

**LEGISLATIVE PRIORITIES 2009**  
**A Summary**  
**National Association for Home Care & Hospice**

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 2009, along with specific recommendations on the issues, as voted on by the membership of the National Association for Home Care & Hospice, and affirmed by its Board of Directors in January 2009:

**SECURE A STRATEGIC ROLE FOR HOME CARE IN ADDRESSING THE NATION'S CHRONIC CARE NEEDS**

**ESTABLISH A CHRONIC CARE MANAGEMENT BENEFIT UNDER MEDICARE.** Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients. The service should be provided by professional nurses and others within home health agencies to ensure a discipline-integrated, community care-based approach to care management. The patient care should be under the guidance and supervision of the patient's attending physician, who should be included as a member of the care team. The services should include:

1. an interdisciplinary team approach to care management that includes physicians, nurses, therapists, medical social workers, and pharmacists
2. evidenced-based care plan development
3. direct patient care services in the home setting
4. the application of telehealth services for appropriate remote monitoring as needed by the individual patient
5. care counseling, care coordination, medication management, and oversight of services related to activities of daily living.
6. the use of interoperable electronic health care records and efficient electronic-based communication tools
7. patient education and support
8. integration and support of informal caregivers such as family members

The Chronic Care Management program should be initially implemented on a pilot basis with authority provided to Medicare to extend the services beyond the pilot at Medicare's discretion.

Reimbursement for the services should be on a shared risk basis wherein partial payment is made to the provider for certain direct care services with additional payment based on performance that demonstrates Medicare savings through such cost reductions as avoidance/prevention of re-hospitalizations, emergent care, and acute exacerbations of a chronic illness.

## **ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR AND ACCESS TO HOME HEALTH SERVICES**

**ENSURE THE FULL MARKET BASKET UPDATE FOR HOME HEALTH PAYMENTS, AND RESTORE AND PERMANENTLY EXTEND THE RURAL ADD-ON:** Congress should reject any proposals to reduce the market basket inflation update for home health agencies and restore and permanently extend the payment differential (“add-on”) for care delivered in rural areas. Congress must also closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. If the system’s payments are found to be insufficient, Congress should increase the home health base payment. Further, Congress should direct the Centers for Medicare & Medicaid Services (CMS) to develop a more adequate system of “outlier” payments under PPS so that high-cost patients will have continued access to services. Finally, Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, and medical shortage areas) can continue to provide care to Medicare beneficiaries.

**ESTABLISH PROCESSES FOR MODIFICATION OF PPS PAYMENT RATES AND 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 of 2000 (BIPA) case-mix adjustment correction authority through public rulemaking.

**ESTABLISH STABILITY AND EQUITY AMONG MEDICARE HEALTH CARE PROVIDERS IN APPLICATION OF THE WAGE INDEX:** Congress should authorize Medicare to implement and apply a wage index model in line with the system recommended by the Medicare Payment Advisory Commission (MedPAC). Otherwise, Congress should allow hospices and home health agencies to obtain a geographic reclassification for wage index purposes in a manner comparable to that available to the hospitals or to allow reclassifications automatically when a hospital in the geographic locale of the hospice or home health agency receives a reclassification. Additionally, Congress should enact legislation that limits an agency’s loss of income due to a dramatic shift in the agency’s wage index (for example, limit the drop in any agency’s wage index from one year to the next to 2 percent). Finally, Congress should extend to all providers protections that ensure that no entity’s wage index falls below the rural wage index value in that state.

**ALLOW NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES AND PHYSICIANS’ ASSISTANTS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE:** Congress should enact legislation that would instruct CMS to allow PAs, NPs and select other professionals to certify and make changes to home health plans of care, as permitted under state law.

**RECOGNIZE HOME TELEHEALTH INTERACTIONS AS BONA FIDE MEDICARE SERVICES:** Congress should clarify legislatively that telehomecare “constitutes a service(s) ... provided on a visiting basis in a place of residence used as an individual’s home” as defined in §1861m of the Social Security Act, and Medicare should provide appropriate reimbursement for technology costs to HHAs. Congress should also approve demonstration projects that would allow for new ways to use technology to monitor patients and avoid more costly health care interventions. Finally, Congress should ensure that all health care providers, including HHAs, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

### **ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR HOSPICE SERVICES**

**PRESERVE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT:** Congress should reject any proposals to cut the hospice market basket update.

**ENSURE ACCESS TO CARE FOR RURAL PATIENTS:** Congress should enact a payment differential (“add-on) for services provided by hospices to patients in rural areas.

**PRESERVE THE BUDGET NEUTRALITY ADJUSTMENT FACTOR IN THE HOSPICE WAGE INDEX:** Congress should direct CMS to preserve the budget neutrality adjustment factor for the Medicare Hospice Benefit wage index annual update.

### **PROTECT AND EXPAND ACCESS TO HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID**

**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 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.

**SUPPORT REBALANCING OF LONG TERM CARE EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE:** Congress should establish firm deadlines for Olmstead/ADA compliance with the penalty of lost federal financial matching payments for failure to meet the deadlines. Further, Congress should authorize an increase in the federal matching payment for expanded Olmstead/ADA-

compliant home and community-based services, and 100 percent federal reimbursement for state Medicaid compliance costs in transitioning to improve home care alternatives. The rebalancing of long term care expenditures in favor of home care should be accomplished consistent with principles that: 1.) authorize care based on need; 2.) assure quality of care through enforcement of comprehensive delivery standards; 3.) provide the Medicaid client with a choice of care delivery models; and 4.) ensure adequate reimbursement levels.

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

## **PROTECT PATIENT AND PROVIDER RIGHTS UNDER MEDICARE ADVANTAGE**

**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.

**PROVIDE ACCESS TO MEDICARE ADVANTAGE ENROLLMENT INFORMATION/ESTABLISH A PROVIDER “HOLD HARMLESS”:** To resolve this issue, Congress should 1.) Require MA plans to determine any health services enrollees receive from other providers and furnish those providers with immediate notification of the MA enrollment, 2.) “hold harmless” providers who in good faith provide needed care to MA enrollees before this notification is received through direct Medicare payment and concomitant reductions in MA payments, and 3.) require CMS to upgrade the timeliness of information contained in the CWF and to make this information available on a nationwide basis.

**LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER TRADITIONAL MEDICARE:** Congress should limit reimbursement to private plans for Medicare to a level consistent with the costs borne by the program for comparable traditional fee-for-service beneficiaries. Congress should also require stronger oversight of plans’ estimates of costs to ensure that Medicare is not inadvertently overpaying plans.