Home Care & Hospice
ALLIANCE OF MAINE

2016 Congressional Bills of Interest

PATIENT-CENTERED APPROACH TO ADVANCED CARE PLANNING

The Care Planning Act (S. 1549) would provide much needed assistance to individuals with serious health conditions by giving them access to more information about potential treatment options and ensuring that the course of treatment they arrive at is consistent with their personal goals, values and preferences.

The bill would create a new benefit under Medicare that embodies key elements that have proven tremendously effective in empowering individuals to make deliberate and thoughtful decisions on the course of care that is right for them. The elements include the use of an interdisciplinary team and allowing for a series of discussions with a variety of experts. The Care Planning Act would remove some of the overwhelming confusion and anxiety that so often accompany health care decision making, and assure that an individual's chosen treatment plan is communicated among care providers.

Introduced 6.10.15 and referred to Committee on Finance. Cosponsored by Sen. Collins.

ALLOW PAs TO SERVE AS HOSPICE ATTENDING PHYSICIANS

Current law limits the choice of a hospice attending physician to the patient's physician or Nurse Practitioner (NP). 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.

Senator Mike Enzi (R-WY) introduced the **Medicare Patient Access to Hospice Act of 2015 (S. 1354)**, which 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. Identical legislation (**H.R. 1202**) was introduced in the House of Representatives by Reps. Lynn Jenkins (R-KS) and Mike Thompson (D-CA).

Both bills were introduced in 2015. Rep. Pingree is a cosponsor of the House Bill (37 cosponsors) There is only one cosponsor on the Senate Bill. None from Maine.
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ALLOW NP/PAs TO ORDER HOME HEALTH SERVICES

We urge Senators and Representatives to co-sponsor the **Home Health Care Planning Improvement Act (S 578/HR 1342)**, which would allow Nurse Practitioners, Advanced Practice Nurses, and Physician Assistants to sign Medicare home health care plans.

» Issue Brief/Talking Points
» House Dear Colleague Letter
» Senate Dear Colleague Letter
» Report Projects Substantial Medicare Savings from Allowing NPs/PAs to Sign Home Health Plans of Care.

Senate Bill: Reintroduced by Sen. Collins on 2/26/2015 in the Senate. Referred to Finance Committee. There are 51 cosponsors including Sen. King.

House Bill: Introduced on 3/16/15. There are 202 cosponsors. Supported by Reps. Pingree and Poliquin.

10/26/2016

THE HOSPICE COMMITMENT TO ACCURATE AND RELEVANT ENCOUNTERS ACT -- HOSPICE CARE (F2F)

Representatives Tom Reed (R-NY) and Mike Thompson (D-CA) introduced legislation (**HR 2208, The Hospice Commitment to Accurate and Relevant Encounters Act -- Hospice CARE**) to address key issues related to the requirement that hospice providers conduct a face-to-face encounter with patients entering their third or subsequent benefit period to gather information that helps support documentation of continuing eligibility for hospice care. HR 2208 revises the hospice face-to-face encounter requirement to allow physician assistants and other appropriate clinicians to conduct the face-to-face and permit hospices to conduct the face-to-face within 7 days of admission under exceptional circumstances.

» Hospice CARE Act Issue Brief

» NAHC's Hospice CARE Act Letter of Support

Introduced 5.1.15. Rep. Pingree is only House cosponsor from Maine.

REPEAL OR REVISE FACE-TO-FACE PHYSICIAN ENCOUNTER REQUIREMENTS

A flawed provision of the Patient Protection and Affordable Care Act requires a patient to have a face-to-face encounter (F2F) with a physician to certify the need for Medicare home health services. It includes burdensome paperwork requirements on physicians that have caused confusion among physicians, home health agencies, and other parties involved. Unfortunately, the confusion and burdensome paperwork from the rule have limited access to care and posed a high risk for denying coverage to Medicare beneficiaries who are homebound and in need of skilled nursing care. Congress should act now to repeal or revise the F2F requirement. The revision should: 1) limit the physician documentation to demonstrating that a timely encounter occurred, consistent with the original intent; 2) narrow the circumstances where a F2F is required by excluding patients transferred from a hospital or SNF where physician encounters are virtually guaranteed; 3) provide an exception in areas where physicians are scarce; 4) permit a waiver in a case-specific situation where a F2F is not feasible; and 5) permit F2F encounters by way of an expanded definition of telehealth.

» Face-to-Face Issue Brief Revision

HOME HEALTH DOCUMENTATION AND PROGRAM IMPROVEMENT ACT OF 2015

Sens. Robert Menendez, D-N.J., and Pat Roberts, R-Kan., have introduced legislation in the Senate that offers a real solution to the challenges faced by home health providers. The legislation, **S. 1650**, provides common-sense fixes to Medicare documentation problems and much needed relief to the documentation of a face-to-face visit. The legislation provides relief from past claims denials and improves the approach CMS uses to collect evidence that beneficiaries are eligible for home health services moving forward. Key provisions include:

- Requires CMS to develop "in consultation with stakeholders" a standardized form to collect evidence that a beneficiary is eligible for home health services;
- Limits the amount of information that CMS may collect on the form;
- Requires CMS to accept forms completed by the home health agencies that are reviewed and signed by the referring physician;
- Exempts home health agencies from collecting documentation for beneficiaries who have been discharged from a hospital or skilled nursing facility within 14 days prior to the initiation of such home health services;
- Requires contractor education to ensure fair and uniform application of the policy nationwide;
- Provides a mechanism for home health agencies to resubmit claims that were denied solely due to compliance issues with the face-to-face documentation requirements for reprocessing as though the face-to-face narrative requirements of did not apply at the time; and
- Requires a study of audit contractor performance on Medicare documentation for home health services and denial and appeals rates.

» Home Health Documentation and Improvement Act of 2015 Fact Sheet (July 2015)
» Official press release
» Learn more about the Face to Face Documentation issue

This is a Senate only bill. Introduced on 6.23.15. It is supported by VNAA. No Maine cosponsors.

OPPOSE PROPOSALS TO IMPOSE SURETY BONDS ON ALL HOME HEALTH AGENCIES

A surety bond requirement for all home health agencies was included in the Medicare Sustainable Growth Rate (SGR) repeal legislation. Although we support strong program integrity measures, surety bonds will not help and will have serious negative effects. The Congressional Budget Office determined that a surety bond will save Medicare $10 million over 10 years. However, the costs of the bonds will exceed $100 million.

- it will hurt small home health businesses that struggle to comply with expensive and unreasonable regulatory burdens;
- it will threaten access to care especially in rural areas;
- it's effectively a tax on the vast majority of ethical providers to cover the cost of a few bad actors;
- it gives too much discretion to CMS in setting the bond amount and implementing the requirement;
- surety bond requirements should be time-limited and targeted to new providers only. Long-standing providers rarely present a risk to Medicare.

» Background/Talking Points

EXTEND THE HOME HEALTH RURAL ADD-ON

Urge your Members of Congress to support efforts to extend the Medicare home health rural add-on. co-**S. 2389**, bipartisan legislation introduced by Senator Susan Collins (R-ME) and Senator Maria Cantwell (D-WA) would extend of the 3 percent rural add-on payment for Medicare home health services which expires at the end of 2017. The delivery of home health services in rural areas is significantly more costly because of the extra travel time to cover long distances between patients, higher transportation expenses, and other factors unique to rural service delivery. Rural agencies are often smaller than urban agencies with fixed costs that must be spread over fewer patients and fewer visits. Without the rural add-on, 57% of rural home health agencies are projected to be underwater by 2017--paid less than their costs. Failure to extend the rural add-on payment will put more pressure on rural home health agencies that are already operating on very narrow margins and could force some of these agencies to close. Many home health agencies operating in rural areas in our state are the only home health providers in large geographic areas. If any of these agencies are forced to close, the Medicare patients in that region could lose all their access to home care. The home health rural add-on payment was instituted by Congress to mitigate the financial pressures on rural home health agencies and the related access barriers encountered by rural residents.
» Issue Brief/Talking Points

This is a Senate only bill. It is sponsored by Sen. Collins. No cosponsors from Maine. Only 1 other sponsor.

OPPOSE MEDICARE HOME HEALTH COPAYS AND PAYMENT CUTS

NAHC urges all home care advocates to ask their members of Congress to "Reject proposals that would impose home health copays and payment cuts to offset the cost of fixing the Medicare physician payment formula, to reduce the deficit, or for other purposes."
» Home Health Copay Issue Brief
» Home Health Copay Talking Points
» Home Health Payments Issue Brief/Talking Points
» A Home Health Co-Payment: Affected Beneficiaries and Potential Impacts
» Potential Impact of a Home Health Co-Payment on Other Medicare Spending

Alliance Notes: There is no bill or inclusion of this in any bill.

SAVE AMERICAN WORKERS ACT OF 2015 (H.R. 30 and S. 30)

The Affordable Care Act (ACA) includes an "employer mandate" that penalizes employers for not providing health insurance for their "full time" workers. However, a full time worker is defined in the law as an employee who works just 30 hours a week and not the widely recognized standard forty hour work week. Home care agencies that are unable to provide health insurance or absorb the ACA penalties will have to restrict their employees to no more than 29 hours per week to ensure their workers are considered part-time under the ACA. This would weaken patient access to care, reduce wages and working hours of home care staff, and require home care companies to rely on part-time caregivers.

Both bills would amend the Internal Revenue Code to change the definition of "full-time employee" for purposes of the employer mandate to provide minimum essential health care coverage under the Patient Protection and Affordable Care Act from an employee who is employed on average at least 30 hours of service a week to an employee who is employed on average at least 40 hours of service a week.

Alliance Notes: H.R. 30 passed in the House on 1/08/2015 (252/172). Poliquin cosponsored and voted in favor; Pingree did not cosponsor and voted against the bill. Senate bill (S. 30) is sponsored by Sen. Collins. It was introduced on 1/06/2015. 41 cosponsors. King does not support the bill.

REQUIRE CMS TO RECONSIDER HOME HEALTH PPS REBASING RULE

Ensure that the Centers for Medicare and Medicaid Services (CMS) preserves adequate and appropriate payment for Medicare home health services and does not impose unreasonable regulatory burdens that would restrict access to care.

Urge Lawmakers to Require CMS to Reconsider Home Health PPS Rebasing Rule
» Home Health Rebasing Overview
» Rebasing Reform Proposal Talking Points
» 2014-2017 Projections State/National 3-13-14
» 2014-2017 Projections Congressional District 3-13-14
» House Home Health Rebasing Dear Colleague Letter 9-17-14
» Home Health Rebasing Relief Letter to House Leadership
» House Home Health Rebasing Dear Colleague Letter 3-6-2014
» House Home Health Rebasing Letter
» Senate Home Health Rebasing Letter

PROMOTE TELEHOMECARE/REMOTE MONITORING

Contact your Senators and encourage them to co-sponsor S. 596, the Fostering Independence Through Technology (FITT) Act of 2013 introduced in the Senate by Senators John Thune (R-SD) and Amy Klobuchar (D-MN). The Act would expand the use of telehealth under Medicare by offering incentives to home health agencies who demonstrate the use of remote monitoring and communication technologies that serve rural and underserved urban communities.
» 113th Congress Talking Points
» Joint Press Release
» NAHC Press Release
» Dear Colleague

Alliance Notes: Senator Collins is a cosponsor.

OPPOSE PROPOSALS TO CUT FEDERAL FUNDING FOR MEDICAID

NAHC urges home care and hospice advocates to ask their Members of Congress to protect access to home care and hospice for low income Medicaid beneficiaries by opposing proposals that would reduce federal Medicaid funding.
» Issue Brief/Talking Points

Alliance Notes: There is no bill.

HOSPICE: PROTECT THE MEDICARE HOSPICE BENEFIT

The Medicare hospice benefit provides essential palliative services to beneficiaries at the end of life. Please help preserve access to these important services. Hospice is undergoing considerable changes and providers are being subject to increasing, costly regulatory requirements. At the same time, reimbursement for care is diminishing. Congress is discussing the federal budget and some are advocating additional cuts to Medicare as well as restructuring of the fee-for-service Medicare program as a means of reducing federal outlays. Some plans would merge Parts A and B and impose a uniform copay and deductible requirement, which could affect services to Medicare hospice beneficiaries.
» Issue Background/Talking Points

REVERSE CLAIM DENIALS RELATED TO THE FACE-TO-FACE PHYSICIAN ENCOUNTER REQUIREMENTS FOR HOME HEALTH SERVICES

CMS Face-to-Face requirements impose burdensome, costly, and confusing documentation requirements that exceed the intent of laws passed by Congress. Home health providers are now experiencing retroactive claims denials that reveal just how confusing and unworkable the CMS documentation requirements really are.

The current regulation has increased the paperwork burden and cost to home health agencies and physicians and added a disincentive for physicians to recommend home health care. CMS recently issued a new proposed rule that would eliminate the physician narrative requirement, an important stride forward. However, the proposed rule does not address past or future denials pending implementation of a new final rule.

Ask lawmakers to urge the CMS Administrator to reverse claim denials related to the physician narrative requirement.

BUNDLING & COORDINATING POST-ACUTE CARE (BACPAC) ACT 2015 (H.R.1458)

Amends the Social Security Act to require a single bundled payment for post-acute care services under Medicare parts A (Hospital Insurance) and B (Supplementary Medical Insurance). Defines "PAC physician" as the physician with primary responsibility for supervising delivery to an individual of a post-acute care (PAC) bundle of services between a qualifying discharge and the earlier of: (1) 90 days later, or (2) the date on which the individual is admitted to a hospital to receive services for a condition unrelated to the one for which he or she received the acute care inpatient hospital services.

Directs the Secretary of Health and Human Services (HHS) to: (1) establish a new Transitional Care Management (TCM) code, with respect to geographic adjustments to the physicians' fee schedule, to pay for care management by a PAC physician; or (2) revise and expand the use of existing TCM codes 99495 and 99494.

Alliance Notes: This is not in NAHC's list of bills and has no cosponsors from Maine. NAHC does not fully support, although VNAA does. Introduced 03/19/2015.

RESCIND THE MEDICARE HOME HEALTH PRIOR AUTHORIZATION PROPOSAL

Congressmen Tom Price (R-GA-6) and James P. McGovern (D-MA-2) are leading a letter urging the Centers for Medicare & Medicaid Services to rescind its proposal to institute Medicare home health prior authorization in five states. This proposal, which could easily spread to additional states whenever CMS wishes, threatens Medicare beneficiaries and upstanding home health agencies because it would be costly, burdensome, and ineffective. Furthermore, CMS lacks the legal authority and justification for imposing prior authorization on home health agencies. Please ask your Representatives to cosign the letter urging CMS to rescind its Medicare home health prior authorization proposal.

» Prior Authorization for Home Health Letter
» Dear Colleague Letter

Alliance Notes: Letter was sent on May 24, 2016. House letter had 116 signers. Neither Pingree nor Poliquin signed-on.

REJECT INCLUSION OF HOSPICE UNDER THE MEDICARE ADVANTAGE BENEFIT PACKAGE

The Senate Finance Committee's Chronic Care Working Group has issued an options paper that includes requiring Medicare Advantage (MA) plans to offer hospice services as part of the MA benefit package. This change would threaten patient/family choice of care provider in their final days of life and reduce the value of the hospice benefit to patients and their loved ones. Congress must reject efforts to make this legislative change.

OPPOSE MEDICARE REGULATION THAT THREATENS TO CUT $350 MILLION FROM HOME HEALTH SERVICES

The Center for Medicare & Medicaid Services (CMS) has issued a proposed rule for 2016 that includes Medicare home health payment rate cuts in the Home Health Prospective Payment System (HHPPS). This proposed rule includes a proposed home health case mix cut in addition to the third year of rate rebasing. The proposal also includes a Value Based Purchasing pilot program that can trigger further reimbursement reductions. Two concerning elements of the rule are the 1.72 percent "case mix" cut in 2016 and again in 2017, and the application of a 5-8% range in penalties and incentive payments for the proposed Home Health Value Based Purchasing (HHVBP) pilot program.

Case Mix Cut: The proposed HHPPS rule cuts home health payment rates by 1.72 percent in 2016 and again in 2017 in addition to the rate rebasing cuts. This proposed "case mix weight change" reduction, otherwise known as the "case mix creep adjustment," is a concern because it is based on a outdated case mix weight change analysis (2000-2001), not the changes in the condition of beneficiaries during the 2012 to 2014 period that the CMS proposal concerns.

Home Health Value-Based Purchasing (HHVBP): the proposed rule would establish a HHVBP program that would impose an incentive/penalty range of 5 to 8 percent over a 5-year period. That means that some home health agencies could lose as much as 8 percent of their payments for an entire year. There is a concern with the aggressive nature in which the Secretary intends to ramp up HHVBP in that the penalties would deprive providers of the resources needed to improve their performance.

H.R. 2446 To amend title XIX of the Social Security Act to require the use of electronic visit verification for personal care services furnished under the Medicaid program, and for other purposes.

Amends title XIX (Medicaid) of the Social Security Act to require states to have in place a system for the electronic verification of visits conducted as part of personal care services or else have their federal medical assistance percentage reduced by specified amounts.
3 cosponsors. None from Maine.

H.R.3298 - Medicare Post-Acute Care Value-Based Purchasing Act of 2015
This bill amends title XVIII (Medicare) of the Social Security Act to: (1) modify market basket percentages for post-acute care (PAC) providers, and (2) establish a PAC value-based purchasing program under which PAC providers receive value-based incentive payments. PAC providers are skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, and long-term care hospitals.

A market basket is an index that reflects inflation and is used to update payments and cost limits. Under current law, market basket percentage increases for PAC providers are generally based on the application of a formula based on costs from the preceding fiscal year, but for FY2018 these increases are fixed at 1%. The bill repeals these fixed increases, leaving FY2018 increases to instead be determined according to the existing formula.

With respect to the PAC value-based purchasing program, the bill: (1) requires the Centers for Medicare & Medicaid (CMS) to establish performance standards and scores by which to rank PAC providers; (2) specifies how CMS must calculate value-based incentive payments for each type of PAC provider in accordance with such ranking; (3) requires CMS to make specified annual adjustments to how incentive payments are calculated; and (4) establishes limits on administrative and judicial review.

Only 2 cosponsors. None from Maine.

H.R. 3119 and S2748 Palliative Care and Hospice Education and Training Act
The Palliative Care & Hospice Education and Training Act amends the Public Health Service Act to require the Dept. of Health and Support H.R.3119 S. 2748 Human Services to award grants or contracts for Palliative Care and Hospice Education Centers. These Centers must improve the training of health professionals in palliative care and establish traineeships for individuals preparing for advanced education nursing degrees, social work degrees, or advanced degrees in physician assistant studies in palliative care.
,220 cosposnors in the House including Reps. Poliquin and Pingree
Both Sens. Collins and King has sihned on to support the bill for a total of 10 in the Senate.

H.R. 6226 The Pre-Claim Undermines Seniors' Health (PUSH) Act of 2016 delays the Medicare demonstration for pre-claim review of home health services for one year to allow Congress, CMS and home health stakeholders to work together to strengthen the program and improve education and training to ensure patient care is not delayed or that individual beneficiaries are not unjustly denied coverage.
4 cosponsors None from Maine