FEDERAL UPDATE
September 2015

CONGRESSIONAL OUTLOOK
Spending issues are moving to center stage with the new fiscal year beginning in less than three weeks.

Congress is having difficulty passing any appropriations bills for fiscal 2016 because of spending caps adopted in 2011. The limits imposed by the caps are increasingly unacceptable to supporters of defense programs as well as to those who support domestic programs subject to the annual appropriations process. This category includes senior housing and Older Americans Act Home and Community-Based Services programs, but not Medicare or Medicaid.

A continuing resolution is needed to keep federal programs in operation when fiscal year 2016 begins on Oct 1. Other factors complicating the spending process, in addition to the caps, are proposals to attach provisions defunding Planned Parenthood and/or the Iran nuclear agreement to a continuing resolution.

To gain enough votes to pass a continuing resolution, the congressional leadership may have to negotiate another budget agreement, similar to the one adopted in 2013, to raise the 2011 spending caps. If a continuing resolution does not pass Congress by Oct. 1, we will see another government shutdown.

Another spending issue that will become increasingly urgent within the next few weeks is the need to raise the debt ceiling, which is the statutory limit on federal borrowing. Congress could simply pass legislation setting a new limit without any changes in government policies or programs. However, debt ceiling legislation typically involves a lot of rhetoric around the need to reform so-called mandatory spending programs. Since Medicare and Medicaid are mandatory programs that combined account for approximately one-sixth of federal spending, any deficit reduction or entitlement reform Congress might undertake could include changes in these programs.

One other option is that Congress could add a debt ceiling increase to the continuing resolution.

<u>Medicare</u>
Two Medicare-related measures enacted this year have left payments to post-acute care providers relatively unscathed. There is still the potential for 2016 budget reconciliation or debt ceiling legislation that could include Medicare or Medicaid cuts, but we have seen no legislative proposals so far.

The two measures signed into law:

Permanent "Doc Fix" This measure, which permanently reformed the Medicare physician payment schedule, specifies a one percent Medicare payment update for skilled nursing facilities and home health care providers in 2018. It also extended the therapy caps exceptions process for two more years, through Dec. 31, 2017, and made the medical review process less onerous.

International trade legislation: We succeeded in removing provisions of this measure, now law, which would have extended the two percent cut in the Medicare payment update through the end of 2024 to offset the cost of trade adjustment assistance benefits. Our advocacy included contact with every member of Congress and a strong grassroots initiative by LeadingAge members.

Observation Days

Rep. Joe Courtney (D-CT) has introduced H.R. 1571, to require all time a Medicare beneficiary spends in the hospital to be counted toward the three-day stay requirement. The bill has 87 cosponsors, bipartisan. The comparable Senate bill is S. 843, introduced by Sen. Sherrod Brown (D-OH), with 20 cosponsors, also bipartisan. We strongly support this legislation.

Congress has passed and the President has signed into law H.R. 876, the Notice of Observation Treatment and Implication for Care Eligibility, or NOTICE Act. The bill requires hospitals that hold any Medicare beneficiaries for longer than 24 hours under observation to provide the beneficiaries with oral and written notification of their outpatient status and its potential implications for eligibility for Medicare coverage of subsequent post-acute care.

We still support the Courtney legislation as a more adequate solution to the observation days problem.

Adult Day Services Act

This bill allows for Medicare coverage of home health services provided in a certified adult day services center. Increases reimbursement for these services by three percent in rural areas. Now in committee with 13 cosponsors. We strongly support.

Home Health Planning Improvement Act

This bill allows nurse practitioners, clinical nurse specialists and physician assistants to write orders for home health care services to be covered by Medicare. In committee in both the House and Senate, with 136 House cosponsors and 35 in the Senate. We strongly support.

Senior Housing Funding

In June, the House passed the 2016 spending bill covering Section 202 housing, Section 8 rental assistance and other programs that finance housing for seniors. We are deeply concerned about this legislation, which severely underfunds affordable senior housing.

- Total funding for Section 202 housing is $3.5 million under current spending levels.
- The bill does not fund any new affordable senior housing programs, such as the Section 202 Capital Advance Grant Program.
- Section 202 Project Rental Assistance Contract renewals, a vital rental assistance support program, are underfunded by $44 million
- All funding for the National Housing Trust Fund is eliminated
- Funds already dedicated to the housing with services demonstration will be recaptured for other purposes.

On the Senate side, the Appropriations Committee approved a draft 2016 spending bill on June 25. This measure underfunds Section 202 housing by $16 million, eliminating the necessary resources to renew all rental assistance contracts.

We are urging both houses to restore funding for Section 202 housing before passing the 2016 spending bill.

Low Income Housing Tax Credit

The Improving the Low-Income Housing Tax Credit Rate Act, introduced in both the House and Senate, would make permanent the minimum nine percent credit rate for new development and establish a minimum four percent credit rate for acquisition deals.

We strongly support this measure, since developers now must deal with a floating rate and less predictability for funding.

The bill is still in committee on both sides of Capitol Hill.

In marking up tax extender legislation on July 21, the Senate Finance Committee included provisions to extend the nine percent credit rate for new construction and four percent credit rate for acquisitions for all allocations made before Jan. 1, 2017. The tax extender legislation has not yet been scheduled for consideration on the Senate floor.

Older Americans Act

Older Americans Act programs continue to operate without official authorization. In July, the Senate passed S. 192, to reauthorize the Older Americans Act. There is as yet no House bill.

We have drafted legislative language that would add some of our high priorities to the final version of the legislation including improved consumer information on adult day providers, improved access to adult day services programs under Titles IIIB and E, and improved quality of and access to transportation services for older adults.

Older Americans Act Funding

The Senate Appropriations Committee in June approved S. 1695, the Labor/Health and Human Services appropriations bill that includes funding for Older Americans Act programs. We have urged increases in this funding to meet the needs of the rapidly growing elder population.

Long Term Services and Supports Financing

LeadingAge continues advocating, both directly and in coalition with other stakeholders, to develop a more effective financing structure for the services LeadingAge members provide. Our Financing Task Force report, *Pathways to Coverage*, is the foundation of our advocacy work.

Taxes

While it now appears unlikely that Congress will attempt a major tax overhaul this year, it is possible that Congress will pass an "extenders" measure, including continuation of the tax-free rollover of IRA funds to charitable organizations.

On July 21, the Senate Finance Committee approved a package of extenders, including the IRA rollover, that would last through Dec. 31, 2016. The tax extenders measure has not yet been scheduled for consideration on the Senate floor. We continue to monitor committee work on taxes closely to make sure that current tax benefits for charitable contributions and tax-exempt organizations are preserved.

REGULATORY UPDATE

CMS Proposed Rule on Requirements of Participation

The proposed rule CMS issued July 16 is the most comprehensive revision and review of the requirements since 1991. The proposed rule adds new requirements, some mandated by the Affordable Care Act and the IMPACT Act, and incorporates guidance CMS has issued over the years.

The proposed rule includes the ACA requirements that nursing homes put in place quality assurance and performance improvement (QAPI) and compliance and ethics programs. Nursing homes will have a year from the time the final rule is issued to put QAPI plans in place.

CMS has also taken a competencies-based approach to facility staffing and plans to incorporate a mandate for facility-wide assessment for determining sufficient nursing and direct care staff as well as meeting requirements such as infection control and specialized rehabilitative services.

The facility-based assessment requirements, identified by CMS in the preamble as a "central feature" to these proposed revisions, include, but are not limited to factors such as:

- Physical characteristics of the home.
- Number and acuity levels of residents.
- Range of diagnoses.
- Care plan content.

In commenting on the proposed rule, our goal will be to meaningfully relate its provisions to high quality nursing home care and identify areas of potential harm or processes that are inconsistent with staff and resources of smaller and rural providers

We have broken the proposed rule into sections, looking for comment and feedback from LeadingAge members, and preparing a comprehensive document. CMS just set the deadline for comments back to October 14. We appreciate the work that many of you have done with members to get their input on the proposed rule and encourage them to file comments with CMS. We now have another 30 days for members to get their comments in. Members should send comments to Evvie Munley.

CMS Skilled Nursing Facility (SNF) Final Payment Rule for 2016

The final rule issued Aug. 4 signals major changes ahead for the way skilled nursing facilities are paid.

- The rule contains a **1.2 percent net increase in payments to SNFs** in fiscal year 2016, which begins Oct. 1. This increase does not reflect the two percent Medicare payment sequestration that is still in effect.

- The rule begins implementation of **value-based purchasing**, which was legislated as part of the 2014 Medicare doc fix. The rule establishes a 30-day all-cause hospital readmission measure for SNFs, which will be the basis for financial incentives for SNF performance. Beginning in 2018, Medicare Part A payments to SNFs will be subject to a two percent withholding, which the SNF may partially earn back based on its rehospitalization rate and level of improvement.

- The rule also begins implementation of **IMPACT Act quality reporting requirements** for fiscal year 2018. The three measures on which quality reporting will begin will be skin integrity, incidence of major falls, and functional status, including cognitive function and changes in that function.

- The rule requires **reporting of direct care staffing levels based on payroll data**, including the category of work performed and the hours of work provided by each category per resident per day. The requirement goes into effect as of July 1, 2016.

CMS Proposed Rule on Medicaid Managed Care Plans

CMS is updating its rules on Medicaid managed care plans. The last rule was issued 13 years ago. The proposed rule applies to both Medicaid and the Children's Health Insurance Program. In comments filed July 27, LeadingAge emphasized the following points:

- The rule should include specific language on beneficiaries with cognitive impairments.
- During the initial period of a state's Medicaid managed care plan, health plans should be required to contract with any willing provider to ensure beneficiary choice.
- We support CMS's efforts to encourage health plans to participate in delivery system and payment reforms.
- Calculations of health plans' spending on Medicaid beneficiaries should include costs related to case management, service coordination and integration of individuals with complex needs into the community.
- Beneficiaries must receive timely notification if their long-term services and supports provider is no longer with their health plan. This notice must include information on choosing a different plan whose network does include their provider.
- To protect beneficiary choice of nursing home and providers of other long-term services and supports, a change in their providers' status to out-of-network should be grounds for beneficiaries to disenroll from a managed care plan and/or to choose a new plan.
- States need to spend more time ensuring that health plans understand and are prepared to meet the needs of a long-term services and supports population more vulnerable than enrollees in traditional managed Medicaid plans.
- State plans must provide for provider and beneficiary engagement when long-term services and supports become part of a Medicaid managed care program.

- Measures developed to assess quality of long-term services and supports and provider improvement under Medicaid managed care plans should align with quality measures already being developed for long-term services and supports.

CMS Home Health Proposed Payment Rule for 2016
On July 6, CMS released the calendar year 2016 home health prospective payment system proposed rule. In addition to rate adjustments, CMS announced a proposal to launch the Home Health Value-Based Purchasing model to test whether incentives for better care can improve outcomes in the delivery of home health services.

We oppose provisions of the rule that call for a 1.72 percent cut in the national, standardized 60-day episode payment amount in calendar years 2016 and 2017. CMS indicates this cut would respond to coding intensity that doesn't correlate with actual changes in patient acuity. However, this reduction would take resources away from providers who are not gaming the system as well as from those who are.

LeadingAge filed comments on the rule September 2.

HUD Selection of Performance-Based Contract Administrators for Section 8 Housing
The U.S. Supreme Court declined to hear HUD's appeal on third-party contracts for operational compliance oversight of Section 8 rental housing. HUD now must use a competitive bidding process known as procurement to select performance-based contract administrators. HUD expects to finalize this process next year. In the meantime, current contractors in 42 states will have their contracts renewed in six-month increments through June 2017.

Bundled Medicare Payment for Hip and Joint Replacement
In July, CMS released a proposed rule to require all hospitals in 75 geographic areas to participate in a bundled payment initiative for Medicare beneficiaries undergoing hip and knee replacements.

Skilled nursing facilities and home health care providers will not participate directly, and therefore will not be at financial risk or share in incentive payments. However, post-acute care providers may serve as "collaborators" that would contract with hospitals to coordinate beneficiaries' care and reduce overall costs.

LeadingAge filed comments on the proposed rule September 8.

Home Care Workers' Coverage under Fair Labor Standards Act
The Department of Labor issued the rule extending federal minimum wage and overtime protections to home care workers in 2013, revising the previous definition of "companionship services." The rule was scheduled to go into effect in January, 2015. It was temporarily vacated in litigation, *Home Care Association of America v. Weil*, in the D.C. Circuit.

On August 21, the U.S. Court of Appeals for the D.C. Circuit upheld the Department of Labor's interpretation of the statutory authority for the rule, thereby paving the way for the rule to take effect. The effective date when the rule will become enforceable will be Nov. 13.

Overtime Pay for White-Collar Employees
On July 7, the U.S. Department of Labor issued a proposed rule that would increase the salary threshold for required payment of overtime for work in excess of 40 hours per week.

The current salary threshold for executive, administrative and professional employees is $455 per week, or $23,660 per year. The proposed rule would raise the threshold to $970 per week/$50,440 per year and annually adjust the threshold for inflation.

LeadingAge filed comments on the proposed rule September 4.