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STATEMENT OF

THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

TO THE

HOUSE ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH

OCTOBER 1, 2015

The National Association for Home Care & Hospice (NAHC) submits this statement for consideration by the Health Subcommittee of the House Committee on Energy and Commerce regarding a legislative proposal to reform the Medicare requirement that Medicare beneficiaries have a face-to-face encounter with a physician to qualify for coverage under the home health services benefit. NAHC is the largest national trade association representing the interests of home health agencies, including rural and urban providers, non-profit and for profit companies, government-based entities, health system integrated providers, and private and publicly-held companies of all sizes. NAHC strongly supports the proposed reforms as needed to address the unmanageable rules that have been instituted by the Centers for

Medicare and Medicaid Services requiring extensive and unnecessary paperwork from physicians.

Medicare law since 2011 requires that a patient have a face-to-face encounter (F2F) with the physician who certifies the need for Medicare home health services. While the intention behind that law was to gain greater physician involvement in ordering home health services, the implementation of the face-to-face encounter rule has led to great confusion among physicians, home health agencies, and other parties involved. Medicare has tried to mitigate the confusion through various modifications, but the requirements remain difficult to understand and apply. As a result, the rule is creating a barrier to access to care and poses the high risk that patients who are, in fact, homebound and in need of skilled care will be denied Medicare coverage.

NAHC has advocated that Congress repeal the face-to-face physician encounter provision. After 5 years of application of the implementing rules, it is apparent that the administration of the face-to-face requirements presents unnecessary and unintended obstacles to access to care as well as costly paperwork obligations that do not achieve any useful purpose. Nevertheless, the reforms proposed in the legislation are a significant improvement over the current requirements and present a manageable middle-ground that maintains the core requirement of a physician face-to-face encounter with the patient while addressing the daunting paperwork burdens that lead to unnecessary problems for qualified Medicare beneficiaries, physicians, home health agencies, and the Medicare program.

NAHC believes that full scale reform of the face-to-face requirements should:

1. Limit the physician documentation requirement to demonstrating that a timely encounter occurred, consistent with the original intent.

2. Narrow the circumstances where a face-to-face encounter 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 face-to-face encounter is not feasible.

5. Permit face-to-face encounters by way of an expanded telehealth definition as the standard in the current law is useless as a patient must leave her home to have a telehealth visit with a physician.

The bill would specifically address the two most important reforms that are needed: the documentation requirements and the unnecessary application of the requirements to patients admitted to home health services following an inpatient stay where multiple physician/patient encounters occur. NAHC strongly supports this measure. In addition, it would address the past claim denials that were issued through application of a documentation standard that no one could understand, a standard later abandoned by CMS. NAHC supports each of these necessary reforms.

The administration of the face-to-face encounter requirement has led to unintended confusion, burdensome paperwork for physicians, increased costs for home health agencies without any material improvement in program integrity, and an endless paper-chase. The requirement has not been effective in targeting any waste or abuse in the Medicare program. An abusive provider has an easier time showing compliance with the requirements through falsified documentation than a home health agency that wants to be fully compliant. Notably, the face-to-face encounter requirements often lead to Medicare rejecting claims for patients who are truly in need of the physician-prescribed skilled care and who meet the benefit's

"homebound" requirement because of a subjective standard of what face-to-face encounter documentation is "sufficient" as that limited documentation supersedes the complete patient record. The reforms set out in the bill will eliminate unnecessary paperwork, refocus the requirement on patients who may not have a strong relationship with their physician, and prevent unwarranted claim denials for patients where the overall record demonstrates that the patient meets Medicare coverage standards.

BACKGROUND

The origins of the physician face-to-face encounter requirement are found in section 6407 of the Patient Protection and Affordable Care Act (hereinafter "ACA"). Section 6407 requires a Medicare beneficiary receiving home health services to have a face-to-face encounter with a physician in order to qualify for Medicare coverage of home health services. That provision requires that "the physician must document that the physician himself or herself…. has had a face-to-face encounter with the individual within a reasonable timeframe as determined by the Secretary."

Medicare implemented this simple statutory requirement by adding a complex, unnecessary, and unauthorized requirement. Under the original 42 CFR 424.22(a)(1)(v) issued in 2010, Medicare also required that the physician provide an "explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services." That explanation became known as the "physician narrative." If a claim for home health services payment did not have a "sufficient" narrative, the claim was denied payment by Medicare. A claim may include a

narrative, but if it is "insufficient" a full claim denial is issued irrespective of whether the entire patient care record supports a grant of coverage.

The narrative requirement triggered tens of thousands of claim denials as it was administered in a manner that was wholly confusing to physicians, home health agencies, and patients along with Medicare administrative contractors. This has led the contractors to evaluate claims in a manner that was inconsistent, arbitrary, and inaccurate. Ultimately, the unauthorized and confusing narrative requirement has resulted in retroactive claim denials where the overall health care record of the patient establishes that the patient is, in fact, homebound and in need of skilled care.

One example highlights the absurdity of the narrative requirement. The patient's physician supplied a narrative that stated:

> "The veteran never leaves his home or his bed. He is a total care patient who is dependent in all ADLs [Activities of Daily Living] and IADLs [Instrumental Activities of Daily Living]."

The Medicare contractor, in reviewing the whole record of the patient, concluded that,

> "The skilled nursing visits were warranted based on the submitted documentation. The patient met homebound criteria and the skilled nursing visits were reasonable and necessary…However, the provided documentation does not support that a complete Face-to-Face evaluation was performed as the homebound eligibility was an insufficient description of how the patient's clinical condition warranted homebound status."

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This Medicare decision can be simply summarized: subjective concerns with the words and grammar chosen by the patient's physician trump the reality of the patient's condition and care needs. In this situation, the Medicare contractor admits that the patient clearly meets the homebound status requirements for coverage, but still issues a claim denial because of perceived flaws in the physician narrative. Such an outcome is wholly irrational.

Unfortunately, this is not an isolated case. It is an example of the common outcome of a policy that permits perceived insufficiency in the physician narrative to preempt reality of a patient's clinical condition, homebound status, and skilled care needs when determining Medicare coverage. The full facts about a patient should control the outcome, not partial information in the form of a narrative composed under ambiguous and incomplete guidance.

On July 7, 2014, Medicare issued a Notice of Proposed Rulemaking that addressed many, but not all, of the concerns expressed by the home health community. 79 Fed. Reg. 38366 (July 7, 2014). Among other changes, Medicare proposed to eliminate the physician narrative, explaining that:

> The home health industry continues to voice concerns regarding the implementation of the Affordable Care Act face-to-face encounter documentation requirement. The home health industry cites challenges that HHAs face in meeting the face-to-face encounter documentation requirements regarding the required narrative, including a perceived lack of established standards for compliance that can be adequately understood and applied by the physicians and HHAs. In addition, the home health industry conveys frustration with having to rely on the physician to satisfy the face-to-face encounter documentation requirements without incentives to encourage physician compliance. Correspondence received to date has expressed concern over the ``extensive and redundant'' narrative required by regulation for face-to-face encounter documentation purposes when detailed evidence to support the physician certification of homebound status and medical necessity is available in clinical records. In addition, correspondence stated that the narrative requirement was not explicit in the Affordable Care Act provision requiring a face-to-face encounter as part of the certification of eligibility and that a narrative requirement goes beyond Congressional intent. 79 Fed. Reg. at 38376.

As a result Medicare stated:

"Therefore, in an effort to simplify the face-to-face encounter regulations, reduce burden for HHAs and physicians, and to mitigate instances where physicians and HHAs

unintentionally fail to comply with certification requirements," …"[t}he narrative requirement in regulation at 424.22(a)(1)(v) would be eliminated."

Medicare later issued a Final Rule eliminating the physician narrative requirement effective January 1, 2015. 79 Fed. Reg. 66032 (November 6, 2014). However, in its place Medicare established a new and equally impossible standard of compliance requiring physicians to maintain sufficient documentation within their own patient records to support their certification of the patient as homebound and in need of skilled care. With that new standard, the home health agency is liable for any physician record shortcoming in that a home health agency's claim for home health services payment will be denied if the physician's record is deemed insufficient.

As with the former requirement of a physician narrative, the current standard is unmanageable by all concerned, the physician, the home health agency and Medicare itself. It remains totally unclear what constitutes a sufficient supporting physician record. In addition, the content of the record is within the physician's control while the impact of an insufficient record is suffered by the home health agency. Further, patients can still be denied Medicare coverage because of the inadequacy of the physician record even when the full record demonstrates that all Medicare coverage standards are met.

Claim Denials Have Reached Unprecedented Levels as a Result of an Unmanageable Documentation Standard

Data from Medicare contractors illuminates the state of confusion rampant within the home health services community. One Medicare contractor, PGBA, reported that in

the period January to December 2013, it reviewed 28,703 claims and denied 9676 on the basis of the face-to-face requirements, an astounding 33.7% denial rate for a paperwork requirement. PGBA is the largest Medicare contractor processing home health claims, predominately covering southern and southwestern states. The same Medicare contractor reported that of the 5,285 denials issued in October to December 2014, 72.1% were based on the face-to-face requirements. Even a year later, the paperwork standards remained so confusing and ambiguous that nearly three-quarters of the claim denials were related.

The Medicare contractor responsible for most providers in the New England states recently released data showing the impact of the face-to-face encounter documentation requirements in that part of the country. It shows the following for Calendar Year 2014:

STATE	**Percent of Reviewed Claims Denied Based on Face-to-Face Requirements**	**Total Charges Denied Based on Face-to-Face Requirements**
Connecticut	57%	$5,951,561
Maine	60%	$1,909,635
Massachusetts	58%	$12,228,170
New Hampshire	57%	$2,079,487
Rhode Island	63%	$1,472,901
Vermont	52%	$1,183,360

It is inconceivable that the highly experienced home health agencies throughout New England could have such a high level of noncompliance with a documentation requirement if that requirement were capable of understanding and application. These retroactive claim denials are not based on a full record review on the patients' homebound status and need for skilled health care services. Instead, they are based on a limited record review, confined to the statements of treating physicians who actually had a face-to-face encounter with the patient, prescribed a plan of treatment, and certified the patients' eligibility for Medicare coverage. In other words, the physicians failed the undefined paperwork test of grammar, sentence structure, and verbiage subjectively applied by Medicare contractors.

Program Integrity Is Preserved with the Reforms Proposed

The central feature of the physician face-to-face encounter requirement is preserved in its entirety in the proposed legislation. A physician must still have a face-to-face encounter with the patient as a condition of payment under the Medicare home health benefit. The primary change coming from this bill relates to what documentation is needed to demonstrate compliance with that condition. Medicare retains the authority to deny a claim for a patient who is not homebound, not in need of skilled care, or otherwise does not meet the conditions for payment. A physician must still certify under penalty of law that the patient meets Medicare payment requirements.

The face-to-face encounter documentation change actually prevents an erroneous denial of coverage to patients who are homebound and in need of skilled care. Today, a

patient who is homebound can be denied coverage simply because it is determined that a part of the overall patient record-- what is in the physician file--is insufficient to establish the patient is homebound. That happens even when the whole patient record demonstrates that the patient is homebound.

The reforms set out in the bill do not weaken other existing and effective program integrity measures. Medicare law requires that physicians must certify the patient meets Medicare coverage standards "under penalty of law," with penalties including imprisonment, civil fines, and disbarment from participating in Medicare. There are many other laws already on the books that can be used to prevent program abuses.

It is notable that Medicare spending is under control more than any other Medicare sector. In 1997, Medicare spending for serving 3.5 million beneficiaries was $17 billion, in 1997 dollars. In 2014, CBO estimates that spending for serving 3.5 million beneficiaries was only $18 billion, but that is in 2014 dollars. Further, actual spending is down in recent years with spending previously at $19 billion in 2012 and 2013.

The documentation requirements in the current face-to-face rules actually favor the bad operator who has an easier time falsifying physician documentation than the reputable home health agency has in getting doctors to produce overwhelming paperwork while caring for patients.

Other Program Integrity Measures to Consider

Participation in the Medicare is a privilege for providers of services. It represents a fiduciary duty to uphold the standards of participation every day and fully stay in compliance

with all rules and regulations. Unfortunately, Medicare has been harmed by a few providers in all Medicare sectors that abuse that privilege and wrongfully drain limited Medicare resources. NAHC has maintained a zero tolerance approach to such providers since its inception in 1983. Over the years, NAHC has contributed new and constructive approaches to program integrity in Medicare home health services. For example, it was NAHC's concept of a provider cap on outlier payments, instituted by CMS and codified into law in the ACA, that closed down the fraudulent operations in South Florida where more than half of the nation's home health outlier payments went between 2008 and 2010. NAHC also advocated for the institution of a targeted new provider moratorium. CMS has now implemented such moratoria in several geographic areas that had evidence of abusive practices.

NAHC believes that the best program integrity measures are those that prevent fraud, waste and abuse in the first instance and stop it as quickly as possible when it exists. Most of the offending home health agencies involve new entrants into Medicare. As such, the best anti-fraud measures stop those behind those criminal schemes from getting into Medicare at all. In that regard, NAHC has proposed the following program integrity improvements:

1. Requiring owners and administrators of home health agencies to undergo criminal background checks. Service staff currently is subject to such checks, but not the individuals who employ them and control the financial relationship with Medicare.
2. Subject new providers to a probationary period in their Medicare participation that allows Medicare to terminate that provider easily if evidence of noncompliance surfaces during that probation.
3. Require that claims for new providers be subject to pre-payment review during the first 6-12 months of Medicare participation.

4. Establishing a credentialing standard for owners and administrators that validates whether they possess sufficient competencies to manage compliant Medicare participation.
5. Require corporate compliance plans consistent with the OIG model for all home health agencies.

These are among the constructive program integrity proposals that NAHC has advocated for many years. We are ready, willing, and able to discuss these in-depth with the Committee.

NAHC sincerely appreciates the Subcommittee's evaluation of proposed reforms to the physician face-to-face encounter law. We also greatly appreciate the opportunity to submit this statement.

If you have any questions on this statement or the issues and concerns with the Medicare face-to-face physician encounter requirements, please contact William A. Dombi, Vice President for Law at wad@nahc.org or 202-547-7424.

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