HOMECARE & HOSPICE
National Association for Home Care & Hospice

2018 March on Washington Lobby Day Toolkit

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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 on 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 their 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.

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- 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 your 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 staffer to follow-up with. Ask for their card so 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. 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 coordinate their visit.
- 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 than just those who were able to travel all the way to DC.

For More Information: Please Contact NAHC Government Affairs at 202-547-7424

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Key Issues in Brief

Proposed Clarifications to Medicare Home Health Payment Reform

The Bipartisan Budget Act (BBA) of 2018 (P.L. 115-123) made sweeping reforms to the Medicare home health benefit. Included in these reforms were a shift to a 30-day unit of service, authorization for the Secretary of HHS to make rate adjustments based on assumptions of provider behavioral changes rather than facts, and the ambitious implementation year of 2020 for these reforms. The BBA also attempted to remedy problems associated with the face-to-face/physician documentation and certification requirements but this change needs strengthening to ensure its intent is achieved. This series of proposals developed by the home health community would make much-needed modifications by clarifying a 30-day unit of payment rather than service, prevent prospective rate adjustments based on behavioral assumptions, allow more time for reforms to be implemented, require that the payment reforms be tested initially with a demonstration, and require that a home health agency's records are considered alongside the physician record when determining claim status.

PRIORITIES

Home Health:

1. Proposed Clarifications to Medicare Home Health Payment Reform
2. Home Health Care Planning Improvement Act (S. 445 / H.R. 1825)
3. The Value of Home Care

Hospice:

1. Cosponsor/Enact The Patient Choice and Quality Care Act (S. 1334 / H.R. 2797)
2. Preserve Access to and Ensure Safe Disposal of Opioids, Other Controlled Medications in Hospice Care
3. Monitor Hospital "Early Discharge" to Hospice Care

Home Health Care Planning Improvement Act (S. 445 / H.R. 1825)

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.

The Value of Home Care

Over 14 million Americans receive home care each year. Home health care brings proven cost savings to health care, promotes better patient outcomes, provides access to the latest therapies and medical technology, and is the patient preferred setting for medical care. Congress should protect and expand access to home health care, eliminate barriers to its provision, and work to expand its use as an effective solution to rising health care costs.

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Proposed Clarifications to Medicare Home Health Payment Reform

Background:

The Bipartisan Budget Act (BBA) of 2018 (Public Law 115-123) contained significant reforms to the Medicare Home Health benefit and payment structure. Included in these reforms was a shift to a 30-day unit of service from the current 60-day model and authorization for the Secretary of Health and Human Services to make prospective and permanent adjustments to reimbursement rates based on assumptions of provider behavioral changes. These reforms are currently mandated to go in to effect in calendar year 2020. Additionally, the BBA attempted to address problems associated with the long standing face-to-face/physician documentation certification requirement, but likely will not have the impact intended.

Issue/Concerns:

- As signed into law, BBA calls for a shift to a "30-day unit of service." The intent behind this reform was to shift the 60-day payment episode to a 30-day payment episode while keeping a 60-day standard for service certification, patient assessment, and documentation. There is concern that CMS could interpret the "30-day unit of service" beyond payment and also apply the 30-day standard to service certification, patient assessment, and documentation requirements;
- Allowing for prospective "behavioral" adjustments based on assumptions and predictions poses the threat of unintended consequences that may end up creating a non-budget neutral payment system;
- By mandating a 2020 start date, providers and other stakeholders will not have the necessary time to evaluate, understand, or offer comment on the reformed payment system. Additionally, CMS may not have the time needed to implement the reforms for a smooth transition;
- With any large-scale reform, there is always the threat of unintended consequences. This situation is no different. In changes of this magnitude, a demonstration program would be useful to prevent confusion among CMS, MACs, and providers, as well as disruption to the delivery of high-quality care; and
- While the correction to the face-to-face/physician documentation certification was well intended, it lacks the directive necessary for its full impact to be realized. As signed into the law, the provision essentially codifies CMS's current practice of possessing the option to consider the home health agency record in determining claim status.

This Proposal Would:

- Clarify that the 30-day unit of service would apply to reimbursement alone and not affect service certification, patient assessment, or documentation;
- Ensure that payment modifications would be based on objective evidence and data rather than preemptive assumptions and predictions;
- Modify the start date for reforms to take place from 2020 to no earlier than 2020;
- Require that the payment model be tested first under a demonstration. This would be implemented prior to 2022; and
- Make a directive that CMS also consider the home health agency record in conjunction with the physician record when determining claim status. This is optional under current law.

For More Information: Please Contact NAHC Government Affairs at 202-547-7424
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Home Health Care Planning Improvement Act (S. 445 / H.R. 1825)

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.

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.

Benefits:

- 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; and
- 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.

This legislation would:

- Allow Non-Physician Providers to certify a patient's eligibility for the Medicare Home Health Benefit;
- Enable NPPs eligibility to certify the face-to-face encounter requirement.

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The Value of Home Care

Background:

Over 14 million Americans receive home-care services through Medicare, Medicaid, VA, Tricare, commercial insurance, and private pay each year. These are people of all ages, infirmities, and disabilities. Nearly 2 million skilled nurses, therapists, social workers and home care aides travel over 7 billion miles each year caring for their patients in all kinds of home care settings. The services range from "high touch" personal care to "high tech" services using innovative technologies. All of this is done with high efficiencies, in a cost effective manner and with unrivaled quality. The value of home care is well established and continues to be demonstrated in care delivery innovations every day. Positive clinical outcomes in the care setting of the patient's choice with cost savings routinely achieved are the hallmarks of home care.

The Value Proposition of Home Health Care

Home health care brings proven cost savings to health care:

- The Centers for Medicare and Medicaid Services (CMS) estimates that home health care in Medicare saves at least $378 million a year in just the nine states that are part of an innovative program, Home Health Value Based Purchasing (HHVBP), by reducing hospitalizations. If HHVBP were expanded nationwide, Medicare savings from unnecessary hospitalizations would exceed $2 billion annually;
- The Cleveland Clinic determined that the use of home health services following inpatient care "decreased the hazard of follow-up hospital readmission and death," and saved Medicare nearly $6500 per patient over the course of a year.

Home health promotes better patient outcomes:

- Institutional care presents risks of infections, care mix-ups, and adverse clinical outcomes. Medicare data clearly shows that the quality of care in home health services is at a high level and continues to achieve greater excellence every year. Importantly, the patient outcomes in home health are fully transparent and publicly available for all to review through the Medicare program, Home Health Compare.

Home health provides access to the latest therapies and medical technology:

- Home health brings advanced medical therapies, technologies, and patient information into the home setting, at standards comparable to or better than in institutional settings. Electronic medical records, point of care planning, and integrated care team management are standard. Also, clinical technologies frequently available only on an inpatient basis such as remote patient monitoring, telehealth, infusion therapies, ventilator care, and many other clinical technologies are now readily accessible. Home health utilizes cutting edge health technologies to support care coordination and share information with physicians and non-physicians to deliver timely and informed medical care to patients.

Home is the preferred setting for medical care:

- Numerous studies establish that 9 out of 10 people prefer home care over nursing home care. They prefer home care because of the freedom and independence of being able live at and receive care in their own homes, rather than having to be hospitalized or reside in an institutional setting. It is the only true patient-centered care setting.

What Congress should do:

Congress must take all steps necessary to protect and expand access to home health care. Congress should also support actions that continue to fuel the continuing evolution of home health care in emerging innovative care models, eliminate antiquated barriers to effective home health care, and expand the use of home health care as an effective solution to rising health care costs, particularly for patients with chronic care needs and at the end of life.

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Zone Program Integrity Contractor Critical Areas Needing Immediate Attention

1. **Improved internal controls and oversight of ZPIC (*Zone Program Integrity Contractor*) contractors with clear, consistent guidelines and parameters related to the review process:**
    a. **Communication from investigators is infrequent and often negligent** when most providers simply want to know what is wrong so that they can quickly initiate a plan of correction. It appears that the ZPIC contractor intentionally keeps providers in the dark for as long as they can.
    b. **Very poor follow up** with returning phone calls or fax correspondence – can take days or even weeks while the agency is struggling with large volumes of record request, many times with no revenue coming in because of a payment suspension.
    c. **Multiple phone calls, emails and fax correspondence have to be made** before the simplest issue or question can be resolved. (i.e. a provider reported waiting 7 days before receiving a password to an encrypted CD containing information needed for appealing the ZPIC denials.) Subsequently the appeal process was greatly delayed.

2. **Alternative process or plan of correction** for home health providers faced with documentation weaknesses that gives way to payment suspension, ultimately leading to bankruptcy or business closure (the majority of the time). This level of punishment is not merited when the core issue is simply missing or inadequate documentation.

3. **Education and Training** – training for investigators performing patient and caregiver interviews in the patient's home, primarily related to the competency in assessing homebound status criteria. In addition, ZPIC auditors need to be adequately trained on the Medicare guidelines.
    a. CMS to monitor the number of ZPIC denials that are overturned by the MAC (*Medicare Administrative Contractor)*. Providers have seen large number of denied claims be overturned by the MAC during the redetermination process. These are claims that were originally denied by the ZPIC. When providers asked for clarification of the differences in case determinations between the ZPIC and the MAC they are given no explanation. This creates a confusing and dire situation for the provider, who has been forced to endure this ordeal in order to just learn that they had it correct in the very beginning.

4. **Consider establishing a Program Integrity Advisory Council (PIAC)**
Members could include:
    a. ZPIC contractor Investigations Manager (or similar leadership role at ZPIC)
    b. ZPIC investigators
    a. Providers
    b. Home Health Patient and/or HH caregiver
    c. Legislative Representative (staffer, correspondent, etc.)
    d. Home Care Association Representative
    e. MAC Clinical Reviewer
    f. ZPIC Clinical Reviewer
    g. CMS official with the department of Program Integrity

    The PIAC responsibilities might include:
    - To make recommendations that improve and better focus the ZPIC investigative efforts on those providers who are truly participating in Medicare fraud and abuse.

- Monitor and measure the inconsistencies between MAC clinical reviewers and ZPIC Clinical reviewers
- Assist with developing better ZPIC investigator/auditor training
- RE-Development of Measurable outcomes for ZPIC investigations other than amount of money recuperated from investigations. For example:
    - Decrease in # fraud cases?
    - Decrease in documentation weaknesses?
    - Decrease in billing aberrancies?
    - Increase in quality of care?
- Review complaints from ZPIC and HHA providers related to ZPIC investigations and report findings to CMS/Legislature.

Zone Program Integrity Contractor (ZPIC**). The goal of the Zone Program Integrity Contractor (ZPIC) is to identify cases of suspected fraud, investigate them, and act to ensure any inappropriate Medicare payments are recouped. Fraud may include things such as:*

- *Billing for services not furnished*
- *Billing that appears to be deliberate for duplicate payment*
- *Altering claims or medical records to obtain a higher payment amount*
- *Soliciting, offering, or receiving a kickback or rebate for patient referrals*
- *Billing non-covered or non-chargeable services as covered*
- *Current ZPIC contractor in Florida is SafeGuard*

A Medicare Administrative Contractor (MAC**) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part **B** (A/**B**) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. Currently Palmetto GBA is the designated contractor in Florida.*