



## *Congressional Bills of Interest*

### **PATIENT-CENTERED APPROACH TO ADVANCED CARE PLANNING (NEW)**

**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.

### **ALLOW PAs TO SERVE AS HOSPICE ATTENDING PHYSICIANS (NEW)**

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. This is a non-controversial change, but one that is very important for hospice patients.

### **ALLOW NPs/PAs TO ORDER HOME HEALTH SERVICES**

Ask your Senators and Representative 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.](#)
- » [Contact Your Legislators](#)

## **THE HOSPICE COMMITMENT TO ACCURATE AND RELEVANT ENCOUNTERS ACT -- HOSPICE CARE (NEW)**

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](#)

## **REMOVE MEDICARE CUTS FROM TRADE LEGISLATION**

Believe it or not, Congress is seriously considering diverting millions of dollars in Medicare funds to pay for legislation reauthorizing the Trade Adjustment Assistance program. Committees in both the House and Senate have passed the bill with the Medicare cuts. However, the full House and Senate still need to vote on the legislation. Medicare providers have already absorbed hundreds of billions of dollars in cuts in recent years. The use of Medicare funds for non-Medicare purposes is an unwise and alarming precedent. Taxes that have been raised to care for Medicare patients should not be used for other purposes as a matter of convenience.

There may be an opportunity to remove the Medicare cuts from the legislation. House Ways & Means Committee Chairman Paul Ryan (R-WI-1), has said he would consider alternatives to the Medicare cuts in order to offset the cost of the trade legislation. Leaders in Congress need to hear from your members of Congress about the importance of removing the Medicare cuts.

## **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. Contact your member of Congress to repeal or revise the F2F requirement.

» [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 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](#)

### **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. Please inform your Senators that 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.

Ask your members of Congress to oppose any proposals to impose a surety bond requirement on all home health agencies.

» [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. 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. Home health agencies in rural areas 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 percent of rural home health agencies are projected to be underwater by 2017--that is paid less than their costs by Medicare.

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. Please support efforts to extend the rural add-on.

» [Issue Brief/Talking Points](#)

» [Contact Your Legislators](#)

## **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](#)
- » [Co-payment White Paper](#)
- » [A Home Health Co-Payment: Affected Beneficiaries and Potential Impacts](#)
- » [Potential Impact of a Home Health Co-Payment on Other Medicare Spending](#)
- » [Contact Your Legislators](#)

## **MODIFY EMPLOYER RESPONSIBILITIES IN THE ACA TO ADDRESS HOME CARE-SPECIFIC NEEDS**

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.

Send a message to Congress asking them to support legislation amending the ACA to define full time as 40 hours a week.

## **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](#)
- » [Senate Small Business Committee Chair Rebasing Letter](#)
- » [Senate Minority Leader Rebasing Letter](#)
- » [Contact Your Legislators](#)

## **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](#)
- » [Contact Your Legislators](#)

## **PROMOTE TELEHOMECARE/REMOTE MONITORING**

Contact your Senators and encourage them to co-sponsor [S. 596](#), the Fostering Independence Through Technology (FITT) Act of 2013 which 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](#)
- » [Contact Your Legislators](#)

## **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.

Your help is needed to ensure continued access to needed hospice services for some of our most vulnerable Medicare beneficiaries. Please do everything within your power to reject further cuts to or imposition of copays or deductibles on Medicare hospice services. Many thanks for your efforts on behalf of terminally ill Medicare beneficiaries.

- » [Issue Background/Talking Points](#)
- » [Contact Your Legislators](#)

## **PROVIDE A PHASE-IN PERIOD FOR NEW HOME HEALTH FACE-TO-FACE RULES**

Since the inception of the current face-to-face rule, the home care community has strived to achieve compliance. There is a clear need for comprehensive and detailed guidance along with widespread dissemination of educational materials, both to home health agencies and to physicians to achieve compliance. NAHC recommends that CMS first issue any necessary guidance, complete essential education, and test the understanding of the affected home health agencies and physicians before enforcing the new requirements with claims audits and coverage denials. Urge that CMS take the following actions to resolve serious issues arising from implementation of the face-to-face physician encounter requirement (F2F) for home health services:

a) Phase-in the new F2F documentation requirements by issuing comprehensive guidance on compliance and education of physicians and home health agencies before instituting full enforcement

- » [NAHC F2F Phase-In Letter to CMS](#)

b) Reverse past F2F claim denials and stop future audits related to the physician narrative requirement

- » [Senate Face-to-Face Letter to CMS](#)
- » [House Face-to-Face Letter to CMS 2013](#)
- » [House Face-to-Face Letter to CMS 2014](#)
- » [Talking Points/Issue Brief](#)
- » [Home Care Face-to-Face Mandate: A Major Problem, a Simple Fix](#)
- » [Face-to-Face Documentation Survey Results](#)

## **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 and Coordinating Post-Acute Care (BACPAC) Act of 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.