



228 Seventh Street, SE  
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# 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.



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#### 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 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.



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## 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.



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#### 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.

### **Maintain Stability in the Medicare Hospice Benefit**

#### **Background:**

The U.S. Congress authorized Medicare coverage of hospice care in 1982; the hospice benefit is unique, and 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.

The Centers for Medicare & Medicaid Services (CMS) implemented a two-tiered payment system for hospice RHC and a service-intensity add-on (SIA) for some services provided in the final days of life beginning January 1, 2016. The system was designed to better reflect the higher costs incurred by hospices when a patient enters onto service. 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/Concerns:**

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

#### **What Congress should do:**

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.



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## **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.

## **Allow PAs to Serve as Hospice Attending Physician (H.R. 1284)**

### **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.



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## Ensure Access to Care for Rural Hospice Patients (H.R. 1828)

### 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.