**Public Policy and Advocacy Report**

**June 2016**

**Obama FY 17 Budget Proposes to Include Ostomy & Urological Supplies in Medicare Competitive Bidding Program**

President Obama released his proposed FY 17 budget in March which included a provision to expand Medicare’s competitive bidding program to new product categories. The budget proposed that inhalation drugs; all prosthetic and orthotics; and ostomy, tracheostomy and urological supplies all be listed as products subjected to competitive bidding. WOCN has serious concerns with this proposal as ostomy supplies and urological supplies are not well suited for a competitively bid program because of their highly customizable nature. WOCN has fought to exclude these products from the program in the past and will continue to so in the future.

Medicare’s competitive bidding program forces suppliers into a program in which each supplier submits bids to provide certain medical equipment and supplies at a lower price than what Medicare now pays for these items. Medicare uses these bids to set the amount it pays for those equipment and supplies under the Competitive Bidding Program. Suppliers with winning bids are chosen as the sole Medicare contract suppliers.

The main issue of concern in the competitive bidding program is that it will almost certainly lead to patient complications as suppliers will be bound by artificial bids to supply products based on price, not by patient need. This is of particular concern to the needs of our ostomy patients, because a supplier is bound by bid they may not be able to afford higher quality products that a more complicated ostomy patient may need. This bidding system forces patients into a “one-size-fits-all” ostomy solution…a disaster for ostomy patients. Ostomy supplies are clinically prescribed, selected, adjusted, and fitted by a certified ostomy specialist for individuals based on the unique medical and physical needs of each person in relation to their disease or condition. The proposal to competitively bid these critical prosthetic supplies fails to recognize that ostomy and urologic prosthetics are not one-size-fits-all generics, and are not interchangeable. In addition ostomy prosthetics should be instituted and adjusted by a certified WOC nurse, meeting the same criteria as other prosthetic equipment.

WOCN has joined with other stakeholders to express our opposition to this short-sighted proposal by sending a letter to Congress urging them not to move forward with the President’s proposal. It is important to remember that the President’s budget is just a proposal and this program cannot be expanded without congressional approval. So it is important that all stakeholders express concern early to prevent its enactment.

**AHRQ’s Safety Program for Nursing Homes: On-Time Pressure Ulcer Healing**

The Agency for Healthcare Research and Quality (AHRQ) created a new program called On-Time Pressure Ulcer Healing to help nursing homes with electronic medical records address pressure ulcers that are slow to heal. According to AHRQ, pressure ulcers remain a serious problem in nursing homes despite regulatory and market approaches to encourage prevention and treatment.

The program uses the On-Time Pressure Ulcer Assessment to provide a set of structured, standardized data elements for comprehensive documentation of weekly pressure ulcer characteristics as well as treatments and interventions. The assessment tool guides clinicians to systematically assess residents with pressure ulcers and thus helps less-experienced clinicians assess and care for these residents. The tool also serves the most experienced clinicians in their pressure ulcer management practice.

Using data elements contained in the standardized assessment tool in combination with clinical data captured from nursing home EMR systems, staff generate reports that support earlier recognition of pressure ulcers at risk for delayed healing and infection. These reports also help improve clinical decision-making related to pressure ulcer treatment plans.

The clinical reports provide both high-level information that leadership may use to monitor residents with pressure ulcers being treated at the facility and more detailed reports that nurses can use to monitor resident status, including ulcer characteristics and healing progress. Reports display pressure ulcer assessment details, treatments, mobility status, bowel and bladder patterns, and other clinical details known to affect wound healing, such as nutrition, temperature, and ulcer pain. WOCN is exploring ways to partner with AHRQ as they roll out this program and continue to explore new options to reduce pressure ulcers.

**CDC Anti-Smoking Campaign**

WOCN has been working with UOAA over the course of the last year to alter the perception of how ostomy patients are being portrayed in the CDC’s very public anti-smoking campaign. In several media outlets and formats ostomy patients are being used to convince the public not to smoke, alluding to the fact that smoking will lead to having an ostomy and that living with an ostomy is an terrible way to live. WOCN and UOAA are very concerned with this messaging and how it can feed the stigma associated with those who live with an ostomy. We have been in communication with the CDC and have expressed our concerns, the Agency has promised to work with us to try and “soften” the message in the future.

**Lymphedema Treatment Act**

The Lymphedema Treatment Act would provide Medicare coverage for compression therapy. We are pleased to announce that this legislation (H.R. 1608) now has a companion bill in the U.S. Senate (S. 2373). This legislation was recently introduced by Senators Maria Cantwell (D-WA), Chuck Schumer (D-NY), Chuck Grassley (R-IA) and Mark Kirk (R-IA). WOCN will continue to support this legislation and has sent out a number of member alert in order to drive cosponsors for this important legislation.

Lymphedema and other conditions, such as venous leg ulcers (VLU), can be controlled by the use of compression therapy; in fact, compression therapy is considered the gold standard for treatment of lymphedema and for the prevention of VLU. The medical literature supports appropriate compression as a means to reduce the incidence of costly recurrence of both of these afflictions. It is imperative that Medicare start covering this proven therapy.

The House legislation now has 227 cosponsors and the Senate companion has 16 cosponsors. The bill was also recently endorsed by the American Medical Association. We are very hopeful that we can push this legislation over the finish line before the end of the congressional session in January.

**WOCN Appointed to CMS Expert Panel**

WOCN Public Policy Coordinator and Past President, Kathleen Lawrence MSN, RN, CWOCN was nominated by WOCN and selected to serve on the Technical Expert Panel (TEP) on Post-Acute Care Patient Assessment Data.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the Centers for Medicare & Medicaid Services (CMS) develop, implement, and maintain standardized patient assessment data elements for post-acute care (PAC) settings to facilitate care coordination and improve Medicare beneficiary outcomes. CMS asked contractors to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractor during measure development and maintenance.

The types of providers covered by the IMPACT act include Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs). CMS) is working to ensure that data elements within PAC assessment instruments are standardized and interoperable. Existing PAC assessment instruments, (MDS, IRF-PAI, OASIS, LTCH CARE Data Set (LCDS)) use different assessment items, and items are created, collected, and reported in many different ways. Therefore, the items currently used in the PAC assessment instruments are neither standardized nor interoperable. Implementation of standardized assessment items across PAC settings, facilitated by health information technology (HIT), is compelling at multiple levels and has important implications for Medicare beneficiaries, families, providers, and policymakers**.**

**Surgical Dressing Codes**

In August 2015, CMS assigned the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Surgical Dressings under the Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) program.

The changes contained in the proposed LCD policy and related policy article would substantially impact coverage for a variety of surgical dressings. Specifically, the draft LCD would:

* Add a section for collagen dressings.
* Add a section for zinc-paste impregnated gauze.
* Add a section for dressings comprised of materials not recognized as effective.
* Revise requirements for incompatible dressing materials.
* Revise requirements for incompatible dressing change intervals.
* Revise utilization (change interval) requirements.

After review of the LCD draft policy WOCN has significant concerns about the proposal and has strongly suggested that this draft be withdrawn and that CMS work with stakeholders to create a more clinically-appropriate document. WOCN’s submitted comments to the DME MACs in 2015, but no final policy has been released to date.

**WOCN Comments on the Future of Global Surgical Codes**

As you may know, CMS had proposed to eliminate the 10- and 90-day global surgery codes. These codes include the patient visit on the day of the procedure, the procedure itself, and any complications resulting from the surgery, and all follow-up care during the 10- or 90-day recovery period. CMS has found that global codes may pay for more follow-up care than is usually furnished to Medicare patients resulting in their proposal to eliminate the 10- and 90-day global payments for all care settings. In addition, CMS currently has no way to value the services provided during this period because they are not billed separately.

A coalition of surgical groups led by the American College of Surgeons successfully included language in the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA) to precluded CMS from moving forward with its plan to transition 10- and 90-day global codes to 0-day global codes. With that legislation becoming law, CMS was forced to abandon its plan change the payment structure of the global codes, but was charged with collecting data on the value of the services provided during the global periods and use that data to revise the global services starting in 2019.

To this end, CMS called for comments on how best to gather this data and WOCN submitted comments in 2015. In early 2016, WOCN was contacted by CMS and asked by the Agency to provide them with a detailed explanation of the services provided by a WOC nurse during the global period. Past President, Jan Colwell spoke with CMS contractors in early 2016 and provided them with a detailed explanation of the role of a WOC nurse and our value during the global period. WOCN will continue to work with CMS on this important project going forward.

**WOCN Submits Comments to CMS on Long Term Care Setting Needs for Ostomates**

In August 2015, CMS released a proposed rule to make major changes to improve the care and safety of residents in long-term care facilities and nursing homes. The rule, Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, adds new requirements and reorganizes other existing regulations impacting long-term care (LTC) facilities. This rule would bring current best practices all facilities that participate in Medicare or Medicaid and implement a number of important safeguards that have been identified by patient advocates and other stakeholders, and include additional protections required by the Affordable Care Act.

In its proposed rule, CMS identified ostomates as a patient population that require additional safeguards, but offered little guidance to facilities on how best to treat this patient population. WOCN responded to CMS with suggestions on how to meet the needs of these patients included providing them with access to a Certified WOC Nurse. To date, no final policy has been released.

**Payment for Complex Wounds in Long Term Care**

Legislation was passed in late 2015 which provided a temporary halt to pending payment reductions in Medicare reimbursements provided to long-term care hospitals that provide specialized care and long-hospital stays for patients with complex conditions and non-healing wounds. Medicare reimbursement rates for long-term care hospitals were scheduled to be limited to only patients with at least three or more intensive care unit days immediately preceding their long-term care hospital stay or to those who need at least 96 hours of ventilator care. All other cases were scheduled to be paid at a lower rate regardless of the severity of illness or the intensity of care needed. WOCN was supportive of this legislation and will continue to push for a long term solution to the proposed cuts.

**Disposable Negative Pressure Wound Therapy Payment**

Legislation was also passed in late 2015 to allow for payment of disposable negative pressure wound therapy devices in the home health setting. The payment would be equal to the payment that currently exists for such devices in the outpatient setting, including the professional services provided. A “disposable device” is defined as: *a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy; and ‘‘(B) a substitute for, and used in lieu of, a negative pressure wound therapy durable medical equipment item that is an integrated system of a negative pressure vacuum pump, a separate exudate collection canister, and dressings that would otherwise be covered for individuals for such wound therapy.*

The provision also calls for the Government Accountability Office (GAO) to study the impact of payment for such disposable devices, including the types of disposable devices that could potentially qualify as substitutes. Additionally GAO must report on the views and information from manufactures, providers and suppliers on the incentives and disincentives under current Medicare coverage and payment policies; the implications of expanding Medicare coverage to include additional disposable devices that are substitutes for other types of DME and different payment methodologies. The report is due 18 months after the enactment. In addition, the GAO is also required to study the impact on utilization, the type of Medicare beneficiaries under the home health benefit who use the disposable devices compared to the substitute DME, and payment rates of other payers including Medicaid. The second report is due in four years. WOCN will follow this study closely and participate in whatever means are deemed appropriate.

Expected proposed rules of implementation are expected by July 1, 2016 and WOCN will likely be commenting on those rules. The provision is being carefully monitored by industry collaborators, and national home care organizations.

**Bladder Health Month Roundtable**

In November 2015, WOCN staff attended a Roundtable event hosted by the Urology Care Foundation to garner support for a Congressional Resolution to officially recognize November as National Bladder Health Month. About 30 patient and provider groups were in attendance at the Roundtable and WOCN has committed to be a part of the group’s efforts to move the Resolution forward. The resolution is expected to be introduced shortly and WOCN will push for its passage through Congress.

**DME Face To Face Requirement Update**

On February 2, 2016 CMS published a final rule implementing the statutory requirements regarding documentation of face-to-face encounters with Medicaid beneficiaries when ordering Durable Medical Equipment (DME).  You may recall that WOCN pushed legislation in Congress to eliminate the physician signature requirement for ordering DME in the home health setting which was mandated by the ACA. Language was included in legislation that was signed into law by President Obama in 2015 which repealed this mandate and clarified that documentation would be considered sufficient if completed by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist.

The final rule issued by CMS codified this language and also provides that the actual face-to-face encounter for home health and medical equipment may be performed by the physician or certain authorized NPPs.  In addition, it states that for initial orders of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The rule also clarified that face-to-face encounter may now occur through telehealth.  For initial orders DME, the physician or authorized non-physician practitioners (NPP) must document that a face-to-face encounter, that is related to the primary reason the beneficiary requires medical equipment, occurred no more than six months prior to the start of services.

In addition, the final rule clarifies that Medicaid home health services and items are not limited to home settings, and cannot be restricted to services furnished to beneficiaries who are homebound.  A beneficiary may receive home health services in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or other setting in which payment is made under Medicaid for inpatient services that include room and board.