

## March on Washington Legislative Priorities Executive Summary

### Home Health Payment Innovation Act (S. 433)

The Bipartisan Budget Act of 2018 allows the Centers for Medicare & Medicaid Services to establish and adjust reimbursement rates in the Medicare Home Health Prospective Payment System (HHPPS) based on assumptions of changes in provider behavior, in response to the new Patient Driven Groupings Model (PDGM) payment system. Subjecting providers to a rate cut while simultaneously implementing the most significant change in the payment structure since the inception of the HHPPS risks instability and threaten providers' ability to maintain operations.

#### **This legislation would:**

- Remove CMS's ability to make assumptions of provider behavior in rate setting;
- Require adjustments to be made on the basis of actual behavior change;
- Phase in adjustments by no more than 2% per year, increase or decrease; and
- Allow for waiver of the homebound requirement for patients covered by Medicare Advantage plans or under a Medicare Shared Savings Program.

### Home Health Care Planning Improvement Act (S. 296)

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 obtain the necessary Medicare certification. The transfer of patients to physicians by their primary practitioner NP or PA does not improve care quality or program integrity.

#### **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.



#### **For More Information**

Contact NAHC Government Affairs at 202-547-7424

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### Home Health Rural Add-on

Home health agencies providing care in rural areas face the added expense of increased travel time and overhead to provide care for their patients, burdens not fully shared by urban or suburban settings. Until 2019, the rural add-on for Medicare Home Health helps to compensate for this through a three percent addition to reimbursement. As included in the Bipartisan Budget Act, this vital add-on has been reduced and is set to be phased out over the next 2-4 years, yet the support remains necessary for many rural providers to continue to deliver high quality care.

#### What Congress can do:

- Extend the Medicare Home Health rural add-on for an additional three years at three percent;
- Require a study on its application and any needed reforms to ensure its ongoing success.

### Hospice MA Carve-in

The Centers for Medicare & Medicaid Services (CMS) announced plans to test inclusion of hospice under the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model program. There is widespread concern that this change could compromise the integrity of the existing patient-centered, bundled hospice benefit, particularly given Medicare's current inability – outside of hospice – to measure quality of care at the end of life. Further, there are already changes being tested under MA that may impact end-of-life care, including increased emphasis on advance care planning and provision of palliative care as a supplemental benefit in advance of hospice eligibility. In light of these circumstances, rather than testing inclusion of hospice under MA, **Congress and the Administration should:**

- Closely monitor trends related to advance care planning under VBID and provision of palliative care as a supplemental MA benefit to determine their impact on care choices at the end-of-life;
- Develop a robust set of metrics and quality measures related to patient/family satisfaction and care coordination, care transitions, advanced illness and end-of-life care that will allow for comparison across settings in MA and fee-for-service;
- Pursue testing of a fee-for-service palliative care model for patients with serious illness based on proposals by the Center to Transform Advanced Care (CTAC) and the American Academy of Hospice and Palliative Care Physicians (AAHPM) to support advanced illness needs and provide a smoother transition to hospice care where appropriate;
- Clarify coverage confusion through education of MA plans, hospice providers and patients.



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