

**NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE  
2007 LEGISLATIVE PRIORITIES**

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**NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE (NAHC)**  
**KEY LEGISLATIVE ISSUES**  
**JANUARY 2007**

Over the last decade the home care and hospice industries have undergone dramatic change.

The Medicare home health program underwent two major payment system changes, one in 1997 and the next, to a fully prospective payment system (PPS), in late 2000. Additional changes are on the way: it is anticipated that in early 2008, the Centers for Medicare & Medicaid Services (CMS) will implement some major changes to the existing home health PPS.

In 1999, home health agencies began collecting and reporting OASIS data, and in 2003 CMS began making publicly available data on quality of care provided under the Medicare home health benefit.

Despite change in virtually every aspect of home health, agencies continue to provide the high level of care that has made home care the preferred mode of service throughout the United States for decades. Home health is also cost effective; study by the Medicare Payment Advisory Commission indicates that under the home health benefit certain post-acute care patients not only have outcomes that are as good or better than their peers convalescing in institutions, but that high quality home care is available at a fraction of the cost.

In recent years, the White House and the nation's governors have aggressively pursued expansion of the availability of home and community-based services in lieu of more costly and restrictive institution-based care. As a result, Medicaid has become an even larger financier of home care services than Medicare.

Hospice as a formalized concept was first brought to the United States during the 1960s, and the first hospice was formed in 1974. Medicare began coverage of hospice services in 1982 to care for terminally ill cancer patients. The patient population served by the nation's hospices under Medicare has changed dramatically — cancer patients now represent less than half of the hospice population. Hospices are caring for patients with more complex diagnoses but for shorter periods of time.

Home care and hospice providers seek a number of legislative reforms in order to more effectively address the challenges they face in 2007. Following are the top-ranked legislative priorities for 2007 as voted on by the membership of the National Association for Home Care & Hospice, and affirmed by its Board of Directors:

## **I. MAINTAIN FINANCIAL STABILITY FOR HOME HEALTH AND HOSPICE UNDER MEDICARE.**

- Ensure full market basket updates for Medicare home health and hospice payments.
- Ensure care access for rural and underserved patients.
- Oppose copayments for Medicare home health services.
- Oppose proposals to “bundle” home health and hospice benefit payments with payments to other providers.

## **II. PROTECT PATIENT AND PROVIDER RIGHTS UNDER MEDICARE ADVANTAGE AND PRIVATE MANAGED CARE PLANS.**

- Require Medicare Advantage plans to provide a home health benefit fully equivalent to original Medicare.
- Limit Medicare Advantage plan reimbursement to the cost of care under fee-for-service Medicare.
- Restrict exorbitant cost-sharing in Medicare Advantage fee-for-service plans.
- Provide access to Medicare Advantage enrollment information/Establish provider “hold harmless.”
- Ensure patients’ rights and “truth in coverage” in managed care plans.
- Establish provider appeal rights in Medicare Advantage.

## **III. REFORM FEDERALLY-FINANCED HOME CARE AND HOSPICE PROGRAMS TO PROMOTE CARE QUALITY AND EFFICIENCY.**

- Establish a frail elderly care management benefit under Medicare.
- Allow physicians’ assistants and nurse practitioners to certify Medicare home health plans of care.
- Modernize the Medicare hospice benefit.
- Establish stability and equity among Medicare health care providers in application of the wage index.
- Recognize home telehealth interactions as bona fide Medicare services.
- Provide financial assistance to home care agencies to expand use of information technologies and implement electronic health records.

#### **IV. ADDRESS THE IMPENDING LONG-TERM CHRONIC HEALTH CARE CRISIS.**

- Support rebalancing of long term care expenditures in state Medicaid programs in favor of home care.
- Require Medicaid home care programs to offer a full range of delivery models with appropriate quality of care standards.
- Establish meaningful standards for long term care insurance.
- Promote respite care for family caregivers.
- Enact a comprehensive, high quality home- and community-based long term care program for all age groups.

i Medicare Payment Advisory Commission (MedPAC) Report to Congress 2006, March 2006, page 193.

ii MedPAC Report to Congress: Issues in a Modernized Medicare Program, June 2005, Chapter 5, page 105.



## **ENSURE A FULL MARKET BASKET UPDATE FOR HOME HEALTH PAYMENTS**

**ISSUE:** 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.

In 2000, Congress adjusted home health payments for (FY) 2001 so that agencies would receive the equivalent of a full market basket update.

In January 2003, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress freeze home health payment rates at the FY 2003 level for FY 2004. MedPAC renewed its market basket freeze recommendation for 2005, 2006, 2007, and 2008. MedPAC bases its recommendation on estimates of 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.

As part of HR1, 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. For 2007, all home health agencies that have complied with quality indicator reporting requirements will receive a full market basket inflation update of 3.3 percent.

In February 2007 the Bush Administration proposed a fiscal year 2008 budget that included a freeze in home health payments for calendar years 2008 through 2012, with additional market basket reductions of 0.65 percent in each successive year.

**RECOMMENDATION:** Congress should reject any proposals to reduce the market basket inflation update for home health agencies.

**RATIONALE:** As the result of the BBA, anticipated Medicare home health outlays were reduced by more than \$74 billion over fiscal years 1998 through 2002. This amount is far in excess of the \$16 billion reduction originally contemplated by the Congress, and has had a profound negative effect upon beneficiary access to care and home health agency viability. 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 BBA. In calendar year 2000, one million fewer beneficiaries received home health services than in 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.

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. 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.

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

**ISSUE:** The Administration's fiscal year 2008 budget proposes to cut Medicare hospice benefit payments by permanently cutting 0.65 percent from the market basket inflation updates. 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. However, MedPAC did NOT recommend any cuts in the inflation update for hospice.

**RECOMMENDATION:** Congress should reject any proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by Government Accountability Office (GAO) and MedPAC should be conducted.

### **RATIONALE:**

- 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 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.
- MedPAC in its June 2006 report to Congress stated, "Changes in the use and provision of hospice care suggest that the benefit should be re-evaluated. Evaluation of the hospice payment system would assess whether the benefit structure and payment rates, developed twenty-five years ago, could be changed to improve the accuracy of the payment rate. 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."

## ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS

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

Additionally, agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and paraprofessionals, and better integrate the use of technologies in agency operations. As a result, agencies may be forced to refuse admission to patients whose care costs would place an agency at financial risk; further, insufficient payments could create perverse incentives to place limits on care, affecting the overall health care outcomes of patients. The Congress had sufficient concerns about the impact of PPS on beneficiary access to care that, in late 1999, it requested a study from the Medicare Payment Advisory Commission (MedPAC) on the advisability of excluding rural home care providers from the PPS system altogether. In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for care delivered in rural areas between April 2001 and April 2003. As part of H.R. 1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress restored the rural add-on at a 5 percent rate for the April 2004 through March 2005 period. In early 2006, Congress approved legislation (S. 1932) to provide a reinstatement of the 5 percent payment differential for one year (calendar year 2006). The 5 percent payment differential expired at the end of 2006.

**RECOMMENDATIONS:** Congress must closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. If the system's payments are found to be insufficient, Congress should increase the home health base payment. Further, Congress should direct the Centers for Medicare & Medicaid Services (CMS) to develop a more adequate system of "outlier" payments under PPS so that high-cost patients will have continued access to services. Congress should restore and permanently extend the payment differential ("add-on") for care delivered in rural areas. Finally, Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, medical shortage areas) can continue to provide care to Medicare beneficiaries.

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

## **OPPOSE COPAYMENTS FOR MEDICARE HOME HEALTH SERVICES**

**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 plans have imposed home health copays. Copays are regressive, inefficient and fall most heavily on the poorest and oldest Medicare beneficiaries.

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

**RATIONALE: A copayment 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.)
- Since implementation of the home health care prospective payment system, there have been substantial declines in use of home health care, increases in use of more expensive skilled nursing facilities (SNFs) and other post acute providers, and some substitution of SNFs for home health services following hospital discharges. (MedPAC Report, June 2003.) A home health copay would worsen this trend.

**Copayments are an inefficient and regressive "sick tax" that would fall most heavily on the poorest and oldest Medicare beneficiaries.**

- About 70 percent of home health users are age 75 or older. More than half of all users are women and more than half have family incomes of \$15,000 a year or less. 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). The elderly already spend 22 percent of their income on health care; those in poor health spend 44 percent and those who are low-income women over 85 spend 52 percent. ("Medicare's Future: Current Picture, Trends and Prescription Drug Policy Debate," Updated Charts, Commonwealth Fund, 7/1/03.) Seniors spend nearly twice as much of their income on their health care now than they did before Medicare began. (AARP, "Out of Pocket Health Spending by Medicare Beneficiaries Ages 65 and Older: 1997 Projection," 12/1/97.)

- Even if Medicaid recipients with low incomes were exempted from the home health copay, a large percentage of them 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.**

- Elderly Medicare patients receiving the home health benefit pay about one-fourth of their home health care expenses out-of-pocket. Those over 85 pay 33 percent out of pocket. (“Personal Health Care Spending by Type of Service, Age Group, and Source of Payment Distribution,” CMS, 1999.) Most elderly Medicare patients in need of home health services must also pay out of pocket for additional custodial home care in order to remain in their homes. (Doing Without: The Sacrifices Families Make to Provide Home Care,” Families USA, 7/94.)
- 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. The Commonwealth Fund estimated that the average Medicare beneficiary in 2000 spent \$1,470 for Medicare premiums and cost sharing exclusive of home health.
- 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.**

- The number of Medicare beneficiaries receiving home health care annually dropped by 1.3 million between 1997 and 2002, resulting in a cumulative total of over 5 million fewer beneficiaries receiving home health services during this period. For 2006 it is expected that nearly 700,000 fewer beneficiaries will receive home health care than in 1997. The average number of visits provided over a 60-day episode has dropped from 36 to 18. Since 1997 the home health benefit has dropped from 8.7 percent of the Medicare program to 3.8 percent, and CMS projects that it will drop to 2.6 percent over the next 10 years.

**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.

- Since 1997, home health spending dropped by nearly half and CMS estimates of future growth have dropped dramatically.

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

- Thirty-seven percent of Medicare recipients have no private supplemental insurance. (Congressional Research Service, “Medicare: The Role of Supplemental Health Insurance,” 10/10/96, p.2). The law governing Medigap policies does not require that all models cover copays.

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

- About 24 percent of all home care users, and 45 percent of long stay home care users (over 200 visits), are Medicaid-eligible. (Mauser and Miller, “A Profile of Home Care Users in 1992,” Health Care Financing Review, Vol 160, Fall 1994, p. 20.)
- 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 rebill. 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.

## **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 Prospective Payment Assessment Commission (the precursor to the Medicare Payment Advisory Commission). In recent years, the House and Senate Budget Committees have suggested bundling as an option to achieve Medicare savings.

**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.

**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.

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

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

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. The result for Medicare beneficiaries 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.

## LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER FEE-FOR-SERVICE

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

The Commonwealth Fund, a private foundation that conducts extensive examination of the U.S. health care system, issued a study in late 2006 adding to existing concerns that the Medicare program is paying substantially more — 12.4 percent — for care for Medicare Advantage (MA) enrollees than for “traditional” fee-for-service (FFS) Medicare beneficiaries. The findings contrast sharply with the stated goals of creating incentives for private plans to enroll Medicare beneficiaries — to save money by privatizing what was established as a health care entitlement program for seniors and disabled individuals.

In total, if Medicare Advantage plans had been reimbursed at 100 percent of the fee-for-service amount for each of the 5.6 million MA enrollees, the trust funds would have been more than \$5.2 billion richer at the end of 2005. The report estimates that aggregate payments to Medicare Advantage plans over the next five years will be some \$30 billion in excess of fee-for-service costs. The study notes, “EVERY [emphasis added] MA plan in every county in the nation was paid more in 2005 than its enrollees would have been expected to cost had they been enrolled in traditional fee-for-service.”

The differences between the costs for private plan and FFS enrollees vary from state to state, ranging from \$500 more in Nevada to \$2,400 in Hawaii per MA beneficiary. The study indicates that generally the variation between Medicare’s expenditures is greater in states where FFS costs are relatively lower.

These results are consistent with earlier studies by the Medicare Payment Advisory Commission and others indicating significant gaps between average care costs for FFS Medicare and MA beneficiaries.

**RECOMMENDATION:** Congress should limit reimbursement to private plans for Medicare to a level consistent with the costs borne by the program for comparable FFS beneficiaries.

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

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

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

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

The Centers for Medicare & Medicaid Services has approved private fee-for-service plans that require enrollees to pay as much as a 50 percent copayment for out-of-network services/supplies. In doing so, a central feature of the private fee-for-service plans, open access, is virtually eliminated.

**RECOMMENDATION:** Congress should either rescind the MMA provision that allows for private fee-for-service plans to restrict access to services/supplies through selected networks, or establish reasonable limits on cost-sharing obligations for non-network services.

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

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

**ISSUE:** Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have become firmly established as a means for providing health insurance coverage for a significant portion of the U.S. population. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) provides new financial support for Medicare HMOs and PPOs under the Medicare Advantage (MA) program, thereby increasing the likelihood of their playing a significant role in services to Medicare patients. Many newly-enrolled HMO/PPO patients, however, fail to understand that enrollment in an HMO/PPO may prohibit their being cared for by their chosen care providers.

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

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

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

**RECOMMENDATION:** To resolve this issue, Congress should:

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

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

## ENSURE PATIENTS' RIGHTS AND "TRUTH IN COVERAGE" IN MANAGED CARE PLANS

**ISSUE:** Managed care can be defined as a system that: integrates the financing and delivery of health care services; employs a variety of techniques to manage utilization and contain costs, including utilization review, case management, and the use of primary care physicians as coordinators and managers of care; and provides significant financial incentives for patients to use low cost providers and procedures. Health maintenance organizations (HMO) and preferred provider organizations (PPO) are the most prominent examples of managed care systems.

Managed care began in the 1930s as prepaid group practices and was promoted on the grounds that they were designed to improve quality and continuity of care and provide preventive health care services including the development of outcome data. However, the purpose of managed care has shifted dramatically since that time. Managed care is now seen mainly as a means of limiting the use of health services, reducing costs or both.

The increased emphasis on managed care as a means of cost containment has caused concerns about quality and access among consumers and providers, who fear that increased reliance on managed care will exacerbate the problems experienced to date. In the first session of the 107th Congress, the House passed patients' rights legislation to address managed care abuses. The Senate did not pass patient rights legislation during 2002. No action was taken by either the House or Senate in the 108th or 109th Congress. There are wide disagreements over the circumstances and extent to which managed care enrollees should be allowed to sue their managed care plans. Patients' rights legislation is expected to remain a major issue for members of Congress and the Administration.

Foremost among the problems experienced by home care recipients and providers are the following:

- The patient's physician loses control of the patient's care;
- Managed care plans create strong financial incentives to deny services, and some plans have illegally denied home care services to patients who need them;
- Patients whose care needs can be both expensive and lengthy are especially vulnerable under managed care plans that seek primarily to control costs;
- When plans fail to achieve sustained cost savings, and many payors have found that promised savings were experienced only as a one-time phenomenon, benefits are reduced or eliminated altogether;
- Patients are sometimes illegally denied home care services and must sue insurers to get the care they need and deserve;
- Managed care organizations have sometimes engaged in unfair competitive practices and heavy-handed bargaining in negotiating referrals to home care agencies;
- Consumers resent their lost freedom of choice in what can seem like a third-party bureaucracy

designed to deprive them of care;

- Unwarranted interference with the caregiving process and excessive paperwork have been continuing problems;
- The potential for fraud and abuse increases under managed care when plans pursue cost savings at the expense of quality and access;
- In the long run, managed care can reduce quality of care by curbing the development and use of new medical technology; and
- Consumers are not told about copay requirements and other limitations on the provision of home health services in the managed care plans.

**RECOMMENDATION:** Managed care is not a panacea for controlling costs and ensuring access to appropriate services. If utilized, managed care plans should be designed carefully so that the pursuit of least costly care does not jeopardize quality of care or access to necessary services. Managed care plans should include mechanisms to preserve consumer choice, ensure easy access to needed services, require and enforce quality assurance standards for all providers, ensure payment rates that recognize the costs associated with high-quality care, allow individuals to challenge adverse decisions, promote fair marketing practices, and provide appropriate consumer education. Plan “truth in coverage” requirements should include consumer education provisions that ensure that consumers understand the cost sharing requirements and other limitations on home health services under managed care plans; potential Medicare Advantage plan beneficiaries should be given clear explanations of how plan requirements for copayments and accessibility of home health benefits will differ from traditional Medicare. To secure many of these goals, a national patient bill of rights should be enacted.

**RATIONALE:** The rapid growth in health costs and the nation’s economic woes have led both public and private payors to turn increasingly to managed care in an effort to get more services for the money they spend. However, studies of managed care have failed to show that cost increase reductions, where they occur, are more than a one-time-only phenomenon; and even strong supporters of managed care are not sure that it will work to hold down costs. Further, a study conducted by the University of Colorado has found that Medicare home health patients in managed care plans received fewer services and had worse outcomes than other home health patients. Clearly, there is a strong need for safeguards to ensure that cost savings are not achieved by denying needed services. Without these safeguards, managed care will ultimately be rejected by both consumers and providers as an appropriate system of financing and delivery of health care services.

## **ESTABLISH PROVIDER APPEAL RIGHTS IN MEDICARE ADVANTAGE**

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

**RECOMMENDATION:** Congress should amend the Medicare law relating to MA plans to provider network and non-network providers of services with administrative appeals rights comparable to those existing under the Medicare fee-for-service program.

**RATIONALE:** Providers of services under MA plans are subject to claim denials and reimbursement disputes. The most efficient system to address these disputes is the administrative appeals process available under the Medicare fee-for-service program. Medicare beneficiaries under the MA program and beneficiaries and providers under the fee-for-service program can access that appeal system.

## **ESTABLISH A FRAIL ELDERLY CARE MANAGEMENT BENEFIT UNDER MEDICARE**

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

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

**RECOMMENDATION:** Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients. The service should be provided by professional nurses within home health agencies to ensure a discipline-integrated, community care-based approach to care management. The services should include care counseling, care coordination, medication management, and oversight of services related to activities of daily living.

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

## **ALLOW PHYSICIANS' ASSISTANTS AND NURSE PRACTITIONERS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE**

**ISSUE:** Both physicians' assistants (PAs) and nurse practitioners (NPs) are playing an increasing role in the delivery of our nation's health care. Moreover, many state laws and regulations authorize PAs and NPs 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. In addition, 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.

Despite the expanded role of PAs and NPs in the BBA, the Centers for Medicare & Medicaid Services (CMS) continues to prohibit PAs and NPs from certifying home health services to Medicare beneficiaries. According to CMS, the Medicare statute requires "physician" certification on home health plans of care.

During the second session of the 109th Congress, legislation was introduced that amended title XVIII (Medicare) of the Social Security Act with respect to the Medicare home health planning process. Specifically, S. 3500 would allow nurse practitioners, physician assistants, and clinical nurse specialists to certify home health plans of care in both rural and urban areas. The bill was not enacted; it is anticipated that it will be reintroduced in the 110th Congress.

**RECOMMENDATION:** Congress should enact legislation that would instruct CMS to allow PAs and NPs to certify and make changes to home health care plans.

**RATIONALE:** PAs and NPs are increasingly providing necessary medical services to Medicare beneficiaries, especially in rural and underserved areas. PAs and NPs in rural or underserved areas are sometimes more familiar with particular cases than the attending physician, so allowing PAs and NPs to sign orders may be most appropriate. In addition, PAs and NPs 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.

## MODERNIZE THE MEDICARE HOSPICE BENEFIT

**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 2006 Report to the Congress found that in 2002 and 2003, hospice patients with a cancer diagnosis had fallen to 43 percent of MHB participants. The next most prevalent diagnoses were neurodegenerative conditions such as dementia, end-stage Alzheimer's disease and Parkinson's disease, followed by cardiovascular disease. The median length of stay remains at about two weeks. In 1983, 20 percent of patients received hospice services for seven days. From 2000 to 2004, more than 25 percent of beneficiaries were on the benefit for less than a week. The current reimbursement structure was created by estimating the original cost of delivering routine home care (93 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 20 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. The combination of decreased LoS and significantly increased costs makes it very difficult for hospices to continue providing much needed services.

**RECOMMENDATION:** Congress must take action to ensure terminally ill Medicare beneficiaries will be able to access the MHB when they reach the final stage of life. Congress should immediately mandate a new hospice demonstration to collect data necessary to structure the appropriate reimbursement system that will reflect care currently given.

**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." 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.

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

**ISSUE:** Since the inception of the Medicare per visit cost limits, home health payment rates have been adjusted to reflect varying wage levels across the nation through the application of a wage index. This payment rate adjustment continues under the Medicare home health prospective payment system (PPS), which was implemented October 1, 2000. However, the wage index that has been utilized by the Centers for Medicare & Medicaid Services (CMS), in accordance with Congressional mandate, has been based upon varying wages within hospitals across the nation. This index is derived from data that explicitly excludes any home health services costs. An attempt some years back to create and utilize a home care-specific wage index failed due to the unavailability of reliable wage data.

While the home health payment rates are based upon the application of a hospital wage index, the index utilized and its manner of application is significantly distinct from that utilized relative to hospital services payment rates. Of particular concern is the fact that hospitals may secure a geographic reclassification for application of the wage index by establishing that the particular hospital draws on an employment pool different from the geographical area to which it would otherwise be assigned for its wage index level. Home health agencies and hospices are not authorized to secure a wage index reclassification. As a result, a hospital may compete for the same health care employees as a hospice or home health agency but be approved for a relatively higher payment rate through the wage index reclassification. Additionally, Congress has established specific wage index criteria for certain geographic locations. However, these criteria apply only to hospitals. Hospitals also are provided extra protection against losses due to dramatic drops in their wage indices by a provision imposing a “rural floor” under which no hospital’s wage index can fall below the state-specific rural wage index.

Finally, home health agencies and hospices are not afforded any type of stop-loss protections. As a result, changes in area wage indices from year to year are sometimes dramatic, and always difficult to plan for. For example, in recent years one area of Texas underwent a 12 percent drop in its wage index value one year, and a 14 percent increase the next year.

**RECOMMENDATION:** Congress should allow hospices and home health agencies to obtain a geographic reclassification for wage index purposes in a manner comparable to that available to the hospitals or to allow reclassifications automatically when a hospital in the geographic locale of the hospice or home health agency receives a reclassification. Additionally, Congress should enact legislation that limits a home health agency’s loss of income due to a dramatic shift in the agency’s wage index (for example, limit the drop in any agency’s wage index from one year to the next to 2 percent). Finally, Congress should extend to all providers protections that ensure that no entity’s wage index falls below the rural wage index value in that state.

**RATIONALE:** In today’s health care environment, health care providers of all types compete for employment of the same personnel. The adjustment of Medicare payment rates intended to reflect variations in wages across the nation should be consistent across all provider types. With increasing shortages of health care personnel, unequal wage index adjustments for health care providers in the same geographic region results in an uneven and discriminatory distribution of the employment pool

of personnel. Further, in recent years some agencies have experienced dramatic increases and drops in their wage indices. This degree of “swing” in reimbursement can have a significant impact on an agency’s financial viability.

## RECOGNIZE HOME TELEHEALTH INTERACTIONS AS BONA FIDE MEDICARE SERVICES

**ISSUE:** Over the past decade, great strides have been made in telehealth technology and its use in the home. In 1995, there were only three telehomecare nursing projects. This number increased to about 10 in 1997, with even greater growth in subsequent years. The reason for this growth is the evolution of technology to allow for effective nurse-patient interactions over regular phone lines using equipment that costs less than a personal computer. National standards have been established by the American Telemedicine Association for the delivery of telehomecare services.

Telehealth technology provides a two-way interactive audio-video connection over telephone lines. During an on-line visit, the nurse at her base station and patients in their own homes see and talk with each other. The following activities can be carried out: health status assessment, monitoring vital signs, medication supervision, monitoring heart and lung sounds, and patient education. Additional devices can be added as needed to perform more in-depth patient tests, such as blood coagulation checks, electrocardiograms, scales, and pulse oximetry. These interactive connections can also be used for remote supervision of home care personnel.

Unfortunately, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare technology and visit costs as reimbursable by the Medicare program. 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.” CMS regulations at 42 CFR 484.48(c) define a home health “visit” as “an episode of personal contact with the beneficiary by staff of the HHA [home health agency].”

During 1999, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the Congress included specific language, in a conference report, directing the Secretary of Health and Human Services to consider new technologies within home health services to improve health outcomes (House Report 106-479). Specifically, the report urges HHS to “consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment.” Telehomecare services is one innovative technology that can assist home health agencies in improving health outcomes while at the same time maintaining quality patient care and containing costs.

During 2000, the Congress provided further clarification on the use of telehealth services within the context of Medicare home health. Public Law 106-554 states that nothing prevents a home care agency from delivering services via telehealth, but specifies the services “do not substitute for in-person home health services ordered as part of a plan of care certified by a physician and are not considered a home health visit for purposes of eligibility or payment.” This means that a telehealth visit cannot be used to count toward the number of visits that would qualify as a full episode of care. Nor can a telehealth encounter be considered a “visit” for purposes of a low utilization payment adjustment visit (LUPA), which is imposed for episodes comprised of four visits or less. During 2003, P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), contained one provision which may open the door for expanded coverage of telemedicine across all provider settings. A provision within MMA Section 721—Voluntary Chronic Care Improvement Under

Traditional Fee for Service stipulates that certain elements of the “Care Management Plans” within the Chronic Care Improvement Programs chosen “shall to the extent appropriate include the use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health assessment.” During the first session of the 109th Congress, Rep. Jim Ramstad (R-MN) introduced HR 3588, the “Medicare Home Health Telehealth Access Act of 2005”, which amends Title XVIII of the Social Security Act to allow certain home telehealth interactions to count as visits under Medicare and establishes a pilot program with coverage for cost-effective home telehealth interventions that result in savings to the Medicare program. Although this legislation was not passed during the 109th Congress, it is expected that it will be reintroduce in the 110th Congress.

**RECOMMENDATION:** Congress should clarify legislatively that telehomecare “constitutes a service(s) ... provided on a visiting basis in a place of residence used as an individual’s home” as defined in §1861m of the Social Security Act. Medicare should also provide appropriate reimbursement for technology costs to home care agencies. Finally, Congress should ensure that all health care providers, including home health agencies, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

**RATIONALE:** Use of technology that results in more efficient and effective delivery of health care services should be encouraged and recognized as covered Medicare expenditures. 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. Furthermore, quality of care and patient satisfaction has been maintained. 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. These innovative approaches to care are of benefit to the entire Medicare program, frequently helping to reduce acute care episodes and the need for hospitalizations.

Currently, some health maintenance organizations and some state Medicaid programs reimburse for telehomecare services. The Medicare program must keep pace with these programs.

## **PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AGENCIES TO EXPAND USE OF INFORMATION TECHNOLOGIES AND IMPLEMENT ELECTRONIC HEALTH RECORDS**

**ISSUE:** Administrative costs and paperwork represent significant expenses in health care. The home care industry has been especially paper intensive. Medicare billing, OASIS assessments, patient charting compliance with the Health Insurance Portability and Accountability Act (HIPAA), and many other activities greatly increase administrative costs. While home health agencies have substantially moved to electronic transactions, continued changes in documentation responsibilities and advancements in technology challenge the ability of home health agencies to maintain up-to-date systems. The implementation of the Medicare home health prospective payment system has required a wholesale revision in agencies' billing, documentation, data needs and data analysis.

The purchase of multi-purpose integrated clinical and financial systems with multiple electronic capabilities requires a significant capital investment. Traditionally, small business loans have not been readily available to most home health agencies because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenue. Keeping pace with these new technology needs has been beyond the financial capabilities of many home care agencies.

**RECOMMENDATION:** Congress should provide financial support and incentives such as small business loans, tax incentives, grants from the Medicare program, and other Medicare technology pass-through support to encourage and facilitate the implementation of electronic capabilities.

**RATIONALE:** With the significant savings that electronic capabilities can provide, it is time to fully support a movement to an electronic environment for health care transactions. Home health agencies will require financial assistance to purchase the necessary systems. Current reimbursement standards under Medicare, Medicaid and other payors do not provide the capital foundation for such purchases.

## **SUPPORT REBALANCING OF LONG TERM CARE EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE**

**ISSUE:** In 1999, the United States Supreme Court held, in *Olmstead v. L.C.*, that state Medicaid programs were required under the Americans with Disabilities Act (ADA) to undertake steps to support access to community-based health care options as an alternative to institutional care. Subsequently, the Bush Administration established its New Freedom Initiative, which has provided guidance to the states in developing *Olmstead*/ADA compliance plans. In addition, the administration has 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 towards 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 provides \$1.75 billion in new federal payments to support the project.

DRA also includes an optional benefit for Home and Community-Based Services for the Elderly and Disabled that allows states to bypass the burdensome “waiver” process that includes requirements for proving the cost effectiveness of services. This new benefit would require 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.

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

**RATIONALE:** After five 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.

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

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

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

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

**RECOMMENDATION:** Congress should require all states contracting with individuals to provide paraprofessional home care services through federally-funded programs to provide adequate assurances that consumers receiving care from such individuals are assessed to be capable (for example, a person receiving highly skilled services such as catheter care must be capable of directing the caregiver in the performance of that task) and willing to assume the required employer responsibilities. Consumers should also be given the option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice. States should also provide a mechanism for resolving any problems that arise between a consumer and providers, and should devise a method for ensuring that backup workers are available. Consumers directing their own care and their caregivers should be afforded the same important protections that are required when care is provided through an agency. Caregivers should be trained, tested, and competent to provide services.

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

## 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.

## PROMOTE RESPITE CARE FOR FAMILY CAREGIVERS

**ISSUE:** The bulk of long-term care is provided by friends and family caregivers. According to the National Family Caregivers Association, more than 50 million Americans provide care for a chronically ill, disabled or aged family member or friend during any given year. The value of the services family caregivers provide for free” is estimated to be \$306 billion per year, or almost twice that spent on formal home care and nursing home services combined. Persons providing such caregiving are burdened by many responsibilities and demands associated with providing long-term care to a disabled relative or friend. Such problems include limitations on one’s personal life, the competing demands of financial obligations and work conflicts, the care recipient’s emotional and physical demands, and personal emotional, financial and family strains.

Late in 2006, the House and Senate passed and sent to the President for his signature the Lifespan Respite Care Act, H.R. 3248; it authorizes appropriations of \$30 million for fiscal year 2007, rising to \$94.8 million by 2011. The bill amends the Public Health Service Act and authorizes the Secretary of Health and Human Services to award grants or enter into cooperative agreements with state agencies to develop lifespan respite care at the state and local levels. The term “Lifespan” respite care is defined in the legislation as a coordinated system of accessible, community-based respite care services for family caregivers. Eligible states will be required to fund at least 25 percent of the program costs. The legislation will empower states to provide respite care services for family caregivers, training and recruitment of workers and volunteers, as well as training and education for family caregivers. The bill also creates a National Resource Center that will be tasked with maintaining a national database on lifespan respite care. During the 106th Congress, the Older American Act Amendments (OAA) of 2000 (P.L. 106-501), established a National Family Caregiver Support Program for state area agencies on aging to develop respite care programs to enable caregivers to be temporarily relieved of their caregiving responsibilities.

**RECOMMENDATION:** Congress should fully fund both the Lifespan Respite Care Program and the National Family Caregiver Support Program, as well as create an in-home respite care in the Medicare home health benefit. Legislation should be enacted that would expand the respite care provision by allowing for more hours and less restrictive eligibility criteria. The persons providing this care should be adequately trained and supervised.

**RATIONALE:** Friends and family caregivers provide the bulk of long-term care services to their elders with only limited support from public programs. Instead of public policies that create disincentives for families to provide care for their disabled relatives, policies should be developed that promote caregiving by supporting the development of services designed to provide relief to family members and other unpaid helpers. Available data indicates that families tend to purchase services only when the responsibility of care becomes too great for them to handle or when they become exhausted. Furthermore, researchers have found little evidence that policies aimed at providing formal services to caregivers and care recipients encouraged caregivers to substitute paid care for care by friends and family. Respite care is especially important for individuals residing in rural areas where fewer community resources are available.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small-scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive long-term care benefit.

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

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

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

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

**RECOMMENDATIONS:** The federal government must take the lead in providing adequate coverage of long-term care needs for the physically disabled, chronically and terminally ill, and cognitively impaired. The foundation of this initiative should be home- and community-based care and hospice. The following provisions should be included in any recommendations:

- Congress should clearly define Medicare and Medicaid responsibilities and coverage standards for chronic and long-term care conditions.
- Long-term and chronic care coverage must be coupled with clear and dedicated financing.
- Any new benefit must be distinguishable from the Medicare and Medicaid home health benefits to eliminate confusion regarding the programs’ respective responsibilities.
- Disabled and chronically ill Americans who are under 65 should be permitted to qualify for home- and community-based services on the same basis as the elderly.
- Home care agencies and hospices should be allowed to perform case management functions instead of using costly external case management procedures that duplicate standard caregiver activities.
- The distinction between acute care benefits and long-term care benefits should not be so rigid as to inhibit the smooth coordination of in-home services.
- Eligibility for benefits should not be based on income. It should be a social insurance program, not a means-tested welfare program. It should ensure that the spouses of those who need long-term care are not impoverished.

- A long-term care program should be a comprehensive federal insurance plan, not a block grant to the states that is adequately and realistically funded. Funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.
- All individuals who need assistance with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and all those with cognitive or mental impairments should be covered. Another factor to consider should be whether there are family caregivers in the home.
- The full range of home- and community-based services should be offered to all eligible individuals at a level appropriate to meet their needs. These services should include nursing care; home care aide services; medical social services; personal care services; chore services; physical, occupational, speech, and respiratory therapy and rehabilitative services; hospice services; respite care; and adult day services; medical supplies and durable medical equipment; minor home adaptations that, among other benefits, enable beneficiaries to receive services at home; transportation services; nutritional services; and patient and family education and training.
- Quality of care must be ensured. Quality assurance standards, including minimal standards of training, testing, and supervision, should be applied to the delivery of services in the home, regardless of the source of payment for those services. The quality requirements contained in the Medicare Conditions of Participation for home health and hospice serve as a good model for the delivery of in-home skilled services.
- For paraprofessional service providers, the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the Home Care Aide Association of America have developed suitable standards for the training, testing, and supervision of paraprofessional workers. State certification of these workers should be required to ensure that all home care aides are appropriately trained, tested, and supervised as well as provided with basic employee benefits and other support.
- Cash and counseling or voucher programs to purchase home care services should include standards to ensure quality of care; protect vulnerable patients from physical, emotional, or financial abuse or exploitation; guarantee adequate training and supervision of home care personnel; and ensure the provision of any required employee benefits. Such programs should ensure compliance with applicable state and federal labor, health and safety laws and regulations.

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

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

