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Submitted for the Record at a Hearing on

No Place Like Home: Home Health Care in Rural America

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Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of home health, hospice, and home care providers across the nation, including home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types -- from small rural agencies to large national companies -- and include government-based providers, nonprofit voluntary agencies, privately-owned companies and public corporations. The provision of high-quality, life-enhancing care to vulnerable individuals and education and support to their loved ones is central to our collective purpose. We welcome the opportunity to submit testimony for the record for a hearing before the Senate Select Committee on Aging on "No Place Like Home: Home Health Care in Rural America," and to provide our views on key issues related to home health care.

MEDICARE HOME HEALTH SERVICES

Background

Since the beginning of Medicare, the home health care benefit has had a special place in the package of services available for coverage by Medicare. It is the only benefit that is available under both Medicare Part A and Part B. 42 U.S.C. 1395d(a)(2); 1395k(a)(2)(A). Early into the Medicare program, Congress saw the wisdom of removing barriers to utilizing home health services, including the elimination of any required cost sharing for Medicare beneficiaries in 1972. 42 U.S.C. 1395l(a)(2); 1395l(b)(2). The benefit covers a wide range of services and supplies, including skilled nursing care, physical therapy, speech-language pathology, occupational therapy, medical social services, and home health aide care. The home health services benefit has no durational or visit volume limit.

It is also a benefit that is available to those beneficiaries who meet the "confined to home" and "skilled care" requirements regardless as to whether the patient has acute, post-acute, chronic, or end of life care needs. Overall, it is a fairly comprehensive home care focused benefit that is not dependent on a pre-institutional care requirement, as well as one that helps avoid the use of costly institutional care.

Notably, the Medicare home health benefit is well managed. Spending on home health services has been relatively stable with 2011 spending at $18.4B and 2017 spending at $17.8B. Utilization levels are also stable with 3.42 million users in 2011 and 3.39 million in 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics. The lack of growth actually is surprising given the nationwide shift towards care in the home and away from inpatient and institutional care.

Today, home health services is the backbone of successes in innovative care delivery programs whether in a bundled payment program of post-acute services, as part of the services managed in an Accountable Care Organization, the Independence at Home demonstration program, or programs focused on specific care needs such as the risk-based reimbursement for joint replacements.

Still, there is room to modernize the Medicare home health benefit and improve the range of services available to Medicare beneficiaries. For purposes of this testimony, we will focus on five areas of important reforms that would directly impact on care access in rural areas. At the

same time, these reforms can bring added support for the access to and delivery of home health services throughout the country.

Home Health Care Planning Improvement Act S. 296/H.R. 2150

Background

Since 1965, Medicare law requires that a physician certify a patient's eligibility for coverage of home health services. Many things have changed in health care since this Medicare provision was enacted. Much of primary care provided today comes from highly skilled non-physician practitioners such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. As a result, these professionals must "hand-off" their patients to a physician simply to comply with outdated Medicare certification requirements. Similar legislation allowing Non-Physician Practitioners (NPPs) to certify a patient's eligibility has been introduced in past Congresses beginning in 2007, garnering strong broad bipartisan support in each session of Congress. In the 115th Congress, 46 Senators and 182 Representatives cosponsored the legislation. Currently, there are 43 Senators and 134 Representatives as cosponsors including the Chair and Ranking member of the Senate Special Committee on Aging.

Today, this legislation is supported by numerous patient advocacy groups, health care professionals, and physician groups as well. There is an obvious reason why there has been such widespread support—our nation depends on non-physician practitioners every day to provide primary care to people of all ages as the availability of physician practitioners diminishes. Across, the country, the states have established a scope of practice authorization that permits these practitioners to order and manage home health services.

As of 2016, Nurse Practitioners, just one of the sectors of non-physician practitioners, comprised 25.2% of providers in primary practices in rural areas and 23% in non-rural areas, having grown from 17.6% and 15.9% in 2008.

Outside of home health services, Medicare recognizes the value and competence of non-physician practitioners. For example, in 2017 Medicare paid for 31 million in office visits by Advanced Practice Registered Nurses and Physician Assistants. Barnes, et al, "Rural and Nondual Primary Care Physician Practices Increasingly Rely on Nurse Practitioners," Health Affairs, June 2018. Over the same period, the number of E&M office visits billed by primary care physicians decreased by 16 percent. http://medpac.gov/docs/default-ource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0 The Medicare Payment Advisory Commission (MedPAC) also notes that in 2017, 34% of Medicare beneficiaries received a billable service from a Nurse Practitioner, up from 16% in 2010.

Similarly, the Journal of the American Medical Association (JAMA) indicates:

> "This analysis demonstrated a narrowing gap between primary care NP and physician workforce supply over time, particularly in low-income and rural areas. These areas have higher demand for primary care clinicians and larger disparities in access to care. The growing NP supply in these areas is offsetting low physician supply and thus may increase primary care capacity in underserved communities."
> https://jamanetwork.com/journals/jama/fullarticle/2720014?resultClick=1

It is notable, that Congress amended Medicare law in 1997 to permit non-physician practitioners to certify Medicare benefit eligibility for the skilled nursing facility benefit. 42 U.S.C. 1395f(a). The Centers for Medicare and Medicaid Services (CMS) itself recognized the value and need for non-physician practitioners in home health services by permitting NPPs to conduct the required face-to-face patient encounter that was instituted in 2010.

Medicare is not alone in the expanding use of NPPs. Recently, the VA health system expanded the use of NPPs in all of its facilities. In addition, a recent Executive Order set out the Administration's overall policy of removing federal government-based barriers that prevent health care professional, e.g. NPPS, from practicing at their highest level possible for their profession. https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/

It is now time to pass S.296 and bring this long overdue modernization of the home health benefit requirements into reality. In 2007, when such legislation was originally introduced, the reform may have been considered an innovation, Today, it is a necessity.

S. 296 would:

- Allow Non-Physician Providers (NPPs) to certify a patient's eligibility for the Medicare Home Health Benefit.
- Permit NPPs to establish and manage the patient's Plan of Care provided it is within the scope of their practice under state law.
- Enable NPPs eligibility to certify the face-to-face encounter requirement.

Here are just some of the barriers to care and inefficiencies that would be addressed with the bill:

Improve Program Integrity

Current physician-focused certification requirements force patients to shift from their primary care practitioner to a physician who has not cared for the patient. In addition, there is a risk that program integrity is compromised when the patient is "handed-off" to a physician for the sole purpose of meeting Medicare certification requirements. The existing standard requires that a physician certify the patient's eligibility for Medicare benefits even though the NPP is likely to have a far greater understanding of the patient's condition and needs

relative to benefit eligibility standards. Permitting NPPs to certify Medicare eligibility enhances Medicare safeguards in the Home Health Benefit as the certification is done by the practitioner that actually cares for the patient.

Quality of Care

NPPs can improve the transitions of care of patients to community-based care, potentially resulting in a decrease in the length-of-stay at hospitals and skilled nursing facilities because it would no longer be necessary to insert a physician who has not cared for the patient into the process. Importantly, it should not increase Medicare home health spending as NPPs would just continue their care of patients and not require the substitution of a physician to complete the certification. A "hand off" to a physician runs the risk of miscommunications and documentation errors as more health care personnel are involved with the patient. This is especially relevant where the physician is not the patient's primary care professional and may barely know the intricacies of the patient's care needs.

Cost Savings

Medicare would reduce spending if NPPs were authorized to certify home health benefit eligibility and establish a patient's care plan as the reimbursement rates for NPPs are less than payment rates for MDs. More importantly, paperwork costs would be reduced as it would no longer be necessary that the primary care practitioner, the NPP, would need to pass the patient over to a physician who would need to compose duplicative paperwork.

Ultimately, S. 296 should be viewed as a long overdue modernization of the Medicare home health benefit. Any program integrity or quality of care concerns existing in 1965 are no longer relevant as non-physician practitioners are not only key players in today's health care delivery, particularly in community-based care and rural areas, but it has been demonstrated countless times in other Medicare health care sectors that such modernization brings great value to both patients and Medicare. It is time to bring the home health benefit into the 21st century too.

Reinstate the Medicare Home Health Rural Add On

Background

The longstanding Medicare rural add-on for home health services will be phased out completely by 2022, threatening the provision of the home health benefit in rural areas. Since the 1990s, the home health services payment system has recognized the special needs of rural areas as there are high travel times, travel costs, and often the need for extended duration of the service visits.

The Bipartisan Budget Act of 2018 extended the 3% rural add-on while also scheduling a phase-out and an add-om differential targeted to certain rural areas. Section 50208(a)(1) of BBA. CMS implemented the BBA requirements in a manner such that Home Health Agencies (HHAs) are categorized as Low Population Density, High Utilization, or All Other. Low Population Density are those HHAs serving a geographic area with a population of 6 or fewer persons per square mile. High Utilization areas are those counties in the highest quartile of all counties based on the number of Medicare home health episodes furnished per 100 Medicare enrollees. The rural add-on will phase out in 2022 as follows:

Category	CY2020	CY2021	CY2022
High Utilization	0.5%	NONE	NONE
Low Population	3.0%	2.0%	1.0%
All Other	2.0%	1.0%	NONE

The theory behind the variable add-on is that it is needed more in sparsely populated areas and less in areas that show a higher than average usage of home health services. If a rural county is both a low population density area and a high utilization area, the lower add-on and early phase-out applies. For a more detailed explanation, see https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf. Page 60541. The ultimate elimination of the add-on appears to be based on a view that it is eventually not needed. None of these assumption is well founded.

The three percent payment modifier to reimbursements for services provided in rural areas has been crucial to maintaining access to care. Rural agencies face higher overhead expenses due to increased travel time between patient visits, demands for extra staff, and the need to support the mandated infrastructure of a home health agency in low patient volume locales. This payment modifier is imperative so that rural agencies will be able to keep their doors open and provide necessary care to homebound patients.

The latest data available (Cost Report Years ending in 2018) shows that the average financial margin for HHAs located in rural areas is negative 6.2%. In other words, the rural-based HHAs receive on average 6.2% less than the cost of care during a time with the add-on in effect at 3%. That average represents a wide range in margins. However, most notable is that 39.9% of such HHAs have Medicare margins below zero. This is in stark contrast to non-rural HHAs where less than 20% have negative Medicare margins in 2018.

The targeting theory set out in BBA 2018 and the CMS rulemaking does little if anything to provide the supports needed to make rural home health services viable. In an analysis done using 1387 cost report from rural-based HHAs (all of those available), an estimated 37.8% of HHAs (517) in the High Utilization category would experience margins below zero upon the elimination of the add-on. In Low Population Density areas, 68.9% of HHAs (74) would have negative margins. The remainder would have 57.3% of HHAs (802) paid less than the cost of care.

NAHC takes issue with any MedPAC analysis of rural HHA Medicare margins in that the MedPAC analysis relies on a "weighted average" where the calculation lumps all HHAs together giving higher weight to those HHAs of larger size. Rural areas do not provide the population density for all HHAs to be of large size. A better measure is the one used here that evaluates based on each individual HHAs Medicare margin. A second and equally significant flaw in the MedPAC methodology is the exclusion of HHAs that are integrated into a health care system. In some rural areas, these are the only HHAs available. To exclude them from any calculation related to the need for the add-on is to ignore their role in essential access to care.

Congress has repeatedly determined, with bipartisan support, that the home health rural add-on is needed to maintain care access and quality in rural areas. Dating back to 2000, the Congress has continually extended the rural add-on with only minimal gaps. As initially applied to the Medicare Home Health Prospective Payment System, the add-on was set at 10%, and then decreased to 5%, followed by 3%. As referenced, the Bipartisan Budget Act of 2018 extended the add-on, but called for phasing it out, leaving many providers questioning how they will be able to stay in business.

With the increasing closure of rural hospitals and the continuing medically underserved populations in rural areas resulting from physician shortages, home health agencies have become a primary care lifeline for many patients. That is just one of the explanations available for the "high utilization" result as home health has become the only service available. It is also difficult to consider the categorizations as reasonable targeting when an area can be both high utilization and low population density.

There are higher costs for home care in rural areas primarily due to travel time and the cost of meeting Medicare standards for operation that disadvantage small, rural providers. Further, home health care is often the substitute for primary care in rural areas with the shortage of physicians. That translates to longer patient visits and lower staff productivity than possible in a short travel time non-rural location. A loss of access to care in rural areas negatively impacts patients and Medicare as care and its costs shift to institutional care. Finally, Congress has repeatedly supported, on a bicameral, bipartisan basis, a rural differential or rate add-on since the 1990s.

<u>What Congress Can Do</u>

Reinstate the 3% rural add-on for three years and require an expanded study on its application and any needed reforms to ensure its ongoing success. While targeting may be an option to consider, the current targeting approach is not reliable.

New Medicare Home Health Payment Model: It Must Be Closely Monitored and Increased Transparency in Rate Setting Is Essential

On October 31, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized "CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements", its annual payment system update for the Medicare Home Health benefit. This rule finalized the Patient-Driven Groupings Model (PDGM) that took effect January 1, 2020. Included within the PDGM model is a preemptive reduction to the base payment rate of 4.36% derived solely from assumptions as to how home health providers might behave in their provision of care and documentation practices under the PDGM model. It is notable that this reduction, as included in CMS's proposed rule, was originally projected as 8.01% in what would have been the largest single year cut to payments since the inception of the home health prospective payment system nearly 20 years ago. The rate reduction is the equivalent of a one year cut of nearly $750 million in a Medicare benefit that totals $18 billion annually.

Under current law, CMS is authorized to make assumptions about prospective provider behavior in rate setting. The behavior change assumptions and the assumed level of impact can be modified annually, with a resultant impact on payment rates. The National Association for Home Care and Hospice (NAHC) greatly appreciates CMS's openness in reconsidering its proposed assumptions leading to a reduction in the rate cut. This was a solid step towards a more equitable payment model. However, the application of behavioral assumptions in prospective annual payment rate setting still greatly concerns NAHC, as does the limited information disclosed regarding the assumption-based calculations. Notably, the risk of relying on assumptions is highlighted by the significant change between the proposed and final assumptions. NAHC is also concerned that assumption-based rate setting actually will trigger provider behavior changes simply to sustain revenue neutrality. In this sense, behavior changes that might not otherwise occur become inevitable.

A payment model where new assumptions and corresponding rate adjustments can be made annually creates an unstable financial environment for providers, thereby posing an ongoing threat to continued operations and access to care for vulnerable Medicare beneficiaries.

NAHC strongly supports the Home Health Payment Innovation Act (S. 433 & H.R. 2573), which was introduced with bipartisan support in both the House and Senate. This important legislation would require rate adjustments based only on real, actual changes in provider behavior in response to the new payment model. With the finalization of the CY 2020 payment rule, it may be necessary to modify the legislation to focus on future years to improve the transparency of any additional behavior adjustments to payment rates and to restrict the use of bald assumptions as the sole or primary basis for such adjustments. These core reforms in the Home Health

Payment Innovation Act remain needed to ensure stability in the home health benefit and preserve access to care for the 3.5 million users of home health services.

NAHC greatly appreciates the actions to date and the ongoing bipartisan and bicameral support of the Congress on this issue as well as CMS for its reevaluation of their projected behavioral assumptions in issuing the final rule. Still, the reform recommended here is essential. As a starting point, it would be very helpful if Congress committed to closely monitoring access to care and changes in service utilization that may be driven by weaknesses in the payment model. There are early, anecdotal reports of access problems for patients in categories with reduced reimbursement levels to the HHAs.

In addition, Congress should call on CMS to provide full transparency on its data and any of its reasoning in future calculations of rate levels and rate adjustments. The CY2021 proposed rule is expected mid- year and CMS is currently working on its draft of that rule. Fair rulemaking and Medicare rate setting requires that CMS provide full disclosure so that affected parties can properly participate in the public rulemaking process.

Innovative Use of Telehealth/Telehomecare

Telehomecare is the use of technologies with the goals of:

- Early detection and intervention of a potential health crisis.
- Empowerment of the patient for self-management through the collection and exchange of clinical information from a home residence to a home health/hospice agency, a secure monitoring site, or another health care provider via electronic means.

The scope of telehomecare includes, but is not limited to, the remote electronic monitoring of a patient's health status and the capturing of clinical data using wireless technology and sensors to track and report the patient's daily routines and irregularities to a healthcare professional; electronic medication supervision that monitors compliance with medication therapy; and two-way interactive audio/video communications between the provider and patient allowing for face-to-face patient assessment and self-care education.

The VA has broadly deployed a range of remote patient monitoring (RPM) technologies and conducted various studies showing improved chronic disease management, cost savings and reduced hospital admissions and emergency department (ED) visits as the result. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology.

Unfortunately, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow HHAs to be reimbursed for telehomecare technology costs by Medicare. The absence of payment for non-physician telehealth interactions and restrictive federal Medicaid and Medicare telehomecare guidelines are barriers to more widespread adoption of telehealth.

Most recently, the Bipartisan Budget Act of 2018 included provisions that expand the ability of MA plans and Accountable Care Organizations (ACOs) to offer telehealth services. However, Medicare beneficiaries generally still not have access to telehomecare.

Beyond Medicare benefit limitations, many rural areas across the United States – the very areas that could most benefit from use of telehomecare technologies -- do not have Internet access sufficient to enable its use. The Administration, Congress, states, and carriers must take action to address this serious deficiency.

At the same time, the technology sector is rapidly developing other valuable new technologies, many of which will help to promote aging in place, while others may provide sufficient advance warning of potential changes in health status that they could reduce acute exacerbations of serious health conditions. These hold great promise for more effectively addressing health care needs of community-based senior citizens. Technologies for use in the delivery of home health and hospice care are increasingly being recognized as essential tools for an industry challenged by an exponential growth in the number of patients over 65 with chronic disease, a shortage of skilled professionals to handle the increased senior population and by diminished reimbursement formulas. Through the effective use of such technologies, the overarching goals of keeping patients safely at home and reducing emergent and acute care spending can be realized.

Congress should:

1.) Establish telehomecare services as distinct benefits within the scope of federal Medicare and Medicaid coverage to include all present forms of telehealth services. As part of these benefits, Congress should allow sufficient flexibility to adopt coverage of emerging technologies, and to allow costs associated with them for cost reporting purposes;

2.) Clarify that telehomecare qualifies as a covered service and permit visit equivalency under the Medicare home health and hospice benefits (including under MA);

3.) Authorize the home as an originating site for telehealth services by physicians under section §1834(m) (3) (C) and provide greater flexibility for the use of remote patient monitoring services;

4.) ensure that all health care providers, including HHAs and hospices (especially those in rural areas with limited availability of health care/clinical providers), have access to appropriate bandwidth so that they may take full advantage of technology appropriate for the care of homebound patients;

5.) Hold cellular carriers accountable to incentives provided by states to expand broadband to rural regions; and

6.) Direct CMS' Centers for Medicare & Medicaid Innovation (CMMI) to study the impact that early adoption of technology has had on access to care and reductions in overall health care costs, as well as to develop demonstration projects that identify the impact that coverage of various technologies can have on care utilization by patients who would otherwise be high utilizers of care.

Telehomecare is a proven and important component of health care today and vital to reducing acute care episodes and the need for hospitalizations for a growing chronic care population. Establishing a basic federal structure for Medicare and Medicaid reimbursement and coverage of telehomecare services will permit states to more easily add this important service to the scope of Medicaid coverage and benefit the entire Medicare program. Studies indicate that over half of all activities performed by a home health nurse could be done remotely through telehomecare.

Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. More specifically, the use of telehealth technologies in both urban and rural areas would help defray additional transportation cost and travel time and also improve the utilization of scarce nurses and therapists. With telehomecare a single clinician is able to care/case manage a larger number of patients than under the traditional in-person visit model. Given the growing financial constraints on agencies -- especially in rural settings -- providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including nontraditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction, and emerging technologies.

Workforce Shortages in Home Care Need to be Addressed

Evidence is mounting that the workforce available to provide care in the homes is insufficient to meet the current needs of the nation's elderly and persons with disabilities. The shortages involve all disciplines of caregivers, but it is particularly acute with nurses, home health aides and personal care attendants. With the aging of America, the shortages will only grow and grow exponentially unless a national home care workforce strategic plan is developed and implemented.

The shortages are likely due to a myriad of reasons including the disproportionate population level of elderly, limitations on health care educational resources, the difficulties of the work itself, compensation, career opportunities, and the inadequate respect for caregivers, to name a few of the possible explanations.

Remedial actions have been ongoing for many years, but they have made only a small dent in addressing the needs. Given that the causes of worker shortages are multi-dimensional, it is apparent that multi-dimensional solutions must be explored.

NAHC is ready and willing to participate as one of the voices needed to evaluate and craft viable solutions. We do not hold any claim to knowing what all the solutions may be. However, we sincerely believe that solutions can be found through a broad partnership of stakeholders, including Congress, committed to the effort.

Conclusion

The National Association for Home Care & Hospice extends its sincere thanks to the Special Committee on Aging for its attention to the important area of home health care in rural America. We also thank the Committee for the opportunity to submit this testimony and we look forward to working with the Committee on its efforts to ensure access to high quality of care at home.