



Andrea L. Devoti, MSN, MBA, RN
Chairman of the Board

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

STATEMENT SUBMITTED BY

ANDREA DEVOTI, CHAIR, NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE BOARD OF DIRECTORS; PRESIDENT AND CEO OF NEIGHBORHOOD HEALTH AGENCIES, WEST CHESTER, PENNSYLVANIA

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

JUNE 14, 2013

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 reform Medicare post-acute care payments, NAHC appreciates this opportunity to provide our views. We agree with the Chairman and Ranking Member that we should find the right reforms in post-acute care that can both improve care for today's seniors and extend the fiscal viability of the program well into the future.

Many studies have found that home health care can prevent expensive hospitalizations and nursing home stays while providing cost effective care in the home setting that people prefer, keeping families together and preserving individual dignity. Our members are participating in the new Affordable Care Act (ACA) innovations with enthusiasm and good ideas, seeking greater efficiency while providing high quality services in the home. We pledge to continue to be good partners in finding solutions.

Some proposals have suggested cutting payments to home health care providers and bundling payments to home health providers with payments to other Medicare providers. We have grave

concerns about the impact of further cuts to home health care payments on access to care and want to ensure that efforts to bundle payments to post-acute care providers recognize the central role that home health should play. We would like to make the following recommendations.

ENSURE MEDICARE HOME HEALTH PAYMENTS ARE ADEQUATE TO PROTECT ACCESS TO CARE

Since 2009, when it was a \$17 billion industry, the Medicare home health benefit has been cut by a disproportionate \$77 billion over 10 years. The cumulative effect of these cuts has been to limit access to patients, pushing thousands of providers to the point of bankruptcy.

With the 78 million baby boomer generation reaching their 65th birthday at the rate of 10,000 per day for the next 19 years, the need for home health services will only increase. Home health keeps families together and is overwhelmingly what patients prefer. It is far more cost effective for Medicare than institutional options. Below are the details of these massive cuts:

- Congress included \$39.7 billion in home health payment cuts under the ACA through 2019. It reduced the home health inflation update one percentage point for 2011, 2012, and 2013, mandated rebasing of home health payment rates beginning in 2014 with a 4-year phase-in, and imposed a productivity adjustment in the inflation update beginning in 2015 that will reduce the inflation update by an estimated 1 percentage point each year. While home health represents less than 6 percent of Medicare spending it took a disproportionate 10 percent in Medicare payment cuts used to pay for the ACA.
- The Centers for Medicare and Medicaid Services (CMS) issued rules that cut home health payment rates by 2.75 percent in 2008, 2.75 percent in 2009, 2.75 percent in 2010, 3.79 percent in 2011, 3.79 in 2012, and 1.32 in 2013 — for total reductions of over 16 percent which was in addition to the ACA rate cuts. The Congressional Budget Office (CBO) recently increased the projected impact of the cuts to more than \$32 billion.
- As a result of sequestration, home health patients and providers will take an additional 2 percent cut reducing payments over the next 10 years by \$6 billion dollars.

The President's FY 2014 budget proposal to cut payments another 1.1 percent over the next ten years would further threaten access to home health care. Moreover, it ignores rebasing scheduled to begin next year, which will likely cut home health rates to the bone. More payment cuts on top of rebasing would devastate access to care.

Congress must closely monitor the implementation of the rate rebasing by CMS. Congress should ensure that CMS properly considers cost trends in home health agencies and the imposition of new costs not included in cost report databases. All types of home health agencies should be included in any CMS analysis of costs. Further, Congress should ensure 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. We will provide the committee with a white paper to explain rebasing and our recommendations in more detail.

Congress should also 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 its case-mix adjustment correction authority through public rulemaking. The procedural standards set out in the Home Health Care Access Protection Act should be enacted and applied prospectively to any further coding weight adjustments.

In summary, the Medicare home care benefit which was \$17 billion in 2009 has been cut by a projected \$77 billion over the following ten years. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending is less today than in 1997. As a result of these cuts 46.8 percent of all Medicare participating agencies are projected to be under water in 2014 — that is, paid less than their costs by Medicare.

We project that with rebasing and further cuts in home health payments over the next ten years as proposed in the President's budget, the percentage of agencies that will be underwater will be nearly 65 percent in 2023. A breakdown of these projections by state is provided in an Appendix below. The risk is particularly high in some states represented on this Subcommittee—Texas, Washington, California, Illinois, Nebraska, Oregon, and Wisconsin—where about 70 percent or more of home health agencies are projected to have negative margins in 2023.

We use the same methodology that MedPAC uses, except that we do not exclude hospital-based agencies as MedPAC does. We think this is a continuing flaw in MedPAC's analysis of agency margins. It should also be noted that MedPAC uses antiquated home health cost reports in computing margins that do not include all agency costs, such as the costs of telehomecare. Although we think this is a significant flaw, we use the same methodology in our analysis. Consequently, we believe our analysis is a conservative estimate of the impact of payment cuts.

In order to protect access to home health care, Congress should resist making additional cuts in home health care payments for any reason, including postponement/elimination of scheduled cuts in Medicare physician fees or for deficit reduction.

**ENSURE HOME HEALTH CARE PARTICIPATION IN TRANSITIONS IN CARE,
ACCOUNTABLE CARE ORGANIZATIONS, CHRONIC CARE MANAGEMENT,
HEALTH INFORMATION EXCHANGES, AND OTHER HEALTH CARE DELIVERY
REFORMS.**

The ACA 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.

The ACA 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 offers an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care brings 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, CMS must recognize the value of home health care 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 as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

Congressional reforms of the health care delivery system recognize home care 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 ACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care 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 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.

With regard to proposals to bundle payments to post-acute care providers, we are encouraged that CMS is testing a post acute care bundling program where all provider payments are held and administered by home health agencies. This would deter unnecessary re-hospitalizations, thus reducing administrative burden and cost, as well as increase the quality and availability of home health care. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program where hospitalization is the exception rather than standard practice.

The Fostering Independence through Technology (FITT) Act and the Home Health Care Planning Improvement (HHCPI) Act are two bills that would greatly enhance the cost saving potential of home health care. The FITT Act would provide payment incentives for the use of telehomecare technologies. The HHCPI would allow nurse practitioners and physician assistants to certify Medicare eligibility for home health care. Currently these health professionals may put a beneficiary in a skilled nursing facility, but not in more cost effective home health care.

Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The

reforms in the ACA 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.

APPENDIX

PERCENTAGE OF HOME HEALTH AGENCIES AT RISK OF CLOSURE DUE TO MEDICARE PAYMENTS LESS THAN THE COST OF CARE		
<i>Potential risks from a combination of CMS regulatory cuts, cuts enacted under the Affordable Care Act, 2% Medicare Sequestration, and an additional 1.1 percent cut in Market Basket Updates over the next ten years</i>		
State/Territory	Percent of Agencies – 2014	Percent of Agencies – 2023
National	46.8%	64.86%
Alabama	29.6%	52.17%
Alaska	75.0%	91.67%
Arizona	46.7%	58.89%
Arkansas	41.2%	58.82%
California	57.4%	74.00%
Colorado	38.1%	46.67%
Connecticut	25.7%	34.29%
Delaware	40.0%	66.67%
District of Columbia	40.0%	46.67%
Florida	45.0%	64.53%
Georgia	32.3%	42.71%
Guam	50.0%	100.00%
Hawaii	77.8%	100.00%
Idaho	56.4%	74.36%
Illinois	50.8%	70.48%
Indiana	57.2%	73.99%
Iowa	52.1%	73.97%
Kansas	49.5%	61.68%
Kentucky	40.2%	56.70%
Louisiana	26.2%	46.15%
Maine	40.0%	76.00%
Maryland	37.2%	76.74%
Massachusetts	32.2%	55.65%
Michigan	47.0%	69.35%
Minnesota	45.1%	54.95%
Mississippi	8.1%	40.54%
Missouri	52.9%	70.97%
Montana	72.4%	79.31%
Nebraska	58.7%	69.84%
Nevada	54.4%	79.35%

New Hampshire	31.0%	62.07%
New Jersey	40.5%	66.67%
New Mexico	54.4%	68.42%
New York	74.0%	86.55%
North Carolina	30.5%	48.05%
North Dakota	80.0%	80.00%
Ohio	33.6%	45.98%
Oklahoma	47.3%	65.67%
Oregon	78.3	86.96%
Pennsylvania	34.9%	52.38%
Puerto Rico	51.4%	71.43%
Rhode Island	19.1%	23.81%
South Carolina	36.0%	60.00%
South Dakota	45.2%	61.29%
Tennessee	22.9%	41.22%
Texas	50.7%	69.12%
Utah	36.4%	62.34%
Vermont	25.0%	58.33%
Virgin Islands	50.0%	50.00%
Virginia	39.7%	58.05%
Washington	62.8%	76.47%
West Virginia	37.0%	52.17%
Wisconsin	64.7%	72.94%
Wyoming	70.4%	81.48%