I

104TH CONGRESS
2D SESSION

H. R. 4229

To amend title XVIII of the Social Security Act to provide for prospective payment for home health services under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1996

Mrs. JOHNSON of Connecticut introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for prospective payment for home health services under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Home Health Services Prospective Payment Amendments of 1996''.

SEC. 2. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 202

of Public Law 104–191, is amended by adding at the end the following new section:

''PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1894. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide for payments for home health services in accordance with a prospective payment system as follows:

''(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, under any other contracting or consulting arrangement, or otherwise).

''(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

''(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

''(B) Physical therapy.

''(C) Occupational therapy.

''(D) Speech-language pathology services.

''(E) Medical social services under the direction of a physician.

''(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

''(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF ASSISTANCE.—

''(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section

1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

''(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

''(A) for fiscal year 1997, is an amount equal to the national average amount reimbursed per visit under this title to home health agencies for such type of service (including medical supplies) during the most recent 12-month cost reporting period ending on or before December 31, 1994, updated by the home health market basket percentage increase for each year before the date in such fiscal year in which this section first applies; and

''(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect under this paragraph for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year.

''(3) PAYMENTS ABOVE PER VISIT RATES.—

"(A) ELECTION.—A home health agency may elect to receive per visit payments in excess of the per visit payment rate under paragraph (1) up to the per visit payment limit under subparagraph (B) if the agency can demonstrate to the satisfaction of the Secretary that it can reasonably expect to incur such costs and that total payments will not exceed the agency's aggregate limit under subsection (c). The Secretary shall further provide for exemptions, exceptions, and adjustments to the per visit payment limit of this section on the same basis as are provided under subsection (c)(3) with respect to the limitations on final payment.

"(B) PER VISIT PAYMENT LIMIT.—For fiscal year 1997, the per visit payment limit under this subparagraph is calculated as established by section 1861(v)(1)(L). For each subsequent year, such payment limit is equal to the limit for the preceding fiscal year under this subparagraph increased by the home health market basket index for the fiscal year involved.

"(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket per-

centage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for discharges in the fiscal year.

''(c) AGGREGATE LIMITS.—

''(1) PHASE I AGGREGATE LIMIT.—

''(A) IN GENERAL.—Before the end of the second 12-month period beginning on the effective date of this section, except as provided in paragraphs (3) and (4), a home health agency may not receive aggregate per visit payments under subsection (a) for such a 12-month period in excess of an amount equal to the product of—

''(i) the number of unduplicated medicare beneficiaries receiving home health services from the agency during the period; and

''(ii) the per patient limit determined for such period.

"(B) ESTABLISHMENT OF PER PATIENT LIMITS FOR INITIAL YEAR.—

"(i) IN GENERAL.—For the initial 12-month period, the per patient limit for an agency is equal to the product of—

"(I) the sum of 75 percent of the updated per visit costs described in clause (ii) for the agency and 25 percent of the regional average described in clause (iii) for the agency; and

"(II) the average annual number of medicare home health agency visits per unduplicated medicare beneficiary for fiscal year 1995.

"(ii) UPDATED PER VISIT COSTS.—The updated per visit costs described in this clause, for a home health agency for a payment period, is the average per visit reasonable costs for home health services of the agency, calculated for the base year, based on fiscal year 1994 cost per visit, updated by the home health market basket percentage increase through the payment period involved.

"(iii) REGIONAL AVERAGE.—The regional average described in this clause, for a home health agency for a payment period, is the average of the updated per visit costs described in clause (ii) for the period for home health agencies located in the same census region in which the agency is located.

"(C) ESTABLISHMENT OF PER PATIENT LIMITS FOR SECOND YEAR.—For the second 12-month period, the per patient limit for an agency is equal to the product of—

"(i) the sum of—

"(I) 50 percent of the updated per visit costs described in subparagraph (B)(ii) for the agency for the period, and

"(II) 50 percent of the regional average described in subparagraph (B)(iii) for the agency for the period; and

"(ii) the average annual number of medicare home health agency visits per unduplicated medicare beneficiary for fiscal year 1995.

"(D) NEW PROVIDERS AND PROVIDERS WITHOUT BASE YEAR.—For a new home health agency or a home health agency for which there is no base year under subparagraph (B)(ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies in the same census region in which the agency is located as determined by the Secretary. A home health agency shall not be treated as a new home health agency by reason of any corporate restructuring or change of name.

"(2) PHASE II AGGREGATE LIMITS.—

"(A) IN GENERAL.—After the end of the second 12-month period beginning on the effective date of this section and until the effective date of any episodic prospective payment system (including a system developed under subsection (h)) that is enacted by the Congress, except as provided in paragraphs (3) and (4), a home health agency may not receive aggregate per visit payments under subsection (a) for a 12-month payment period in excess of an amount equal to the sum of the following:

''(i) The sum (for all case-mix categories) of the products (determined separately for each such category) of—

''(I) the total number of episodes for the category for which the agency receives payments during the payment period, and

''(II) the per episode limit determined under subparagraph (B) for the category and payment year.

''(ii) The product of—

''(I) the number of unduplicated medicare beneficiaries receiving home health services from the agency beyond 120 days during the payment year, and

''(II) the per patient limit for services provided beyond 120 days, as specified in subparagraph (E).

''(B) ESTABLISHMENT OF PER EPISODE LIMITS FOR FIRST 120 DAYS.—

''(i) IN GENERAL.—The per episode limit under this subparagraph for a payment year for a case-mix category for the area in which a home health agency is lo-

cated (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) is equal to the product of—

"(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1995; and

"(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

"(ii) DETERMINATION OF AREA.—In the case of an area which the Secretary determines has an insufficient number of home health agencies to establish an appropriate per episode limit under this subparagraph, the Secretary may establish an area other than the area used to determine the area wage under section 1886(d)(3)(E)

for purposes of establishing an appropriate per episode limit.

''(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop and apply a more accurate methodology for determining case-mix categories subject to prior public notice and comment under section 553 of title 5, United States Code.

''(D) EPISODE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

''(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

''(II) is immediately preceded by a 45-day period in which the individual did not receive visits for a type of

home health service described in subsection (a)(2).

''(ii) PRORATION OF EPISODE LIMIT SPANNING PAYMENT YEARS.—The Secretary shall provide for such rules as appropriate to prorate episode limits under this paragraph which begin during a payment year and end in a subsequent payment year.

''(E) ESTABLISHMENT OF A PER PATIENT ANNUAL LIMIT FOR SERVICES PROVIDED AFTER 120 DAYS.—

''(i) IN GENERAL.—The per patient limit for services provided by a home health agency after 120 days for a payment period is equal to the product of—

''(I) the sum of 50 percent of the updated per visit costs described in paragraph (1)(B)(ii) for the agency and year and 50 percent of the regional average described in paragraph (1)(B)(iii) for the agency and year; and

''(II) the average annual number of medicare home health agency visits

over 120 days per unduplicated medicare beneficiary for fiscal year 1995.

''(ii) NEW PROVIDERS AND PROVIDERS WITHOUT BASE YEAR.—The provisions of subparagraph (D) of paragraph (1) shall apply with respect to clause (i)(I) in the same manner as they apply to subparagraph (B)(ii) of paragraph (1).

''(3) EXEMPTIONS AND EXCEPTIONS.—

''(A) EXTRAORDINARY COSTS.—The Secretary shall provide for an exemption from, or an exception and adjustment to, at the request of the home health agency, the methods under this subsection for determining payment limits where events beyond the home health agency's control or extraordinary circumstances, including the case mix of such home health agency, create reasonable costs for a payment year which exceed the applicable payment limits.

''(B) OTHER FACTORS.—The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such methods, as the Secretary deems appropriate, as determined by the Secretary.

"(C) TIMELY DETERMINATION.—The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 120 days after receiving a completed application from the home health agency for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

"(D) LIMITATION.—The cumulative expenditures for exemptions and exceptions under this paragraph shall not exceed the cumulative amount that would have been payable under paragraph (4)(B) if the 10 percent limitation under clause (ii) of such paragraph did not apply.

"(4) RECONCILIATION OF AMOUNTS.—

"(A) PAYMENTS IN EXCESS OF LIMITS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year

in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

"(B) SHARE OF SAVINGS.—

"(i) COMPUTATION.—If a home health agency has received aggregate per visit payments under subsection (a) for a payment year in an amount less than the limit determined under paragraph (1) or (2) (as applicable) with respect to such home health agency for such payment year and, with respect only to paragraphs (1) and (2)(E), the home health agency has an average payment per unduplicated medicare beneficiary at or below 125 percent of the regional average (described in paragraph (1)(B)(iii) or (2)(E)(iii), respectively), subject to clause (ii), the Secretary shall pay such home health agency a payment equal to 50 percent of the difference between the aggregate payment and each applicable limit under paragraphs (1), (2)(B), or (2)(E).

"(ii) LIMITATION.—In no case shall payments under clause (i) for an agency

for a year exceed 10 percent of the aggregate per visit payments made to the agency for the year.

''(iii) INSTALLMENT PAYMENTS.—The Secretary may make the payments to a home health agency under clause (i) during a payment year on an installment basis based on the estimated payment that the agency would be eligible to receive with respect to such payment year.

''(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services.

''(e) ADJUSTMENTS.—

''(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to a home health agency under this section to ensure that the agency does not engage in the following for the purposes of circumventing the limits:

''(A) Discharging patients to another home health agency or similar provider.

''(B) Altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title.

''(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES.—

''(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency.

''(B) ADJUSTMENT OF LIMITS.—The Secretary shall adjust limits under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

''(3) MONITORING LOW-COST CASES.—

''(A) IN GENERAL.—The Secretary shall develop and implement a system designed to monitor significant changes in the percentage distribution of low-cost and high-cost patients

for which home health services are furnished by a home health agency over such percentage distribution determined for the agency under subparagraph (B).

''(B) DISTRIBUTION.—The Secretary shall profile home health service patients to determine the distribution of patients for the purpose of determining regional and national trends.

''(C) LOW-COST AND HIGH-COST PATIENTS.—For purposes of this paragraph, the Secretary shall define a low-cost and high-cost patient in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

''(D) REPORT ON ACCESS.—The Secretary shall report to Congress on an annual basis findings and recommendations for ensuring access to appropriate home health services.

''(f) SPECIAL RULE FOR CHRISTIAN SCIENCE PROVIDERS.—

''(1) PAYMENT PERMITTED FOR SERVICES.—Notwithstanding any other provision of this title, payment shall be made under this title for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and are certified for purposes of this title under criteria established by the Secretary, in accordance with a payment methodology established by the Secretary.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to services furnished during cost reporting periods which begin after the date on which the Secretary establishes the payment methodology and the certification criteria described in paragraph (1).

''(g) REPORT BY MEDICARE PROSPECTIVE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Prospective Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

''(1) Case-mix and volume increases.

''(2) Quality monitoring of home health agency practices.

''(3) Whether providers of service are adequately reimbursed.

''(4) On the adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

''(5) The appropriateness of the methods provided under this section to adjust the aggregate limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

''(6) The geographic areas used to determine the per episode and per patient limits.

''(h) DEVELOPMENT OF EPISODIC PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall develop a method payments for home health services under this title in accordance with an episodic prospective payment system. In developing the system, the Secretary shall take into consideration—

''(A) the data and processes from subsection (c)(2) that have proven valid and reliable, and

''(B) the degree of disruption resulting from changing the payment system.

''(2) ADDITIONAL CONSIDERATIONS.—The per episode amount under the system shall include all services covered and paid under home health services under this title as of the date of the enactment of this section, including medical supplies. In defining an episode of care under the system, the Secretary shall consider an appropriate length of time for an episode, the use of services and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current data available to the Secretary and shall include consideration of the cost of new regulatory requirements, changes in technology, and new care practices.

''(3) USE OF CASE MIX ADJUSTER.—Under the system the Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

''(4) UPDATES AND LABOR ADJUSTMENT.—Under the system, the episode payment amount shall be updated annually by the home health market basket index and the labor portion of the episode amount shall be adjusted for geographic differences

in labor-related costs based on the most current hospital wage index.

''(5) OUTLIERS.—Under the system the Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(6) COORDINATION REQUIREMENT.—Under the system, a home health agency shall be responsible for coordinating all care for a beneficiary under this title.

''(7) INPUT.—The system shall be developed with input from and coordination with representatives from the home health services industry and consumers of home health services.

''(8) PROPOSAL.—The Secretary shall submit to Congress a proposal for the system, consistent with this subsection, not later than 4 years after the date of the enactment of this section.

''(9) IMPLEMENTATION.—The system developed under this subsection shall become effective only pursuant to an Act of Congress. It is the intent of Congress that the effective date of the system be not later than 18 months after the enactment of such an Act.

''(i) DEVELOPMENT OF DATA BASE.—Within 60 days after the date of the enactment of this section, the Secretary shall initiate the development of a data base upon which a fair and accurate case mix adjustor, as required by subsections (c)(2)(C) and (h)(3), can be developed and implemented. The data base must—

''(1) be capable of linking case mix data with cost and utilization data;

''(2) contain data from HCFA Forms 485 and UB–92;

''(3) contain additional data elements sufficient to support the case-mix categories in subsection (c)(2)(C); and

''(4) contain any additional data elements determined necessary by the Secretary in consultation with representatives of the home health industry.''.

(b) APPEALS TO PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(a) of such Act (42 U.S.C. 1395oo(a)) is amended by inserting '', any home health agency which has received payment pursuant to section 1894 may obtain a hearing by the Board, with respect to such payment,'' after ''subsection (h)''.

(c) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) of such Act (42 U.S.C.

1395x(v)(1)(L)) is amended by adding at the end the following new clause:

''(iv) This subparagraph shall apply only to services furnished by home health agencies before the effective date of section 1894.''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply to payment for home health services furnished on or after such date (not later than 6 months after the date of the enactment of this Act) as the Secretary of Health and Human Services specifies.

SEC. 3. REVIEW BY PEER REVIEW ORGANIZATION OF HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3) is amended following new subsections:

''(g)(1) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of the level of care and quality of services provided individuals receiving home health services pursuant to sections 1812(a)(3) and 1832(a)(2)(A)(i).

''(2) If—

''(A) a home health agency has determined that a patient does not meet the conditions for payment

of home health services under section 1814 or section 1833,

"(B) the home health agency has determined that a patient no longer requires home health services,

"(C) the home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's attending physician, or

"(D) the patient has been authorized by the home health agency to receive a level of care less than that considered by the patient as appropriate to meet the patient's needs,

the home health agency shall provide the patient (or the patient's representative) with a notice (meeting the conditions prescribed by the Secretary under section 1879) of the determination.

"(3)(A) If the patient (or patient's representative)—

"(i) has received a notice under paragraph (2), and

"(ii) requests the appropriate peer review organization to review the determination,

the organization shall conduct a review under subsection (a) of the validity of the home health agency's determination and shall provide notice (by tele-

phone and in writing) to the patient or representative and the home health agency and attending physician involved of the results of the review. Such review shall be conducted regardless of whether the home health agency will charge for continued home health services or whether the patient will be liable for payment for such continued care.

''(B) If a patient (or a patient's representative) requests review under subparagraph (A) while the patient is still a patient of the home health agency and not later than noon of the first working day after the date the patient receives the notice under paragraph (2), then—

''(i) the home health agency shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

''(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

''(4) If—

''(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date that the patient (or patient's representative) receives the notice under paragraph (2), and

''(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the home health agency shall not charge the patient for home health services furnished before noon of the day after the date the patient or representative receives notice of the peer review organization's decision.

''(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).

''(h) The utilization and quality control peer review organization shall monitor the delivery of home health services in a manner which includes a review of home health agencies that present significant variation in utilization.''.

(b) HEARING RIGHTS.—Section 1155 of such Act (42 U.S.C. 1320c–4) is amended by adding at the end the following: ''Notwithstanding the previous provisions of this section, any beneficiary receiving home health services subject to review under section 1154(g), and the provider, who is dissatisfied with a determination, shall be entitled to a hearing by the Secretary and to judicial review of any final determination to the same extent as provided under section 1869.''.

(c) ELIMINATION OF CERTAIN FISCAL INTERMEDIARY RESPONSIBILITIES.—Section 1816(j) of such Act (42 U.S.C. 1395h(j)) is amended by striking ''home health services,''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply to contract years beginning after the date of the enactment of this Act.

SEC. 4. RETROACTIVE REINSTATEMENT OF PRESUMPTIVE WAIVER OF LIABILITY.

(a) IN GENERAL.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of the Omnibus Budget Reconciliation Act of 1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking ''December 31, 1995'' and inserting ''the date of implementation of a prospective payment system for home health care services under section 1894(h) of the Social Security Act''.

(b) PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking ''December 31, 1995'' and inserting ''the date of implementation of a prospective

payment system for home health care services under section 1894(h) of such Act''.

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