House Committee on Energy & Commerce – Subcommittee on Health

"Examining Potential Ways to Improve the Medicare Program"

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Oral Testimony of Sarah Myers, Executive Director

Oregon Association for Home Care

October 1, 2015

Good Morning Chairman Pitts, Ranking Member Green, Distinguished Members of the House Subcommittee of Health, and Congressman Walden. My name is Sarah Myers, and I serve as Executive Director of the Oregon Association for Home Care. I am grateful for this opportunity to be with you today to discuss one potential way in which the Medicare program can be significantly improved.

By way of brief background, the Oregon Association for Home Care includes 58 home health agencies and 2,125 professionals who deliver Medicare home health services to nearly 30,000 homebound seniors, many of whom live in rural communities.

As you know, home health patients are among the most vulnerable in the Medicare program. In fact, federal data shows that they are older, poorer, sicker and more likely to be a minority and disabled than all other Medicare beneficiaries – combined. The chart below provides further detail on the disproportionate vulnerability of Medicare's home health patients:

Avalere Health – Home Health Beneficiary Study: Key Findings[1]	**Medicare Home Health Beneficiaries**	**All Other Medicare Beneficiaries**
Women	60.07%	53.9%
Beneficiaries aged 85+	24.4%	12.1%
Beneficiaries with 4+ chronic conditions	74.7%	48.5%
Beneficiaries needing assistance with 2+ Activities of Daily Living (ADLs)	23.5%	7.6%
Beneficiaries at or below 200% of Federal Poverty Level (FPL)	66.2%	47.9%
Beneficiaries from ethnic or racial minority population	19.3%	14.9%
Dual-eligible Medicare-Medicaid beneficiaries	26.7%	17.7%

Due to their frail condition, these seniors have been deemed homebound by their physician, meaning they cannot leave their home without help or potential injury to themselves.

That's where skilled home health care providers come in.

We deliver nursing, therapy, infusion, medical social worker and support services to patients recovering from an acute illness following a hospitalization, to patients with severe disabilities that may confine them to a wheelchair or bed, and to patients whose disease state has advanced to the degree that their health and or mobility now compromises their continued ability to maintain independence without assistance.

Not only do our professional home health services meet the clinical needs of our patients, but they help our patients avoid being re-hospitalized and, as a result, they help generate significant savings for the Medicare program and taxpayers.

Home health care is especially important to rural America. Without easy access to hospitals, nursing homes, or other facilities, rural residents depend on home health. In fact, more than 631,000 Medicare beneficiaries in nearly 2,000 rural counties relied on home health care services in 2013.

[1] http://homehealth4america.org/media-center/attach/207-1.pdf

That is why I am here today — to ask you to help us continue serving the frail seniors who need our care and the rural communities who depend on our delivery system.

One of the greatest burdens we face today is the implementation of the face-to-face requirement.

Let me be clear: we strongly supported your action to ensure that no claim would be paid unless it was for services ordered by a physician as a result of a face-to-face encounter with the patient. That's good medicine, it's good program integrity policy, and it was an important addition to existing antifraud protections governing physician certification of patients' Medicare eligibility.

What has created such a burden on physicians and home health providers is not the policy but how it has been implemented. Simply put, this important safeguard has been implemented with impossible-to-meet documentation requirements that go well beyond what was written in the law by Congress.

The problems we are encountering include rampant inconsistencies and a lack of standardization that have forced providers to chase physicians multiple times to address issues of semantics – not to improve patient care or improve quality performance. In addition, documentation compliance has become a moving target, resulting in countless hours of providers and physicians attempting to meet Medicare's unclear documentation rules, resulting in thousands of denied claims.

Whether it's a missing signature on a completed form or a description that is deemed by some reviewer to be wanting regarding a patient's clinical condition, the implementation has resulted in a process that has ultimately created a paperwork mess of what should be simple – straightforward documentation of patient care.

A consequence of the regulatory demands we now face is that thousands of claims have been denied based on "insufficient documentation" even though a review of the full patient record reveals that the patient meets Medicare coverage criteria.

This is not happening in a vacuum — it's occurring at the same time as home health providers are struggling under an unprecedented 14%, four-year cut — a cut which is pushing home health agencies to the brink.

Medicare has tried to fix the documentation nightmare. Unfortunately, its efforts have fallen far short.

To put this problem into perspective, the following are specific examples of claims and care delivery issues experienced and related by Oregon home health providers as a result of this situation:

- "One denial was based on the way [Veterans Affairs] VA writes their Face to Face…the MD name is an electronic signature and it shows up in the area labeled "referring provider". This was denied even though I had a letter from a VA representative stating this is the form they use nationwide, they do not have the ability to change it and that it had previously been approved by CMS."

- "One referral that was on paper, not electronic, was dated at the top of the form by the MD: 1/10/14. He completed the remainder of the form accurately. At the end of the form he put the date next to his name 1/14. (the 10 was missing next to his name, although it was included on the top of the same page.) The reviewer did not like the format denying the claim and stating that "...a date was left off even though the face to face date was accurate.'"

- "Recently Medicare withdrew payment on a care episode from 2014 because although all paperwork was received and in place, the physician had not written MD behind their signature."

- "We had an 82 year old female patient that was seen for a pre-op visit with her [primary care physician] PCP on 4/16/15. This patient had a right [total knee amputation] TKA by orthopedic surgeon on 05/1/15. She was recovering at home and fell at home sustaining a hyper flexion injury and ruptured extensor mechanism. She was [wheelchair] w/c bound for 6 weeks, so was admitted to a Transitional Care Unit.

Upon discharge from the Transitional Care Unit, she was admitted to Home Health on 07/17/15. She followed up with orthopedic surgeon on 07/23/15. Face-to-face form was sent to this orthopedic surgeon to complete for his 07/23/15 office visit. We did not receive face-to-face documentation back, so 2nd request was faxed to the orthopedic surgeon on 08/07/15, followed up again on 08/17, 09/03 and 09/16/15. The orthopedic surgeon called us on 09/23/15 and he was very upset that we had requested him to complete the face-to-face documentation form. He stated that we 'needed to make retribution to him for the documents that we keep sending and the time he has put into this whole situation.'"

- "Client had a visit but the MD had put the wrong date on the face to face form. When we received [the additional documentation request] ADR, we requested from MD office the correct face to face; we worked long and hard on this (multiple phone calls and faxes to get the correct dates and other information) and were finally able to obtain the correctly dated form only to find out we were outside of our appeal dates and had to return the reimbursement for that case."

As illustrated above, current documentation policy not only creates nonsensical scenarios at times, it is also imposing a tremendous burden on home health agencies that threatens to impair their ability to continue providing seniors the home health care services they need. This is, in short, an instance where sound public policy has been undermined by an overly complicated and often counter-productive regulatory process.

Fortunately, there is a solution: Congressman Walden is authoring legislation that would establish a simple approach to documenting physicians' face-to-face encounter with their patients. In place of confusing requirements, this reform would ensure the policy is clearly and logically upheld through physician recording of the date of the encounter and use of a standardized form to identify the clinical condition for which home health is needed.

Clearly, a significant change in process is needed to alleviate the confusion and frustration of complying with face-to-face documentation encounter rules. Simplifying the process to clarify and streamline documentation with a more

standardized approach that is coordinated with stakeholder input and that reduces the time required for providers and physicians to complete it is critical so that patient care can continue to be the first priority.

Congressman Walden's proposed solution will also ensure that CMS provides education to providers, physicians, and claims processors so that a consistent application of the program integrity requirement is achieved to ensure full compliance. Standardizing the implementation of this program integrity requirement will make evident beneficiary eligibility through the consistent application of the documentation process. Furthermore, targeting the circumstances under which a face-to-face visit by a patient with their physician is required will greatly improve the continuity of patient care. Especially for patients admitted to home care within 14 days of a discharge from a hospital or skilled nursing facility, this will greatly improve the continuity and quality of patient care, minimize administrative paperwork, avoid costly provider claim denials for technicalities, and reduce the Medicare program's huge claims processing backlog.

We need this legislation — it will preserve your good program integrity policy while reducing unneeded paperwork and enabling us to continue serving homebound seniors in Oregon and all across America.

In closing, I want to thank Congressman Walden and all of you for your support of home health care and your dedication to America's rural communities. Your efforts mean so very, very much to us all.

Thank you.

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