NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
2012 LEGISLATIVE PRIORITIES

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Home care and hospice providers seek a number of legislative reforms in order to more effectively address the challenges they face. Following are the top-ranked legislative priorities for 2012, along with specific recommendations on the issues.

I. SECURE THE STRATEGIC ROLE CONGRESS INTENDS FOR HOME CARE AND HOSPICE IN ADDRESSING THE NATION’S ACUTE, CHRONIC, AND LONG TERM CARE NEEDS.

A. ENSURE HOME CARE AND HOSPICE PARTICIPATION IN TRANSITIONS IN CARE, ACCOUNTABLE CARE ORGANIZATIONS, CHRONIC CARE MANAGEMENT, AND OTHER HEALTH CARE DELIVERY REFORMS. Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS’s implementation of the health care delivery reform provisions in the Patient Protection and Affordable Care Act (PPACA) to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

B. ALLOW NPs AND PAs TO SIGN HOME HEALTH PLANS OF CARE. Congress should enact legislation that would allow Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Physician Assistants to certify and make changes to home health plans of treatment.

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

D. ENACT A COMPREHENSIVE HOME AND COMMUNITY-BASED LONG TERM CARE PROGRAM FOR ALL AGE GROUPS. 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.

E. ENSURE THE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL TO MEET THE GROWING NEEDS OF THE BABY BOOM GENERATION. The first wave of the 78 million Baby Boomers generation began reaching the age of 65 in 2011. Some 10,000 Boomers will reach the age
of 65 every day for the next 19 years. This paradigm shift will have a profound effect on health care as increasing numbers of Boomers will need help in managing multiple chronic illnesses as they grow older. According to the Bureau of Labor Statistics 4 out of 5 of the most needed jobs are in the field of home care. These much needed professions include nurses; home care aides; personal care assistants; and physical, speech, and occupational therapists. The shortages that are already apparent in home care and hospice will increase dramatically over the coming years. Congress should address this need with initiatives which help train individuals to fill these jobs. These initiatives should include career ladders to allow individuals with education and experience to progress from aides to LPNs and RNs.

II. ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR AND ACCESS TO MEDICARE HOME HEALTH SERVICES.

A. DEFEAT THE “SICK TAX”—OPPOSE EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS MEDICARE HOME HEALTH SERVICES. Congress should oppose any copay or deductible proposal for Medicare home health services and should prohibit Medicare Advantage plans from charging a home health copay or deductible. The imposition of a home health copay or deductible would be a “sick tax” on some of the oldest, poorest, sickest Medicare beneficiaries, restricting access to home health services and leading to an increase in costly hospitalizations and nursing home stays.

B. BLOCK CMS REGULATORY “CASE MIX CREEP” CUTS AND REQUIRE A NEW PROCESS FOR CALCULATING CASE MIX ADJUSTMENTS. Congress should restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of the Benefits Improvement and Protection Act (BIPA) case-mix adjustment correction authority through public rulemaking. The procedural standards set out in the Home Health Care Access Protection Act should be enacted immediately and applied prospectively to any further coding weight adjustments.

C. ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES. Congress must closely monitor the implementation of the rate rebasing by CMS. Further, Congress should amend the legislation to require that the rate rebasing include all usual and customary business costs consistent with standards under the Internal Revenue Code, including telehealth services, all disciplines of caregivers, and usual business operating expenses along with needs for operating capital and operating margins.

D. REFORM MEDICARE HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT. Congress should: 1) monitor the impact of the face-to-face encounter requirements and devise more constructive ways to secure physician involvement in home health care; 2) revise the face-to-face requirements to eliminate or significantly modify the physician documentation requirements as set out in the Medicare rule to eliminate the need for a physician to spell out why the patient’s clinical condition requires Medicare covered home health services; 3) revise the PPACA section 6407 to move the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications. 4) Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit; 5) Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-
face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency; and 6) Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

E. ENSURE FULL MARKET BASKET UPDATES TO MEDICARE HOME HEALTH. Congress should reject any proposals to reduce the market basket inflation update or impose additional rate reductions for home health agencies. Congress should maintain its carefully crafted schedule of payment rate changes as contained in PPACA in order to secure access to continued care.

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

G. ENACT HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES. Congress should continue its work in combating waste, fraud, and abuse in our nation’s health care system. A comprehensive waste, fraud, and abuse package that includes home care and hospice program integrity provisions is needed. Any such legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with regulations. A program integrity plan should include strict standards on entry to participate as a provider of care, targeted requirements to maintain compliant participation, and the inclusion of providers as partners in oversight enforcement.

III. ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR AND ACCESS TO HOSPICE SERVICES.

A. REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS. Congress should approve provisions in S.722/H.R. 3506 that would ease some of the burdens associated with the face-to-face requirement for hospice patients. Additionally, Congress should revise the requirements for the hospice face-to-face requirement to allow for reimbursement of costs related to the face-to-face requirement. Congress should also allow use of telehealth technologies to assist hospices in meeting the face-to-face requirement. Congress should direct CMS to ensure that its data systems are available and contain adequate information for hospices to be able to determine with certainty whether a potential hospice patient will require a face-to-face encounter.

B. ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT. Congress should restore the market basket update, rescind productivity reductions authorized under P.L. 111-148, and reject any further proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by the Government Accountability Office 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.

C. OPPOSE EXPANSION OF COPAYMENTS FOR MEDICARE HOSPICE BENEFIT. Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit.

D. ENSURE ACCESS TO HOSPICE CARE FOR RURAL PATIENTS. Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas.
E. CLOSELY OVERSEE REVISION OF HOSPICE BENEFIT PAYMENT SYSTEM. Congress must carefully review MedPAC’s recommendations and closely oversee CMS’ activities related to hospice payment reform to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress should support efforts by Sen. Wyden and Rep. Reed to ensure that any revisions to hospice payment are tested in the “real world” to avoid unintended consequences. In the meantime, Congress should oppose any reductions in the annual hospice updates until all payment reforms are instituted and then only after all issues related to coverage and payment for hospice services are fully examined. Any system reforms must assure preservation of access to care, quality of care, and reasonably sufficient reimbursement rates to maintain a viable and stable delivery system.

IV. PROTECT AND EXPAND ACCESS TO HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID.

A. ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM CARE EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE. Congress should ensure that CMS properly implements the Medicaid home care expansion in PPACA and encourage broader coverage of home and community-based services under Medicaid. Congress should establish firm deadlines for Olmstead/ADA compliance with the penalty of lost federal financial matching payments for failure to meet the deadlines. Further, Congress should authorize an increase in the federal matching payment for expanded Olmstead/ADA-compliant home and community-based services, and 100 percent federal reimbursement for state Medicaid compliance costs in transitioning to improve home care alternatives. Congress should monitor carefully any shift of Medicaid beneficiaries into long term managed care and ensure that the patients’ rights to home care under the ADA and the Olmstead decision are fully secured. The rebalancing of long term care expenditures in favor of home care should be accomplished consistent with principles that: 1) establish Medicaid home care as a mandatory benefit in state Medicaid programs; 2) authorize care based on need; 3) assure quality of care through enforcement of comprehensive delivery standards; 4) provide the Medicaid client with a choice of care delivery models; and 5) ensure adequate reimbursement levels.

B. MANDATE HOSPICE COVERAGE UNDER MEDICAID. Congress should mandate Medicaid hospice coverage for all populations served.

C. ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE. 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: 1) assure access to care comparable to the non-Medicaid patient population; 2) ensure reimbursement sufficient for providers to conform with quality and safety standards; and 3) guarantee payments sufficiently adequate to incentivize providers of care to operate efficiently while meeting the cost of care provision.

D. INCREASE FEDERAL MEDICAID PAYMENTS TO STATES. Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision and supporting continuation of home care and hospice services.

V. PROTECT ACCESS TO HOME CARE AND HOSPICE SERVICES, INCLUDING FOR CARE PAID DIRECTLY BY INDIVIDUALS.
A. MODIFY EMPLOYER RESPONSIBILITIES IN HEALTH REFORM TO ADDRESS HOME CARE-SPECIFIC NEEDS. Congress should amend the legislation to exempt home care providers from the employer responsibilities, provide a subsidy to home care providers to supply health insurance, and/or provide a subsidy or tax credits to home care clients to cover the increased cost of care triggered by the employer responsibility provisions. Congress should help the states ensure that low wage home care workers have health insurance by enacting proposals such as those contained in the Caregiver Access to Health Insurance Act. Congress should amend the reform legislation to allow for a definition of full time employee that evaluates the individual’s working hours over a 180 day period. Finally, Congress should amend the health care reform legislation to require that all government health programs adjust provider rates to meet the additional costs that will be incurred by health care providers to make health insurance available to all their employees.

B. OPPOSE CHANGES TO THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT. A companionship services exemption under wage and hour laws should be maintained at the state and federal level until a comprehensive plan can be implemented that addresses service funding, worker health insurance, and career development. Congress should block any attempt by the Department of Labor to modify the existing and longstanding definition and application of the companionship services exemption, and support legislative efforts to maintain the current companionship services exemption.

C. REQUIRE COVERAGE OF HOME HEALTH CARE AND HOSPICE AS ESSENTIAL HEALTH INSURANCE BENEFITS. Congress should require that insurance companies provide a standardized benefit package that includes coverage for home health care and hospice. Any listing of “Essential Benefits” in insurance offered through health insurance exchanges under the Patient Protection and Affordable Care Act should include home health care and hospice.

C. PERFECT THE CLASS ACT, DON’T REPEAL IT (See Priority in Section I, Item D. above).
ENSURE HOME CARE AND HOSPICE PARTICIPATION IN TRANSITIONS IN CARE, ACCOUNTABLE CARE ORGANIZATIONS, CHRONIC CARE MANAGEMENT, AND OTHER HEALTH CARE DELIVERY REFORMS

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) includes significant health care delivery system reforms in addition to expansion of Medicaid eligibility, health insurance reforms, and Medicare payment changes. These health care delivery reforms have the potential to radically alter how and where patients receive care. Overall, these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations.

PPACA includes, among other health care reforms, new benefits, payment changes, pilot programs and demonstration projects such as Accountable Care Organizations, Transitions in Care penalties for re-hospitalizations, a Community Care Management benefit, and trials of integrated and bundled payment for post-acute care.

Home care and hospice services offer an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care and hospice bring decades of experience in managing chronically ill individuals with a community-based care approach, limiting the need for inpatient care and creating a comprehensive alternative to most institutional care.

If these health care delivery reforms are to fully succeed, the Centers for Medicare and Medicaid Services (CMS) must recognize the value of home care and hospice as part of the solution to out-of-control health care spending, particularly for patients with chronic illnesses. CMS should take all possible steps to ensure that any pilot programs or demonstration projects include home care and hospice as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

RECOMMENDATIONS: Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS’s implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

RATIONALE: Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and rehospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.
ALLOW NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES AND PHYSICIANS’ ASSISTANTS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

At the end of 2011, however, the Secretary of Health and Human Services (HHS) announced that the agency was unable to find a strategy to make the program financially viable and implementation of the CLASS Act was suspended. Since the announcement, efforts have been made in Congress to repeal the CLASS Act.

The health care reform legislation also includes enhanced federal Medicaid matching funds to encourage state Medicaid programs to increase diversion of Medicaid patients from costly institutional long term care to more cost-effective home and community-based care. It also extends to spouses of individuals receiving Medicaid home and community-based care the same protections against impoverishment that are currently provided to spouses of nursing home residents.

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. Congress should perfect the CLASS Act, not repeal it.

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

- Congress should clearly define Medicare and Medicaid responsibilities and coverage standards for chronic and long-term care conditions.
- Long-term and chronic care coverage must be coupled with clear and dedicated financing.
- Any new benefit must be distinguishable from the Medicare and Medicaid home health benefits.
to eliminate confusion regarding the programs’ respective responsibilities.

- Disabled and chronically ill Americans who are under 65 should be permitted to qualify for home- and community-based services on the same basis as the elderly.
- Home care agencies and hospices should be allowed to perform case management functions instead of using costly external case management procedures that duplicate standard caregiver activities.
- The distinction between acute care benefits and long-term care benefits should not be so rigid as to inhibit the smooth coordination of in-home services.
- Eligibility for benefits should not be based on income. It should be a social insurance program, not a means-tested welfare program. It should ensure that the spouses of those who need long-term care are not impoverished.
- A long-term care program should be a comprehensive federal insurance plan, not a block grant to the states that is adequately and realistically funded. Funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.
- All individuals who need assistance with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and all those with cognitive or mental impairments should be covered. Another factor to consider should be whether there are family caregivers in the home.
- The full range of home- and community-based services should be offered to all eligible individuals at a level appropriate to meet their needs. These services should include nursing care; home care aide services; medical social services; personal care services; chore services; physical, occupational, speech, and respiratory therapy and rehabilitative services; hospice services; 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.
- For paraprofessional service providers, the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the Home Care Aide Association of America have developed suitable standards for the training, testing, and supervision of paraprofessional workers. State certification of these workers should be required to ensure that all home care aides are appropriately trained, tested, and supervised; payment should be sufficient to allow for coverage of basic employee benefits and other support.
- Cash and counseling or voucher programs to purchase home care services should include standards to ensure quality of care; protect vulnerable patients from physical, emotional, or financial abuse or exploitation; guarantee adequate training and supervision of home care personnel; and ensure the provision of any required employee benefits. Such programs should ensure compliance with applicable state and federal labor, health and safety laws and regulations.

RATIONALE: Any long-term care plan adopted by the Congress should cause a paradigm shift toward much-needed federal coverage for care in the home and community setting rather than in institutions. Currently, 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.
ENSURE THE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL TO MEET THE GROWING NEEDS OF THE BABY BOOM GENERATION

ISSUE: The first wave of the 78 million Baby Boomers generation began reaching the age of 65 in 2011. Some 10,000 Boomers will reach the age of 65 every day for the next 19 years. This paradigm shift will have a profound effect on health care as increasing numbers of Boomers will need help in managing multiple chronic illnesses as they grow older. According to the Bureau of Labor Statistics 4 out of 5 of the most needed jobs are in the field of home care. These much needed professions include nurses; home care aides; personal care assistants; and physical, speech, and occupational therapists. The shortages that are already apparent in home care and hospice will increase dramatically over the coming years. 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 2009, the Office of Occupational Statistics and Employment Projections at the Bureau of Labor Statistics, within the U.S. Department of Labor, released employment projections for the American workforce for 2008-2018. The health care and social assistance sector is projected to grow substantially during this 10 year period. The projected job growth in the health care sector includes increases in the following occupations: home health aides, an increase of 50 percent; personal and home care aides, an increase of 46 percent; physical therapists aides, an increase of 36.3 percent; physical therapist assistants, an increase of 33.3 percent; occupational therapists aids, an increase of 30.7 percent; physical therapists, an increase of 30.3 percent; and occupational therapists assistants, an increase of 29.8 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.

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.
DEFEAT THE “SICK TAX”—OPPOSE EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS 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 (MA) plans have imposed home health copays. Copays are regressive, inefficient and fall most heavily on the poorest and oldest Medicare beneficiaries.

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

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

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

- Congress modernized the home health benefit by eliminating copays in 1972 and a home health care deductible in 1980 to encourage use of less costly, noninstitutional services. The Urban Institute’s Health Policy Center concluded that copays “…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays.” (“A Preliminary Examination of Key Differences in the Medicare Savings Bills,” 7/13/97.)
- A study published in the New England Journal of Medicine (“Increased Ambulatory Care Copayments and Hospitalizations among the Elderly,” January 2010) found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations. It concluded that raising cost sharing for ambulatory care among elderly patients may have adverse health consequences and increase total spending on health care. The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay.

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

- About 86 percent of home health users are age 65 or older – 70 percent age 75 or older. More than 60 percent of all users are women. Home health users are poorer on average than the Medicare population as a whole. About 43% of home health users have limitations in one or more activities of daily living, compared with 9% of beneficiaries in general. (AARP, “Home Health Copayment Would Have Negative Consequences for Medicare Beneficiaries,” 8/7/98.)
- The Commonwealth Fund cautioned lawmakers that cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs. (“One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” 9/01).
- Even if Medicaid recipients with low incomes were exempted from the home health copay, a large percentage of low income beneficiaries would be ineligible for protection from the home health copay because of the restrictive asset limitation, which has not been adjusted since 1989 and serves as a major barrier. (The Commonwealth Fund, “The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs,” October 2002.)
Home care patients and their families already contribute to the cost of their home care.

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

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

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

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

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

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

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

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

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

- Although 17 percent of Medicare beneficiaries purchase Medigap coverage and 34 percent have coverage from an employer sponsored plan, there is no assurance that these plans will cover a home health copay. (Kaiser Family Foundation, 2009) The law governing Medigap policies does not require that all models cover copays. Likewise, the 22 percent enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

Copayments would impose an unfunded mandate on the states.

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

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

• Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care.

• Nurses and home care aides might be placed in the position of having to collect copays, a task for which they are unsuited. They would have to carry large sums of money, increasing their exposure to robbery and muggings. Collecting copays in a person’s home is not like a hospital or physician’s office where clerical staff can handle billing and collection.
BLOCK CMS REGULATORY “CASE MIX CREEP” CUTS AND REQUIRE A NEW PROCESS FOR CALCULATING CASE MIX ADJUSTMENTS

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

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

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

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

RECOMMENDATION: Congress should restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of the BIPA case-mix adjustment correction authority through public rulemaking. The procedural standards set out in S. 3315 should be enacted immediately and applied prospectively to any further coding weight adjustments.

RATIONALE: An intended consequence from the transition of cost reimbursement to prospective payment is stability and reasonable certainty regarding Medicare home health service payment rates. With cost reimbursement principles allowing for retroactive payment adjustments, home health agencies suffered through an environment of financial instability. PPS should operate with at least a modicum of stability of payment rates and CMS should not be allowed to arbitrarily adjust payment rates through the application of vague and ambiguous standards.
ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES

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

The 2011 congressional recommendations from the Medicare Payment Advisory Commission (MedPAC) advises Congress to begin rebasing in 2012 and complete it in 2013. In a public meeting, a commission staff member suggested rates should be based on average costs although previous MedPAC commissioners (and staff) specifically indicated that cost is just one consideration.

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

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

ISSUE: Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) establishes as a condition of payment for home health services coverage under Medicare that a patient have a face-to-face encounter with the physician who certifies the need for home health services. The encounter also can be provided by certain non-physician practitioners, such as physician assistants and nurse practitioners. However, when a non-physician practitioner provides the encounter, the patient’s physician must still certify that the encounter occurred and compose documentation detailing the finding from the encounter in addition to any documentation produced by the non-physician practitioner. Also, while section 6407 allows the encounter to occur through the use of telehealth, the law extremely limits that option by referencing Medicare telehealth coverage requirements that rule out services in a patient’s home.

While the intention behind section 6407 was to gain greater physician involvement in ordering home health services, early indications are that physicians are hostile to the new requirement, particularly the documentation standards that Medicare included in the implementing rule. Those documentation requirements are not contained within the law passed by Congress. Under the rule, a physician is required to document clinical findings with respect to the patient’s need for home health services and explain how those clinical findings support Medicare coverage for prescribed care.

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

The implementation of the face-to-face encounter rule has led to great confusion among physicians, home health agencies, and other parties involved. Medicare has tried to mitigate the confusion through various communications, but the requirements remain difficult to understand and apply. As a result, the rule is creating a barrier to access to care with practitioners determining that it is easier to care for patients in alternative settings to home health care.

RECOMMENDATION:

• Congress should monitor the impact of the face-to-face encounter requirements and, if necessary, repeal the provision and devise more constructive ways to secure physician involvement in home health care.
• Revise the face-to-face requirements to eliminate or significantly modify the physician documentation requirements as set out in the Medicare rule to eliminate the need for a physician to spell out why the patient’s clinical condition requires Medicare covered home health services.
• Revise PPACA section 6407 to remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications.
• Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.
• Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency.
• Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

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

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

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

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

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

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


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

In March 2010, MedPAC again recommended elimination of the home health market basket update for 2011, as well as rebasing of rates to “reflect the average cost of providing care.” Additionally, MedPAC suggested that Congress direct the Secretary of Health and Human Services (the Secretary) to modify the home health payment system (through possible use of risk corridors and blended payments) to protect beneficiaries from “stinging or lower quality of care” in response to rebasing. MedPAC also recommended that Congress identify categories of patients likely to receive greatest clinical benefit from home health and develop quality outcome measures for each category of patient. Finally, MedPAC recommended that Congress direct the Secretary to review agencies that exhibit unusual patterns or claims for payment and provide authority to the Secretary to implement safeguards (including a moratorium, preauthorization requirements or suspension of prompt payment requirements) to address high risk areas.

MedPAC’s recommendations are predicated on findings of “excessive” Medicare profit margins for freestanding agencies. More comprehensive study of agency margins performed by the National Association for Home Care & Hospice has found significantly lower Medicare profit margins that virtually disappear when all payers are taken into account. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges.
In recent years, MedPAC has also expressed interest in imposition of a “productivity adjustment” which would reduce payments to Medicare providers to reflect gains in productivity.

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

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

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

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

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

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

Crude measures such as across-the-board reductions or freezes will only exacerbate inequities in the system, and contribute further to access concerns. Access to care continues to be a serious problem in home health, and it is anticipated that these concerns will only increase with further cuts to home health payments. Home health care is efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.
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. Those plans that have adopted the traditional Medicare episodic reimbursement model have done so only through intense negotiations with network providers. Private fee-for-service plans are an exception, with many using the episodic reimbursement method used in the traditional Medicare home health program because of the deeming of such approach as compliant with federal requirements under MA. For enrollees of plans that do not provide an episodic home health benefit, the result is restricted access to home health services and, more importantly, barriers to clinical stability and rehabilitation.

RECOMMENDATION: Congress should specifically mandate that all Medicare Advantage plans provide an episodic, care management home health services benefit and prohibit continuation of the antiquated home health benefit currently provided by most Medicare Advantage plans.

RATIONALE: Medicare Advantage plans are required to provide, at a minimum, benefits equivalent to those available to enrollees under the original Medicare plan. Significant clinical gains have been afforded to Medicare beneficiaries receiving home health services under original Medicare that do not occur in Medicare Advantage plans because of the continued focus on a per-visit benefit structure.
ENACT HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

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

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures supported by NAHC that are home care and hospice specific. However, the home care and hospice communities believe that more can be done.

RECOMMENDATION: Congress should continue its work in combating waste, fraud, and abuse in our nation’s health care system by passing additional measures that include:

• The institution of corporate compliance plans by all home health agencies and hospices to ensure adherence to all federal and state laws with proper funding support.
• Strengthen admission standards for new home health agencies, including standards for capitalization, claims review, and experience.
• Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency or hospice as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
• Strengthening of program participation standards to include experience credentialing and competency testing of home health agency or hospice personnel responsible for maintaining compliance with Medicare standards; such as the Certified Home Care Executive (CHCE), credentialing available through the National Association for Home Care & Hospice (NAHC).
• The investment of sufficient government and industry resources to expedite refinements to the Medicare payment systems so that providers are appropriately reimbursed for the costs of providing services.
• Providing consumers and prospective consumers of Medicare home health services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
• Implementation and development of credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicare and Medicaid.
• Supplying adequate administrative financing to Medicare/Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
• Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
• Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services or hospice care.
• Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.
• The establishment of a Joint Program Integrity Advisory Council.
• Development and authorization of an industry-directed enforcement entity working in conjunction with federal and state authorities.
Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

**RATIONALE:** It is particularly important to ensure that limited health care dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers. A comprehensive fraud and abuse package that includes home health and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed. Moreover, any anti-fraud legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General often characterizes as fraud technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets Medicare reimbursement requirements related to medical necessity. In such cases, provider education may be a more appropriate response than more punitive measures.
REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS

ISSUE: Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient’s 180th-day recertification, and prior to each subsequent recertification. The provision applies to recertifications on and after January 1, 2011.

In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010) states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient’s third or subsequent benefit period. The regulation requires that the hospice physician or NP attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the patient’s terminal prognosis of six months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification.

A number of concerns have arisen relative to the hospice face-to-face requirement:

- Hospices must complete the face-to-face encounter PRIOR TO the beginning of the applicable benefit period. As the result, a patient’s care may be delayed while the hospice identifies an available physician or NP and completes the encounter requirement.
- If a patient is on continuing hospice care but the hospice is not able, due to staffing limitations or other complications, to conduct the face-to-face prior to the benefit period for which the encounter is required, the hospice will not be paid for services provided until the face-to-face has been completed.
- The face-to-face requirement is applicable to a patient’s full time on hospice regardless of when previous hospice service was provided. A patient may have been off hospice service for a lengthy period of time, after which he or she begins rapid deterioration and need immediate admission. In such cases the face-to-face requirement may delay admission.
- CMS data systems are not all available 24 hours, seven days a week to access patient information and most do not have full information related to a patient’s history on hospice care to establish with absolute certainty whether a face-to-face encounter is required.
- Hospices will not be reimbursed for costs related to the face-to-face requirements, which may be prohibitive -- particularly for small hospices in rural areas.
- Hospices may not utilize telehealth services to meet the face-to-face requirement.

On Dec. 23, 2010, CMS announced a three-month delay in enforcement of the face-to-face requirements to allow time for hospices to establish operational protocols necessary to comply with the new law. In early 2011, CMS modified requirements so that under well-documented “exceptional circumstances” (for example, a hospice is unable to schedule a timely face-to-face prior to beginning needed services for a newly readmitted hospice patient or a hospice is not aware that a patient requires a face-to-face encounter because CMS’ data systems do not contain adequate information) hospices are given an additional two days within which to complete the face-to-face.

In 2011, Sen. Ron Wyden (D-OR) and Rep. Tom Reed (R-NY) introduced S. 722/H.R. 3506, the Hospice Evaluation and Legitimate Payment (HELP) Act. The legislation would permit hospices to utilize physician assistants and other clinicians for completion of the face-to-face encounter. Additionally, under CMS’ “special circumstances”, the legislation would give hospices seven days from the beginning of the benefit period within which to complete the encounter.
**RECOMMENDATION:** Congress should approve provisions in S.722/H.R. 3506 that would ease some of the burdens associated with the face-to-face requirement for hospice patients. Additionally, Congress should revise the requirements for the hospice face-to-face requirement to allow for reimbursement of costs related to the face-to-face requirement. Congress should also allow use of telehealth technologies to assist hospices in meeting the face-to-face requirement. Congress should direct CMS to ensure that its data systems are available and contain adequate information for hospices to be able to determine with certainty whether a potential hospice patient will require a face-to-face encounter.

**RATIONALE:** The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.
ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

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

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

RATIONALE:
• Beginning in FY2010, the Centers for Medicare and Medicaid Services (CMS) began phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. In each year the phase out reduces scheduled annual increases by 0.6 percent. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent.
• MedPAC has projected that Medicare hospice financial margins for 2012 (without consideration of costs related to volunteer and bereavement services) will average about 5 percent; however, financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is some concern that MedPAC’s estimates may not take into full account costs associated with the face-to-face encounter requirements that went into effect Jan. 1, 2011.
• A study by Duke University showed that patients who died under the care of hospice cost the Medicare program an average of about $2,300 less compared with those who did not. In its June 2004 report on the Medicare hospice benefit, the GAO determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursements. A cut in the market basket update would impair the ability of hospices to maintain Medicare beneficiary access to care.
• The GAO recommended that CMS should collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. It did not recommend an across-the-board cut in hospice payments. CMS is in the process of collecting such data for analysis.
• At its November 2008 and subsequent meetings, MedPAC discussed potential recommended revisions to the Medicare hospice benefit reimbursement system. There is concern about the costs of short stay patients not being fully covered under the current reimbursement system. Financial margins for hospices with shorter stay patients are generally significantly lower than those of...
hospices serving long-stay patients. Paying accurately for all types of patients is important to ensure access to services for all Medicare beneficiaries who want to elect hospice care and to ensure that the program is paying rates that cover providers’ costs for all types of patients.
OPPOSE EXPANSION OF COPAYMENTS FOR MEDICARE HOSPICE SERVICES

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

In recent discussion, some members of the Medicare Payment Advisory Commission (MedPAC) have suggested that it may be advisable to consider imposition of some type of copayment for Medicare hospice services. Additionally, as part of policy discussions on reform of Medicare, some have advocated consolidation of Parts A and B and imposition of uniform beneficiary copayments and deductibles on all Medicare services.

RECOMMENDATION: Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit.

RATIONALE: Historically copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many “curative” interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days, and 95 percent of hospice care is provided in the home. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.
ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS

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

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

RATIONALE: Hospices in rural areas have difficulty recruiting and retaining adequate staff to meet the full panoply of services required under the Medicare hospice benefit, as well as the increasing number of regulatory requirements (such as the face-to-face encounter requirement). Additionally, hospice caregivers must drive greater distances to patients’ residences than in urban areas. There is no consideration of consistently more expensive fuel costs in hospice reimbursement rates. The hospice wage index is updated annually using the most currently available hospital wage data as well as any changes by the Office of Management and Budget in the core-based statistical areas followed by the budget neutrality adjustment. In most states, the rural wage index is lower, resulting in comparatively lower reimbursement rates.
CLOSELY OVERSEE REVISION OF HOSPICE BENEFIT PAYMENT SYSTEM

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

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

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

The Centers for Medicare & Medicaid Services (CMS) began collecting numbers of visits and costs per visit for some of the services that hospices provide in July 2008. Data collection was expanded in January 2010. Collection and in-depth analysis of these and other data are essential to establishing an appropriate method for reforming payments for Medicare hospice services.

The final 2010 health care reform legislation (Public Law 111-148) requires the development of payment system reforms along the lines of the MedPAC recommendations (Section 3132(a)). Payment system reforms are authorized by P.L. 111-148 to be put in place no earlier than October 1, 2013.

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

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

RECOMMENDATION: Congress must carefully review MedPAC’s recommendations and closely oversee CMS’ activities related to hospice payment reform to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress should support efforts by Sen. Wyden and Rep. Reed to ensure that any revisions to hospice payment are tested in the “real world” to avoid unintended consequences.
In the meantime, Congress should oppose any reductions in the annual hospice updates until all payment reforms are instituted and then only after all issues related to coverage and payment for hospice services are fully examined. Any system reforms must assure preservation of access to care, quality of care, and reasonably sufficient reimbursement rates to maintain a viable and stable delivery system.

**RATIONALE:** Regardless of the level of care taken when developing a new payment system, unintended consequences that have a dramatic impact on the population served may result. These consequences frequently only come to light when the system is actually tested on operating care providers. For this reason, most payment reforms under Medicare have undergone a “demonstration” phase. S. 722/H.R. 3506 would incorporate a “demonstration phase” into the hospice payment reform process to ensure that the new payment system will not have a negative impact on the delivery of high quality care in the hospice program. Congress must ensure this most humane service for America’s terminally ill patients and their families remains a benefit available at the hour of greatest need – the final stage of life.
ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND 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, both the Bush and Obama administrations have voiced support for increased federal payments to assist states in transitioning Medicaid nursing facility patients into home care services. In some states, Medicaid has moved with reasonable and deliberate speed. In others, action seems nonexistent. One problem is the limits on valuable federal support for the administrative actions needed. Another problem is the pressure from institutional care providers to slow any progress towards home care alternatives.

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

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

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

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

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

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

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

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

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

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

ISSUE: In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an optional benefit under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient’s life as comfortable and meaningful as possible. As of 2011, 48 states had chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states experience growing budget concerns, many are taking steps to eliminate coverage of hospice under their Medicaid programs or limit the number of days covered, which would leave some of the country’s most vulnerable of individuals without appropriate care at the end of life. South Carolina is one of the states that has, unfortunately, already announced its intent to eliminate the hospice benefit from its Medicaid program.

The 2010 health care reform measure greatly expanded the populations eligible for Medicaid. Additionally, as the result of a provision in the final health reform legislation, which became Public Law 111-148, states must now cover hospice and curative services concurrently for those children eligible for Medicaid or Medicaid-expansion Children’s Health Insurance Program (CHIP) programs. However, hospice remains an optional benefit for adults.

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

RATIONALE: States expanded their Medicaid programs to cover hospice care in an effort to provide a more cost-effective and compassionate manner of caring for terminally-ill adults and children, including indigent and disabled individuals. Mandating hospice under Medicaid would speed access to hospice services. Hospice, with its combination of inpatient and outpatient care and case management by an interdisciplinary team composed of doctors, nurses, social workers and counselors, can provide high quality, comprehensive end-of-life care for the terminally ill patient while saving taxpayer funds. But with the current financial strains on Medicaid programs, even some states that currently offer hospice are considering dropping their Medicaid hospice benefit.
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. In addition, the Patient Protection and Affordable Care Act of 2010 (PPACA) expands Medicaid funding for home care services by nearly $13 billion through 2019. Data already 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. In 2011, the Centers for Medicare and Medicaid Services proposed a new federal regulation that would establish rate setting standards. The proposed standards are not perfect, but go a long way to setting out a sensible framework that state must follow in rate setting. Further, with the initiation of the Medicaid Access and Payment Advisory Council (MACPAC) it is expected that Congress will be better advised on the shortcomings of existing Medicaid payment rates throughout the states.

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

ISSUE: The National Governors Association reports that the states are suffering severe shortfalls in their budgets and have begun, or are planning, to cutback their Medicaid programs. This will likely result in cuts in home and community based care and impede efforts to implement the Olmstead decision, which requires states to offer home care as an alternative to institutionalization.

As part of his FY 2004 budget, President Bush proposed sweeping financing and programmatic changes for Medicaid. Under the proposal, states would have two options: they could continue to run Medicaid under existing rules and receive the normal federal Medicaid matching payments, or they could opt to turn their Medicaid program into a block grant with broad flexibility to change program rules. The capped federal payments would be front-loaded over the 10-year life of the block grant to provide states some additional funds in the first few years, but these funds would be offset through reductions in federal payments to states in the later years. The National Governors Association did not endorse the proposal.

In 2003 Congress rejected President Bush’s approach and instead provided a $10 billion increase in Medicaid payments to the states for the period April 1, 2003 – June 30, 2004. Each state received a 2.95 percentage point increase in its federal Medicaid matching rate for this period. An additional $10 billion was allocated to state governments for health care and other social services.

Instead of proposing a cap on federal Medicaid spending, in 2006 the President proposed to cut Medicaid spending by $25 billion over five years through certain “reforms,” including restricting the ability of states to enhance federal matching payments and tightening restrictions on individuals transferring away assets to qualify for Medicaid.

In 2008 Medicaid advocates and governors campaigned for a temporary increase in the Federal Medicaid matching rate as part of a stimulus package to revive the economy. Congress took up a stimulus package early in 2009 that included a substantial increase in the Federal contribution to Medicaid over two years. Congress has extended the enhanced FMAP several times. However, with the expiration of the enhancement in 2011, Medicaid programs across the country are in financial jeopardy. The resulting actions include elimination or restrictions of home care programs, restricted eligibility criteria for home care programs, payment rate reductions, and a shift of fee-for-service program models to managed care where experiences indicate that home care will be difficult to secure for Medicaid patients. Congress should support further federal matching payment assistance to the states as the country’s economic difficulties have taken a great toll on state Medicaid budgets.

RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision and supporting continuation of home care and hospice services.

RATIONALE: Many states have begun efforts to expand home and community-based alternatives to institutionalization in their Medicaid programs. The federal government, through such programs as the New Freedom Initiative, has sought to facilitate this development. Medicaid is one of the biggest items in state budgets, so it will certainly be a focus of state efforts to save money. States are required to balance their budgets, so federal assistance is essential to preserve and expand home and community-based care within the Medicaid program.
MODIFY EMPLOYER RESPONSIBILITIES IN HEALTH CARE REFORM TO ADDRESS HOME CARE SPECIFIC NEEDS

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

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

The Paraprofessional Healthcare Institute (January 2006) found that 40 percent of home care workers lack health insurance coverage (compared to the Bureau of Labor Statistics estimate of 16 percent for all workers). The estimate for home care workers does not include privately paid workers and those who work part time, so the overall percentage of home care workers without health insurance is likely well over 50 percent. To address this during the 107th Congress, Senator Richard Durbin (D-IL) developed the Caregiver Access to Health Insurance Act. This legislative proposal would make $4 billion annually available to states to provide health insurance for low wage caregivers through any of the following four methods: 1) Medicaid expansion; 2) enrollment in the state and local employees’ health insurance program; 3) Federal Employees Health Benefits Plan for non-federal employees; or 4) subsidies through private health insurance. The proposal has not been formally introduced as legislation.

RECOMMENDATION: Congress should amend the legislation to exempt home care providers from the employer responsibilities, provide a subsidy to home care providers to supply health insurance, and/or provide a subsidy or tax credits to home care clients to cover the increased cost of care triggered by the employer responsibility provisions. Congress should help the states ensure that low wage home care workers have health insurance by enacting proposals such as those contained in the Caregiver Access to Health Insurance Act. Congress should amend the reform legislation to allow for a definition of full time employee that evaluates the individual’s working hours over a 180 day period. Finally, Congress should amend the health care reform legislation to require that all government health programs adjust provider rates to meet the additional costs that will be incurred by health care providers to make health insurance available to all their employees.

RATIONALE: Home care employers do not have the ability to control service pricing like most other employers that are affected by the employer responsibility provisions in the health care reform legislation.
It is counter to the philosophy of health care reform that consumers of private pay home care services would need to pay higher rates for care. Further, most have limited incomes that might force them to choose Medicaid-funded nursing home care if home services are beyond their reach. In addition, Medicaid programs historically do not increase provider payment rates sufficiently to cover the increases in provider costs. Finally, the work hour flexibility is one of its attractions to employees. The application of employer responsibilities should accommodate the varied work schedules of home care workers in a way that does not disadvantage the employers.
OPPOSE CHANGES TO THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT

ISSUE: In 1974, Congress established an exemption for companionship services from the Minimum Wage and Overtime Requirements of the Fair Labor Standards Act. Congress made a societal choice in balancing the interests of the worker relative to the needs for care to the elderly and the infirm. Current law provides the Secretary of the U.S. Department of Labor (DOL) the authority to define and determine the scope of the companionship exemption.

In June 2007, the US Supreme Court ruled that the DOL companionship services exemption regulation was valid thereby reversing the Court of Appeals in a final decision.

Since the Supreme Court ruling, there has been a re-focusing of efforts by some opposed to the DOL rule. Currently, they are attempting to get Congress to change the law while also seeking legislative and/or regulatory remedies at the state level. Legislative efforts in the 110th, 111th and 112th Congresses intended to eliminate the current companionship services exemption for home care aide workers are opposed by the National Association for Home Care & Hospice (NAHC) because they do not go far enough to protect workers.

Some states already have passed laws that eliminated the companionship services exemption. In others, there are efforts to interpret the regulations in a manner different than the federal rules.

Advocates for changing the exemption have expanded their efforts with the Obama administration to encourage DOL to change the regulation. These efforts include enlisting the aid of 15 Senators to send a letter to the Secretary of Labor requesting that the exemption be modified through regulation to exclude home care aides employed by agencies or family of the client. DOL issued a proposed rule on December 27, 2011 that would significantly restrict the exemption and make it inapplicable to workers employed by home care companies.

In the absence of a mandate that government payment programs increase payment rates to cover the added cost of wages that would result from these efforts, home care aide employers are expected to restrict working hours to avoid overtime pay. Further, these efforts do nothing to create career opportunities for home care aides or to address their need for health insurance. This isolated action related to a single element of the home care aide working conditions will have a reverse negative impact on those workers. Legislation has been introduced in the 112th Congress that is intended to codify the current definition of companionship services. NAHC is supportive of the “Companionship Exemption Protection Act” (H.R.3066) because it creates certainty for home care providers and patients rather than leaving the definition open to changes through the regulatory process.

RECOMMENDATION: A companionship services exemption under wage and hour laws should be maintained at the state and federal level until a comprehensive plan can be implemented that addresses service funding, worker health insurance, and career development. Congress should block any attempt by the Department of Labor to modify the existing and longstanding definition and application of the companionship services exemption, and support legislative efforts which maintains the current companionship services exemption.

RATIONALE: Most home care providers are small business with limited resources. The companionship exemption result would be to reduce the availability of care to the elderly and the infirm and to increase the costs of service delivery with no corresponding increase from third party payers, such as Medicaid.
A comprehensive rather than a piecemeal approach to worker compensation and working conditions is necessary if access to high quality of care and continuity of services is to be achieved.
REQUIRED COVERAGE OF HOME HEALTH CARE AND HOSPICE AS ESSENTIAL HEALTH INSURANCE BENEFITS

ISSUE: Among the many different proposals to improve the U.S. health care system, one common set of recommendations has dealt with reforms to the private health insurance market. These have generally addressed questions of preexisting conditions, portability, setting premium rates and increases, guaranteed issue and renewability, and standardized benefit packages.

The Patient Protection and Affordable Care Act (PPACA)(H.R. 3590; Public Law No. 111-148), prohibits premium variations based on one’s health status or sex (community rating) and places limits on variations based on age. However, the legislation leaves it up to the Department of Health and Human Services (HHS) to determine if home health care and hospice are covered in standardized benefit packages. HHS has announced in a bulletin its intention to issue a regulation giving wide discretion to the states to make the final determination of what are “essential benefits” in the standardized benefit packages offered in state health insurance exchanges.

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

RATIONALE: All Americans should have access to home care and hospice coverage in their health insurance. According to a recent national study, home health is a benefit in 77 percent of health plans and hospice in 66 percent. Home health has proven to be effective in reducing health care expenditures by reducing hospitalizations, shortening hospital stays, and serving as an alternative to costly post-acute inpatients stays. In addition, cost savings are realized at the end of life through the delivery of hospice services. Failure to include home health and hospice coverage will result in increased costs and fewer options to enrollees. Furthermore, failure to include home health and hospice benefits is inconsistent with the Administration’s focus on home and community based services and could be in violation of the American with Disabilities Act (ADA).
Notes: