September 14, 2010

Donald Berwick, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1510-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Response to CMS IFR re: Face-to-Face Requirement for Home Health Certification

Dear Dr. Berwick,

The undersigned organizations, who represent physicians, nurse practitioners, and physician assistants who provide medical care for home care patients, are pleased to respond to the proposed rule regarding the "Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices" as published in the *Federal Register* on July 23, 2010. Specifically, we are responding to the part of the proposed rule that implements a provision in the Patient Protection and Affordable Care Act that requires a face-to-face encounter prior to certifying home health services.

In general, CMS proposes that a physician responsible for certifying a patient for home health services must document that a face-to-face patient encounter, related to the condition for which the patient is receiving home health services, has occurred no more than 30 days prior to and no later than two weeks after the home health start-of-care date with him or herself or with an authorized non-physician practitioner working in collaboration with or under the supervision of the certifying physician. Documentation would include the date of the encounter and how the clinical findings of that encounter supported the patient's eligibility for the Medicare home health benefit. These provisions would be effective for home health episodes beginning January 1, 2011, or later.

In general, we agree with the need to improve access to medical services and prevent fraud and abuse in home care. We believe the proposed regulations represent a laudable goal. However, the United States lacks the primary care infrastructure to meet these goals for the foreseeable future. As a result, as proposed, the regulation could diminish access to home health services for some of the most seriously ill Medicare beneficiaries. This could cause an increase in the use of hospitals and nursing homes, contrary to CMS goals.

Therefore, in order to make achieving measurable progress more feasible, given the current office-based and home-based medical workforce, we make the following recommendations:

1. Prior to Start of Home Care Face-to-Face Requirement: We support a shorter time frame for a face-to-face encounter than the legislative language that suggested up to 6 months prior to home care. The proposed requirement for a face-to-face encounter within 30 days prior to the start of home care, however, appears too short. Chronic illnesses among the elderly are commonly associated with office visit follow-up every three months. Therefore, we recommend the requirement be extended to 90 days prior to start of care.

2. After the Start of Care Face-to-Face Requirement: We support an extension of the allowed time frame to include a number of weeks after the start of home care but are concerned about the ability of patients in all communities to reliably obtain an appointment for a face-to-face encounter within two weeks after a hospital or nursing home discharge, particularly if they don't have an established primary care relationship in that community. To be consistent with visit requirements in skilled nursing homes, we believe that a 30 day period after the start of care would be more reasonable.

3. Condition-specific Face-to-Face Requirement: We do not support the requirement that the face-to-face encounter be for the condition associated with the referral to home care. This could limit access to home care services as an alternative to emergency room use for general or non-specific symptoms or for a well known, stable condition that is not addressed at every office visit. We also see difficulty in enforcing such a rule. For example, a patient with chronic lung disease followed with frequent office visits may have worsened shortness of breath. Would the prior office visit be acceptable for certification even if an exacerbation of breathing problems were found to be due to infection? Would a patient with late effects of stroke followed closely in the office be able to be certified for rehabilitation for a new fall? In other words, the diagnoses listed on an office encounter are not a reliable predictor of need for closely associated, but differently coded, home care diagnoses.

4. Types of Non-Physicians Permitted to do Face-to-Face Encounters: We support the proposal that the face-to-face encounter be with a certifying physician or a non-physician practitioner.

5. Payment: We believe that the requirements for documentation on the certification of the date of face-to-face encounter, and a narrative description of the encounter-supported findings that the patient was homebound and in need of intermittent skilled nursing and/or therapy services, will create a significant increase in physician time spent in the certification process. Therefore, we think this rule should be associated with an appropriate increase in the Medicare payment for certification of home care (HCPCS code G0180). The regulation should clarify that G0180 is separately billable even if the certification occurs as part of a face-to-face visit (e.g. post-start of care house call).

6. Advance Beneficiary Notice or Payment for lack of Face-to-Face: We are concerned about timely access to home care services for Medicare beneficiaries who have not had a recent, relevant, face-to-face encounter with a physician before beginning home health care. Some home health agencies may refuse to risk non-payment for service rendered, in cases where patients do not have a required visit prior to the start of care, for fear there won't be such a visit in the weeks after the start of care. The start of care may be deferred until such a visit occurs. Lack of timely access to home care may lead to longer nursing home stays or unnecessary emergency room utilization. Costs to Medicare could increase as a result. We suggest that the rule clarify whether a home health agency may ask the patient to sign an Advance Beneficiary Notice, permitting the agency to hold the patient accountable if the patient does not have a required face-to-face visit. We do not think that is optimal Medicare policy, however. A better alternative would be to allow payment to home health agencies for episodes of care that lack appropriate certification solely due to a failed timely face-to-face encounter, when adequate explanation is provided in a narrative. Reasonable excuses could include, but not be limited to, unanticipated a) re-hospitalization or nursing home admission, b) death, or c) physical or mental inability to leave home without use of ambulance service. A discount in payment for such admissions could adequately deter fraud and abuse by agencies, or admission to the hospital simply to avoid non-payment for an episode.

7. Video-conferencing: We believe that advances in video-conferencing from the home setting to a physician's office should be recognized in this rule. We recognize that such visits are not separately payable by Medicare as a telehealth service under section 1834(m) of the Social Security Act, because a patient's home is not a recognized originating site under the statute. However, we believe that such visits may represent a better evaluation of the patient related to the need for home care than an office visit, given the ability to observe the client in their usual setting. If the home health agency professional participated in such a video-conference, collaboration between the patient, caregivers, the physician, and the home health agency would be assured. Thus, we think the definition of a telehealth visit for purposes of the required face-to-face visit should be expanded to include live, two-way audiovisual communication between the patient and the physician or appropriate non-physician provider.

8. Medical Directors: We anticipate that this rule will beneficially expand the collaboration between home health agencies and their medical directors, as has occurred in nursing homes. Specifically, when referred patients have not had a timely face-to-face encounter, prior to start of care, with their primary care physician and have difficulty leaving home for an office visit, we expect some agencies to request their medical directors, or a contracted physician, to perform home visits for the required face-to-face encounters and then certify the episodes of home care. We estimate that such a need for a medical home visit would occur in 5% - 10% of home care referrals. Thus, an agency with 500 admissions per year would have an estimated need for one such medical home visit per week. We believe that this is an appropriate role for a home health agency medical director, just as it is a routine activity of hospice medical directors. We also believe this law and associated regulations is an opportunity for CMS to upgrade the quality of home health medical services to the minimum standards required in hospice and nursing homes, which

require a medical director who has defined responsibilities to oversee care of the agency's patients. We seek clarification in this regulation so that documented time associated with medical director or contracted physician visits to patients at home that are medically necessary and appropriate may be compensated by home health agencies (within the exceptions in section 1877 of the Social Security Act and 42 CFR 411.354).

9. Integrated Health Systems: There are a wide variety of roles for nurse practitioners and physician assistants in home care. Similarly, there are varied contractual and employment relationships. In some of the best models, physicians, nurse practitioners or physicians assistants, and home health agency staff are all employed or work collaboratively within an integrated system. The development of Accountable Care Organizations may further promote such a model. In some such cases, the nurse practitioner or physician assistant might be housed in the home health agency. Therefore, we seek clarification regarding the prohibition of agency employed nurse practitioners performing the required face-to-face visits prior to home health certification. We believe that nurse practitioners and physician assistants employed by an integrated health system, where they are typically working in true collaboration and/or are supervised by physicians should be permitted in this regulation, even if they are also part of the home health agency program.

10. Penalties: Changes in the CMS 485 form resulting from this regulation will require changes in software for home health electronic medical record vendors. Education of home health agencies and physicians will also be required. We doubt that both these tasks can be completed adequately prior to the January 1, 2011, deadline. We seek clarification as to whether penalties to physicians or home health agencies for errors in completion of paperwork will be strictly enforced starting January 1, 2011, given the constraints in achieving goals for information technology and training between now and then.

Thank you for this opportunity to comment on this matter. If you or your staff has any questions regarding our comments, please contact Constance Row, Executive Director, American Academy of Home Care Physicians, 410-676-7966.

Sincerely,

American Academy of Home Care Physicians
American Academy of Family Physicians
American Academy of Physician Assistants
American Medical Association
American Medical Directors Association
Coalition of Geriatric Nursing Organizations