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TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

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The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Ways and Means Subcommittee on Health reviews proposals to change cost-sharing for services received under the Medicare program, NAHC appreciates this opportunity to provide our views. Some proposals have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s created an incentive for Medicare beneficiaries to receive costly institutional care by deterring them from accessing more cost-effective home health care services. Reinstating the home health copay today would undo the progress made in reducing unnecessary hospitalizations and nursing home stays.

Moreover, home health services and hospice care already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups

contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay would discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. With hospice patients, barriers to comfort at the end of life add both avoidable costs and avoidable pain.

We respectfully submit that Congress should oppose any copay proposal for Medicare home health and hospice services.

HOME HEALTH CARE

Proposals to impose a home health copay should be rejected for the following reasons:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health 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."[i] Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.[ii] A home health copay would cause the same adverse health consequences and increased use of more costly acute care and hospitalizations. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."[iii] Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher overall Medicaid costs.[iv] The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.[v] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[vi] A recent Economic Policy Institute analysis concluded that the imposition of increased cost sharing would have a "penny-wise, pound-foolish result."[vii]

- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.[viii] Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.[ix] The Commonwealth Fund cautioned 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."[x]

- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below $22,000, just under 200 percent of the federal poverty level.[xi] Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.[xii]

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[xiii]

- **Individuals receiving home care and their families already contribute to the cost of their home care.** 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 individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $450 billion a year in unpaid care to their loved ones,[xiv] and too frequently having to cut their work hours or quit their jobs. If beneficiaries cannot access home health services and are forced into institutional settings, Medicare will bear the costs of these services that are currently funded by patients and their families.

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not "order" home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary and that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization of home health care. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.[xv]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (MedPAC)) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are already struggling to pay for their Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay, and only 17

percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.[xvi] Likewise, the 25 percent of beneficiaries 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 costly administrative burdens and 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 built into the base payment for home health care. Home health agencies cannot absorb these costs, as nearly 50 percent of home health agencies are projected to be paid less than their costs in 2014 by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.[xvii]

HOSPICE

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.

Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit. The average Medicare hospice beneficiary receives care at a cost of approximately $11,500. With the cost sharing changes that have been proposed, a 20 percent copay would impose a charge of approximately $2,300 on terminally ill individuals in the last days of their lives. Given the requirement that a patient be determined to be terminally ill with a plan of care developed by an interdisciplinary team, there is no need for an additional check on utilization of care. Implementing a Medicare copayment for these services would cause many terminally ill patients to second guess their physician and care team in the last days of their life.

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.[xviii]

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. Congress has already addressed concerns relative to extended length of stays in hospice care by requiring a face-to-face encounter prior to the start of the third and later benefit periods. Through that change, ineligible individuals are screened out and improper Medicare payments are avoided. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate, desirable, and cost effective 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.

PROPOSALS TO ADDRESS CONCERNS ABOUT PROGRAM INTEGRITY

Rather than applying a copay to address concerns that have been raised about possible overutilization and wasteful spending on home health services in certain parts of the country, NAHC suggests targeted approaches that do not restrict access to care and penalize Medicare beneficiaries and ethical home health providers. It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by $1 billion in in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

In that spirit, we offer ten recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse as well as harm caused by ignorance, lack of competence, or confusion.

1) **Implement a targeted, temporary moratorium on new home health agencies.** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

2) **Require credentialing of home health agency executives.** Congress should strengthen Medicare program participation standards to include experience, credentialing, and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

3) **Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care.** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increases. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

4) **Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan.** Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.

5) **Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors.** CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a "probationary enrollment" for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

6) **Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries.** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council appointed by the Secretary of HHS

with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose would be to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance oversight system improvements that should be developed and implemented by home health agencies.

7) **Require criminal background checks on home health agency owners, significant financial investors, and management.** A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

8) **Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight.** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. **C**ongress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

9) **Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards.** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following

steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

10) **Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention**. While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

In relationship to hospice care, NAHC's affiliated Hospice Association of America (HAA) has developed a similar list of program integrity recommendations that we would be happy to supply to the Committee.

MEDICARE INNOVATIONS TO PROMOTE HIGH QUALITY CARE AT LOWER COST

NAHC suggests the following reforms in the Medicare benefit structure that would incentivize high quality care while saving Medicare dollars:

1) **Ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, 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.

2) **Allow nurse practitioners and physician assistants to sign home health plans of care.** Congress should enact the bipartisan Home Health Care Planning Improvement Act that

would allow Nurse Practitioners (NP) and Physician Assistants (PA) to certify and make changes to home health plans of treatment. NPs and PAs are playing an increasing role in the delivery of our nation's health care, especially in rural and other underserved areas. Medicare reimburses NPs and PAs for providing physician services to Medicare patients. NPs and PAs can certify Medicare eligibility for skilled nursing facility services, but not more cost effective care in the home.

3) **Recognize telehomecare interactions as bona fide Medicare services.** Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act, which 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.

4) **Ensure appropriate development of performance-based payment for Medicare home health services.** MedPAC has recommended application of a "pay for performance" (P4P) system for home health and other Medicare provider payments. Starting in 2008, Medicare began a P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending. Congress should monitor the progress of the ongoing P4P demonstration and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services.

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