Lobbying Tips

Scheduling a Meeting with Your Member of Congress (or their staff)

1. Call the office where you would like to meet: This contact information can be found at the website of your Senator or Representative. When you call, ask for the name of the scheduler and the person who handles health care issues and tell them you would like to schedule a meeting.

2. Follow up on your request—be persistent: Call the office if no one has contacted you in a week. If it seems like it will be difficult to get a meeting with your Member of Congress at this time, you could ask to meet with someone who works on health care issues. Try to be accommodating and understanding of the Congressional schedule which keeps Representatives and Senators in Washington, DC for many days throughout the year.

Get Ready for the Meeting with Your Member of Congress (or their staff)

1. Prepare for the meeting: You’re a home care or hospice expert so you are already prepared to talk about the industry. You do not need to be an expert, but you should be familiar with the basics of the issue you will be discussing. Be familiar with the key home care issues. However, if you don’t know something, it is perfectly ok to say, “I don’t know, but I can look into it.” It helps to become familiar with the Member’s latest position or actions on the issue.

2. Establish a principal spokesperson for the group: A main speaker for the group should be established ahead of time. One person from the group should also take notes for future reference.

3. Managing the Meeting

   The basics:
   - Be polite, courteous, and on time.
   - Be personable
   - State the purpose of your visit clearly.
   - Ask for support

   The specifics:
   - Don’t be disappointed in meeting with a staffer as opposed to a Member of Congress. Staffers are as important because they’ll be doing the legwork and research. Treat the staff with respect, as equals, and with value.
   - You’ll be having several different types of meetings, some begin with staff, and some will give you the hallway treatment. You have to be very flexible. Some people come with a very rigid structure of what to say, but write things on a card in case you have to walk and talk. They might seem unengaged, so bounce back and forth from Senator/Representative to aide to keep both interested.
   - If you can come to the office ahead of time, it’s no problem to leave some material in advance (and then go to your other meeting), and then come back. Make sure you have a second copy of your material. Leaving it early, gives them a chance to review.
   - Begin and end with gratitude for their time and consideration. Something like, “I know you’re busy, but it’s great to get a minute of your time in considering our clients and our patients.”
   - Be respectful and polite! Try to engage in conversation and find out what they care about and believe in. Plan out what you’re going to say!
   - It’s not just what you have to say; it’s also how you say it. You want to be a memorable meeting. Speak slowly, emphasizing the main points without going into excessive detail. Questions they ask will allow you to add more detail without overwhelming them with information all at once.
- If the Senator or Representative joins your meeting later, do not repeat what you’ve already said to the staffer, they will likely try to shut it down. Say something like, “I spoke to your staff, we gave them a lot of information and they were very helpful, but I just want to emphasize one point.”

- If the Senator/Representative has already signed the bill, say “Thank you so much for supporting this bill. What can we do to help you get more of your colleagues to sign the bill as well?” They will love to give you advice.

- Treat this as building a relationship! Get them to feel really good about you!

- If you’re running late to a second appointment, have one person step out and call the other office to let them know so you’re meeting is not declined when you do arrive.

**Do Not Forget:**

- Invite them on a home care visit. It is very helpful for Senators and Representatives to see first hand the great care being provided in the home and challenges faced.

4. **Follow up:**

- Make sure you know the name of the key aide to follow-up with. Ask for their card so that you can spell their name correctly and have their email address.

- Send the Member/staffer a follow-up email thanking them for their time and consideration. Briefly restate the issues discussed and the way you would like to see them respond to the issue. Offer to be available to answer any additional questions should they have some. Attach digital copies of the legislation summaries in your follow-up email. These can be found under the “Policy and Advocacy” section at www.nahc.org. Be sure to reiterate the home care visit invite and offer to handle the logistics.

- Visit the Legislative Action Center, click the “Add your voice” link on issues that interest you, fill out the information to send the drafted letter to your Congressional Delegation. Be sure to pass this link onto your colleagues so that they may submit a letter as well.

- Following your meeting, be sure to post about your experience and the issues you advocated for on social media. Building public awareness is a key to success.

5. **Follow-up in the district:** If your initial meeting was in Washington, DC, then follow-up with a meeting or action in the Congressional district. This also gives an opportunity for more people to get involved then just those who were able to travel all the way to DC.
Executive Summary

Face-to-Face Physician Encounter/Physician Certification

The Centers for Medicare and Medicaid Services (CMS) requires a Medicare beneficiary to see a physician for a face-to-face encounter to qualify for the home health benefit. CMS then relies solely on the documentation from the encounter to determine a beneficiary's eligibility for the home health services benefit. However, this record does not necessarily tell the patient’s entire story, leading to claims being wrongly denied.

This legislation would:

- Direct CMS to review the complete patient record including the Home Health Agency’s documentation when determining Medicare coverage eligibility.
- Allow CMS to resolve a backlog of claims appeals through a negotiated settlement rather than costly hearings before Administrative Law Judges.

Non-physician Practitioner Certification Authority

Nurse Practitioners (NPs) and Physician Assistants (PAs) are often the primary care practitioners for Medicare patients. NPs and PAs are authorized to certify Medicare beneficiary eligibility for Medicare coverage of a number of health services, including the skilled nursing facility services and durable Medical equipment benefits. However, these highly skilled clinicians are not authorized to certify a patient’s eligibility for Medicare home health services even in states where they can fully order home health care. With the Medicare restriction, NPs and PAs must “hand-off” their patients to physicians in order to get the necessary Medicare certification.

This legislation would:

- Allow Non-Physician Practitioners to certify a patient’s eligibility for the Medicare home health benefit and authorize them to establish, sign and date the plan of care where permitted under state law.

Pre-claim Review (PCR) Demonstration Program

CMS instituted a costly and burdensome process in August 2016 that requires home health agencies in certain states to submit all claims for pre-claim review prior to submitting a payment claim. If an HHA fails to submit the matter for pre-claim review, the payment claim is automatically rejected and the payment rate is reduced by 25% on any claim later approved through an appeal. The Illinois phase of the project began in August 2016 and has demonstrated that any compliance concerns are limited to paperwork and documentation matters that are correctable. Alternative, much less costly and burdensome measures are readily available to address these paperwork issues.

2017 legislation is needed to:

- Pause PCR for one year to allow for program evaluation.
- Direct the Secretary of Health and Human Services to conduct a study on the impact of PCR and develop alternative corrective solutions.

Medicare Home Health Rural Add-On

Home health agencies receive a 3% payment rate add-on for services provided to patients residing in rural areas. The add-on is intended to address higher care costs that occur in rural areas due to increased staff travel time and staff shortages. This add-on has been applied nearly continuously since 2000 though a series of congressionally authorized extensions. However, it is scheduled to expire on December 31, 2017.

This legislation would:

- Extend the 3% add-on for services provided in rural areas for 5 years.
Postpone the Implementation of the Home Health Conditions of Participation

The Centers for Medicare and Medicaid Services (CMS) issued a new regulation on January 13, 2017 that establish comprehensive changes to the Conditions for Participation (COPs) for home health agencies that serve Medicare patients. The new COPs are effective on July 13, 2017. These changes have been in the works since 1997. CMS estimates that the first year cost for home health agencies to implement the new rule is nearly $300 million with annual compliance costs at $260 million. CMS and HHS must delay the effective date of the new rule until July 13, 2018 to provide sufficient time for HHAs to assure compliance.

Members of Congress should:
- Contact CMS and HHS and recommend that the effective date be postponed, or
- Enact a Resolution of Disapproval under the Congressional Review Act to rescind the new rules.

Maintain Stability in the Medicare Hospice Benefit

Nearly one-half of all Medicare beneficiaries who die in a given year have utilized hospice services. The hospice benefit is a model for care delivery innovations with a patient-centered, interdisciplinary team approach to care within a bundled payment model that incentivizes efficiency and performance. However, the hospice benefit has undergone numerous changes in recent times with significant payment rate cuts of over 12%, the institution of an updated payment model, increased data reporting, and changes in the population of patients served.

Congress should:
- Monitor the impact of recent Medicare hospice policy changes on the delivery of care.
- Reject any proposals that have the potential to diminish hospices’ ability to provide appropriate services to patients in their final days of life and support to those patients’ loved ones.

Restoration of the Fair Labor Standards Act Home Care Overtime Exemptions

The Fair Labor Standards Act (FLSA) includes overtime exemptions for “companionship services” and “live-in domestic services.” Under rules promulgated in 1975, these exemptions applied to employees providing personal care to the elderly and disabled in their own homes. The U.S. Department of Labor implemented revised rules, effective October 15, 2015, that eliminated the application of the exemptions to these home care services. As a result, individuals have had less access to home care, care costs have risen presenting new financial burdens to vulnerable citizens and government-funded health care programs such as Medicaid and the VA, and triggered limits on working hours to avoid overtime costs leading to reduced income for home care aides and personal care attendants.

Congressional support is needed:
- To encourage the Department of Labor to restore the FLSA rules in effect for nearly 40 years.
- To enact legislation, if necessary, to restore the exemption and preempt any later rulemaking that would again restrict the exemptions.
Home Health Care Planning Improvement Act

Background:
Medicare law requires that a physician certify a patient’s eligibility for coverage of home health services. Many things have changed in health care since this Medicare provision was enacted in 1965. Much of the primary care provided today comes from highly skilled non-physician practitioners such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. As a result, these professionals must “hand-off” their patients to a physician simply to comply with outdated Medicare certification requirements.

Legislation to allow Non-Physician Practitioners (NPPs) to certify a patient’s eligibility was introduced in the 114th Congress and will be reintroduced this year. That legislation had 206 bipartisan cosponsors in the House of Representatives and 52 bipartisan cosponsors in the Senate.

Issues/Concerns:
- Current physician-focused certification requirements force patients to shift from their primary care practitioner to a physician who has not cared for the patient.
- There is a risk that quality of care and program integrity is compromised when the patient is “handed-off” to a physician for the sole purpose of meeting Medicare certification requirements.

Talking Points:
- Permitting NPPs to certify Medicare eligibility enhances Medicare safeguards in the Home Health Benefit as the certification is done by the practitioner that actually cares for the patient.
- NPPs can improve the transitions of care of patients to community-based care potentially resulting in a decrease in the length-of-stay at hospitals and skilled nursing facilities because it would no longer be necessary to insert a physician who has not cared for the patient into the process.
- Importantly, it should not increase Medicare home health spending as NPPs would just continue their care of patients and not require the substitution of a physician to complete the certification.

What Congress should do:
- Senator — Cosponsor S. 445
- Representative — Sponsor a companion bill in the House.
Preserve Access to Medicare Rural Home Health Services Act (S. 353)

Background:
The longstanding Medicare rural add-on for home health services is set to expire on December 31, 2017. This three percent payment modifier to reimbursements for services provided in rural and underserved areas continues to be crucial to maintaining access to care. Rural agencies face higher overhead expenses through factors such as increased travel time between patient visits and demands for extra staff. This payment modifier is imperative so that rural agencies will be able to keep their doors open and provide necessary care to homebound patients.

Congress has repeatedly determined, with bipartisan support, that the home health rural add-on is needed to maintain care access and quality in rural areas. Dating back to 2000, the Benefits Improvement and Protection Act established a ten percent addition to services provided in rural areas. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reestablished the rural add-on at five percent. The Deficit Reduction Act of 2006 extended the five percent add-on through 2006. The Patient Protection and Affordable Care Act reinstated the rural add-on at a rate of 3 percent through December 31, 2015. The three percent add-on was extended as part of the Medicare Access and CHIP Reauthorization Act in 2015 through December, 2017.

Issues/Concerns:
- There are higher costs for home care in rural areas primarily due to travel time.
- Home care is often the substitute for primary care in rural areas with the shortage of physicians.
- A loss of access to care in rural areas negatively impacts patients and Medicare as care and its costs shift to institutional care.

Talking Points:
- Congress has repeatedly supported, on a bicameral, bipartisan basis, a rural differential or rate add-on since the 1980s.
- Rural home care brings great value to rural residents as it helps prevent the need for urgent care, inpatient hospitalizations, and institutional care.
- Home health agencies have demonstrated that the combination of highly skilled staff and modern health care technologies brings high quality of care to rural residents.

What should Congress do:
- Extend the 3% rural add-on through December, 2022.
- Offset the cost of the add-on through a revision to the Medicare home health outlier payment funding.
- Enact S. 353 and any House companion bill.

For More Information: Please Contact NAHC Government Affairs at 202-547-7424
Medicare Home Health Face-to-Face Physician Encounter/Certification Reform

Background:
As part of the Patient Protection and Affordable Care Act (PPACA), a Medicare beneficiary must have physician face-to-face encounter to qualify for the home health benefit. However, Medicare’s implementation goes far beyond a simple and sensible requirement of a physician encounter, creating an unmanageable paperwork burden for physicians and home health agencies.

Initially, the Centers for Medicare and Medicaid Services (CMS) required an ill-defined physician “narrative” leading to thousands of claim denials solely on the basis that the physician narrative was deemed “insufficient.” As a result of these problems, CMS rescinded the narrative requirement beginning January 1, 2015.

The current physician encounter documentation requirement may be worse. Eligibility determinations are now based the physician’s record to the exclusion of the rest of the patient’s medial record. As a result, eligible patients are denied coverage.

Issue/Concerns:
- Claims are being wrongly denied hindering access to and delaying necessary home health services.
- Unnecessary administrative paperwork requirements have been added to physician’s responsibilities, reducing the time available for patient care.
- A lengthy backlog of home health services appeals has developed leaving providers without reimbursement for services already provided.

Talking Points:
- Patient eligibility for Medicare coverage of home health services should be based upon the full patient record, not just a very limited part.
- Physicians should be permitted to focus on patient care not endless Medicare paperwork that simply repeats what is in other documentation.
- While a requirement that patients have a face-to-face physician encounter adds elements of integrity to the Medicare eligibility certification process, duplicative paperwork does not.

What Congress should do:
Support the legislative proposals that:
- Direct CMS to determine a beneficiary’s eligibility for Medicare coverage of home health services through a review of the entire patient record, including the records of the home health agency. Where the physician’s record may be insufficient to determine eligibility, the home health agency’s record can fill information gaps. This will move CMS from a partial record review to a complete record review, ensuring payment accuracy.
- Allow CMS to negotiate settlements for the backlog of 20,000 – 30,000 denied cases currently facing appeal. CMS has indicated that it needs this authority so that the cases can be settled efficiently for all parties.
Medicare Home Health Conditions of Participation

Background:
The Centers for Medicare and Medicaid Services (CMS) issued a new regulation on January 13, 2017 that established comprehensive changes to the Conditions of Participation (CoPs) for home health agencies that serve Medicare patients. The CoPs set out standards for operations that cover a wide range, including: staffing qualifications, care planning, patient rights, patient assessments, emergency preparedness, infection control, documentation requirements, and data responsibilities. The new CoPs are effective on July 13, 2017. These changes have been in the works since 1997. CMS estimates that the first year cost for home health agencies to implement the new rule is nearly $300 million with annual compliance costs at $260 million.

We have asked CMS and HHS to delay the effective date of the new rule until July 13, 2018 in order to assure compliance.

Issues/Concerns:
The home health community recommended that CMS provide 12-18 months for implementation given the extensive nature of the CoP changes. The 6 months of implementation time that CMS gave is insufficient to ensure appropriate compliance. While the new rule brings some improvements in terms of compliance flexibility and a focus on patient outcomes, the rule also requires extensive paperwork and process changes.

Talking Points:
- The new rule has been in development for 20 years. Compliance is the goal rather than meeting an unreasonable deadline for compliance.
- There is no quality of care concern that currently exists with home health agencies. Given the absence of quality of care deficiencies, the new rule mainly serves to modernize the CoPs.
- CMS has not issued essential interpretive guidance on what is needed to bring the new CoPs into day-to-day operations. It is unreasonable to expect HHAs to initiate costly changes to comply with the CoPs until that guidance is issued.

What Congress can do to help:
Members of Congress should:
- Contact CMS and HHS and recommend that the effective date of the new rules be reset at July 13, 2018.
- Consider enacting a Resolution of Disapproval under the Congressional Review Act to rescind the new rules in CMS/HHS does not extend the effective date.
Stop Medicare Home Health Pre-Claim Review

Background:
In August of 2016, the Centers for Medicare and Medicaid Services (CMS) launched the Pre-Claim Review Demonstration for Home Health Services (PCR). PCR is currently implemented in Illinois, with plans to expand into Florida, Massachusetts, Texas, and Michigan. According to CMS, PCR’s intent is to reduce fraud and reduce expenditures while maintaining or improving quality of care. In practice, PCR has created barriers to care and unnecessary burdens for providers who are not engaging in fraudulent behavior.

Issues/Concerns:

Patient Experience:
- In some cases, Medicare is rejecting approval of necessary services resulting in patient care delays. The delay may be due to a provider or patient’s decision to wait until they have received an affirmative decision.
- Upon a claim being rejected, beneficiaries receive a confusing letter from Medicare. This creates beneficiary fear that they will not receive the care their doctor has ordered.

Provider Experience:
- The errors that have been uncovered through the project are paperwork and documentation related rather than fraud or the provision of unnecessary care.
- Claim determinations are often unclear and inconsistent.
- HHAs are providing care with no guarantee of reimbursement.
- PCR has been poorly communicated to all involved parties, including doctors.
- PCR has been a significant administrative burden on providers, HHAs, and Medicare contractors.

Talking Points:
- The results from claims processed by PCR point to documentation errors, not fraud. This has placed a burden on legitimate home health providers, rather than targeting true fraud. The Office of the Inspector General has identified fraud characteristics, and program integrity efforts would be better focused on these findings. Other common-sense steps could also be taken to curb documentation errors that would have less interference to patient care, including clear guidance from Medicare, the use of tools such as uniform documentation checklists, and uniform documentation standards.
- Medicare contractor operating expenses will likely exceed what legitimate savings might be realized and delaying necessary home care services may push patients back into more expensive institutional care settings.

What Congress Should Do:
- Contact CMS and tell them to end the Pre-Claim Review demonstration program and explore efficient and effective alternatives to correcting minor documentation deficiencies.
Restoration of the Fair Labor Standards Act Home Care Overtime Exemptions

Background:
The Fair Labor Standards Act (FLSA) includes overtime exemptions for “companionship services” and “live-in domestic services.” Under rules promulgated in 1975, these exemptions applied to employees providing personal care to the elderly and disabled in their own homes. The U.S. Department of Labor implemented revised rules, effective October 15, 2015, that eliminated the application of the exemptions to these home care services. As a result, individuals have had less access to home care, care costs have risen presenting new financial burdens to vulnerable citizens and government-funded health care programs such as Medicaid and the VA, and triggered limits on working hours to avoid overtime costs leading to reduced income for home care aides and personal care attendants.

Issues/Concerns:
- The regulatory elimination of the FLSA home care exemptions was done in a vacuum as it included no protection for the highly vulnerable home care clients/patients who often subsist on limited incomes and can not afford higher care costs.
- Medicaid and VA home care finance much of the home care affected by the FLSA rule change. These programs have not responded to the increase in care costs triggered by the rule change with increased financial support.
- Without improved financial support, home care companies have no choice but to restrict employee working hours to avoid overtime costs. However, there are still increased costs stemming from the expanded need for recruitment and training additional staff.
- The shift to a part-time workforce makes it more difficult to recruit and retain personal care aides while demand is increasing with the aging population.

Talking Points:
- In 1974, Congress established the home care exemptions in order to provide the elderly and disabled with improved access to home care services at an affordable cost.
- The application of the exemptions for nearly 40 years served to help create greater opportunities for individuals to stay in their own homes and outside of institutional care.
- Personal care aides have experienced no increase in their overall compensation as the employers are unable to afford the cost of overtime due to the client population’s financial status and the payment rate controls of government health care programs such as Medicaid and the VA. These workers have been forced to take several part-time jobs to maintain their income.

Congressional support is needed:
- To encourage the Department of Labor to restore the FLSA rules in effect for nearly 40 years.
- To enact legislation, if necessary, to restore the exemption and preempt any later rulemaking that would again restrict the exemptions.
Background:
The U.S. Congress authorized Medicare coverage of hospice care in 1982; the hospice benefit is unique in a number of ways:

- Hospice was the first Medicare benefit to be reimbursed at prospectively-set daily rates (one of four rates is applied depending on the level of care complexity). Roughly 97% of hospice “days” of service are paid at the routine home care (RHC) rate -- the lowest daily rate for hospice services.
- Hospice requires an interdisciplinary approach to care, and requires that certain “core services” be provided by employees of the hospice.
- Hospice is the only benefit under Medicare that requires providers to offer bereavement services at no charge to patients’ family members, and to ensure that volunteers play a role in the delivery of services.
- Hospice requires that patients electing the benefit have a terminal illness and no more than a six-month life expectancy if the disease/condition progresses according to its anticipated course.
- Hospice requires that the patient electing services waive his or her right to receive curative services for the terminal and any related conditions, and care of those conditions must be provided or arranged by the hospice. For conditions unrelated to the terminal condition, the patient retains the right to seek services outside of hospice.

The public’s understanding of the nature of hospice and the value it can bring to patients and their loved ones has grown over the years, and in 2014 close to half of all Medicare decedents were the recipients of hospice care.

Given significant changes in the Medicare hospice program and the beneficiary populations it has served since 1982, the Affordable Care Act (ACA) required reform of the payment system for hospice RHC. In response, the Centers for Medicare & Medicaid Services (CMS) implemented a two-tiered payment system for hospice RHC beginning January 1, 2016. The system was designed to better reflect the higher costs incurred by hospices when a patient enters onto service. CMS also created a service-intensity add-on (SIA) to the daily RHC rate in the final seven days of life to help offset the increased costs incurred if the patient receives RN and/or social work visits.

The impact of these changes on hospice utilization, care patterns, and finances is not yet known.

In addition to payment reform changes, hospices have been subject to significant payment reductions and increased administrative costs in recent years; and additional cuts and administrative burdens are anticipated over forthcoming years.

As the result of the payment cuts and imposition of the Budget Control Act’s 2 percent across-the-board sequester, hospice payments for FY2016 were 12 percent LESS than they would otherwise have been. This gap continues to rise, and will do so over the foreseeable future.

Issues/Concern:
In recent years the Administration and the Medicare Payment Advisory Commission (MedPAC) have suggested additional changes to hospice payment policies, including:

- Inclusion of hospice under the Medicare Advantage (MA) benefit package
- Potential “rebasing” of hospice payment
- Creation of a hospice-specific market basket
- Reductions in payments for patients provided hospice services in nursing facilities

Any of these or other significant changes to the hospice program at this time would have a destabilizing impact on the delivery of hospice services, either through severe cuts, additional increased administrative costs, or major upheaval relative to care processes and coordination. Such changes will severely challenge the ability of hospice providers to appropriately serve terminally ill patients and their families.
Talking Points:

Medicare hospice providers have been subject to a series of significant challenges in recent years, including:

- Imposition of a new payment system
- Imposition of a productivity adjustment beginning in FY2013, and an additional 0.3 percentage point reduction to the market basket update for FY2013 through FY2019
- Elimination, through regulation, of the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index, which has reduced payments by 4 percent overall
- Significantly higher operating costs due to increased administrative requirements, including significantly expanded cost reporting requirements, new quality reporting requirements, additional data reporting requirements on claims, and a burdensome timely-filing requirement for hospice Notices of Election
- Decreasing financial margins

Congressional Support is Needed:

Until such time as the full impact of recent Medicare hospice policy changes on the delivery of care can be determined, Congress should reject any proposals that have the potential to diminish hospices’ ability to provide appropriate services to patients in their final days of life and support to those patients’ loved ones.
Topics to be Ready to Present if Raised by the Congressional Office

HOME HEALTH ISSUES:
Value-Based Purchasing

Background:
In the last Congress, legislation was introduced that would shift home health services and other post-acute care services to a Value-Based Payment (VBP) system. With VBP, providers are financially rewarded for outcomes that meet established performance measures and penalized when they fall short. In a typical VBP design, a defined percentage of payments is withheld to fund an incentive pool. At the end of the year, provider performance is then evaluated under a series of measures. Providers that exceed the mid-range of performance benchmarks receive bonus payments. Those below the mid-range do not, leading to a payment reduction. The performance measures can include quality of care outcomes, inpatient readmission rates, spending on care, or the use of certain operational processes.

Issues/Concerns:
There are VBP designs that can range from very good to very bad. Key factors in determining the bona fides of the design include:

- The amount of payment at risk is important. Too much jeopardizes the providers’ ability to improve performance. Too little means that there is no incentive to improve.
- The performance measures define the value. VBP is a behavioral modification concept. As such, the performance measures should fit what value is expected from the care of patients.
- There are factors beyond the control of providers. For example, patient behaviors and the actions of unaffected providers involved in the patient’s care can affect performance outcomes.

Talking Points:
- Home health agencies have demonstrated that they positively respond to small incentives to improve performance and that they operate on very small financial margins. The amount of payment at risk should be no greater than 2%.
- Performance measures should reflect the entire population of patients served by the provider. With home health care, some patients can and will improve in their functions while the maintenance of function and stabilization of other patient’s condition is a successful outcome.
- While spending on patient care is undeniably important, it should never be the sole or dominant measure of value and performance. Providers should not be incentivized to deprive people of needed care.
- With respect to post-acute care, the Impact Act will establish a uniform patient assessment process that will be used in inpatient discharge planning. A Post Acute Care VBP should be implemented only after that reform is in place, validated, and deemed reliable.

What Congress should do:
Incorporate the principles set out in the Talking Points into any legislative VBP proposal and include patient and provider representatives in such development.

Medicare Home Health Payment Rates

Background:
The Medicare Payment Advisory Commission is recommending that Congress institute a 5% reduction in Medicare home health payment rates in 2018. In addition, MedPAC recommends that Medicare rebase (recalculate) payments rates once again with a two year rebasing starting in 2018. Medicare initiated a 4 year rate rebasing that began in 2014 and concludes in 2017. That rebasing cut payment rates by nearly 12% in the aggregate.

Issues/Concerns:
Medicare home health agencies have had to operate with payment rate cuts that exceed any other provider sector. Further rate cuts will severely jeopardize care access.
Talking Points:
- HHAs have had payment rate cuts totaling over 17% since 2014. These include rate rebasing (12%); productivity adjustment (1.2%); case mix weight adjustment (2%); and sequestration (2%).
- Medicare home health spending is under control with the utilization and spending at $18 billion for the last several years while other Medicare spending continues to grow.
- The overall financial margin for home health agencies is below zero percent. Over 35% of home health agencies have Medicare margins less than zero, creating an ongoing risk that care access will be lost.
- MedPAC’s analysis fails to consider all home health services costs, disregards essential home health agencies that are part of hospitals, ignores the impact of other payers such as Medicaid, and underestimates the effect of the ongoing rate cuts.
- Home health agencies have established that home care is the best solution to preventing unnecessary hospitalizations, readmissions, and institutional care. The home health care delivery system must be stable to achieve those outcomes.

What should Congress do:
- Reject any proposals that would institute rate rebasing and any across-the-board rate cuts in Medicare home health services.
- Evaluate the impact of the last several years of rate cuts on care access and quality after the completion of the 2014-2017 rate rebasing.
- Focus on payment reforms that emphasize value and performance over payment rates.

HOME HEALTH & HOSPICE ISSUES:

Medicaid Block Grants/Per Capita Caps

Background:
The current discussions regarding repealing and replacing Obamacare include proposal to reform Medicaid. The most common reform raised is to shift Medicaid to a program where the federal financial contribution is limited or capped. In a block grant design, federal Medicaid would pay the states a preset overall amount. With per capita caps, federal Medicaid would contribute a set amount based on the number of enrollees in Medicaid. States under both federal payment reforms would have significant flexibility in designing the state’s Medicaid scope of benefits, provider participation standards, and provider payment rates. To the extent that the federal contribution does not cover the cost of the program, the state would be responsible for the rest.

Issues/Concerns:
There are numerous unknowns regarding the outcome of a Medicaid block grant or per capita cap reform. The only two real “knowns” are that the change would effectively shift federal Medicaid to a defined contribution program and that states would have the flexibility to completely change the makeup of Medicaid.

Talking Points:
- Under any Medicaid reform, states should be required to maintain access to home and community based care and hospice services as a priority for the beneficiary population. Both the Republican and Democratic Party national platforms in 2016 established home care as a national priority.
- The Supreme Court held in 1999 that the Americans with Disability Act (ADA) requires Medicaid programs to provide care in the least restrictive environment. Any reforms should continue this standard and require states to rebalance Medicaid spending for long term services and supports in favor of cost effective home care over costly institutional services.

What should Congress do:
Ensure that home and community-based care and hospice services be maintained as a Medicaid priority through any Medicaid reform.
Program Integrity in Home Care and Hospice

Background:
In recent years, various enforcement agencies have focused on fraud and abuse in health care programs. While much of the activity is centered on pharmaceutical companies, hospitals, and physicians, home care and hospice have not been immune to fraudulent providers. There have been whistleblower actions and prosecutions under the federal False Claims Act, along with stepped up claims audits. The home care and hospice communities have responded with a wide variety of legislative and regulatory proposals to enhance Medicare and Medicaid program integrity along with improved provider education and support as preventive measures.

Issues/Concerns:
- Fraud in health care hurts all stakeholders including patients, providers, and government-based health care programs.
- Broad-based program integrity measures tend to adversely affect honest and compliant health care providers more than to successfully address fraud, waste, and abuse.
- An “us vs. them” approach leads to program integrity failure as the vast majority of health care providers do not engage in any fraudulent or abusive activities and often know useful ways of enhancing program integrity efforts.

Talking Points:
- Home health and hospice providers have taken numerous steps to combat fraud, waste and abuse. These include:
  - Controlling unnecessary growth in the utilization of their services. Medicare spending on home health services is the same today as it was in 2010. Hospices have reduced live discharge rates for patients under their care, and spending outside of hospice while patients are on service has also lessened. These actions are indicative of responsible care planning and Medicare and Medicaid benefit utilization.
  - Home health agencies led the effort to secure and implement targeted legislative and regulatory reforms that curtail abuses including the establishment of a cap on Medicare outlier payment that saves $1 billion each year and the institution of moratoria on new home health agencies that controls spending and helps avoid the admission of abusive providers.
  - Hospices and home health agencies have worked with enforcement officials to identify risk areas and to define the “red flags” in provider behaviors that warrant investigations and audits.
  - Hospice and home health services are highly cost effective services that help keep Medicare and Medicaid financially viable.
  - Targeted reforms and enforcement actions are readily available with today’s databases and predictive modeling techniques. Precise program integrity action is cost efficient and successful, and avoids needlessly increasing health care costs.

What should Congress do:
- Continue to work with the home care and hospice community to design and implement constructive and targeted program integrity measures.
- Advise federal and state regulatory bodies on the value of using targeted predictive modeling for audit and enforcement actions.
- Establish standards for the admission of providers into Medicare and Medicaid that prevent the entry of parties that will abuse the programs.
HOSPICE ISSUES:

While our principal hospice message for visits to Capitol Hill in conjunction with the National Association for Home Care & Hospice’s (NAHC’s) March on Washington is that Congress should reject policy or payment changes that would threaten the stability of the hospice delivery network (see “Maintain Stability in the Medicare Hospice Benefit”), there are a number of other hospice-related issues that may be raised during your discussions. Following are some talking points that address these important issues in the event that they should arise.

Reject Efforts to Include Hospice as Part of the Medicare Advantage Benefit Package

Background:

In recent years the Medicare Payment Advisory Commission (MedPAC) and others have recommended that Congress include hospice as part of the Medicare Advantage (MA) benefit package for patients enrolled in MA plans.

Issues/Concerns:

- Medicare beneficiaries enrolled in MA will no longer have a choice of the hospice provider that will care for them in their final days of life.
- MA plans will pay certified hospice providers less than the cost of care, and may reduce the scope of services that are currently offered under the fee-for-service hospice benefit. As a result, patients and families will suffer.
- Medicare hospice eligibility rules require that a patient be determined terminally ill with a prognosis of six months or less if the disease follows its normal course. Tensions could arise between the MA plan and a contracted hospice relative to whether a patient does or does not meet Medicare’s eligibility requirements.
- MA involvement with hospice coverage could threaten the autonomy of the hospice interdisciplinary team relative to patients’ plans of care.
- Financial incentives may lead MA plans to shift responsibility for unrelated services to a contracted hospice provider.
- MA plans may impose additional cost sharing on hospice beneficiaries, or alter the scope and duration of the hospice benefit terms.
- Hospice is undergoing significant changes and uncertainties related to those changes have created concerns about financial stability within the hospice program. Bringing hospice under MA will increase these uncertainties.
- The terms under which MA plans enter into contracts with hospice organizations could run counter to the current hospice payment reform goal of ensuring that hospice payments better reflect actual costs of care over the course of a patient’s stay on hospice.

What Congress should do:

Congress should reject efforts to include hospice as part of the Medicare Advantage benefit package.

Revise Requirements for Hospice Face-To-Face Encounters

Background:

Once a patient has utilized two 90-day hospice benefit periods, hospices are required to conduct a face-to-face encounter between the patient and a hospice physician or hospice-employed nurse practitioner (NP); this encounter must be conducted PRIOR to the beginning of the applicable hospice benefit period. If a hospice fails to meet the face-to-face requirement on a timely basis, payment for days of service prior to the requirement being met is denied.
Issues/Concerns:
The requirements for the hospice face-to-face encounter have very limited flexibility in terms of the clinician that may conduct the encounter and the time frames for completion of the encounter. Given these circumstances, hospices are discouraged from taking terminally ill patients onto service if the stringent face-to-face requirements have not been met, which may delay access to vital hospice services.

- At times hospices are challenged to identify a physician or NP to conduct the face-to-face encounter in short order. Face-to-face requirements under the home health benefit allow physician assistants (PAs) to conduct the face-to-face encounter. Expansion of the types of clinicians that are permitted to conduct the face-to-face would give hospices the staffing flexibility needed to arrange timely encounters, and allow for more timely access to hospice services for terminally ill individuals.
- Patients who desire readmission to hospice care and require a face-to-face encounter often times have begun rapid deterioration in their condition and require timely access to services. While CMS does allow, under exceptional circumstances, for the hospice to conduct the face-to-face within 48 hours of admission, this is frequently insufficient time for the hospice to schedule the face-to-face. Additional time is needed to ensure that these patients have timely access to hospice services.

What Congress should do:
In recent years, legislation titled The Hospice Commitment to Accurate and Relevant Encounters Act, or Hospice CARE Act, was introduced to allow hospices to utilize PAs and other appropriate clinicians to perform the required face-to-face encounter, and also provide additional time for hospices to complete the face-to-face encounter when exceptional circumstances occur. Rep. Tom Reed (R-NY) was the lead sponsor on this bill, and it is anticipated that this legislation will be reintroduced in the 115th Congress. Members of Congress should encourage and support Rep. Reed’s efforts in this regard.

Allow PAs to Serve as Hospice Attending Physician

Background:
Current law limits the choice of a hospice attending physician to the patient’s physician or nurse practitioner (NP).

Issues/Concerns:
While NPs have been permitted to serve as hospice attending physicians, physician assistants (PAs) are not authorized to do so. Hospice patients should be able to choose their PAs to continue to provide services related to the terminal prognosis upon election of hospice care.

What Congress should do:
In recent years, legislation titled “The Medicare Patient Access to Hospice Act” would grant Medicare beneficiaries, upon election of hospice care, the right to select their PAs to serve as their attending physicians for purposes of hospice care. This is a non-controversial change, but one that is very important for hospice patients. Rep. Lynn Jenkins (R-KS) has reintroduced this legislation in the House of Representatives as H.R. 1284; members of the House should join in cosponsoring this legislation.

Create an Advance Care Planning Benefit Under Medicare

Background:
While the Centers for Medicare & Medicaid Services (CMS) has taken action allowing physicians and other Part B practitioners to bill for advance care planning services, it is widely believed that these services are most effective when provided by a well-trained interdisciplinary team of professionals.
Issues/Concerns:

- In recent years, several bills have been introduced that would expand the availability of trained professionals to assist individuals with advanced illness in making determinations about their desired course of treatment so that it is consistent with their personal goals, values and preferences.
- The Care Planning Act, introduced in the 114th Congress by Sens. Mark Warner and Johnny Isakson, would create a new benefit under Medicare that covers advance care consultations with the involvement of a trained interdisciplinary team to help empower seriously ill individuals to make deliberate and thoughtful decisions on the course of care that is right for them.

What Congress should do:

A new version of the Care Planning Act is under development by its sponsors; members of Congress should support efforts to ensure that individuals with advanced illness have access to team-based services that assist with advance care planning, such as those envisioned in the Care Planning Act.

Ensure Access to Care for Rural Hospice Patients

Background:

People in the final stages of life should have access to quality and compassionate hospice care and the services of their chosen care practitioner no matter where they live, but a technicality in current law forces patients at rural health clinics (RHCs) and federally qualified health centers (FQHCs) to give up treatment for their terminal condition by their primary care provider if they want hospice care.

Issues/Concerns:

- Currently, if a RHC or FQHC-employed physician or nurse practitioner wants to bill for hospice attending physician services, he or she must do so separately to Part B, but many center or clinic-employed care providers do not operate separate physician practices. This deters them from serving as the attending physician, and deprives the hospice patient of the continuity of care and comfort that they want and deserve. This may discourage patients from using hospice care.
- The Rural Access to Hospice Act corrects this mistake by allowing rural health clinics and federally qualified health centers to bill Medicare for those attending physician services.

What Congress should do:

It is anticipated that the Rural Access to Hospice Act will be reintroduced in the 115th Congress; members of Congress should support efforts to correct current law to allow rural patients to be treated for their terminal illness by their chosen primary care practitioner.