

**United States Senate Committee on Finance
and
United States House of Representatives
Committee on Ways and Means**

**Joint Hearing on the Social Security and Medicare Trustees'
Reports**

Submitted by:

The American Association for Homecare

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The following statement is respectfully submitted to the U.S. Senate Committee on Finance and the U.S. House of Representatives Committee on Ways and Means on behalf of the American Association for Homecare (AAHomecare). AAHomecare is a national association that resulted from a merger of three smaller national home health associations; the Home Care Section of the Health Industry Distributors Association (HIDA Homecare), the Home Health Services and Staffing Association (HHSSA) and the National Association for Medical Equipment Services (NAMES). AAHomecare is the only association representing homecare providers of all types including not-for-profit, proprietary, facility-based, freestanding, and government-owned home health agencies and home medical equipment providers. The members of AAHomecare would like to express their gratitude to this Joint Committee for initiating an in-depth review and analysis of the Medicare program as an important first step in adjusting modalities within the current structure which are no longer effective or have simply become outdated.

Home Care Is the Answer

AAHomecare is pleased to report that the homecare industry has clearly benefited from a recent explosion of innovative technological developments. These medical device breakthroughs allow Americans to receive an array of complex therapies in the privacy and comfort of their own homes. For example, the use of space-age materials makes wheelchairs and mobility aids lighter and the application of microchip computer technology within implantable devices assists in delivering life-saving medications. Technology makes it possible for the care received in the home to equal and often exceed care received in a traditional hospital setting at a fraction of the cost. Ongoing advances in therapeutic medical technologies will continue to make this possible while simultaneously reducing health care costs and improving the overall quality of homecare delivery and services.

Home care is not only patient-preferred, but numerous studies¹ have clearly demonstrated that providers of home care services are a cost-efficient component of the healthcare delivery system. A study conducted by the Hudson Institute, an independent research organization, effectively denotes these savings. The study, entitled *The Cost Effectiveness of Home Health Care*, examines the highly successful In-Home/ CHOICE program instituted by the State of Indiana in 1985. Indiana provides 100% of the funding for this program, which covers the cost of home care for qualified residents in need of long-term care to prevent unnecessary hospitalizations.

The authors of the study note that home care programs like that in Indiana could go a long way toward alleviating the current crisis in health care funding for America's rapidly increasing aging population. By avoiding institutionalized care, Indiana has been able to reduce inpatient caseload costs by at least fifty percent. The cost savings associated with this increased reliance on home care services were considerable. The study states that home care for the elderly in Indiana can be provided for one half the cost of skilled nursing facility care. In addition, the quality control and screening procedures used in the Indiana program have successfully avoided problems with fraud and abuse. The Hudson Institute study concluded, "Properly crafted and administered, home health care can play a critical role in helping society meet the looming health care needs of the 'Baby Boom' generation."

Access To Home Care Services Has Been Severely Compromised

Unfortunately, as advances in home care service and delivery advance, access to benefit coverage for Medicare beneficiaries' remains in a state of flux. The Congressional Budget Office (CBO) originally estimated that the Balanced Budget Amendment of 1997 (BBA'97) would reduce spending earmarked for the Medicare home health benefit by approximately \$16.1 billion over five years. The actual impact of the BBA'97 however was much more dramatic.

No other health care provider group has been as negatively impacted by the BBA'97 as the community of home health service providers. Last year, CBO revised their estimate to a reduction of \$70 billion over five years, more than four times the original estimate. In March 2000, the Congressional Budget Office (CBO) announced that home health services had a more stunted rate of growth than any other health care sector. Likewise, according to the American Hospital Association's *Year 2000 Lewin Study*, the BBA'97 has resulted in coverage reductions of thirty and one-half percent for hospital-based home health services, the largest reduction of any hospital service to date.

These dramatic reimbursement reductions have made an inevitable impact on the availability of the home health benefit. The George Washington University Center for Health Services, Research, and Policy released two studies reviewing the impact of BBA'97 on home health care service providers and beneficiaries. Both studies revealed a declining number of Medicare home health patients. The studies also cited that those individuals most likely to lose access to Medicare-covered services included beneficiaries suffering from chronic and complex conditions such as diabetes, congestive heart failure, and multiple sclerosis. Sixty-eight percent of hospital discharge planners reported increased difficulty in obtaining home health services for Medicare beneficiaries. Fifty-six percent of the discharge planners reported increases in the number of beneficiaries requiring substitute placements, primarily in skilled nursing facilities, in lieu of home health services.

Principles for Medicare Reform

As a result of these far reaching reimbursement reductions, AAHomecare clearly appreciates the need for substantive Medicare reform. We believe that by expanding access to home care services, Congress will be able to adequately meet increasing demands to provide safe, effective and less costly health care services to Medicare beneficiaries for many years to come. Accordingly, AAHomecare strongly urges Congress to include home care coverage as an essential component within the health care delivery system. We believe the following principles must be incorporated into any Medicare reform proposal:

Access Medicare beneficiaries should have timely access to medically necessary home care items and services. National and local Medicare coverage policy should provide beneficiaries access to appropriate technology and therapeutics in their homes rather than aim to control utilization. Funding for a home care provision should be sufficient to ensure adequate access to medically necessary home care services for all beneficiaries. Regulatory oversight of home care should be reasonable and not overly burdensome to beneficiaries or providers and suppliers.

Choice Medicare beneficiaries should be guaranteed the freedom to choose their provider/supplier. The ability to choose a health care provider/supplier will guarantee access to high quality home care items and services. Moreover, Medicare beneficiaries should retain the right to choose “upgraded” items and services when they are willing to pay more than the Medicare allotment.

Fairness Medicare beneficiaries and the providers/suppliers who serve them should receive adequate notice and an opportunity to comment on changes in Medicare policy that will effect coverage and reimbursement. Further, Medicare beneficiaries should be able to seek and obtain timely prior authorization for home care items and services and appeal decisions on Medicare coverage and claim denials.

Accessibility Information about Medicare coverage criteria and payment policies should be comprehensive, readily available and easy to understand to beneficiaries and their caregivers. Beneficiaries and the home care providers/suppliers who serve them should not be burdened with unwieldy documentation requirements for determining eligibility, coverage, or payment requests.

Stop Further Cuts to the Medicare Home Health Care Benefit

Recognizing the difficult task of successfully passing Medicare reform this year, AAHomecare respectfully requests that Congress make appropriate changes to the current system. The Association urges the Joint Committee to stop the decimation of the Medicare home health benefit by eliminating the additional 15% payment cut scheduled to be implemented on October 1, 2002. This cut has no basis in public policy and was included in the BBA'97 merely as a scoring mechanism. The threat of the additional 15% reduction only exacerbates existing impediments to access.

Moreover, the overhang expectation of another 15% cut does not allow home health care providers to recover from the initial devastating impacts of the BBA'97. As a result, home health providers simply cannot take the financial risk of accepting the sicker, more costly patients or making home health services available in rural areas, as they must take into account the anticipated cut in funding. As home health agencies have undergone PPS, one key concern has been that related to diminished cash flow. Home health agencies do not have the capital that their institutional health care colleagues possess to support regulatory changes. Many home agencies are unable to secure loans needed for PPS implementation because lending institutions are leery of the financial viability of these providers. For these reasons, AAHomecare respectfully asks Congress to support the full repeal of the scheduled 15% cut to the Medicare home health benefit.

Inherent Reasonableness

In 1985, the Health Care Financing Administration (HCFA) was granted the authority to alter Medicare reimbursements for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) through the Inherent Reasonableness (IR) authority. This authority allowed HCFA to adjust reimbursements for individual items and services if the payments are found to be grossly

deficient or excessive. A BBA '97 provision (Section 4316) granted HCFA a greatly expanded IR authority to adjust DMEPOS reimbursements by as much as 15% each year without industry consultation, notification in the *Federal Register*, or public comment. HCFA and the Durable Medical Equipment Regional Carriers (DMERCs) quickly announced planned IR reductions for a number of DMEPOS items. AAHomecare remains concerned about the arbitrary nature of these reductions, the lack of sound evidence validating the necessity for the reductions, and the apparent violation of the 15% threshold established in the BBA '97.

The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) contains a provision (Section 223) that requires HCFA to: "(1) reevaluate the appropriateness of the criteria included in the interim regulation... and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority." In addition, the report language states that the IR authority should "be administered judiciously and applied only after public concerns and suggestions about proposed administrative criteria have been openly addressed."

Last year, the General Accounting Office (GAO) report (GAO/HEHS-00-79) described the data collection techniques used by the DMERCs to support their proposed reductions as "deficient," "inconsistent," and "inappropriate." In fact, the GAO confirms industry contention that the DMERCs failed to determine what type of enteral formula the Medicare Program covers prior to announcing planned cuts rationalized on the basis of flawed data. Not only did the carriers collect data on the wrong items, they failed to use a uniform and standardized survey technique. The GAO dubbed the data collection efforts "judgmental" and "less rigorous," and listed a number of deficiencies in the survey process. For instance, the GAO states that the DMERCs:

- ◆ "did not choose their sample in a consistent way, nor did they set sufficient criteria so that we [the GAO] could be assured that the locations sampled represented retail prices nationally." (p.21)
- ◆ "did not follow a consistent methodology, leading to differences in how they collected an analyzed retail prices..." (p.21)
- ◆ "did not establish criteria to define populous state, less populous state, urban area, and rural area, and consequently each DMERC used different criteria in selecting locations." (p.22)
- ◆ "did not develop a consistent set of survey questions to use when they requested prices from retail stores." (p.23)
- ◆ did not "fully consider the geographic distribution of Medicare beneficiaries." (p.22)
- ◆ "The DMERCs did not consider relative prices in the localities from which they sampled." (p.22)

Despite these inadequacies, HCFA officials have indicated that they plan to move forward with IR reductions for a number of DMEPOS items, regardless of the aforementioned problems with HCFA data collection methodology. AAHomecare remains concerned that HCFA implementation of the expanded IR authority granted in the BBA has been based on inadequate research and precedent Congressional intent which will ultimately threaten beneficiary access to quality medical equipment and home health care services. We implore Congress to insist that the Medicare reimbursement adjustments be based on consistent, reliable data.

In addition, AAHomecare asks this Congress to restrain HCFA from superceding the 15% authority granted in the BBA'97. As you are aware, the BBA outlined specific notice and comment guidelines for Medicare to follow when enacting payment adjustments over 15%. AAHomecare suggests that by including the legislative language addressing the process for implementing adjustments greater than 15%, Congress was expressing its intent for HCFA to follow this process. We are disappointed that HCFA has chosen not to meet this requirement and ask Congress to reiterate this original intent.

Medical Supply Coverage and the Prospective Payment System (PPS)

AAHomecare is also concerned about the bundling of the 177 supply codes into the home health agency (HHA) prospective payment system (PPS) base rate. AAHomecare maintains that the bundling of non-routine medical supplies into the HHA PPS rate and consolidated billing for medical supplies ignores the inherent complexities of the home health market and threatens the continuity of required medical care. AAHomecare urges Congress to refine the current consolidated billing requirement by excluding ostomy and other medical supplies that are provided for the management of chronic illnesses. Of note, this adjustment to the PPS would be budget neutral if enacted.

To adequately illustrate this supply problem, consider the case of a Medicare beneficiary with an ostomy for a urinary bypass who is receiving HHA services for a broken hip. The HHA would provide therapy and aide services for hip rehabilitation but the beneficiary would remain self-sufficient in his/her ostomy management. Nevertheless, the HHA plan of care may not address the beneficiary's need for supplies such as drainage bags, nighttime drainage bottles, tubing, adhesives and anti-infective cleansers. In addition, the HHA professionals meeting the acute rehabilitative care needs of the beneficiary would not provide any services related to ostomy care. In this case, the chronic condition would be incidental to the HHA services required.

Bundling and consolidated billing would require the company providing the ostomy supplies to cease serving the beneficiary and make the HHA responsible for the supply function. This change in medical supply providers may be unnecessarily burdensome for the beneficiary particularly if the supplies offered by the HHA are substantially different or incompatible with the equipment and supplies provided by the existing supplier.

The bundling of supplies into the PPS rate threatens to cause a great deal of confusion and a dramatic rise in billing errors. Currently, there is no way for a HME supplier to be notified when a beneficiary with chronic supply needs enters the plan of care of a HHA. Any HME provider who submits a claim for supplies with a date of service coinciding with a HHA plan of care violates the False Claims Act (FCA), thereby becoming liable for treble damages and up to \$10,000 in fines per claim. Understandably, the inherent risks associated with bundling and consolidated billing may cause HME providers to become reluctant to serve beneficiaries with additional chronic supply needs.

Competitive Bidding Should Be Carefully Examined

The results of the current HME competitive bidding demonstration project should be thoroughly evaluated before expanding competitive bidding into new areas. The demonstration has the

potential to eliminate market competition, harm beneficiary access to quality medical services, and cause irreparable damage to small businesses.

Competitive bidding is inappropriate for HME because the health services that accompany medical equipment are as important to beneficiary well being as the products themselves. Home oxygen equipment cannot be simply “drop-shipped” to patients as supportive instruction and education services are crucial to incur positive health outcomes. History reveals that once an artificially low bid is awarded and a contract holder faces budgetary pressures, the first thing eliminated are these services. Once services are withheld, a beneficiary is much more likely to experience health problems. Unfortunately, HCFA has failed to incorporate any real quality control measures into the demonstration design.

Further, in order to implement the competitive bidding demonstration, HCFA waived the section of the Social Security Act (42 USC Sec.1395a) that guarantees a beneficiary’s ability to choose a health care provider. The beneficiaries enrolled in the demonstration project have also not been given the option to “opt out” of the demonstration if they become dissatisfied with the program. If a beneficiary is dissatisfied with the services provided by the “winning” bidders, the beneficiary is offered no alternative. HCFA has yet to examine the impact of the demonstration project on beneficiary satisfaction or health outcomes. AAHomecare strongly urges Congress to carefully examine the results of the HCFA HME competitive bidding demonstration project and the overall suitability of the demonstration design before moving this project into additional areas.

Home Medical Equipment

HME providers supply medically necessary equipment and auxiliary services that enable beneficiaries to adequately meet their rehabilitative and/or therapeutic goals. Pursuant to a physician's order, HME providers deliver medical equipment and supplies to a consumer's home, set it up, educate and train the consumer and caregiver in its use, provide required maintenance service, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other home care providers performing an integral role in home health case management.

The BBA’97 instituted a freeze on the annual inflation adjustment for Medicare’s durable medical equipment (DME) fee schedules. Additionally, the BBA’97 cut reimbursement for home oxygen therapy by thirty percent. These cuts have had a dramatic impact on a market dominated by small, independently owned and operated service providers. AAHomecare members report a dramatic increase in bad debt and an unprecedented number of bankruptcies since 1997 as resulting fallout from BBA’97 reductions.

The larger, national HME provider chains have also been reeling from the negative impacts of the BBA’97. *PriceWaterhouseCoopers* (PWC) recently updated a 1999 survey of nine publicly held HME companies. PWC observes that each of these companies earned a positive net income in 1996 but by 1999 two-thirds of these companies were losing money, bankrupt or out of business completely. Ironically, this dramatic fiscal reversal occurred at a time when the average U.S. corporate profit margin rose by eighteen percent.

In order to recover from the destabilization caused by rapidly increasing costs and declining reimbursements, AAHomecare asks Congress to restore the full cost of living adjustment (COLA) for both DME and oxygen services in fiscal year 2002. By restoring the COLA, you will enable HME providers to continue to provide high quality in-home medical services.

Conclusions

Home care continues to evolve to meet the increasingly complex needs of today's Medicare beneficiaries. By capitalizing on technological advances, home care providers and suppliers have the potential to conduct increasingly complex medical and therapeutic regimens in the comfort of beneficiaries' homes. These advances serve the needs and preferences of the Medicare population, and reduce program expenditures by avoiding costly hospitalizations.

AAHomecare respectfully requests this Congress to acknowledge the contribution that home care providers and suppliers have made to Medicare cost containment by permanently eliminating the pending 15% cut in reimbursement. Further, the annual COLA for home medical equipment providers must be restored. In addition, we ask Congress to continue to provide the needed oversight of the implementation of IR authority outlined in the BBA'97. HCFA and its carriers must implement a sound cost assessment methodology that uses statistically reliable data and also conduct a thorough examination of the results of the HME competitive bidding demonstration project. Finally, in order to ensure continuity of care and avoid unnecessary billing confusion, we urge Congress to refine the requirement that non-routine medical supplies be included in the PPS rate and remove supplies specific to the needs of chronic care patients from PPS.

Thank you again for the opportunity to submit written testimony. Please feel free to contact Heather Fraser at AAHomecare with any questions or comments concerning the issues raised in this discussion.

ⁱ For recent studies, please see:

- Styring, William & Dueterberg, Thomas, *The Cost Effectiveness of Home Health Care: A Case Study on Indiana's In-Home/CHOICE Program*, (Vol. 1, No. 11), November 1997, (Hudson Institute, Indianapolis, IN).
- Mann, Williams C. et al, "Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly," *Archives of Family Medicine*, May/June 1999 (Vol. 8, pp. 210-217).