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TESTIMONY
BEFORE THE
COMMITTEE ON SMALL BUSINESS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
Reducing the Regulatory Burden on Small Business:
Improving the Regulatory Flexibility Act

PRESENTED BY
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ON BEHALF OF THE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE, INC.

November 15, 2007

Madam Chair and distinguished members of the Committee on Small Business, thank you for the opportunity to present testimony regarding the regulatory burden on small business and potential improvements in the Regulatory Flexibility Act (“RFA”). The RFA and its progeny, the Small Business Regulatory Enforcement Act (“SBREFA”) and the Congressional Review Act (“CRA”) are extremely valuable to small businesses as those businesses work to efficiently operate in an environment subject to federal regulation.

My name is William A. Dombi. I am Vice President for Law at the National Association for Home Care & Hospice, Inc.(“NAHC”), located in Washington, D.C. NAHC is a trade association that represents the interests of home care providers and hospices nationwide. NAHC has over 6000 members that serve over 5 million of our nation’s most vulnerable populations—the elderly and disabled of all ages in need of health services for recovery, rehabilitation, or end of life care. The vast majority of these entities are small businesses with many having annual revenues under \$2 million. They serve patients in the large metropolitan areas as well as the most hard to reach frontier areas of Montana, Alaska, and Wyoming. Services are provided in homes throughout nearly 99% of the nation’s zip code areas. Whether by car, bus, snowmobile, or float planes, home care and hospice providers find a way to provide high quality health care to people in need.

Federal regulations are a part of the everyday life of home care and hospice. The primary payers of these services are Medicare and Medicaid with estimated combined expenditures of those programs at over \$50 billion annually. The applicable federal regulations focus on quality of care, service coverage standards, and reimbursement requirements. Literally all facets of the delivery of this care are touched by federal regulations. The federal agency with the greatest degree of federal regulatory impact is the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services. (“CMS”).

Relative to its compliance with the RFA, CMS has improved, but can still do better to consider the impact of its rules on small businesses. Further, the Congress can take steps that can strengthen the RFA, leading to an increased likelihood that

CMS regulations will fully consider the impact of its policies on small businesses while achieve reasonable and appropriate regulatory results.

NAHC recommends that the following three steps be taken to strengthen the RFA:

1. Uniform RFA compliance standards should be implemented to ensure that federal agencies conduct a comprehensive impact analysis of proposed and final rules that includes consideration of all permissible options in the rulemaking.
2. The RFA should be amended to expand its application to interpretative policies and guidelines as well as the “legislative” rules currently subject to its protections.
3. The Congressional Review Act should be amended to allow for a congressional Resolution of Disapproval on an element of a regulatory action instead of the entire rule, provided that the targeted rule is not a part of an integrated regulatory scheme that would be affected as a whole.

I offer the following illustrations of recent CMS regulatory action to demonstrate the need for these reforms.

The Medicare Home Health Prospective Payment System Rulemaking

On April 26, 2007, CMS published its Notice of Proposed Rulemaking (“NPRM”) regarding refinements and reforms to the Medicare Home Health Prospective Payment System (“HHPPS”). These long awaited changes affected the payment model that has been in effect without change since October 2000. Most of the proposed changes were anticipated and welcomed by the home health services community. CMS had developed the proposal in a fairly transparent fashion through Open Door meetings, discussions with industry representatives, and the use of technical advisory groups that included non-CMS representatives. However,

the proposed rule also included an element that had not been expected. The rule proposed to reduce base payment rates by nearly 10% over a three year period through three consecutive rate reductions of 2.75%. These reductions would be permanent, cumulative, and result in a compounded financial impact.

In the NPRM, CMS disclosed little of the basis for the rate reduction proposal. CMS alleged that home health agencies had engaged in “upscoring” of patients to achieve higher amounts of payment under HHPPS since base payment rates are adjusted upwards and downwards dependent on the assessment score of the specific patient. Few details regarding the evidentiary foundation for the CMS conclusion of so-called “case mix weight creep” were disclosed in the NPRM. Nevertheless, NAHC and others in home care undertook detailed analysis of the potential reasons for changes in the case mix weight scores. Under Medicare law, a rate adjustment is authorized only to the extent that case mix weight changes are unrelated to changes in patient characteristics. NAHC’s analysis showed significant changes in patients receiving home health services such as higher incidence of knee replacement patients and patients of advanced age. In comparison, CMS alleged that all the change in case mix weight scores was unrelated to changes in patient characteristics.

In the final rule issued by CMS, the three year rate reduction is extended to four years with an additional 2.71% cut proposed for 2011. These total cuts represent an 11.75% reduction in payment rates for home health services. NAHC estimates that by 2011, nearly 52% of home health agencies (“HHAs”) across the country will receive Medicare payment that is less than the cost of care with no subsidization available through other payers to cover that financial shortfall. In many states, over 70% of HHAs will have negative Medicare margins. Access to care is in serious jeopardy. The loss of home health services will adversely affect both Medicare patients and Medicare itself as the affected patients end up with higher cost institutional care.

Where does the RFA fit into this matter? First, CMS has pursued its regulatory action in a non-transparent manner. The RFA impact analysis that is

displayed in the NPRM and Final Rule is not subject to evaluation and public comment unless the basis for the underlying action is fully disclosed. While it is readily apparent that CMS applied two completely different methodologies in evaluating alleged case mix creep in the NPRM and the Final Rule, CMS consistently withheld the details of those methodologies and accompanying analyses from the public. Still today, CMS has yet to release the technical report that sets out the analysis despite repeated requests from the public as well as several congressional offices. Offering impact conclusions is useless unless the public is afforded the opportunity to test those conclusions and to validate/invalidate them as appropriate.

Second, the impact analyses displayed in the NPRM and Final Rule fall far short of what should be RFA compliance standards. Both the NPRM and the Final Rule merely express the change in average case mix weights that will be experienced in aggregate segments of the home care community such as type of HHA and geographic location. In addition, the impact analyses merely set out the forecasted change in Medicare revenue for these same segments. Glaringly absent is an impact analysis that evaluates the likely impact of the rule on the ability of the affected businesses to stay in operation or its affect on the operation of that business that continues to exist after the payment cuts. Most notable is the absence of an analysis of the impact of the rule for the full four years of the payment rate cuts that are included in the rule. CMS sets out its meager evaluation only in relationship to the potential 2008 effect rather than through 2011, the fourth year of the planned rate cuts.

As stated earlier, NAHC's analysis shows nearly 52% of all HHAs nationwide in the red on Medicare payments by 2011, likely meaning the closure of many businesses. Addendum A highlights the extent of impact of the CMS rule. This map shows the percentage of HHAs in each state that will end up with Medicare financial margins below zero after the planned cuts take effect. Nowhere in the CMS impact analysis is this type of review given although the potential

closure of thousands of HHAs would seem to be an impact worthy of consideration under the RFA.

Addendum B further illustrates the financial impact of the CMS regulatory cuts. While the RFA impact analysis by CMS references 1-2% changes in revenue based on type and location of HHAs, Addendum B sets out the multi-billion dollar loss of revenue in the congressional districts of the Committee's members that will accrue over the four years of cuts set out in the CMS rule. All told, these regulatory cuts will cut Medicare revenues for home health services by over \$6 billion by 2012 in a program where spending continues well below estimates of the Congressional Budget Office at \$13.1 billion in 2006 and only 3.2% of total Medicare spending.

This illustration of the depth and quality of the RFA impact analysis by CMS strongly demonstrates the need for either a more detailed statutory standard for the RFA impact analysis or a uniform RFA regulatory standard that offers detailed criteria for RFA impact analysis compliance by CMS and other federal agencies. NAHC suggests that the Small Business Administration be empowered to promulgate RFA compliance standards.

Medicare Hospice Billing Standards

In an effort to secure more detailed data on Medicare hospice services, CMS issued a Transmittal earlier this year that requires hospices throughout the nation to completely amend their billing submissions. Ultimately, CMS decided to postpone the compliance date for the new guidelines in response to complaints raised by NAHC and others in the hospice community. However, the lack of a formalized responsibility for CMS to evaluate the propriety and impact of its planned policy changes on hospices lead to extensive efforts by hospices and their billing vendors to attempt to comply with new requirements that do not fit hospice care. Presently, the hospice community remains hopeful that CMS will eventually understand the irrationality of its guidelines and rescind the policy altogether.

The Transmittal, 1304 (July 20, 2007)

<http://www.cms.hhs.gov/transmittals/downloads/R1304CP.pdf>, requires hospices to completely revise their Medicare billing processes in two ways. First, the hospices would be required to include a listing of each discipline-specific visit rendered during the course of hospice care for the billing period. For over 20 years, hospices billed Medicare consistent with coverage and payment standards that set payment on a “per diem” rather than a per visit basis. Medicare covers hospice care, with varying coverage standards and payment rates, based on the number of days of routine home care, continuous care, inpatient services, and respite care. While a hospice is fairly capable of visit-based billing for those days considered “routine home care,” it is unrealistic to require a hospice to record “visits” during those days when the patient is an inpatient at a hospital or skilled nursing facility receiving 24/7 care or during a “continuous care” day when the coverage requirements focus on the hours of ongoing care. The Transmittal has been rescinded recently, but the effect of that rescission is nothing more than a postponement of the application date from January 1, 2008 to July 1, 2008. Transmittal 1372 (Rescission of Transmittal 1304 changing the effective date).

Second, the Transmittal requires that hospices include per visit charges on the Medicare billings. This requirement exists even though Medicare payment is not based on charges nor has it ever been based on charges. Further, this requirement ignores the fact that hospices do not have visit charges since payers of services generally conform to the Medicare “per diem” method. When confronted with the fact that visit charges do not exist, CMS officials offered a range of suggestions that included “make them up” to “figure it out.”

CMS took no steps to implement these controversial guidelines through formal rulemaking. The Transmittal was issued by CMS through its electronic publishing process without notice in the Federal Register and without providing any opportunity for public comment on the matter as a proposal. Since the Transmittal did not represent a formal legislative rule under the Administrative

Procedures Act, CMS undertook no action related to the RFA. No impact analysis was conducted. No options were publicly explored and disclosed.

The concepts of the RFA have as much value in CMS action that does not rise to the level of formal regulation as they have in a formal legislative rule. The Transmittal requirements discussed herein will necessitate significant changes in billing practices and operations of hospices if compliance is to be achieved. Failure to comply will mean the claim is rejected by Medicare. The denial of Medicare payment translates into the demise of the hospice since at least 90% of the revenue for most hospices comes from Medicare. This Transmittal will require hospices to establish methods for calculating reasonable visit charges even though their existing cost accounting systems are not designed to accommodate such. In addition, the new requirements will necessitate the expensive acquisition of new billing software from outside vendors. Finally, the requirements will mean that hospices will need to develop visit tracking and documentation systems for inpatient and continuous care where such care documentation approaches are the equivalent of a foreign language. All of these changes come at a significant cost to hospices with no anticipated increase in payment and no understanding of their real purpose or value.

As currently devised, the RFA does not apply to guidelines, interpretative policies, and other rulemaking that does not involve a legislative rule. However, it is these less formal actions that have the most profound impact on the day-to-day operations of health care providers in their relationships with CMS. It is these actions that often represent the greatest change and have the greatest cost for small health care businesses. Amending the RFA to include guidelines such as this hospice Transmittal will go a long way toward bringing about reasonable and rational standards for health care providers to do business with CMS.

The Congressional Review Act: Needed Improvements

The Congressional Review Act (“CRA”) provides a last chance (short of litigation) opportunity to address regulatory action that oversteps congressional design and interests expressed in statutory authorizations. Under the CRA, Congress is permitted through a Resolution of Disapproval to invalidate a regulation issued by a federal agency. 5 USC 801-808. The CRA provides for an expedited process for consideration of the resolution by each house of Congress.

While the CRA has been fully used only in a few circumstances, it has proven to be of significant value to small businesses in its ability to provide a process to allow the conveyance of a message from Congress concerning dissatisfaction with a promulgated rule. Statement of J. Christopher Mihm, Government Accountability Office, *FEDERAL RULEMAKING: Perspectives on 10 Years of Congressional Review Act Implementation*: Testimony Before the Subcommittee on Commercial and Administrative Law, Committee on the Judiciary, House of Representatives, GAO-06-601T . <http://www.gao.gov/new.items/d06601t.pdf>. However, the CRA does maintain some weaknesses that could benefit from some statutory reform. These weaknesses are set out in detail in a report issued by the Congressional Research Service. *Congressional Review of Agency Rulemaking: An Update and Assessment After Nullification of OSHA’s Ergonomics Standard*, Congressional Research Service, Library of Congress (January 6, 2003).

One such weakness is the apparent requirement that the Resolution of Disapproval must be directed at the entire rule issued by the federal agency rather than a portion of that rule. CRS Report, pp.13-15. This weakness may be intentionally or inadvertently exploited by CMS through its recently instituted method of publishing unrelated rules in a single rulemaking proceeding.

This odd CMS approach to rulemaking has no logical basis. Two recent examples illustrate the strange character of the process and the resulting weakness in the CRA. In the NPRM and Final Rule setting out the changes to the Medicare HHPPS for 2007, CMS included the wholly unrelated rule modifying standards

applicable to the Medicare Durable Medical Equipment benefit under Medicare Part B. 71 F.R. 44082 (August 3, 2006); 71 F.R. 65884 (November 9, 2006). Beyond the confusion that such an approach triggers for the general public attempting to monitor and respond to rules of concern, it adds a potential barrier to Congress when there is interest in pursuing a Resolution of Disapproval of an element of that published rule. For example, if Congress wished to invalidate the DME rule, it may be dissuaded from doing so if Congress prefers not to invalidate the home health services rule at the same time.

The first example is not isolated within CMS. A second recent example is the publication of the physician fee schedule for 2008. <http://www.cms.hhs.gov/PhysicianFeeSched/downloads/CMS-1385-FC.pdf>. That rule not only contains extensive standards and comprehensive payment rates for the wide range of physician services, it also contains the wholly unrelated standards for professional qualifications of Physical and Occupational Therapists. With this rule, public notice of the therapist standards is masked by the rule title: "Revision to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008...." At the same time, the CRA powers of Congress are impacted in that any consideration of a Resolution of Disapproval on the physician fee schedule or therapist qualification rules is burdened by a CRA requirement to address both in the resolution.

One final example of the CRS weakness is the recent HHPPS rule discussed otherwise in this testimony. Certain congressional offices were forced to submit a legislative proposal outside the efficient CRA process to invalidate the case mix creep part of the HHPPS rule because congressional legislative counsel concluded that the CRA required the resolution to affect the whole rule rather than an element. Since these offices did not wish to disturb the important refinements of HHPPS, a separate bill was introduced in the House and Senate as the only viable alternative means to invalidate the portion of the whole rulemaking of concern. see, S. 2181 and H.R. 3865. An amendment to the CRA allowing for a targeted

resolution in circumstances where the element addressed by the resolution is not an integral part of the whole rulemaking would bring the CRA efficiencies into reality.

CONCLUSION

Thank you for the opportunity to provide this testimony. While CMS has made great strides towards RFA compliance, continued improvement in both its actions and the RFA standards will go a long way to providing small business with the protections against unwise and unwarranted federal regulation expressed by Congress in the RFA and its progeny, SBREFA and CRA. We look forward to the opportunity to work with the Committee on these matters.

ADDENDA

Addendum A: Percent of Home Health Care Agencies with Negative Medicare Profit Margins, 2011

Addendum B: Impact on Home Health: Legislative and Regulatory Cuts

Impact on Home Health: Proposed Legislative and Regulatory Cuts

Small Business Committee Democrats

Proposed Legislative Cuts to Home Care Market Basket Update

*H.R. 3162 'The Children's Health and Medicare Act of 2007' provides a one year reduction in Medicare home health services payment rates through a one year freeze of the market basket update for FY 2008. Over five years, this proposal would reduce outlays for home health by \$2.6 Billion.

Proposed Regulatory Cuts to Home Care **Case Mix Weight Adjustment

The Centers for Medicare and Medicaid Services (CMS) has proposed a 2.75% across-the-board rate reduction for home health services for each of 2008, 2009, and 2010, as well as a 2.71% reduction in 2011. This reduction is based on an unfounded allegation that the "case mix weight" that is used to calculate payment rates has increased unrelated to changes in patient characteristics. Over five years, this proposal would reduce outlays for home health by \$6.03 Billion.

HCIS 2005 Data Set for Medicare Home Health						
National Data Set			Projected Losses		Projected Losses from Case Mix Weight Adjustment	
			H.R. 3162 (SCHIP/Medicare Bill)			
Total National Reimbursement			FY 2008	FY 2008-12	FY 2008	FY 2008-12
\$12,885,434,991			(\$410M)	(\$2.6B)	(\$400M)	(\$6.03B)
District Data Set			Projected Losses		Projected Losses from Case Mix Weight Adjustment	
			H.R. 3162 (SCHIP/Medicare Bill)			
	Medicare Reimbursement	% of National Reimbursement	FY 2008	FY 2008-12	FY 2008	FY 2008-12
Nydia M. Velazquez (D-NY-12)	\$273,027	0.0021%	(\$8,610)	(\$54,600)	(\$8,400)	(\$126,630)
Heath Shuler (D-NC-11)	\$35,473,940	0.2753%	(\$1,128,730)	(\$7,157,800)	(\$1,101,200)	(\$16,600,590)
Charles A. Gonzalez (D-TX-20)	\$73,690,273	0.5719%	(\$2,344,790)	(\$14,869,400)	(\$2,287,600)	(\$34,485,570)
Rick Larsen (D-WA-02)	\$13,023,061	0.1011%	(\$414,510)	(\$2,628,600)	(\$404,400)	(\$6,096,330)
Raul M. Grijalva (D-AZ-07)	\$6,258,534	0.0486%	(\$199,260)	(\$1,263,600)	(\$194,400)	(\$2,930,580)
Michael H Michaud (D-ME-02)	\$34,390,220	0.2669%	(\$1,094,290)	(\$6,939,400)	(\$1,067,600)	(\$16,094,070)
Melissa L. Bean (D-IL-08)	\$21,699,038	0.1684%	(\$690,440)	(\$4,378,400)	(\$673,600)	(\$10,154,520)
Henry Cuellar (D-TX-28)	\$79,025,325	0.6133%	(\$2,514,530)	(\$15,945,800)	(\$2,453,200)	(\$36,981,990)
Daniel Lipinski (D-IL-03)	\$34,184,562	0.2653%	(\$1,087,730)	(\$6,897,800)	(\$1,061,200)	(\$15,997,590)
Gwen Moore (D-WI-04)	\$12,162,374	0.0944%	(\$387,040)	(\$2,454,400)	(\$377,600)	(\$5,692,320)
Jason Altmire (D-PA-04)	\$40,555,562	0.3147%	(\$1,290,270)	(\$8,182,200)	(\$1,258,800)	(\$18,976,410)
Bruce L. Braley (D-IA-01)	\$18,507,734	0.1436%	(\$588,760)	(\$3,733,600)	(\$574,400)	(\$8,659,080)
Yvette Diane Clarke (D-NY-11)	\$20,132,012	0.1562%	(\$640,420)	(\$4,061,200)	(\$624,800)	(\$9,418,860)
Brad Ellsworth (D-IN-08)	\$24,994,677	0.1940%	(\$795,400)	(\$5,044,000)	(\$776,000)	(\$11,698,200)

Henry C. Johnson (D-GA-04)	\$15,737,359	0.1221%	(\$500,610)	(\$3,174,600)	(\$488,400)	(\$7,362,630)
Joseph A. Sestak (D-PA-07)	\$27,248,434	0.2115%	(\$867,150)	(\$5,499,000)	(\$846,000)	(\$12,753,450)

Addendum B

Impact on Home Health: Proposed Legislative and Regulatory Cuts Small Business Committee Republicans

Proposed Legislative Cuts to Home Care Market Basket Update

*H.R. 3162 'The Children's Health and Medicare Act of 2007' provides a one year reduction in Medicare home health services payment rates through a one year freeze of the market basket update for FY 2008. Over five years, this proposal would reduce outlays for home health by \$2.6 Billion.

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HCIS 2005 Data Set for Medicare Home Health						
National Data Set			Projected Losses		Projected Losses from Case Mix Weight Adjustment	
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Total National Reimbursement			FY 2008	FY 2008-12	FY 2008	FY 2008-12
\$12,885,434,991			(\$410M)	(\$2.6B)	(\$400M)	(\$6.03B)
District Data Set			Projected Losses		Projected Losses from Case Mix Weight Adjustment	
			H.R. 3162 (SCHIP/Medicare Bill)			
	Medicare Reimbursement	% of National Reimbursement	FY 2008	FY 2008-12	FY 2008	FY 2008-12
Steve Chabot (R-OH-01)	\$17,877,868	0.1387%	(\$568,670)	(\$3,606,200)	(\$554,800)	(\$8,363,610)
Roscoe G. Bartlett (R-MD-06)	\$20,369,344	0.1581%	(\$648,210)	(\$4,110,600)	(\$632,400)	(\$9,533,430)
Sam Graves (R-MO-06)	\$20,774,900	0.1612%	(\$660,920)	(\$4,191,200)	(\$644,800)	(\$9,720,360)
W. Todd Akin (R-MO-02)	\$52,391,196	0.4066%	(\$1,667,060)	(\$10,571,600)	(\$1,626,400)	(\$24,517,980)
William Shuster (R-PA-09)	\$16,326,910	0.1267%	(\$519,470)	(\$3,294,200)	(\$506,800)	(\$7,640,010)
Marilyn N. Musgrave (R-CO-04)	\$15,019,454	0.1166%	(\$478,060)	(\$3,031,600)	(\$466,400)	(\$7,030,980)
Steven A. King (R-IA-05)	\$11,516,665	0.0894%	(\$366,540)	(\$2,324,400)	(\$357,600)	(\$5,390,820)
Jeffrey Fortenberry (R-NE-01)	\$13,004,461	0.1009%	(\$413,690)	(\$2,623,400)	(\$403,600)	(\$6,084,270)
Lynn A. Westmoreland (R-GA-03)	\$17,423,103	0.1352%	(\$554,320)	(\$3,515,200)	(\$540,800)	(\$8,152,560)
Louie Gohmert (R-TX-01)	\$82,068,800	0.6369%	(\$2,611,290)	(\$16,559,400)	(\$2,547,600)	(\$38,405,070)
Dean Heller (R-NV-02)	\$27,077,309	0.2101%	(\$861,410)	(\$5,462,600)	(\$840,400)	(\$12,669,030)
David Davis (R-TN-01)	\$44,347,106	0.3442%	(\$1,411,220)	(\$8,949,200)	(\$1,376,800)	(\$20,755,260)

Mary Fallin (R-OK-05)	\$53,776,294	0.4173%	(\$1,710,930)	(\$10,849,800)	(\$1,669,200)	(\$25,163,190)
Vern Buchanan (R-FL-13)	\$42,791,357	0.3321%	(\$1,361,610)	(\$8,634,600)	(\$1,328,400)	(\$20,025,630)
James D. Jordan (R-OH-04)	\$18,473,921	0.1434%	(\$587,940)	(\$3,728,400)	(\$573,600)	(\$8,647,020)