to permanently reinstate the budget neutrality adjustment factor in the Medicare Hospice Benefit wage index annual update. CMS should be directed to collect sufficient data to responsibly analyze the need for refinements in the hospice reimbursement system before Congress acts to make permanent changes.

RATIONALE: The elimination of the BNAF creates a serious risk of loss of access to hospice care. The Medicare Payment Advisory Commission (MedPAC) has reported that the average hospice margin was 3.4 percent in 2005; elimination of the BNAF decreases hospice reimbursement by 4 percent. There is no reliable data available to indicate whether the majority of hospices would be able to sustain such an overwhelming cut in reimbursement rates. There is a very real danger of putting community hospices out of business resulting in a lack of access to the hospice benefit, particularly in rural areas. In January of 2009, MedPAC's Commissioners voted out a set of recommendations to the Congress that included changing the hospice payment system. However, MedPAC is relying on CMS to gather the data needed to ensure responsible analysis prior to making any refinements/changes. CMS is in the process of collecting data on hospice services and costs. MedPAC has not recommended a cut in the hospice benefit.

In 1994, as a result of disparity in wages from one geographical location to another, CMS established a committee to negotiate a wage index methodology that could be accepted by the industry and the government. The National Association for Home Care & Hospice participated in the Hospice Wage Index Negotiated Rulemaking Committee along with representatives of CMS and other hospice stakeholders. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee signed an agreement for the methodology to be used for updating the hospice wage index which is now in place. At that time, CMS agreed to continue the same budget neutrality adjustment factor that was put into place when the benefit was created in 1983. Given that the agreement was entered

into in good faith by all parties, action in this area should only be considered as part of a broader effort to refashion the hospice benefit.

A June 2004 report by the Government Accountability Office (GAO) determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursement. The GAO recommended that CMS 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. The Medicare budget also will suffer through the loss of hospice care. A recent Duke University study showed that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared with those that did not.

ASSURE SNF/NF MEDICARE BENEFICIARY RESIDENTS' RIGHT TO CHOOSE A HOSPICE PROVIDER

ISSUE: In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare Hospice Benefit (MHB). As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF has the right to deny hospice services to their residents or at a minimum choose the hospice the SNF/NF will allow to provide the services.

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

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

OPPOSE DECREASING HOSPICE REIMBURSEMENT FOR DUALY-ELIGIBLE PATIENTS RESIDING IN NURSING FACILITIES

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

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

The final 2010 health care reform legislation, Public Law 111-148, requires the development of payment reforms consistent with recommendations of the Medicare Payment Advisory Commission (H.R. 3560, Section 3132(a)). The reforms are not predetermined but are dependent on data development and analysis that has not yet been conducted.

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

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

A study, funded by the Agency of Healthcare Research and Quality, US Department of Health and Human Services and conducted by investigators from Brown University Medical School examined data from 183,742 nursing home residents in five states which showed strong evidence that nursing-home residents in hospice care have about half the chance of being admitted to a hospital in their last 30 days of life compared to peers not receiving hospice services. In March 2000, the Office of Disability, Aging and Long-Term Care Policy, Department of Health and Human Services, and the Urban Institute released a study, "Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents."

The study showed that:

- Hospice patients in daily pain are twice as likely to receive level 3 analgesics as are non-hospice patients in daily pain.

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

ENSURE ACCESS TO 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, there are fewer cap payments to absorb the expense.

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

RATIONALE: Hospices in rural areas have difficulty in recruiting and retaining adequate staff to meet the full panoply of services required under the Medicare hospice benefit. Additionally, hospice caregivers must drive greater distances to patient's 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.

PROTECT HOSPICE AGENCIES FROM THE IMPACT OF SEQUENTIAL BILLING

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

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

RATIONALE: 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.

ENSURE ACCESS TO MEDICATIONS NECESSARY FOR PAIN CONTROL

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

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

RATIONALE: Terminally ill patients should not suffer due to inadequate pain management and lack of access to appropriate medications. Creating laws and policies that impose arbitrary limitations on physicians who prescribe controlled substances could have the unintended consequences of discouraging or limiting adequate treatment of terminally ill patients.

MANDATE HOSPICE COVERAGE UNDER MEDICAID

ISSUE: In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an option under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient's life as comfortable and meaningful as possible. Currently, 47 states have chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states examine their Medicaid budgets, hospice care is vulnerable and may be cut. South Carolina has unfortunately already announced its intent to eliminate the hospice benefit from its Medicaid program.

Health care reform measures in Congress in 2010 greatly expand the populations eligible for Medicaid. However, hospice remains an optional benefit. The final reform legislation, which became Public Law 111-148, includes a modification of the Medicaid hospice benefit for pediatric patients that allows the child to receive the full range of other Medicaid benefits and services while on Medicaid hospice. The hospice benefit is mandatory for children because of requirements under the EPSDT program.

RECOMMENDATION: Congress should mandate Medicaid hospice coverage for all populations served.

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

MODERNIZE THE MEDICARE HOSPICE BENEFIT AND 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 16 days. 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. Although there have been significant technological, pharmaceutical, and medical delivery advances made over the past 25 years, there has been no reimbursement adjustment specific to them. 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 a data development 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. The balance of the services and costs of hospice care must be captured to get a full picture of what hospices are providing.

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)). The start date for data collection is January 1, 2011, with system reforms in operation 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.

RECOMMENDATION: Congress must carefully review MedPAC's recommendations and ensure the impact of making changes to the reimbursement system do not affect the ability of terminally ill Medicare beneficiaries to access the MHB when they reach the final stage of life. Congress should work with the National Association for Home Care & Hospice and the hospice industry in

legislating any changes in the Medicare Hospice Benefit.

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. 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: Congress asked MedPAC to provide a report on the adequacy of the MHB reimbursement rates by June of 2002. They were unable to do so due to a lack of data. In 2004, MedPAC reported that Medicare would need to collect additional data in order to do a comprehensive evaluation of patient costs and services. In 2006, MedPAC again reported that the “necessary data are not available for research on potential payment system refinements.” In its June 2008 Report to the Congress, MedPAC stated, “Because of the lack of data on services provided to patients with specific diagnoses, we could not determine the adequacy of Medicare payments relative to the cost of hospice care on a condition-specific basis, nor could we determine conclusively whether the payment system encourages or discourages the admission of certain patients to hospice on the basis of profitability.” In 2007, CMS began collecting some hospice visit data items and are in the process of expanding the visit data that hospices must report. It will take several years of data collection before CMS can begin an analysis to determine if the current payment system is adequate or if there is a more appropriate payment structure. 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.

ENSURE THE PORTABILITY OF ADVANCE DIRECTIVES

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

The final health care reform legislation (Public Law 111-148) did not address the need for portability of advance directives. However, the original legislation approved by the House (H.R.3962) provided for payment to physicians and other health care professionals to provide a voluntary advance care planning consultation (Section 1233); it also contained a provision regarding the dissemination of advance care planning information (Section 240).

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

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

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 30 percent of persons use hospice for one week or less, up to 12 percent of patients receiving Medicare hospice survive longer than six months and the mean length of stay is 16 days or less, according to a recent study "What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?" from the Duke University Center for Palliative Care and Department of Medicine. It is often difficult to make the determination that a patient is terminally ill because the course of terminal illness is different for each patient. A recently-published study reported that the recommended clinical prediction criteria are not effective in a population with a survival prognosis of six months or less. This information demonstrates what has been well known by those in the hospice community: that 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."

In the 2009-2010 health care reform measures no new penalties were proposed for erroneous certification of a terminal illness by a physician. Instead, the final legislation required that a hospice certifying physician (or advance practice nurse) determine continued eligibility prior to the 180th day and for each certification thereafter through a face-to-face encounter and attest to the visit. The hospice may not be reimbursed by Medicare if it makes the required visit.

RECOMMENDATION: Congress should oppose imposition of 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.

SUPPORT QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT PROGRAM FOR HOSPICE

ISSUE: The new hospice conditions of participation (CoP) require hospices to develop, implement, maintain, and evaluate an effective, data driven quality assessment and performance improvement program. The Centers for Medicare & Medicaid Services (CMS) has indicated its intent to require hospices to either develop their own or use currently available systems of measures to track patient outcomes in such areas as pain management, quality of life, skin integrity, and patient satisfaction. The requirement will include retaining the information in a database that permits analysis over time. A CMS contractor completed one research and demonstration project to develop systems of measures for the hospice industry; CMS is looking to test the measures in a subsequent project. The National Association for Home Care & Hospice completed a quality assessment performance improvement (QAPI) collaborative project in 2007 that resulted in adapting and developing succinct data collection instruments to help hospices meet the need for data collection and contribute to the options CMS has to choose from.

The final 2010 health care reform legislation provides a strong start towards the development and implementation of a quality reporting program by requiring the Department of Health and Human Services (HHS) to publish quality measures by October 1, 2012 and quality reporting by hospices in FY2014. These measures would cover all dimensions of hospice quality as well as care efficiency. Failure to submit quality measures by a hospice would result in a 2 point reduction in the annual market basket index update (Section 3004).

RECOMMENDATION: Congress should direct CMS to work with the hospice industry to establish standards of care for providers of the Medicare Hospice Benefit and authorize necessary funding. Agencies should be responsible for ongoing QAPI programs based on patient outcomes. There is not a standard set of performance measures for use in hospice care.

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

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

RATIONALE: The ideal QAPI program is based on what happens to patients. However, there are no standard outcome measures for hospice care. Research and demonstration projects are not factored into the current per diem reimbursement structure. Every effort must be made to keep data collection and the paperwork burden to a minimum to allow concentration of resources on patient care.

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 final health reform law (Publis 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 includes:

- The institution of corporate compliance plans by all Medicare-participating hospices to ensure adherence to all federal and state laws;
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare hospice;
- Strengthening program participation standards to include experience credentialing and competency testing of hospice personnel responsible for maintaining compliance with Medicare standards;
- Investment of sufficient government and industry resources to expedite refinements in the structure and payment methodology of the hospice benefit under Medicare;
- Providing consumers and prospective consumers of Medicare hospice services with a clear summary of program coverage requirements to enhance consumer reporting of non-compliant activity;
- Implementation and development of credentialing and competency standards for government contractors and federal regulators responsible for issuing Medicare determinations; and
- Enhancement of education and training of hospice staff through joint efforts with regulators and government contractors.

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.

MANDATE FREQUENCY OF SURVEYS FOR MEDICARE HOSPICE BENEFIT PROVIDERS

ISSUE: Only 1 percent of Medicare hospice benefit providers are surveyed each year. There is no legislative requirement for the frequency of surveys for providers of the Medicare Hospice Benefit (MHB). The Centers for Medicare & Medicaid Services' (CMS) failure to require that hospice providers be surveyed on a regular basis can result in lack of compliance with regulations and poor quality of care. CMS states they recognize the problem but do not have the funds necessary to conduct more frequent surveys. CMS currently has hospice providers on a six-year cycle for surveys but that sometimes extends to 10 years and more in some parts of the country.

RECOMMENDATION: Congress should mandate that CMS ensure that MHB providers are surveyed at least every three years and provide the funding to do so.

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

REQUIRE DEMONSTRATION PROJECTS TO STUDY SPECIAL SERVICES AND FINANCING OF END-OF-LIFE CARE

ISSUE: People in the last phase of life need a different care system for many months or sometimes years before death. Eligibility for the Medicare hospice benefit is limited to people who have a terminal illness with a prognosis of six months or less. Most people die slowly of relentless but rather unpredictable chronic illness and disease. Studies show that about 75 percent of Americans die in institutions where they often receive futile high-tech interventions and are in pain. Currently, for a beneficiary in the last year of life Medicare spending is almost six times more than for those who are not in their final year of life. The last month expands to 20 times as high as average monthly expenditures for those not in their last year of life due to rapid acceleration of inpatient hospital spending. About 28 percent of Medicare funds are now spent on care in the last year of life, which is comprised, for the most part, of expensive, high-technological interventions and “rescue care.”

According to a recent study from the Duke University Center for Palliative Care and Department of Medicine, “What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?” hospice saves the Medicare program an average of \$2309 per hospice user. It further states that one-fourth of persons use hospice for one week or less, up to 12 percent of patients receiving Medicare hospice survive longer than six months and the mean length of stay is 16 days or less.

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

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

The final health reform law (Public Law 111-148) includes a three-year demonstration program that allows Medicare hospice patients to receive concurrently all other Medicare-covered services needed by the patient (Section 3121(b)). The program is expected to be budget neutral by establishing that concurrent care is cost effective. This provision is complemented with a comparable Medicaid change on hospice for pediatric patients (Section 2302).

The final health reform law also includes authorization to award grants for the development of projects to educate health care professionals in pain care (Section 4305).

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

RATIONALE: Demonstration projects that study special care needs and evaluate the practices and procedures that will improve patient outcomes and resource utilization for end-of-life care would contribute valuable information about care needs and costs at the end of life.

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

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

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

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

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

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

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

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

ELIMINATE MEDICARE PROVISION REQUIRING HOSPICE SOCIAL WORKERS TO PRACTICE UNDER THE DIRECTION OF A PHYSICIAN

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

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

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

ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

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

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.

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

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

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

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

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

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

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

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

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

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

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

ESTABLISH MEANINGFUL STANDARDS FOR LONG-TERM CARE INSURANCE

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

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

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

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

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

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 and hospice services should be reimbursed at levels at least equal to that of nursing home care. Favorable tax treatment should be extended to more generous plans which provide home care benefits for those who need assistance with one activity of daily living (ADL) or one instrumental activity of daily living (IADL), or when

home care is otherwise deemed medically necessary by a physician. Congress should 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.

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. Today, just 48 percent of small businesses are able to offer health insurance — that is a 10 percent drop in just five years. With the economic crisis that surfaced in 2008 and continues in 2010, small businesses are challenged to offer health insurance to employees. Small businesses are particularly challenged 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 health care reform legislation passed in March 2010 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.

RECOMMENDATION: Congress should increase tax credit support for health insurance for employees of small businesses. Further, there should be a standard benefit package that includes home care and hospice.

RATIONALE: Home health agencies 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 will 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.

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

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

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

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

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

ENSURE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

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

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

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

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

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

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

by encouraging more collaboration between nurses and other health care professionals and more involvement by nurses in the decision-making process.

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

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

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

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

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

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

In March 1997, the then-Health Care Financing Administration published proposed rules governing the conditions of participation (CoP) in the Medicare program which included a provision to require home health agencies to conduct a criminal background check of home health aides as a condition of employment. The new Hospice CoP require hospices to conduct a criminal background check on all hospice employees and contracted workers providing direct patient care or with access to patient records.

Criminal background checks cannot be relied on as the sole method of keeping consumers safe. No matter how effective, the criminal background check should not substitute for the most basic and prudent personnel practices that any responsible employer would undertake to establish the appropriateness, safety and suitability of an applicant.

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

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

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

Senator Kohl introduced legislation in the 110th and 111th Congress to expand the pilot projects to make the program available to every state. His legislation was included in the Senate health care reform bill that became Public Law 111-148 in March 2010.

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

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

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

OPPOSE PROPOSALS TO “BUNDLE” HOME HEALTH AND HOSPICE BENEFIT PAYMENTS WITH PAYMENTS TO OTHER PROVIDERS

ISSUE: The idea of bundling post-acute care services into hospitals’ diagnosis-related groups (DRG) payments or into other combined payments has been advanced by some Members of Congress and the 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 present health care reform situation will play a significant role in regards to the establishment of a post-acute care services bundling program. The final health reform law (Public Law 111-148), calls for launching a post-acute care bundling pilot program by 2013.

RECOMMENDATION: Congress should reject proposals to bundle home health payments into hospital DRGs or other provider payments because it would cause major disruption to the health care industry, be anti-competitive, increase the federal regulatory burden and erect a new and unnecessary barrier to beneficiaries’ access to quality care. Conversely, Congress should consider a post-acute care service bundling program where all provider payments would be held by home health agencies. This would deter unnecessary rehospitalizations, 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.

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

Bundling home care payments into hospital DRGs would severely compromise both the quality and availability of home health care for Medicare beneficiaries. Many hospitals have limited experience with the provision of non-hospital, post-acute care. 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 would vastly increase the administrative burden on home care providers by requiring multiple payment systems for home health — one for post-acute patients and one for patients entering home care from the community — and would require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients, rather than using the current single-billing system. This multiple-track system will result in uneven Medicare coverage for patients with the same care needs as every hospital interprets and applies coverage rules differently. Many of these same arguments apply to proposals to bundle home health payments in with payments to other post-acute care providers.

