



Special Alert

December 18, 2000

Congress Passes Medicare Changes Providing Relief to Homecare

In the final hours of the 106th session, Congress passed the long awaited Medicare changes for homecare patients and providers. The legislation titled the “Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000” (HR 5661) was incorporated into the Appropriations Act for the Departments of Labor and Health and Human Services (HR 4557). The House approved the measure by a vote of 292 to 60. The Senate adopted the package by voice vote, which does not require an electronic vote by the senators.

The final Medicare proposal spends approximately \$35 billion over five years (Of this, total amount, about \$2 billion is dedicated to rural providers). The following is a breakdown of the spending proposal:

- \$5 billion for Medicare and Medicaid beneficiary improvements,
- \$12 billion for hospitals,
- \$2 billion for nursing homes,
- \$2 billion for home health agencies,
- \$3 billion for other providers including durable medical equipment providers,
- \$11 billion for managed care plans.

The legislation is similar to the House version that was considered in October of this year. Generally, AAHomecare’s major legislative priorities including the restoration of the CPI for durable medical equipment providers, a delay in AWP for nine months and a delay of the 15% cut for home health services are addressed.

The Clinton Administration won agreement for an additional funding increase for rural home health services. The negotiations between the Clinton Administration and congressional leaders also tried to resolve the consolidated billing requirement for non-routine medical supplies to be billed through home health agencies. During the negotiations, two options were considered. One was to delay consolidated billing and the second was to “carve-out” ostomy and wound care supplies. In the final hours, however, the provision was left intact with no changes. The proposal calls only for a study to be conducted by the General Accounting Office (GAO).

The homecare provisions included:

- **Full Update for Durable Medical Equipment**

The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. The payment increase for 2002 would be 0%. The increase for periods after 2002 would be equal to the full increase in the CPI-U for the 12 months ending the previous June. The provision specifies that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for DME are the amounts in effect before enactment of this provision, 0.3 percent. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28%. The net effect of this provision is to compress a full CPI-U update for one year into 6 months.

AAHomecare is currently clarifying the scope of this provision as it pertains to oxygen and oxygen equipment, and we will keep members informed.

- **1-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits to Home Health Services**

The provision would require that the aggregate amount of Medicare payments to home health agencies in the second year of the PPS (FY2002) shall equal the aggregate payments in the first year of the PPS, updated by the market basket index (MBI) increase minus 1.1 percentage points. The 15 percent reduction to aggregate PPS amounts, which, under current law, would go into effect October 1, 2001, would be delayed until October 1, 2002.

The GAO (rather than the Secretary) would be required to submit, by April 1, 2002, a report analyzing the need for the 15 percent or other reduction.

If the Secretary determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary may adjust PPS amounts to eliminate the effect of such coding or classification changes.

- **Revised Part B Payment for Drugs and Biologicals and Related Services**

The provision would require the GAO to submit a report to Congress and the Secretary on the reimbursement for drugs, biologicals, and related services under Medicare; the report would include specific recommendations for revised payment methodologies. The Secretary would revise the current payment methodologies for covered drugs, biologicals, and related services based on these recommendations; however, total payments under the revised methodologies could not exceed the aggregate payments the Secretary estimates would have been made under

the current law. The provision would establish a moratorium on reductions in payment rates, in effect on January 1, 2001, until the Secretary reviewed the GAO report.

The GAO study is to be completed within nine months and sent to the Congress and Secretary for their review.

- **Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001**

The provision would modify the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, would apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates would be increased by 2.2 percent for 60-day episodes (or visits) ending in that time period. This increase would be included in determining subsequent payment amounts.

- **Temporary Two-Month Periodic Interim Payment**

The provision would provide for a one-time payment for certain home health agencies that were receiving periodic interim payments under current law. Home health agencies that were receiving such payments as of September 30, 2000, receive a one-time payment equal to four times the last 2-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts would be included in the tentative settlement of the agency's last settled cost report before implementation of the PPS.

Exceptions to this payment include the following: 1) an agency notifies the Secretary that such agency does not want to receive such payment, 2) an agency is not receiving payments pursuant to section 405.371 of title 42, Code of Federal Regulations, 3) an agency is excluded from the Medicare program under Title XI of the Social Security Act, 4) an agency no longer has a provider agreement under section 1866 of such Act, 5) an agency is no longer in business, or 6) an agency is subject to a court order providing for the withholding of Medicare payments under Title XVIII of such Act.

- **Study on Costs to Home Health Agencies of Purchasing Non-routine Medical Supplies**

The provision would require that, no later than August 15, 2001, the GAO shall submit to Congress a report regarding the variation in prices home health agencies pay for non-routine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary would be required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

- **Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas**

The provision would clarify that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary would be authorized to include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status.

No later than January 1, 2002, the GAO would be required to submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas and to make recommendations on whether national standards for supervision would be appropriate in assuring quality.

- **Clarification of the Homebound Benefit**

The provision clarifies that the need for adult day care for a patient's plan of treatment does not preclude appropriate coverage for home health care for other medical conditions. The provision also clarifies the ability of homebound beneficiaries to attend religious services without being disqualified from receiving home health benefits.

After a year of implementation of the new "homebound" definition, the General Accounting Office is to report to Congress on the impact of the new definition. The report is to include additional costs to the Medicare program and issues surrounding access to home health services.

- **Temporary Increase for Home Health Services Furnished in a Rural Area**

For home health services furnished in certain rural areas during the 2-year period beginning April 1, 2001, Medicare payments are increased by 10%, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase would not be included in determining subsequent payments.

- **Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays**

Effective January 1, 2001, the provision would limit the current law consolidated billing requirement to services and items furnished to SNF residents in a Medicare part A covered stay and to therapy services furnished in part A and part B covered stays.

The Inspector General of HHS would be required to monitor Part B payments to SNFs on behalf of residents who are not in a Part A covered stay.

- **Full Update for Orthotics and Prosthetics**

The provision would modify updates to payments for orthotics and prosthetics. In 2001, the increase would be equal to the percentage increase in the CPI-U during the 12-month period ending with June 2000. For 2002, payments would be increased by one percent over the prior year's amounts. The provision would specify that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for these items would be the amounts in effect before

enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 2.6%.

- **Imposition of Billing Limits on Drugs**

The provision would specify that payment for drugs under Part B must be made on the basis of assignment.

- **MedPAC Study on Low-Volume, Isolated Rural Health Providers**

MedPAC would be required to study the effect of low patient and procedure volume on the financial status and Medicare payment methods for hospital outpatient services, ambulance services, hospital inpatient services, skilled nursing facility services, and home health services in isolated rural health care providers.

- **Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items**

Under the provision, certain prosthetics or custom fabricated orthotics would be covered by Medicare if furnished by a qualified practitioner and fabricated by a qualified practitioner or qualified supplier. The Secretary would be required to establish a list of such items in consultation with experts. Within one year of enactment, the Secretary would be required to promulgate regulations to provide these items, using negotiated rulemaking procedures.

Not later than 6 months from enactment, the GAO would be required to submit to Congress a report on the Secretary's compliance with the Administrative Procedures Act with regard to HCFA Ruling 96-1; certain impacts of that ruling; the potential for fraud and abuse in provision of prosthetics and orthotics under special payment rules and for custom fabricated items; and the effect on Medicare and Medicaid payments if that ruling were overturned.

- **Use of Telehealth in Delivery of Home Health Services**

The provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment.

- **Reimbursement Improvements for New Clinical Laboratory Tests and Durable Medical Equipment**

The provision would specify that the national limitation amount for a new clinical laboratory test would equal 100% of the national median for such test. The Secretary would be required to establish procedures that permit public consultation for coding and payment determinations for new clinical diagnostic laboratory tests and new durable medical equipment. The Secretary would be required to report to Congress on specific procedures used to adjust payments for advanced technologies; the report would include recommendations for legislative changes needed to assure fair and appropriate payments.

- **Retention of HCPCS Level III Codes.**

The provision would extend the time for the use of local codes (known as HCPCS level III codes) through December 31, 2003; the Secretary would be required to make the codes available to the public.

If you should have any questions regarding the legislative changes, please contact AAHomecare's government relations department at (703) 836-6263.

