

**Statement for the Record
Submitted to
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing on Examining Potential Ways to Improve the Medicare Program
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By
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Visiting Nurse Associations of America**

The Visiting Nurse Associations of America appreciates the opportunity to submit this statement on examining potential ways to improve the Medicare program to the Subcommittee on Health of the U.S. House of Representatives Committee on Energy and Commerce.

The Visiting Nurse Associations of America (VNAA) is a national organization that supports, promotes and advances mission-driven, nonprofit providers of home and community-based health care, hospice and health promotion services. VNAA represents over 140 home care agencies in over 40 states. As safety net providers, VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicare, Medicaid, privately insured, and uninsured patients.

VNAA members provide high-quality patient-centered care at home as well as offer support for family caregivers. Our members serve the most clinically complex and vulnerable patients who will benefit from care delivered in the home, and play a critical role in coordinating medical and social services for patients. VNAA members are also active participants in new care delivery models that aim to improve accountability and improve patient outcomes, including accountable care organizations (ACOs) and bundling programs, among others.

VNAA members are champions of efforts to reduce waste, fraud and abuse in both the Medicare home health and hospice programs. Our members support Medicare rules and regulations that reward and encourage high-quality care and penalize inappropriate or unnecessary care. They specifically support fraud reduction efforts that are effectively targeted to increase program integrity and efficiently implemented to prevent against unnecessary administrative burden for participating Medicare providers.

We appreciate the opportunity to comment on draft legislation authored by Congressman Greg Walden (D-OR-02). This legislation would make important modifications to face-to-face Medicare documentation requirements for home health services. VNAA thanks the Committee for highlighting this crucial issue that impacts home health agencies and the patients they serve.

Home health agencies are frequently denied payment due to poorly designed and frequently misunderstood Medicare documentation requirements. Current law requires a physician to document

that a face-to-face encounter between an authorized provider and a beneficiary occurred in order to certify eligibility for home health services. This provision is intended to ensure that beneficiaries are being referred to the most appropriate care setting and to reduce the potential for waste, fraud and abuse within the home health benefit.

Unfortunately, the rules around what information physicians must document have been unclear and auditors who review the information have applied inconsistent and often conflicting standards on what is deemed "satisfactory." This has resulted in negative unintended consequences for providers and beneficiaries and an unprecedented level of home health claim denials.

CMS reported that in 2014, 51.4 percent of home health claims were "improperly paid." In other words, while the claims were paid, CMS estimates that there was a problem with the claim that could warrant payment denial. Documentation problems were cited as the reason for 89.5 percent of these "improper payments." These home health claims accounted for 19 percent of all Medicare improper payments. This is a significant increase over the 2010 improper payment rate for home health claims of less than 5 percent. In 2010, only 27.5 percent of the claims had problems with improper documentation. The increase in the improper payment rate from 5 percent to 51.4 percent between 2010 and 2014 was due to implementation of the face-to-face documentation requirement.

VNAA estimates that tens of thousands home health claims have been inappropriately denied due to the current unclear and unworkable Medicare face-to-face documentation rules. Face-to-face claim denials are often overturned on appeal; however a significant backlog of appeals remains. Continued unpaid and unresolved claims – for care that is otherwise medically necessary and appropriate – are making it hard for home health agencies to keep their doors open, particularly in underserved and rural communities.

VNAA members have provided the following examples that illustrate the impact:

An agency in Michigan reported \$544,559.45 of claim denials in 2014 due to the face-to-face documentation requirement. This number equals 53 percent of the agency's total Medicare reimbursement for that year. The agency reported inconsistencies among auditors: for example, two different auditors reviewed the same documentation for a patient who had two episodes of care. One auditor accepted the documentation, the other denied the claim. The agency reports that these problems have strained relationships with physician partners who are frustrated by inconsistent documentation standards.

An agency in Connecticut reported spending \$175,000 in 2013 and 2014 on staff time and other resources to manage the face-to-face documentation process.

Another agency in Connecticut reported that auditors denied \$190,489 in claims due to face-to-face in 2014. This agency dedicated two full-time clerical employees and one manager to comply with the documentation requirements.

An agency in Massachusetts reported that auditors denied \$630,000 in claims due to the face-to-face requirements in 2014. CMS subsequently sent notices to patients that the services were denied, creating confusion and concern. The agency had to reassure patients and families that they were not financially liable due to the denials.

An agency in Georgia reported \$350,000 in claim denials due to lack of consistent and uniform audit rules. As a result, the agency decided not to file over \$5 million in claims because they were not confident that the physician paperwork would not hold up to audits being conducted at the time.

The home care community, patient groups and Congress have expressed many of these concerns to the Centers for Medicare & Medicaid Services (CMS) and yet there is still no meaningful or workable resolution. To address this problem, VNAA supports draft legislation authored by Congressman Walden that would significantly improve the implementation of the Medicare face-to-face documentation requirements.

The draft legislation clarifies and streamlines the face-to-face documentation rules in order to reduce the paperwork burden on physicians and home health agencies and reduce the risk of inappropriate denials of care. It directs CMS to develop a standardized form in consultation with stakeholders to collect evidence demonstrating that a beneficiary is eligible for home health services. It also provides a mechanism for home health agencies to resubmit claims that were denied solely due to the current documentation rules.

A worthy goal of this legislation is to reduce the time physicians must spend on fulfilling the paperwork requirements. The legislation will enable physicians to review and approve documentation prepared by a home health agency, resulting in a more efficient and effective documentation process.

Increased education for all parties involved in ordering and managing the home health benefit is another key component of the legislative draft. The draft legislation would require a new focus on educating Medicare audit contractors, physicians, and home health agencies to ensure a fair and uniform application of the streamlined documentation policy. Auditors have been inconsistent with the application of documentation requirements across the country and education is needed to reduce inappropriate denials.

VNAA believes the draft legislation will make common-sense improvements to today's unworkable and administratively burdensome Medicare face-to-face documentation requirements and will ensure Medicare patients can continue to have access to high-quality Medicare home health services. We appreciate the opportunity the Subcommittee on Health has given us to share our thoughts on examining potential ways to improve the Medicare program. If Committee Members or other interested parties wish to learn more information about face-to-face Medicare documentation requirements, contact Sarah Bogdan, Director, Legislative Affairs, at 571-527-1533 or sbogdan@vnaa.org.