

**TESTIMONY BEFORE THE SPECIAL COMMITTEE ON AGING
U. S. SENATE
MARCH 31, 1998
ON BEHALF OF THE
NATIONAL ASSOCIATION FOR HOME CARE**

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Mr. Chairman,

Thank you for the opportunity to present testimony today on issues related to the Medicare home health benefit. My name is Bill Dombi. I am the Vice President for Law for the National Association for Home Care (NAHC) and Director of NAHC's Center for Health Care Law.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention the Members of this Committee have shown to the problems created by the three home health provisions of the Balanced Budget Act of 1997 (BBA) which are the subject of this hearing: the home health interim payment system, surety bonds, and the exclusion of venipuncture as a qualifying service. We appreciate the opportunity provided by this Committee to express our concerns about the devastating impact these provisions are having on home health agencies and the patients they serve.

We have seen the arguments in favor of these BBA provisions, citing recent growth in the home care benefit and the need to curb home health utilization. It should come as no surprise, however, that home health care has expanded rapidly. A number of factors have played a role in this trend. Demographics show that the number of elderly and disabled is increasing. Hospital stays are becoming shorter, driven by cost controls. Nursing home use is declining. More patients and physicians are aware of home care. Technological advances are permitting more services to be delivered at home. Judicial rulings made home care more broadly and readily available. Finally, for most people, the home is the preferred setting for most health and supportive services. All of these factors have played a role in home care's increasing use and popularity. Given these many factors, we must guard against the temptation to attribute this growth to overutilization. To do so will lead to the loss of vital services for our elderly and disabled citizens.

The BBA cut home health spending by \$16.2 billion over five years. Although home care represents only 9% of Medicare, it was slated for about 14% of the cuts in Medicare spending. Moreover, there is

evidence to support the conclusion that the actual savings, if nothing is done to repeal or modify these three BBA provisions, may be over \$40 billion due to Congressional Budget Office (CBO) scoring "offsets."

INTERIM PAYMENT SYSTEM

BBA made dramatic changes in the reimbursement system for Medicare home health services. These changes became effective for cost reporting periods beginning on or after October 1, 1997, and are intended to remain in effect until October 1, 1999, when a new prospective payment system (PPS) is implemented for cost reporting periods beginning on or after that date.

Under the new interim payment system (IPS), agencies are reimbursed the lowest of their (1) actual allowable costs; (2) aggregate per-visit cost limits; or (3) a new aggregate per beneficiary limit.

The purpose of IPS was to restrain the growth in home health utilization and limit the growth in expenditures. A number of significant problems have emerged which have led to results which, NAHC believes, were unintended by Congress in putting this system in place.

Reduced Cost Limits

IPS reduced the per-visit cost limits in two ways. First, the limits are calculated based on 105% of the median per-visit costs of freestanding home health agencies, rather than the previous method of 112% of the mean. Second, the new cost limits do not take into account the market basket price increases that occurred between July 1, 1994 and June 30, 1996. The combined effect of these two provisions represents a 21% reduction in the cost limits. The Health Care Financing Administration (HCFA) has estimated that 65% of all providers will be over these limits, as opposed to their estimation that 30% of providers would be over the limits in the previous year. NAHC believes that the percentage of those over the limits is even higher.

Problems With and Inequities Created by the New Per-Beneficiary Limits

In addition to the reduced cost limits, the new per-beneficiary limit has been of tremendous concern because of the inequities it creates. The per-beneficiary limit is a blended limit--75% agency-specific data and 25% census region data, with fiscal year (FY) 1994 as the base year. The idea behind the agency-specific component of the limit was that it would serve as a proxy for case-mix. The blend of census division data was intended to level the playing field, so that agencies within a census division with a lower cost per-patient than the census division would get a higher limit and agencies with a cost per-patient higher than the census division would end up with a lower limit. Census division data was used because there is significant variation in utilization in different areas of the country. So far, this variation has not been adequately explained, and there exists some evidence that usage is affected by the availability of Medicaid and other home and community-based alternatives in the area. Unless or until there is evidence that the regional differences in utilization reflect improper usage, it is important that regional differences be reflected in payment rates.

The primary impediment to developing a full PPS has been the lack of a case-mix adjuster to account for the characteristics of patients served that influence an agency's cost of providing services to those patients. Case-mix adjustment is necessary to ensure that agencies are not penalized for servicing a mix of patients whose care needs are more expensive and to eliminate the incentive for agencies to reject patients who require an unusually heavy burden of care. The theory behind the agency-specific component of the per-beneficiary limits was that an agency's own case mix would be the best predictor

of the case mix of patients it would serve in subsequent years.

This concept works far better in theory than practice. Using FY94 as a base year means using 1993 data for a substantial number of providers with the result that payments are based on five-year-old data. Out-of-date payment levels do not reflect changes that have occurred in the population served by home care or the types of services agencies are providing in 1998, 1999, or beyond. Over this time period, there has been an increase in the number and percentage of higher-cost patients in the system.

There has also been a rise in the number of home health agencies, which further disperses patients. Referral patterns have also changed. Agencies which did not provide therapy services or medical supplies in the base year, but have subsequently provided these services, will have to determine how or even whether or not they can continue to provide these services. Further, there is no mechanism for providers or patients to appeal or request an exception to the limits.

The per-beneficiary limit has been an extremely divisive issue in the home care community because certain types of providers and certain geographic areas are affected differently by these limits. This problem is compounded by the treatment of "new providers." Under the BBA, new providers, those who do not have a full base year ending in FY94, are to receive the "median of these limits," which HCFA has interpreted to mean national averages, rather than census division limits. Since nearly one-half of all providers under this definition are new providers, this leads to inequitable results. Some new providers who deliver care in census regions with limits which are below the national average will have higher limits than existing agencies in the census division. In other areas, the opposite effect results. In Louisiana, we are told, one agency has a per-beneficiary limit estimated to be \$3,000 per year, and a competing agency in the same city has a limit of \$13,000.

Many agencies that have been in existence for years that have worked to get their costs down and become more efficient in anticipation of a prospective payment system end up being harmed by the per-beneficiary limits calculation. They end up with lower limits, based on the agency-specific data, and are penalized for their own efficiency. This is a system that does not distinguish in any way between efficient and inefficient agencies and sets up serious competitive inequities.

Beneficiary Impact

The most devastating impact of the IPS, however, is on beneficiaries. IPS will significantly reduce access to home health services and restrict the level of care received by patients in their homes. The inadequacy of the new reimbursement limits leaves providers with the Hobbesian choice of restricting access to their services or financially destroying the organization by delivering care to patients that push the agency's operating costs above the reimbursement limits. Patients who need the most care are most at risk for cutbacks, or being denied access to care. These beneficiaries tend to be the oldest, sickest, poorest, and most frail Medicare beneficiaries. With lower Medicare payments, providers will have to cut back on staff, leaving them unable to care for all who need home care. Patients who need care the most will either not receive care, or will be cared for in more costly settings like emergency rooms, hospitals, and nursing homes.

It is important to note that although the reimbursement system has dramatically changed, the Medicare coverage criteria (except for the venipuncture exclusion) have remained the same. Providers will need to lower both their unit costs and their utilization of services in order to remain viable under IPS. Lowering either of these without adversely affecting patient care or the quality of services, however, may be extremely difficult.

Home health costs have grown much more slowly than both the health care market basket and the consumer price index (CPI). Therefore, it will be very hard for providers to reduce unit costs, continue to comply with quality standards, and stay under the cost limits.

Providers will also have to reduce utilization levels which could have a drastic impact on beneficiary care. One way to limit utilization is to cut the number of visits across-the-board to all patients. This could place some Medicare beneficiaries at risk since they will receive less care than they need to remain in the home. Lower utilization will also require family caregivers to carry a larger burden. Studies show that family caregivers already provide a majority of home care services. Under IPS, their burden will increase. Further, less visits mean higher costs per visit.

To lower utilization and costs, home care providers may be forced to selectively admit patients. Beneficiaries who require high-intensity services for a short period (e.g. infected wound patients who require two or three dressing changes a day) or long-term patients who require services over an extended period (e.g. a multiple sclerosis patient with limited skilled care needs, but who requires extensive home health aide services for help with activities of daily living) will no longer be desirable types of patients for home health agencies to serve. Without home care, these types of patients could end up with an increased number of acute-care episodes, thus increasing costs to Medicare, or end up in nursing homes at higher costs to state Medicaid programs.

This raises the issue of appropriate versus inappropriate discharges from care. HCFA has yet to come out with material to educate beneficiaries or to guide agencies, so NAHC has attempted to develop educational materials for both providers and beneficiaries. Our best efforts, however, cannot take the place of guidance from HCFA since this is an unclear area of the law which calls for official establishment of responsibilities. It is critical that providers understand how to appropriately discharge patients from service, should that be necessary. It is also vital that beneficiaries understand how IPS affects them and their home care benefits.

Publication of Per-Beneficiary Limits

It is also important to remember that the new per-beneficiary limits will not be published by HCFA until April 1998. These limits will be retroactive to October 1, 1997. This means that nearly 2/3 of all home health providers will have been on IPS before the actual limits are published. In effect, they have been "flying blind," making business decisions on educated guesses. It is no wonder that many agencies are behaving conservatively in terms of patient admissions because of fears that they will end up significantly over these new unknown limits.

Development of PPS

Under the BBA, HCFA is charged with developing a full PPS to be implemented October 1, 1999. HCFA has testified before Congress that they find this deadline "challenging." NAHC is concerned that they will not develop PPS by this deadline and that the IPS, with its serious flaws, will remain in effect well beyond the two to three years it was intended to remain in place. Further, to the extent that HCFA must spend time and resources on IPS, it is further diverted from its task of developing PPS.

Reduction of Limits by 15%

On October 1, 1999, regardless of whether HCFA has developed PPS, home health expenditures are to be reduced by an additional 15%. This further reduction would be devastating to providers and would severely jeopardize the ability of beneficiaries to access care and restrict the level of care they could

receive in their homes. The additional 15 % reduction is unnecessary because the budget target will be achieved without it. Although the CBO estimated that the BBA would cut Medicare home care expenditures by \$16.2 billion over five years, the reductions in per-visit cost limits and the per beneficiary limits will likely cut home care expenditures by as much as \$40 billion over the same period.

IPS Studies

Two recent studies on IPS echo many of the concerns that the industry has raised about the potential impact of IPS on beneficiaries and providers. A recent study commissioned by The Commonwealth Fund found that changes in Medicare payments for home health care resulting from the BBA have the unintended consequence of reducing access to services for the oldest, poorest, and sickest Medicare beneficiaries. These individuals tend to need the most home care, for the longest periods of time. The report also found that:

-IPS places new financial pressures on home care providers to reduce high volume, or longer-stay, episodes of care.

-Most longer-stay patients are not using the Medicare home health benefit solely or predominantly, for long-term care. These individuals tend to have substantial acute care needs as well.

-The home care agencies most affected by IPS will not necessarily be the most inefficient. Agencies serving more patients with greater care needs than they served in FY94 will likely have difficulties maintaining the provision of appropriate care.

Another recently-released study by The Lewin Group, entitled "Implications of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act" concluded that:

-The sickest and most fragile patients may have difficulty accessing services, experience reductions in service, or be shifted to less appropriate care settings as a result of the per-beneficiary limit, which is based on 1993-94 cost data.

-The IPS was enacted to restrain growth of the Medicare home health benefit. However, CBO's 1998 baseline indicates that growth in the benefit has already been restrained without the implementation

SURETY BONDS

Included in BBA was a requirement that each home health agency participating in Medicare and/or Medicaid secure a surety bond of at least \$50,000, on a continuing basis. Agencies participating in both programs are required to secure two separate bonds. As members of the Committee are aware, the recommendation for this proposal came out of the Health and Human Services Inspector General's Office, based on the Florida Medicaid program's experience with a surety bond requirement for home health agencies and durable medical equipment suppliers.

However, the manner in which HCFA has sought to implement the federal requirement goes far beyond the Florida model, and provides a prime example of a situation where "more" is not necessarily "better." In fact, the two sponsors of the original surety bond legislation (Rep. Karen Thurman and Rep. Pete Stark) have expressed opposition to HCFA's implementation of the requirement, stressing that it goes beyond what Congress intended when it passed the BBA.

NAHC is fully supportive of efforts within Congress and HCFA to ferret out fraud and abuse and to prevent the admission of any unscrupulous provider into the home health care industry. The surety bond provision of BBA was intended to accomplish these ends. Since the enactment of BBA and the issuance of implementing regulations by HCFA, much has been learned by the home health industry, Congress, and the Medicare program relating to the surety bond concept. It now appears that these goals might be far better met through some other means. Standard qualifications for a surety bond relate to the profitability and financial standing of a business. However, Medicare and Medicaid home care services, the primary funding source for home care services nationwide, generally provide reimbursement at cost or less than cost and do not provide the financial foundation for the accumulation of assets. Nonetheless, a home care provider can be financially solvent and fully compliant with all Medicare and Medicaid requirements, thereby placing these programs at no risk. Even if the surety industry is capable of considering non-financial factors in qualifying an applicant for a bond, collateral and personal indemnification requirements will remain imposed upon an industry that will not have the capability of meeting those requirements.

NAHC believes that the best approach for Congress to take is a preventative measure rather than relying upon a surety bond as a fallback to correct mistakes which should have been avoided in the first place. The preventative measures come in the form of strengthened criteria for qualifying a home health agency as a provider of services. A home health agency should be afforded the privilege of serving Medicare and Medicaid patients only after it can demonstrate that it is capable of complying with coverage standards, reimbursement requirements, and the conditions of participation which are designed to protect the quality of care offered to patients. Currently, a prospective Medicare/Medicaid home health agency need only demonstrate compliance with the conditions of participation. Initial and ongoing evaluation of competency in the areas of reimbursement and coverage will provide far better protection for the Medicare and Medicaid programs than the use of a surety bond, which serves only to partially reimburse Medicare and Medicaid for mistakes long after they occur. NAHC is encouraged by the efforts of the Senate Special Committee on Aging to establish these strengthened participation criteria and recommends that the committee continue this direction as an alternative to the ill-fitting concept of a surety bond.

HCFA issued interim final regulations to implement the home health surety bond requirement on January 5. However, there was such overwhelming objection to the regulations from individuals involved in the home health and surety industries that HCFA was forced to revamp the regulations. HCFA has announced three specific changes it intends to make -- all three of these changes respond to concerns raised by the surety industry and which have discouraged companies from writing bonds. Unless HCFA is prepared to make additional changes beyond those that have been announced, many reputable home health agencies will still be unable to secure bonds. It is unclear when the final regulation governing home health surety bonds will be available, but HCFA has stated that agencies will have 60 days after publication of the final regulation to secure bonds. Until that final regulation is published, it will be impossible to determine how many home health agencies will be unable to purchase bonds.

We do not believe that the Congress ever intended for the surety bond requirement to be so troublesome. Surety bonds were meant to serve as a deterrent to "fly by night" providers in Medicare and Medicaid -- to screen out entities that pose a significant risk to the integrity of the programs. HCFA has instead fashioned surety bond regulations that serve as an insurance against the loss of any program overpayments. Given that less than two-tenths of one percent of program revenues are unrecouped overpayments, this approach is unnecessary and onerous.

In Florida, agencies were required to purchase a bond of \$50,000 in value; agencies in good standing

with the Medicaid program that had participated for at least one year were permitted to forgo the requirement. In Florida, once a new agency has proven itself reputable, it no longer must purchase a bond. The federal bonding requirement, however, is continuous. HCFA has set the value of the bond at the greater of \$50,000 or 15 % of previous year's revenues from the Medicare and/or Medicaid programs. The minimum \$50,000 amount can raise serious problems for the small, often rural, home health agency. Further, the 15 % calculation could lead to a prohibitively high cost for a home health agency. At this level of bonding, HCFA appears to be establishing a level of protection needed only if every agency incurred the maximum potential overpayment and every agency failed to repay any part of the overpayment.

Some of the industry's concerns relate to the language used in the legislation itself. For example, the home care industry believes that it is appropriate for Medicare to recognize the cost of securing a surety bond. With current reimbursement to home health agencies based upon reasonable costs incurred in providing care, the failure to recognize the cost of a surety bond as allowable guarantees that Medicare services are provided at less than the cost of delivering the care. Further, since the concept of a surety bond acts as a participation screening device, the bond serves the purpose of the payor and not the provider. In operation, it acts as adjunct to the payors' qualification of a home health agency to participate. Accordingly, since it serves as a function of governmental administrative responsibility, the program should pay for the cost of the bond. This would be consistent with other government bonding arrangements.

While the absence of reimbursement for the bond cost causes great difficulty for the small HHAs, the greater concern is the likelihood of collateral or personal guarantee requirements at several times the bond value. Small HHAs faced with these requirements may not continue to operate. A similar concern exists in applying the bond requirement to Medicaid services. With low reimbursement rates nationwide the bond cost may discourage HHAs from continuing participation.

In applying the bond requirement, HCFA should also consider whether the home health agency is in good standing with the Medicare and Medicaid programs. HCFA has exercised its authority to establish a waiver of the requirement for government-operated home health agencies on the basis of a belief that the interests of the Medicare and Medicaid programs are adequately protected. A similar standard should be employed to apply to all types of home health agencies allowing an agency that has demonstrated ongoing compliance and fiscal responsibility to be eligible for a waiver or a reduced bond amount.

An additional concern is the potential that the surety company can become the payor of first resort rather than allowing the home care agencies to establish an appropriate repayment plan for any repayment. Bond companies are affected with this standard, as their risk of liability is substantially increased. Home care agencies are even more severely affected in that a payment under the bond would lead to the termination of the provider agreement even in cases where the home health agency is willing, and able to make repayments.

HCFA must establish a standard which requires that the recoupment of an overpayment through their bond occurs only after fair and adequate opportunities are given to providers of services to enter into repayment plans. Currently, the program operates without any objective criteria for determining the eligibility of a provider of services to secure a repayment plan from the Medicare program. The lack of objective standards allows for an environment of arbitrary decision making. Further, the historical evidence of inappropriate intermediary determinations on claims and cost reports justifies the creation of a repayment plan system which allows home health agencies to pursue their appeals rights while repaying an alleged overpayment without risk of program termination.

The requirement that home health agencies obtain a separate bond each year dramatically increases the

bond costs for home health agencies and correspondingly the bond company exposure. This cumulative or aggregate liability with resultant cost for the home health agencies renders the market for bonds inaccessible and the terms for qualification unmanageable. HCFA should allow for the existence of a continuous bond without risk of cumulative liability.

While the concerns relating to the January 5 regulatory issuance warranted HCFA's action to postpone the bond compliance date, clarification is needed from HCFA regarding the requirement that new providers secure bonds before being permitted to participate in Medicare and/or Medicaid. This standard particularly affects existing providers with branch offices that are transitioning to subunits under HCFA's August 1997 policy directive. These HHAs should be allowed to achieve provider status without the bond and fulfill the bond requirement consistent with the time standard that will be imposed on existing HHAs.

Finally, serious questions are raised in this rulemaking endeavor regarding the authority and appropriateness of waiver of the rulemaking protections available under the Administrative Procedures Act (APA). HCFA's failure to develop these regulations on a timely basis turn HCFA's explanation for waiver into a self-fulfilling prophecy. HCFA was well aware of the intent to move forward with a bonding requirement as part of the BBA. In fact, HCFA was an early proponent of the surety bond requirement, along with the Office of Inspector General. Accordingly, although the legislation was signed into law on August 5, 1997 there was more than sufficient time for HCFA to develop a proposed regulation for public review prior to its finalization. HCFA, however, chose to publish interim final rules on surety bonds for HHAS, while the surety bond rules for DME were published in proposed form. The steps taken by HCFA relative to the identical bonding requirement for durable medical equipment suppliers indicate that a reasonable interpretation of the law is available to pursue a proposed rulemaking route even with the January 1 effective date.

In addition, full compliance with the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996, Public Law 104-121, does not appear to have been achieved with respect to HCFA's issuance of the surety bond regulations for home health. Under 5 U.S.C. § 801(a), the federal agency promulgating rules shall submit to each house of Congress and the Comptroller General a report containing a copy of the rule, a concise statement relating to the rule, including whether it is a major rule, and the proposed effective date of the rule before the rule can take effect. NAHC disagrees with HCFA that the surety bond rule does not represent a "major rule" under SBREFA in that the impact on small businesses is well in excess of \$100 million. HCFA grossly underestimated the cost of the bond without adequate evidentiary backup and further failed to consider the financial impact on small businesses that would be forced to close and terminate Medicare provider agreements due to the inability to access a bond under reasonable terms sufficient to comply with the regulatory standards.

Similarly, HCFA failed to explore and evaluate alternative regulatory approaches and set forth reasons for rejecting or accepting them. Irrevocable letters of credit, committed liquid assets, and other alternatives should be explored as a means of providing the Medicare program with protections comparable to that available through the surety bond method. As a consequence of the failure to meet APA rule making requirements and the standards set in SBREFA, the promulgated regulations led to a crisis within the Medicare and Medicaid programs as few bond companies were willing to entertain consideration of the issuance of bonds and the vast majority of home health agencies failed to qualify or find access to any bond. HCFA should not proceed further with the implementation or enforcement of any final rules regarding a surety bond requirement until adequate opportunity for public comment occurs and compliance with the SBREFA is ensured.

General Recommendations:

1. HCFA should develop the surety bond regulations based on the intended principle and purpose of screening out inappropriate HHAs rather than as an insurance policy against overpayments.
2. Legislation should be enacted to allow recognition of the costs of a surety bond.
3. The bond amount should be reduced below \$50,000 for small HHAs.
4. HCFA should reduce the bond amount to no greater than \$50,000.
5. HCFA should establish standards for waiver of the bond requirement for any HHA in good standing.
6. HCFA should establish objective criteria for the eligibility of an HHA for a Medicare repayment plan.
7. HCFA should postpone the bond compliance date for new subunits so that it is consistent with the time standard for existing HHAs.
8. HCFA should modify the regulations to eliminate or limit any risk of cumulative liability for the surety.
9. HCFA should not implement or enforce the surety bond regulations until the completion of the notice and comment procedures under the APA.
10. HCFA should comply with all procedural requirements of SBREFA including Congressional notice and the exploration and evaluation of alternatives.

VENIPUNCTURE

Effective February 5, 1998 a provision included in the BBA removed blood drawing (venipuncture) as a qualifying service for the Medicare home health benefit. Prior to February 5, if a beneficiary needed venipuncture and met all other home health criteria, he or she could receive venipuncture from a home health nurse along with other Medicare-covered home health services ordered by his or her physician, including home health aide services. Under the new policy, if venipuncture is the sole skilled service needed, Medicare will only cover venipuncture provided by lab technicians under Part B, and homebound beneficiaries in need of blood monitoring will lose eligibility for home health services.

Beneficiaries qualifying for home health services based on venipuncture are some of the oldest and most disabled Medicare beneficiaries, many with multiple diagnoses including diabetes, heart disease, stroke and clinical depression. Many homebound individuals with chronic conditions and complex medication regimens will no longer receive nurse assessments for purposes of preventing acute episodes and hospitalizations. The home health aide services that are sometimes provided by the agencies in conjunction with blood monitoring make it possible for beneficiaries to remain in stable condition and at home. Without such services, many of these individuals may need to be admitted to long-term care facilities.

NAHC has received hundreds of phone calls and letters from consumers, physicians, providers, and other organizations raising concerns about the severe impact on patients resulting from the removal of venipuncture as a qualifying service under the Medicare program. Members of Congress have taken action and expressed their concern about the effects this provision is having on patients. However,

HCFA has reported that they do not believe that Medicare beneficiaries were placed at risk as a result of this provision.

Impact of the Venipuncture Exclusion

HCFA has recently criticized home health agencies for alarming beneficiaries regarding the venipuncture exclusion. However, the reality is that thousands of Medicare beneficiaries have been denied care as a result of this change in the home health benefit.

Representative Robert Adherholt (R-AL) reported that in Alabama alone, between 15,000 and 20,000 venipuncture recipients were in jeopardy of losing their home care benefits. The Texas Association for Home Care estimated that about forty thousand Medicare beneficiaries in Texas would lose their home health benefits February 5 as a result of the elimination of venipuncture as a qualifying service. Projected to all Medicare-certified Illinois providers, an Illinois Homecare Council survey estimated 7,000 Medicare patients would be discharged after February 5, leading to higher utilization in skilled nursing or hospital facilities, and potentially higher utilization under the Medicaid benefit.

Dr. Don Williamson, who directs the state health department in Alabama, reported that a home health agency in his department dropped about one quarter of its 8,400 Medicare patients as a result of the venipuncture exclusion. When asked to comment on the new rule, he said, "I don't want to see thousands of elderly patients disenfranchised and end up in hospitals and nursing homes if they can be maintained at home... It troubles me that at a time when we're providing health insurance to uninsured children, old people are potentially losing a benefit they need." ("Thousands of Medicare Patients Losing Service," Anderson Independent-Mail, Anderson, S.C., February 11, 1998)

In an interview with Eli's Home Care Week, an official from one of HCFA's own Medicare fiscal intermediaries admitted, "a lot of people are going to, fall through the cracks" as a result of the elimination of venipuncture as a qualifier. "Probably several things will happen," the official notes: these beneficiaries will end up in "an emergency room, a skilled nursing facility, or someplace worse like the mortuary. It is a cold cruel world, but the Medicare home health benefit will change effective February 5 and we don't want to see those services on a home health claim. After February 5, it's too bad, so sad." (Interview reported in Eli's Home Care Week, Volume VII, Number 5, February 2, 1998)

Limited Availability of Other Services As Qualifying Skilled Services

HCFA has stated that most of the individuals who currently qualify for Medicare home health benefits through venipuncture will still be covered because they have needs for other skilled services, such as management and evaluation or observation and assessment. However, the need for these skilled services does not trigger a home health benefit sufficient in duration to meet the needs of most homebound venipuncture patients. Typically, Medicare covers these as separate skilled services for homebound venipuncture patients for only a few weeks until the patient stabilizes.

A March 10, 1998, letter received by NAHC illustrates this problem. An 85-year-old Medicare beneficiary in advanced stages of emphysema and congestive heart failure was discharged from home health on February 5 because her need for venipuncture no longer qualified her for the home health benefit. She was stable at the time of discharge. However, within a week she had to be transferred to the hospital in acute distress. She remained there a few days and returned home, again eligible for home health for a brief period until she stabilizes again. She is typical of venipuncture patients who will "ping pong" in and out of hospitals and on and off home care, at greater cost to the Medicare program, because of the exclusion of venipuncture as a qualifying home health service.

In the interview with Eli's Home Care Week and despite HCFA's indications to the contrary, the Medicare fiscal intermediary warned home health agencies against using management and evaluation as a qualifying need. "It is something that we feel agencies are going to try to use, and it is not appropriate." The official points out that observation and assessment "is generally short term, the patient comes out of the hospital following a hip fracture, for instance, and they are placed on coumadin therapy until their medical condition stabilized. At that point, the nurse needs to pull out if all they are doing is the venipuncture. " Observation and assessment, the official concludes, is "not going to be the catch-all."

Restricted Availability of Part B At-Home Lab Services and Loss of Home Care Aide Services

HCFA has indicated that no one will lose venipuncture services, because Medicare covers this service by a lab technician under Part B. With regard to access to services, it is important to note that (1) currently 2.1 million people who have Medicare Part A do not have Part B and will not have coverage; (2) in many parts of the country, particularly in rural and other under-served areas, at-home lab services are not available because of long travel times, security concerns, lab technician regulations, and low reimbursement; and (3) homebound beneficiaries who access the Medicare benefit through the skilled venipuncture service will lose other home health services, including home health aide services that are critical to allowing beneficiaries to remain at home.

Out of concern for the impact of this provision on rural and other underserved areas, Senators Grassley, Rockefeller, Baucus, Bryan, and Bumpers warned in a letter to HCFA Administrator Nancy-Ann Min DeParle that, "Bedridden patients will be put at tremendous risk. Some families will be forced to somehow transport very frail seniors once a month to have their blood drawn. Many will probably go without prescribed monitoring, putting them at great risk for serious medical complications."

In a January 26 news release, the Medical Association of Alabama, like many physicians and medical groups around the country, expressed concern that with the withdrawal of the venipuncture service comes the termination of services provided by home health aides. Dr. Williamson, as the Alabama State Health Officer, wrote to HCFA that he had "grave concerns that many home health patients, as a result of this legislative change and the interpretation of this change by the fiscal intermediaries, will be forced into emergency rooms, hospital admissions, and nursing home admissions when heretofore they have been able to be maintained at home."

No Studies, Reports, Hearings, or Assessment of Impact on Patients and Cost Shifting to Other Programs

HCFA has repeatedly stated that the venipuncture exclusion is necessary to combat fraud and abuse. However, no studies were done by the U.S. Department of Health and Human Services Office of the Inspector General nor any other agency, and no hearings were held to determine the impact that this provision would have on thousands of frail elderly or the cost shifting to other programs (such as Medicaid) that will result from it.

In announcing his support of "The Medicare Venipuncture Seniors Protection Act," Representative William Jenkins (R-TN) stated the budgetary case against the venipuncture exclusion: "If our intent is to save money in health care, it does not make sense to discontinue this (venipuncture) benefit. Many of these individuals could be placed into nursing homes and onto the Medicaid program. In Tennessee, one recent study has indicated that an additional 3,000 nursing beds will be needed by the year 2000. More beds will be needed if this inequity is not corrected. " Many state governments have expressed their

concern about increased Medicaid costs due to the venipuncture exclusion.

The National Council of Senior Citizens, the National Council on Aging, the National Senior Citizens Law Center, and the Older Women's League have expressed concern in a letter to Congress that the venipuncture "provision was passed without benefit of any hearings or public debate. Venipuncture should be reinstated until a number of very serious questions are answered," they concluded. "Specifically, Congress and the public should have a clear understanding of who would be affected by this prohibition."

We would like to give special recognition today to a distinguished member of this Committee, Senator Richard Shelby (R-AL) who has shown tremendous leadership in this area. Senator Shelby has introduced S. 1580, which would reinstate venipuncture as a qualifying home health service. Legislation has also been introduced by Representatives Nick Rahall (D-WV) and Robert Aderholt (R-AL) (H.R. 2912 and H.R. 3137). H.R. 2912 repeals the BBA venipuncture provision; H.R.3137 and S. 1580 would delay implementation for 18 months. All three bills require a study of the venipuncture home health service and a report to Congress. We urge Members of Congress and the Senate to support these bills. As of today, the number of cosponsors on H.R. 2912 alone is approaching 100.

We urge you to delay implementation of this BBA provision until the impact of the venipuncture exclusion can be assessed as outlined in the proposed legislation. By passing such legislation, Congress could make certain that patients needing care receive the care they need while Congress works to address any valid concerns about the venipuncture benefit.

CONCLUSION

We at NAHC, along with many Members of this Committee, have pressed for the development of an episodic prospective payment system (PPS) for home health that would include an adequate case mix adjuster to account for the costs of care of intensive care patients, thus creating incentives for efficient delivery of services while ensuring that high-cost chronically ill patients are not discriminated against. We urge you to ensure timely development and implementation of such a prospective payment system, as called for in the BBA.

Medicare is a vital part of the fabric that protects our nation's most vulnerable individuals. Even it does not provide complete protection, however. Millions of elderly disabled individuals have chronic long-term care needs that go unmet. Millions struggle to pay for prescription drugs. Millions need mental health care. Rather than chopping away at home care -- a health care benefit that works and that helps keep people at home and with their families -- let's focus on the future of Medicare and look for creative ways to improve the health and lives of America's seniors and disabled population. I urge you to take action to correct these three home health provisions in the BBA that are endangering access to home health services.

Thank you again, Mr. Chairman, for the opportunity to present our views. You and the Committee have our thanks for bringing these three home health issues to this level of consideration. We look forward to working closely with you to resolve these issues, and ultimately to making PPS for home care a reality.