EXAMINING POTENTIAL WAYS TO IMPROVE THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

OCTOBER 1, 2015

Serial No. 114–81

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

20–311 PDF WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan
Chairman

JOE BARTON, Texas
Chairman Emeritus
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOSEPH R. PITTS, Pennsylvania
GREG WALDEN, Oregon
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
Vice Chairman
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
CATHY McMORRIS RODGERS, Washington
GREGG HARPER, Mississippi
LEONARD LANCE, New Jersey
BRETT GUTHRIE, Kentucky
PETE OLSON, Texas
DAVID B. McKINLEY, West Virginia
MIKE POMPEO, Kansas
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Ohio
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina
LARRY BUCSHON, Indiana
BILL FLORES, Texas
SUSAN W. BROOKS, Indiana
MARKWAYNE MULLIN, Oklahoma
RICHARD HUDSON, North Carolina
CHRIS COLLINS, New York
KEVIN CRAMER, North Dakota

FRANK PALLONE, JR., New Jersey
Ranking Member
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANICE D. SCHAKOWSKY, Illinois
G.K. BUTTERFIELD, North Carolina
DORIS O. MATSUI, California
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY McNERNEY, California
PETER WELCH, Vermont
BEN RAY LUJAN, New Mexico
PAUL TONKO, New York
JOHN A. YARMUTH, Kentucky
YVETTE D. CLARKE, New York
DAVID LOEBSACK, Iowa
KURT SCHRADER, Oregon
JOSEPH P. KENNEDY, III, Massachusetts
TONY CÁRDENAS, California7

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania
Chairman

BRETT GUTHRIE, Kentucky
Vice Chairman
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
CATHY McMORRIS RODGERS, Washington
LEONARD LANCE, New Jersey
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina
LARRY BUCSHON, Indiana
SUSAN W. BROOKS, Indiana
CHRIS COLLINS, New York
JOE BARTON, Texas
FRED UPTON, Michigan *(ex officio)*

GENE GREEN, Texas
Ranking Member
ELIOT L. ENGEL, New York
LOIS CAPPS, California
JANICE D. SCHAKOWSKY, Illinois
G.K. BUTTERFIELD, North Carolina
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
DORIS O. MATSUI, California
BEN RAY LUJÁN, New Mexico
KURT SCHRADER, Oregon
JOSEPH P. KENNEDY, III, Massachusetts
TONY CÁRDENAS, California
FRANK PALLONE, JR., New Jersey *(ex officio)*

C O N T E N T S

[1] The information has been retained in committee files and also is available at *http://docs.house.gov/meetings/IF/IF14/20151001/104006/HHRG-114-IF14-20151001-SD006.pdf*.

EXAMINING POTENTIAL WAYS TO IMPROVE THE MEDICARE PROGRAM

THURSDAY, OCTOBER 1, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Burgess, Lance, Griffith, Bilirakis, Elmers, Bucshon, Brooks, Collins, Green, Schakowsky, Butterfield, Castor, Matsui, Luján, Schrader, Kennedy, and Pallone (ex officio).

Also present: Representative Walden.

Staff present: Clay Alspach, Chief Counsel, Health; Rebecca Card, Staff Assistant; Noelle Clemente, Press Secretary; Graham Pittman, Legislative Clerk; Heidi Stirrup, Policy Coordinator, Health; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Meredith Jones, Democratic Director of Communications, Member Services, and Outreach; Samantha Satchell, Democratic Policy Analyst; Matt Schumacher, Democratic Press Assistant; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. It is 10 o'clock, so we will begin.

The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's hearing will consider three bipartisan legislative bills designed to strengthen the Medicare program:

H.R. 556, the Prevent Interruptions in Physical Therapy Act, sponsored by our colleague Representative Gus Bilirakis of Florida, would add therapists—physical, occupational, and speech—to the list of providers allowed to transfer care for a Medicare patient in circumstances of illness, pregnancy, or vacation;

H.R. 1934, the Cancer Care Payment Reform Act, sponsored by the House Republican Conference chairman, Cathy McMorris Rodgers of Washington, establishes a national Oncology Medical Home Demonstration Project to improve Medicare payments for cancer care;

Thirdly, draft legislation, authored by Representative Greg Walden of Oregon, would make changes to documentation and face-to-face requirements for home health providers under the Medicare program.

Together, these three bills continue the commitment this Congress has to strengthen the Medicare program and to keep the promise for seniors, which was started earlier this year by permanently repealing and replacing the broken sustainable growth rate, the SGR, an effort spanning several years to enactment this past April.

I want to thank our witnesses for agreeing to testify today. They bring real world experience regarding problems in the Medicare program, and we welcome their views on the legislation before us today.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The chairman will recognize himself for an opening statement.

Today's hearing will consider three bipartisan legislative bills designed to strengthen the Medicare program.

H.R. 556, the Prevent Interruptions in Physical Therapy Act, sponsored by our colleague Rep. Gus Bilirakis (FL) would add therapists (physical, occupational, and speech) to the list of providers allowed to transfer care for a Medicare patient in circumstances of illness, pregnancy, or vacation.

H.R. 1934, the Cancer Care Payment Reform Act, sponsored by the House Republican Conference chairman, Cathy McMorris Rodgers (WA), establishes a national Oncology Medical Home Demonstration Project to improve Medicare payments for cancer care.

Draft legislation authored by Rep. Greg Walden (OR) would make changes to documentation and face-to-face requirements for home health providers under the Medicare program.

Together these three bills continue the commitment this Congress has to strengthen the Medicare program and keep the promise for seniors—which was started earlier this year by permanently repealing and replacing the broken Sustainable Growth Rate (SGR)—an effort spanning several years to enactment this past April.

I want to thank our witnesses for testifying today. They bring with them real world experience of problems in the Medicare program and I look forward to their testimony on these pieces of legislation.

Finally, I would like to commend the sponsors of these pieces of legislation for their efforts in bringing these various pieces of legislation forward.

[The proposed legislation appears at the conclusion of the hearing.]

Mr. PITTS. And I will yield to any of my colleagues on my side of the aisle if they would like to make any statements. None?

All right. I yield back.

I recognize Mr. Luján of New Mexico for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. BEN RAY LUJÁN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. LUJÁN. Thank you very much, Chairman Pitts. And I appreciate you and the ranking member and all the members of the subcommittee for allowing us to be here today for this important conversation.

I am pleased that, today, the committee is considering H.R. 556, the Prevent Interruptions to Physical Therapy Act. Physical therapy.

Congressman Bilirakis and I introduced this bill in the previous Congress and again at the beginning of this Congress because, under current law, physical therapists are not allowed to enter locum tenens agreements. The physical therapy act changes this by allowing physical therapy practices to hire a qualified locum tenens physical therapist to treat Medicare patients during an absence by one of the practice's regular physical therapists.

For many seniors, physical therapy services provide a path to restore mobility after an injury or a medical procedure and a way to restore function and return to the activity level that they have long enjoyed. With the help of their physical therapists many patients are able to recover and continue to live independently with a higher quality of life.

There are times, however, when physical therapy services can be interrupted due to the provider having an illness, taking a vacation, maternity leave, or continuing their professional education. In other words, Mr. Chairman, you know, life moves on as well; but, unfortunately, physical therapists aren't able to try to bring in some of their peers to provide coverage, like doctors, osteopathic physicians, dental surgeons, podiatrists, optometrists, or chiropractors.

These interruptions can easily be handled by entering into what is called a locum tenens agreement with another qualified provider. Under these arrangements, the regular provider is able to bill and receive payment under Medicare part B for the locum tenens provider services as if they had performed them themselves. The locum tenens provider is compensated directly by the practice of the regular provider.

These arrangements are common and extremely beneficial to patients and providers alike as the relationship between the patient and the practice is continued by another licensed, qualified provider during their short-term leave. Especially in isolated rural areas, a locum tenens provider can keep a small medical practice open to serve patients who would otherwise have to travel long distances to another provider. By hiring a locum tenens, a provider is able to ensure that their patient care does not lapse.

The Senate companion bill was voted out of committee in June, and I am pleased that our bill is before the committee today; and I look forward to the testimony and questions about this commonsense legislation.

And, again, I want to thank Congressman Bilirakis for his leadership. It has been a pleasure and an honor to work with him on this important issue.

With that, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman.

In lieu of the chairman, the Chair recognizes Mr. Bilirakis of Florida for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GUS M. BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. Thanks for also addressing this particular bill this morning. The Prevent Interruptions in Physical Therapy Act is a bipartisan bill that I introduced, along with my good friend and colleague, Ben Ray Luján.

Currently, Medicare allows a wide range of medical providers, including doctors of medicine, osteopathy, and chiropractors, the ability to bring in other licensed professionals under their provider number. This allows for substitutes for when a practice is short-staffed for a short period of time for reasons such as illness, maternity or paternity leave, or vacation. Such instances are referred to as "locum tenens arrangements." Physical therapists currently are excluded from employing locum tenens in their practices, forcing seniors to either find a new physical therapist or not receive treatment during the time their therapist is out.

To illustrate the problem that occurs, this is a letter from Alicia Nixon, a physical therapist in Hillsborough County, Florida, and I quote, "I am a private practice owner and have served mostly Medicare patients for the last 11 years. The current Medicare rules have been very difficult and detrimental, at times, to my practice's viability. Just as important, there have been times that were completely unavoidable and that the Medicare patients were not able to be seen in order to remain in compliance with the current regulations. It has been almost impossible to take a vacation or time to attend conferences or seminars because of my need to be onsite at the clinic. I was recommended to have surgery 6 years ago that I still have not had because it would require me to be away from the practice for over 6 weeks for recovery. When I received a court summons, I had to close the clinic for 2 days, with patient visits having to be canceled, and all staff lost wages from the necessary closure," end quote.

At one point, this practice lost a physical therapist. It took about a year to fill that vacancy, and then she writes again and I quote: "In the timeframe that I was looking to fill the vacancy here at the practice, my biggest fear was that, if I was in an accident and physically not able to be onsite for a period of time, it would mean certain closure of the office. It is very sad that an office that has provided excellent services to the Medicare community is so vulnerable because of the current regulations." We need to pass this bill, Mr. Chairman. It is pro-patient and pro-physical therapist.

I yield back. Actually, I would like to yield the rest of my time to Chairman Greg Walden. Thank you.

Mr. WALDEN. I thank the gentleman very much.

Mr. Chairman and Ranking Member, thank you for holding this hearing. It is a very important issue. We need to explore the problems with this face-to-face regulation.

Our Nation has made a promise to seniors who rely on Medicare, and we must keep it, and one way to keep this promise is through home health services.

So I am happy to introduce Sarah Myers, who will be sharing her knowledge about what is going on out there. She is the Executive Director of the Oregon Association of Home Health Care. Sarah has

been recognized for her outstanding contribution to the Oregon home care community and has provided the Oregon delegation with a wealth of information on the critical issues facing home health providers and the patients that they serve.

In general, home health, as you know, is less expensive, more convenient, and just as effective as care in a skilled nursing facility. Receiving care at home gives seniors more control over their health care, and it provides a sense of comfort, familiarity, and normalcy for the patient and for their loved ones.

I know this firsthand because it was the choice my parents and I made, and, in Oregon, more than 20,000 Medicare beneficiaries make that same choice.

However, under current documentation requirements associated with a so-called "face-to-face requirement" have placed significant pressures on the home health care community and the people they serve. In order for a patient to meet the eligibility criteria for home health, a physician must document that a face-to-face meeting occurred between the patient and a physician or a nonpatient practitioner—or a nonphysician practitioner.

While intended to be a way to reduce waste, fraud, and abuse by ensuring the orders and certification of home health care are based on actual knowledge of the patient's condition, unclear documentation requirements from the Government have led to a slew of payment denials and additional documentation requests.

So we have a situation in which a complicated regulatory process simply needs to be streamlined and standardized, and that is what this election would do.

First, it requires the Secretary to develop a single standardized form which satisfies the requirements of the home health certification;

And second, the bill streamlines the process and eases the requirements if the patient has been discharged from the hospital or skilled nursing facility;

Third, anyone who uses this form must receive proper notification and education on the documentation requirements;

And finally, the Secretary must implement a process to reopen review claims which were denied solely due to the face-to-face documentation concerns and issue revised decisions if the claims were denied because of the patient narrative—a requirement that even CMS recently dropped because of the burden on providers.

So, Mr. Chairman, this isn't just about a backlog of appeals and red tape. It is about improving access to and quality care of our seniors, and that is why this legislation has the support of the home health providers, including the Partnership for Quality Home Healthcare, the National Association for Home Care & Hospice, and the Visiting Nurse Associations of America.

Mr. Chairman, I ask unanimous consent to submit their statements for the record.

I also would like to submit into the record three letters to CMS from 2011, 2013, and 2014 from the House and Senate, expressing concerns with the face-to-face documentation request.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. WALDEN. I thank the chairman, and I appreciate his indulgence and your work on this legislation.

I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

I am always happy to come together to examine bipartisan ways to improve the Medicare program and beneficiary access, and I would be remiss in not mentioning that a witness from the administration would have made this hearing more informative. The administration would have been able to speak to whether these bills are implementable and what we could do to improve them.

The first bill under discussion today is an example of why the administration's input would help inform our decisionmaking. The bill would set up a national Oncology Medical Home Demonstration Project in the Medicare program through care coordination management fees based on performance and shared savings and arrangements with oncology practices.

We laid the foundation for these types of payment reform demonstrations in the Affordable Care Act through the establishment of accountable care organizations, medical homes, and demonstrations within the Centers for Medicare & Medicaid Innovation, CMMI.

If someone from the administration were here, they would be able to tell us about the oncology care model, a demonstration project that the Center for Medicare & Medicaid Innovation has initiated. The oncology care model would also pay coordination management fees to practices and require performance and financial accountability.

I think this type of model is worthwhile. We should absolutely be looking at ways to improve oncology care in our country; but I am interested in learning why the legislation is necessary when CMMI is already implementing a similar model.

The second bill we are considering is H.R. 556, the Prevent Interruption in Physical Therapy Act, which would expand the locum tenens designation to include physical therapists.

Currently, Medicare allows physicians who are absent from their practices for extended periods—for reasons such as illness, pregnancy, vacation, or continuing medical education, to retain substitute physicians to take over their practices until they return. The ability to bring in a substitute physician is called "locum tenens," and this bill would allow physical therapists to enter into these arrangements.

When there are limited options in rural or in medically underserved areas, I understand the concerns for patients' access when a physical therapist needs to be absent from his or her practice; and I look forward to working with my colleagues on this legislation to ensure it helps those who need it most.

Last, the committee is considering a discussion draft of a bill that would change the Medicare home health face-to-face requirement.

Understand that this bill is a discussion draft that has yet to be introduced, but I have concerns with further walking back the face-to-face requirement that we put in place in the Affordable Care Act.

This requirement was the result of both the inspector general and MedPAC recommendations to root out waste and fraud in the Medicare system. CMS has been listening to industry's concerns about the requirement, and work with them to make it more streamlined and easy to comply with. In fact, over the last few years, my staff and I have advocated us for these actions; however, we must be extremely careful when removing requirements that shore up program integrity.

So, again, thank you, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Mr. Chairman, thank you for holding this hearing today. I am always happy to come together to examine bipartisan ways to improve the Medicare program and beneficiary access. I would be remiss in not mentioning that a witness from the administration would have made this hearing more informative. The administration would have been able to speak to whether these bills are implementable and what we could do to improve them.

The first bill under discussion today is an example of why the administration's input would help inform our decision-making. The bill would set up a national Oncology Medical Home Demonstration Project in the Medicare program through care coordination management fees based on performance and shared savings arrangements with oncology practices. We laid the foundation for these types of payment reform demonstrations in the Affordable Care Act through the establishment of Accountable Care Organizations, Medical Homes, and demonstrations within the Centers for Medicare & Medicaid Innovation (CMMI).

If someone from the administration were here, they would be able to tell us about the Oncology Care Model, a demonstration project that the Center for Medicare and Medicaid Innovation has initiated. The Oncology Care Model would also pay coordination management fees to practices and require performance and financial accountability. I think this type of model is worthwhile-we should absolutely be looking at ways to improve oncology care in our country, but I am interested in learning why legislation is necessary when CMMI is already implementing a similar model.

The second bill we are considering today is H.R. 556, the Prevent Interruptions in Physical Therapy Act, which would expand the "locum tenens" designation to include physical therapists. Currently, Medicare allows physicians who are absent from their practices for extended periods for reasons such as illness, pregnancy, vacation, or continuing medical education to retain substitute physicians to take over their practices until they return. The ability to bring in a substitute physician is called locums tenens, and this bill would allow physical therapists to enter into these arrangements. When there are limited options in rural or medically underserved areas, I understand the concerns for patient access when a physical therapist needs to be absent from his or her practice. I look forward to working with my colleagues on this legislation to ensure it helps those who need it most.

Last, the committee is considering a discussion draft of a bill that would change the Medicare home health face-to-face requirement. I understand that this bill is a discussion draft that has not yet been introduced, but I have concerns with further walking back the face-to-face requirement that we put in place in the Affordable Care Act. This requirement was a result of both Inspector General and MedPAC recommendations to root out waste and fraud in the Medicare system. CMS has been listening to industry's concerns about the requirement and worked with them to make it more streamlined and easy to comply with. In fact, over the last few years, my staff and I have advocated for these actions. However, we must be extremely careful when removing requirements that shore up program integrity.

Again, thank you, Mr. Chairman, for holding this hearing, and I yield the rest of my time to the Democratic sponsor of the Prevent Interruptions in Physical Therapy Act, Congressman Luján.

Mr. PALLONE. I yield the rest of my time to the ranking member, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I thank our ranking member.

And I would like to ask unanimous consent that my full statement be placed in the record.

Mr. PITTS. Without objection, so ordered.

Mr. GREEN. I want to thank the Chair for calling this hearing today.

This marks the 50th anniversary of Medicare, and since 1965, the landmark program has provided affordable health insurance coverage and access to care for our Nation's seniors. Few programs have improved the lives of Americans as significantly as Medicare.

Today, we have three separate bills. The first is H.R. 556, the Prevent Interruptions in Physical Therapy Act.

It would allow physical therapists to employ locum tenens in their practices. Under Medicare law, health care providers are permitted to employ only licensed professionals under their provider number to care if they are temporarily unable to do so. H.R. 556 would add physical therapists to the list of providers who would enter into these agreements, known as "locum tenens agreements," so that patients do not see a disruption in care.

H.R. 1934, the Cancer Care Payment Reform Act, would establish a national Oncology Medical Home Demonstration Project. Research has shown there is a disconnect between cost and the quality of cancer care for Medicare beneficiaries, and many have suggested the fee-for-service model is inappropriate. I know, recently, the Center for Medicare & Medicaid Innovation announced at launch a 5-year oncology care model starting next spring. The demonstration proposed in H.R. 1934 shares many of the characteristics of that Center for Medicare & Medicaid Innovation.

Mr. Chairman, like I said, I would like to ask unanimous consent for the full statement to be placed in the record.

Again, thank you for calling the hearing.

Mr. PITTS. The Chair thanks the gentleman.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN

Good morning, and thank you all for being here today.

This hearing is titled "Examining Potential Ways to Improve the Medicare Program."

I want to thank the chairman for having this hearing. Before we get in to the legislative proposals we will be discussing, I think it is important to reflect on the Medicare program at large.

This year marks the 50th anniversary of Medicare.

Since 1965, this landmark program has provided affordable health insurance coverage and access to care for our Nation's seniors.

Few programs have improved the lives of Americans as significantly as Medicare.

Fifty years ago, almost half of elderly Americans lacked health insurance.

Today, Medicare provides lifesaving insurance to nearly 100 percent of adults over 65.

Fifty-four million elderly and individuals with disabilities have health insurance through Medicare.

At the anniversary of this historic law, we celebrate the successes of the Medicare program.

We must also renew our commitment to further strengthening it, so that it remains available in perpetuity for generations to come.

Today we are considering three pieces of legislation.

The first is H.R. 556, the Prevent Interruptions in Physical Therapy Act.

This bill will allow physical therapists to employ locum tenens in their practices.

Under current Medicare law, a variety of health care providers are permitted to employ other licensed professionals under their provider number to care for their patients if they are temporarily unable to do so.

H.R.556 will add physical therapists to the list of providers who can enter into these agreements, known as "locum tenens arrangements," so their patients do not see a disruption in care.

H.R. 1934, the Cancer Care Payment Reform Act, will establish a national Oncology Medical Home Demonstration Project to examine changing the structure of Medicare payments for cancer care.

The intent of this bill is to test the potential of alternative payment models in oncology.

Research has identified a disconnect between the costs and the quality of cancer care for Medicare beneficiaries.

Many have suggested that the fee-for-service model is inappropriate, and have suggested that Congress explore the potential of alternate models, including oncology patient-centered medical homes, ACOs and bundled payments for oncology services.

Recently, the Center for Medicare and Medicaid Innovation (CMMI) announced the launch of a 5-year Oncology Care Model starting next spring.

The demonstration project proposed by H.R. 1934 shares many characteristics of the CMMI demo.

It is important we do not waste resources by duplicating efforts, or undermine ongoing demonstrations without good reason, but I thank the bill sponsors for their commitment to improving oncology care for Medicare beneficiaries.

I look forward to furthering the discussion on how we can continue to build on the promise of the new provider delivery model advanced in the Medicare Access and CHIP Reauthorization Act.

The final piece of legislation we will discuss is a draft bill to amend the Medicare home health face-to-face documentation requirements.

Home health care is critically important to Medicare beneficiaries who are confined to their homes.

While we must ensure that this service is available to individuals in need of care, substantial concerns about spending growth and quality within the home health benefit have been identified by the OIG, GAO and independent researchers.

Since 2001, Medicare spending on home health services has doubled.

In 2013, the cost of home health services reached almost $18 billion.

In order to address concerns about the appropriateness of some services and vulnerability to fraud and waste, the Affordable Care Act included Medicare home health integrity provisions.

The ACA mandated that physicians or another provider have a face-to-face encounter with the patient to attest to their eligibly for the home health benefit.

CMS has implemented this requirement and simplified the certification and documentation process.

However, many home health agencies have expressed concern that the mandate is overly burdensome.

The intent of the draft bill is to address some of these documentation concerns.

I look forward to hearing more about the implementation of the face-to-face requirement, ways the process can be improved, and how we can build on program integrity provisions of the Affordable Care Act.

It would be difficult to overstate the importance of Medicare to our Nation's seniors—both today and future generations.

I want to thank our witnesses for being here today and look forward to exploring the proposal, and other ways we can strength this vital safety net program.

Thank you, and I yield back.

Mr. PITTS. We are voting on the floor. We have 11 ½ minutes to go, and 400 people haven't voted, so we are going to start the witnesses.

As usual, all members' written opening statements will be made a part of the record; and I'll introduce them in the order of their testimony.

First, we have Sarah Myers, CAE, Executive Director of the Oregon Association of Health Care. Welcome. Dr. Bruce Gould, President of the Community Oncology Alliance. Welcome. And Sandra Norby, PT, AT, owner, HomeTown Physical Therapy, LLC.

Thank you each for coming. Your written testimony will be made a part of the record. You will be each given 5 minutes to summarize.

Ms. Myers, you're recognized for 5 minutes.

STATEMENTS OF SARAH MYERS, EXECUTIVE DIRECTOR, OREGON ASSOCIATION FOR HOME CARE; BRUCE GOULD, M.D., MEDICAL DIRECTOR, NORTHWEST GEORGIA ONCOLOGY CENTERS, AND PRESIDENT, COMMUNITY ONCOLOGY ALLIANCE; AND SANDRA NORBY, OWNER, HOMETOWN PHYSICAL THERAPY, LLC

STATEMENT OF SARAH MYERS

Ms. MYERS. Chairman Pitts, Ranking Member Green, members of the subcommittee, and Congressman Walden, thank you for this opportunity to speak with you today.

My name is Sarah Myers, and I am the Executive Director of the Oregon Association for Home Care.

Our organization represents over 58 home health agencies, employing over 2,000 professionals and providing Medicare home health services to more than 30,000 Medicare beneficiaries who are homebound and many of whom are rural.

As you know, home health patients are among the most vulnerable in the Medicare program, and, in fact, Federal data shows that they are older, sicker, poorer, and more likely to be a minority and disabled than all other Medicare beneficiaries combined. Due to their frail condition, these seniors have been deemed homebound by their physicians, meaning they cannot leave their home without help or potential injury to themselves.

That is 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. We also serve patients with severe disabilities that may confine them to a wheelchair or bed. Home health providers also care for patients whose disease state has advanced to the degree that their health and their mobility are now compromised, and compromises their continued ability to maintain independence without assistance.

Not only do our professional home health services meet the clinical needs of our patients in the patient preferred home setting, but they help our patients avoid being rehospitalized, and as a result, they help generate significant savings from the Medicare program and taxpayers.

Home health care is especially important to rural America. Without any access to hospitals, nursing homes, or other facilities, residents truly depend on home health. In fact, more than 630,000

Medicare beneficiaries in nearly 2,000 rural counties relied on home health services in 2013.

That is why I am here today, to speak to you and 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; but let me be clear: We strongly supported your action to require that no claim would be paid unless it was for services ordered by a physician as a result of the face-to-face encounter with the patient. That is good medicine, and that is good program integrity policy.

We need to keep in mind that the physician also certifies the patient's eligibility for Medicare coverage under penalty of various anti-fraud laws. What has created the burden on physicians and home health providers is not the policy but how it has been implemented with impossible-to-meet documentation requirements that are not in the law enacted by Congress.

Inconsistencies in the lack of standardization have forced providers to chase physicians multiple times to address issues of semantics, not to improve patient care or to improve quality performance. 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 is a missing signature on a completed form or an insufficient description regarding a patient's clinical condition, the implementation has resulted in a process that has, ultimately, created a paperwork mess of what should be straightforward documentation. Patient care is the priority. Burdensome paperwork and navigating red tape should not be.

What is most alarming with the documentation demands 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 either. It is occurring at the same time home health providers are struggling under an unprecedented 14 percent, 4-year cut. A cut which is pushing home health agencies to the brink.

Medicare has tried to fix the documentation nightmare. However, its efforts have fallen far short. Fortunately, there is a solution. Congressman Walden is authoring legislation that would establish a simple approach to documenting physicians' face-to-face encounters with their patients. In place of confusing requirements, physicians would simply record the date of the encounter and use a form to identify the clinical condition for which home health is needed.

We need this legislation. It will preserve your good 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 very, very much to us. Thank you.

[The prepared statement of Ms. Myers follows:]

House Committee on Energy & Commerce – Subcommittee on Health

"Examining Potential Ways to Improve the Medicare Program"

Thursday, October 1, 2015 – 2322 Rayburn House Office Building

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.

Sarah A. Myers, CAE
Executive Director
Oregon Association for Home Care

4676 Commercial St. SE, #449
Salem, OR 97302
(503) 364-2733
smyers@oahc.org
www.oahc.org

Mr. PITTS. The Chair thanks the gentlelady.

We still have 5 minutes, and 374 Members haven't voted. We will try one more.

Dr. Gould, you're recognized for 5 minutes.

STATEMENT OF BRUCE GOULD

Dr. GOULD. Thank you. Chairman Pitts, Ranking Member Green, and members of the committee, I thank you for the opportunity to share my views on payment reform in oncology and specifically on the Cancer Care Payment Reform Act, H.R. 1934.

I am a practicing medical oncologist and Medical Director of Northwest Georgia Oncology Centers, a private community oncology practice headquartered in Marietta, Georgia. Additionally, I serve as President of the Community Oncology Alliance, COA, a nonprofit organization dedicated to advocating for community oncology practices and, most importantly, the patients they serve. Close to 70 percent of Americans with cancer are treated by private practice clinics. I finally want to mention, of relevance here, that I am the son of two parents who passed away from cancer.

Community oncology practices, such as mine, have struggled from major cuts to reimbursement by Medicare. For example, the decision by CMS to apply sequestration to the underlying costs of cancer drugs has led to many drugs being reimbursed for less than their acquisition price. As a result, over 300 practices have closed treatment sites and, more significantly, close to 550 practices have merged with hospital systems.

The data is clear on the consolidation of cancer care in the United States. It is creating access to care problems for patients in rural areas and, very significantly, increasing the costs of cancer care for seniors in the Medicare program. This unwanted trend has been documented by reports this year by the GAO and MedPAC.

Despite reimbursement pressures from Medicare, our practice, years ago, made a decision to ambitiously transform ourselves into a patient-centric Oncology Medical Home. Our goal was simple: to better control the costs of cancer care while enhancing the quality of the patient experience. Among other things, we improved care coordination for our patients, established a structured triage, initiated a comprehensive patient satisfaction survey, and developed our own treatment guidelines.

One benefit of this transformation is that same-day appointments are rarely available in our nonclinics. Therefore, if our patients are ill, they can come to our clinics rather than going to the hospital emergency room. Medicare moneys are saved by the avoidance of needless emergency room visits and hospitalizations, and the patients are happier by not being subjected to hours of waiting in the emergency room.

Our hard work has recently been recognized by the commission on cancer through their accreditation of our practice as one of the first Oncology Medical Homes. Our dedication to value-based care has led us to partnering with private payers and CMS on oncology payment reform pilots.

One program we and several others completed with UnitedHealthcare resulted in cancer care savings of 34 percent as compared to a case control group. The results were published in the

peer-review "Journal of Oncology Practice," a copy of which I have submitted with my remarks for the record.

We are also part of a national $19 million grant from the Centers for Medicare & Medicaid Innovation, CMMI. The grant funded the "COME HOME" pilot, which was designed to be a real world test of the oncology and medical home tenants. Findings from NORC at the University of Chicago, the independent research entity CMMI contracted with to measure results, were nothing short of remarkable. They showed an overall reduction of cancer care costs due to reduced hospitalizations, re-admissions, and emergency department utilizations. I have included these results with my written testimony.

I am here today to implore Congress to immediately pass the Cancer Care Reform Act, H.R. 1934, a bipartisan bill, introduced by Representatives Cathy McMorris Rodgers and Steve Israel. The bill lays out the specific plans for a demonstration project based on the Oncology Medical Home. It is built on successful models that have already been tested in the oncology payment reform with both private payers and CMS.

I commend Mrs. McMorris Rodgers for reaching out to practicing community oncologists for crafting her bill. In addition to support from oncologists, her legislation also has the support of patient groups, private payers, biotech companies, and pharmaceutical distributors. I also commend Congress for passing a fix to SGR, along with a path to meaningful payment reform. Community oncology practices like mine want to be part of the alternative payment reform path that the Energy and Commerce Committee developed in the SGR legislation. However, we need a Medicare alternative payment model in oncology for that to happen.

H.R. 1934 is a critical bridge to getting us to that point. I ask Congress to pass this important legislation that will lower the costs of cancer care while enhancing the quality of care for patients.

Thank you for your attention.

[The prepared statement of Dr. Gould follows:]

Testimony on:

CANCER CARE PAYMENT REFORM ACT (H.R. 1934)

United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health Care

Examining Potential Ways to Improve the Medicare Program

Washington, DC

October 1, 2015

Bruce Gould, MD

Medical Director, Northwest Georgia Oncology Centers, P.C.

President, Community Oncology Alliance

Testimony Summary

Committee on Energy and Commerce, Subcommittee on Health

Examining Potential Ways to Improve the Medicare Program

Bruce Gould, MD

Medical Director, Northwest Georgia Oncology Centers, P.C.

President, Community Oncology Alliance

- I implore Congress to pass the *Cancer Care Payment Reform Act* (H.R. 1934), a bipartisan bill introduced by Representatives Cathy McMorris Rodgers and Steve Israel. This bill lays out the specific plans for a demonstration project based on the Oncology Home Model. It builds upon the successful models that have already been tested in oncology payment reform with both private payers and CMS.
- Community oncology practices like ours want to be part of the alternative payment reform path that the Energy and Commerce committee developed in the SGR legislation; however, we need a Medicare alternative payment model in oncology for that to happen. H.R. 1934 is a critical bridge to getting us to that point.
- My practice has participated in several oncology payment reform pilots with both private payers and Medicare, through a CMMI grant. These have proven very successful in enhancing the quality of cancer care and reducing costs. Many of the concepts in these successful programs have been incorporated into H.R. 1934 by Congresswoman McMorris Rodgers
- I ask Congress to pass this important legislation that will lower the costs of cancer care while enhancing the quality of care for patients.

Chairman Pitts, Ranking Member Green, and members of the committee — I thank you for the opportunity to share my views on payment reform in oncology and, specifically, on the Cancer Care Payment Reform Act, H.R. 1934.

I am a practicing medical oncologist and medical director of Northwest Georgia Oncology Centers, a private community oncology practice headquartered in Marietta, Georgia. Additionally, I serve as President of the Community Oncology Alliance (COA), a non-profit organization dedicated to advocating for community oncology practices and, most importantly, for the patients they serve. Close to 70% of Americans with cancer are treated by private practice clinics. I finally want to mention, and of relevance here, that I am the son of two parents who passed away from cancer.

Community oncology practices such as mine have been struggling from major cuts to reimbursement by Medicare. For example, the decision by CMS to apply sequestration to the underlying costs of cancer drugs has led to many drugs being reimbursed for less than their acquisition price. As a result, over 300 practices have closed treatment sites and, more significantly, close to 550 practices have merged with hospital systems. The data is clear on the consolidation of cancer care in the United States: it is creating access to care problems for patients in rural areas and, very significantly, increasing the cost of cancer care for seniors and the Medicare program. This unwanted trend has been documented by reports this year by the GAO and MedPAC.

Despite reimbursement pressures from Medicare, our practice years ago made a decision to ambitiously transform ourselves into a patient-centric Oncology Medical Home. Our

goal was simple — to better control the costs of cancer care while enhancing the quality of the patient experience. Among other things, we improved care coordination for our patients, established a structured triage, initiated a comprehensive patient satisfaction survey, and developed our own guidelines. One benefit of this transformation is that same day appointments are readily available in our nine clinics. Therefore, if our patients are ill, they can come to our clinics rather than go to the hospital emergency rooms. Medicare monies are saved by avoidance of needless emergency room visits and hospitalizations, and patients are happier by not being subjected to hours waiting in the emergency room. Our hard work has recently been recognized by the Commission on Cancer through their accreditation of our practice as one of the first Oncology Medical Homes.

Our dedication to value based care has lead us to partnering with private payers and CMS on oncology payment reform pilots. One program we and several others completed with UnitedHealthcare resulted in cancer care savings of 34% as compared to a case control group. The results were published in the peer-reviewed *Journal of Oncology Practice*, a copy of which I have submitted with my remarks for the record.

We are also part of a national, $19 million grant from the Centers for Medicare & Medicaid Innovation (CMMI). This grant funded the "COME HOME" pilot which was designed to be a real world test of the Oncology Medical Home tenants. Findings from NORC at the University of Chicago, the independent research entity CMMI contracted with to measure results, were nothing short of remarkable. They showed an overall reduction of cancer care costs due to reduced hospitalizations, readmissions, and

emergency department utilizations. I have included these results with my written testimony.

I am here today to implore the Congress to immediately pass the Cancer Care Payment Reform Act (H.R. 1934), a bipartisan bill introduced by Representatives Cathy McMorris Rodgers and Steve Israel. This bill lays out the specific plans for a demonstration project based on the Oncology Medical Home. It builds upon the successful models that have already been tested in oncology payment reform with both private payers and CMS. I commend Mrs. McMorris Rodgers for reaching out to practicing community oncologists for help in crafting her bill. In addition to support from oncologists, her legislation also has the support of patient groups, private payers, biotech companies, and pharmaceutical distributors.

I also commend Congress for passing a fix to the SGR along with a path to meaningful payment reform. Community oncology practices like mine want to be part of the alternative payment reform path that the Energy and Commerce committee developed in the SGR legislation; however, we need a Medicare alternative payment model in oncology for that to happen. H.R. 1934 is a critical bridge to getting us to that point. I ask Congress to pass this important legislation that will lower the costs of cancer care while enhancing the quality of care for patients.

Thank you for your attention and I would be happy to answer any questions.

Original Contribution

Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model

By Lee N. Newcomer, MD, Bruce Gould, MD, Ray D. Page, DO, PhD, Sheila A. Donelan, MS, and Monica Perkins, PhD

UnitedHealthcare, Minnetonka, MN; Northwest Georgia Oncology Centers, Marietta, GA; and Center for Blood and Cancer Disorders, Fort Worth, TX

Abstract

Purpose: This study tested the combination of an episode payment coupled with actionable use and quality data as an incentive to improve quality and reduce costs.

Methods: Medical oncologists were paid a single fee, in lieu of any drug margin, to treat their patients. Chemotherapy medications were reimbursed at the average sales price, a proxy for actual cost.

Results: Five volunteer medical groups were compared with a large national payer registry of fee-for-service patients with cancer to examine the difference in cost before and after the initiation of the payment change. Between October 2009 and December 2012, the five groups treated 810 patients with breast, colon, and lung cancer using the episode payments. The registry predicted fee-for-service cost of the episodes cohort was $98,121,368, but the actual cost was $64,760,116. The predicted cost of chemotherapy drugs was $7,519,504, but the actual cost was $20,979,417. There was no difference between the groups on multiple quality measures.

Conclusion: Modifying the current fee-for-service payment system for cancer therapy with feedback data and financial incentives that reward outcomes and cost efficiency resulted in a significant total cost reduction. Eliminating existing financial chemotherapy drug incentives paradoxically increased the use of chemotherapy.

Introduction

The cost of health care in the United States is on an unsustainable trajectory. Using current trends, economists predict that in less than 3 years, it will require 50% of the average U.S. household income to pay the costs of out-of-pocket expenses and the health insurance premium for a family.[1] Cancer therapy is a contributor to these rising costs; it accounts for 11% of UnitedHealthcare's commercial health plan budget, and the proportionate share is rising. The existing fee-for-service payment provides theoretical incentives for overuse and the selection of expensive branded drugs rather than lower cost generic medications. New payment models that reward cost-effective and high-quality treatment are needed.

One approach for cost reduction is to reduce the payment amount for each service. After Medicare decreased the reimbursement levels for drugs in 2005, an analysis of patients with lung cancer revealed that oncologists treated more patients with chemotherapy and increased the usage of expensive drugs.[2] The effect on quality was not measured. Medicare continues to experience increases in cancer costs, probably caused by factors like the introduction of new expensive drugs and increased numbers of beneficiaries.

Another potential solution to rising costs is paying for care by the episode. Medicare has used this approach for hospital care for more than a decade with the Diagnosis Related Groupers, but the method has not been tested for chronic illness care in an ambulatory setting. Proponents argue that a fixed payment for a defined time period provides the incentive to become more efficient while limiting the provider risk to a manageable sum of money. Bach et al[3] proposed a payment model for cancer therapy that uses the monthly national average chemotherapy cost for each cancer type as the basis for the episode payment. This proposed system would require physicians to use lower cost regimens to remain profitable. Further, it would provide an incentive for pharmaceutical firms to reduce the prices of any medications that exceed the episode payment budget amount.

The Bach proposal attacks drug costs, but it has no effect on other cost categories for cancer care. UnitedHealthcare data suggest that these other categories are significant. For commercially insured patients, chemotherapy drugs represent 24% of total care costs, inpatient and outpatient facility services account for 54%, and physician services constitute the remaining 22%. In a previous article, Newcomer proposed a payment method that removes any adverse incentive to use expensive pharmaceuticals while simultaneously creating an incentive to reduce the total costs of care and improve outcomes.[4] The program included a quality improvement approach that mandated an annual review and discussion of use and quality data. This article reports the results of a 3-year trial of this program.

Methods

UnitedHealthcare collaborated with five volunteer medical oncology groups for the pilot. The program changed four elements of the previous fee-for-service contract relationship. First, the medical groups proactively registered all patients with breast, colon, and lung cancer and provided clinical data to the payer. Second, a single episode payment was made at the initial visit. The method for calculating this payment is described below. Third, all drugs were paid using the average sales price rate

as a proxy for the acquisition cost of the drug. All other physician services continued to be reimbursed using the existing fee-for-service contract with the payer. Fourth, the medical groups met annually to review data on cost and quality outcomes.

The program began in October 2009, and it is described in detail in another article.[4] One group dropped out of the program after it was acquired by an academic medical center in June 2011; it was replaced by a new medical group from another city. Nineteen clinical episodes were created for patients with breast, colon, and lung cancer (Table 1). Each medical group selected a single chemotherapy regimen for each adjuvant therapy episode on the basis of their interpretation of the medical literature. Predefined chemotherapy regimens were not selected for episodes treating metastatic disease.

Using the existing fee schedule for each group, UnitedHealthcare calculated the drug margin for each adjuvant regimen, including supportive care medications, by subtracting the average sales price from the contracted rate for the drugs. Average sales price was used as a proxy for acquisition cost in this study. UnitedHealthcare also added a small case management fee that included physician hospital care to each episode. The payer had previously created a registry of more than 65,000 patients with breast, colon, and lung cancer with sufficient clinical and claims data to assign them to the same episode categories. The national average drug margin for each episode in this registry was calculated by subtracting the aggregate average sales price from the aggregate amount paid for chemotherapy drugs and dividing by the total number of patients in each episode. If any episode payments were less than the national average, the larger amount was substituted. A specific treatment regimen was not selected for patients with metastatic cancers, so the registry national average was used as the episode payment amount for episodes 10, 11, 14, 18, and 19 (Table 1). An arbitrary reimbursement was negotiated for the two episode categories that did not use any cancer chemotherapy (episodes 1 and 12). The time period for an adjuvant episode was the time to complete the therapy plus 2 months. A recurring 4-month time period was selected for metastatic episodes.

The medical groups submitted clinical information at the time of initial patient presentation to determine the correct episode. These data included the histology, clinical stage, relevant genetic information, and intent of treatment (curative or palliative). The episode fee was paid immediately. All services were billed to UnitedHealthcare using standard fee-for-service format. Table 2 summarizes the payment methods for the services provided.

The medical groups were free to change their preferred drug regimen at any time; new studies and new drug releases did change the preferred regimens during this study. Patients could also be enrolled onto clinical trials. The new drug substitutes were paid at average sales price, but there were no changes in the episode fee. By contractual agreement, episode fees would be changed only if the groups lowered the total cost of care or improved the survival for the episode.

The oncology groups collaborated with UnitedHealthcare to develop more than 60 measures of quality and cost for these episodes (Table 3). The measures were intended to compare the performance across the groups, to generate hypotheses for quality improvement and cost reduction, and to measure improved outcomes or reductions in the total cost of care.

All analytic work was completed by UnitedHealthcare. The study design used a retrospective observational method that compared the operational and control cohort during the prepilot and pilot time periods. Controls were obtained from the registry.

Table 1. Episode Payment Categories and Duration

Cancer Type	Episode No. and Description	Duration (months)
Breast	1. Stages 0, I; no chemotherapy	6
	2. Stages I, II; HER2 overexpression, ER/PR negative	12
	3. Stages I, II; HER2 overexpression, ER/PR positive	12
	4. Stages I, II; HER2 underexpression, ER/PR negative	6
	5. Stages I, II; HER2 underexpression, ER/PR positive	6
	6. Stage III; HER2 overexpression, ER/PR negative	12
	7. Stage III; HER2 overexpression, ER/PR positive	12
	8. Stage III; HER2 underexpression, ER/PR negative	6
	9. Stage III; HER2 underexpression, ER/PR positive	6
	10. Stage IV; anti-estrogen therapy only	4
	11. Stage IV; treatment with all other medications	4
Colon	12. Stages I, II; no chemotherapy	6
	13. Stages II, III	9
	14. Stage IV	4
Lung	15. Small-cell, any stage	4
	16. Non–small-cell, stages I, II	4
	17. Non–small-cell, stage III	4
	18. Non–small-cell, stage IV, nonsquamous histology	4
	19. Non–small-cell, stage IV, squamous histology	4

Abbreviations: ER, estrogen receptor; HER, human epidermal growth factor receptor; PR, progesterone receptor.

Table 2. Summary of Payment Method Used in Fee-for-Service and the Episode Model for Various Service Types

Service Type	Payment Method	
	Episode Model	Standard Model
Physician office visit	FFS	FFS
Chemotherapy administration	FFS	FFS
Chemotherapy medications	ASP + 0%	ASP + contracted %
Diagnostic radiology	FFS	FFS
Laboratory	FFS	FFS
Physician hospital care	Episode	FFS
Hospice management	Episode	FFS or none
Case management	Episode	None

Abbreviations: ASP, average sales price; FFS, fee-for-service.

Table 3. Quality and Use Measures From the Episode Payment Program

Each clinical episode (19 separate episodes)	Total cost of care
	Emergency room and hospitalization rates
	Parenteral drug costs per episode
Aggregate	Average drug cost per episode
	Admissions for cancer symptoms
	Admissions for treatment-related symptoms
	Time to first progression for relapsed patients
	No. of lines of therapy for relapsed patients
	Hospice days for patients who died
	Days from last chemotherapy to death
	Costs in the last 30 days of life
	Survival from date of condition enrollment (relapsed patients only)
	Cost per admission and length of stay
	Diagnostic radiology use
	Laboratory service use
	Durable medical equipment use
	Surgical services, use and cost
	Febrile neutropenia occurrence rate
	Granulocyte colony-stimulating factor usage rate
	Erythropoietin use

NOTE. All medical groups were identified in the results reporting.

Members of both cohorts had the same accrual period for each prepilot and pilot period. The baseline period for the study began with episodes starting October 2006 through July 2009, and the pilot period included episodes beginning October 2009 through December 2012. The unit of measurement for the pilot was a unique episode.

The primary metric of the pilot was total medical cost per episode of care, which excluded retail pharmacy claims. The estimated sample size to demonstrate a 10% effect was 400 observations. The secondary metric, chemotherapy drug cost (CDC), measured the cost of chemotherapy medications using the average sales price for all observations. The results for both measures were determined using the aggregate of all of the 19 episode categories.

The total medical cost was modeled as a function of the episode payment condition, age, and sex using a linear regression technique. The model included terms that indicated whether the observations were from the episode medical groups or controls and whether the observations were from the prepilot period or the pilot period. An interaction term between treatment group and time period was included and was the key term used to interpret the success of the program. The savings estimate of the pilot program was derived from the log-transformed regression model of total medical cost per episode.

Results

There were 1,024 patients enrolled in the episode program through the end of 2012. Of these, 810 patients were used in the analysis. Patients were ineligible if they had not completed a treatment episode by year end 2012 (n = 210), did not incur any medical cost in the analytic time window (n = 3), or had an incorrect episode assignment (n = 1). Any differences in the patient mix, as well as differences in baseline performance, were accounted for in regression modeling.

The predicted fee-for-service total cost for the episodes cohort was $98,121,388, but the actual total medical cost for this cohort was $64,760,116, representing a net savings of $33,361,272. The predicted CDC was $7,519,504, and the actual CDC was $20,979,417, with a net increase in spending of $13,459,913. In a subset analysis, the control group was limited to 50 medical groups that contributed at least 70 patients to the registry—the minimal number contributed by each episode medical group. There was no difference in the results using this smaller control population.

The study was not powered to determine the expenses that drove the differences in total medical cost. A subset analysis did demonstrate a statistically valid decrease in hospitalization and therapeutic radiology usage for the episode arm.

Most quality outcomes had insufficient numbers for statistical analysis. Kaplan-Meier survival curves were monitored for all patients with metastatic disease. Lung cancer survivors were the only evaluable subgroup, and there was no significant survival difference between the episode and registry patients. Hospitalization rates showed that one medical group was an outlier for all cancer types. The group learned that follow-up appointments to their clinic were scheduled for several weeks after the initial hospital discharge, causing frequent readmissions for the same problem. The group now evaluates patients within 48 hours of discharge, and their hospitalization rates have decreased to peer levels. Overall, multiple quality measures were monitored, and none of them provided an early signal that quality of care was different than controls.

Discussion

This program had two objectives. The primary objective was to decrease the total medical cost by using aligned financial incentives supported by actionable use and quality information. This goal was met, as demonstrated by a 34% reduction of the predicted total medical cost. The secondary objective was to remove the linkage between drug selection and medical oncology income. Without this linkage, it was expected that CDC trends would decrease. Paradoxically, the pilot resulted in 179% more CDC than predicted when compared with the controls. Despite the additional $13 million for chemotherapy drugs, the total medical costs were reduced by $33 million.

The source of the cost savings is enigmatic. The primary end point of the study was detection of a 10% change in the total medical costs for the aggregate group. Subset analyses confirmed statistically valid decreases in hospitalization and usage of therapeutic radiology, but it is not possible to make a statistically valid quantification of the savings. The study used two interventions—financial incentives and data sharing—to change behavior. It is not possible to determine the relative effect of each incentive, but this is an important question to answer in future studies.

The five groups met twice during the study period to review and analyze more than 60 measures of cost, quality, and use.

They had not been exposed to performance data about their practice from any source before joining this project. This measurement may have been the stimulus to improve results. This phenomena, known as the Hawthorne effect, is defined as, "the stimulation to output or accomplishment that results from the mere fact of being under observation."[5] During the meetings, the group leaders discussed potential solutions for variation, and they later shared the data with their practice partners. The regular measures for this payment model may have stimulated different care decisions by the participating physicians.

Larger medical oncology groups like those in this study may have more sophisticated internal resources than smaller groups. For example, larger groups could allow their physicians to focus on specific cancers or they can augment their electronic medical record systems with decision support tools. However, when the comparison group in the registry was restricted to larger medical groups, the results did not change.

Improvement projects by the individual medical groups were not tracked by the study team. Anecdotally, the ability to improve specific performance issues was mixed. The group with high hospitalization rates discussed above is an example of a successful intervention. The use of diagnostic radiology was more problematic. The analyses demonstrated a four-fold variation in the use of diagnostic radiology procedures during the 4-month episode for metastatic disease in all three cancer types. The physician leaders for the medical groups were unable to obtain consensus about defined intervals for radiological evaluation of metastatic disease.

Collaboration was an essential element to the success of the pilot. The data for the project were available to all participants. Variation was explicitly discussed as an opportunity for improvement and not a failure of health care delivery. Problem solving involved the participation of physicians, the medical group business executive, nursing staff, and payer staff. We believe that collaboration was an essential element to obtaining the result.

The increased CDC was not expected. The episode payment program contains several incentives for decreased chemotherapy costs. First, if the selection for a chemotherapy regimen yielded a lower drug margin than the UnitedHealthcare national average for the episode, the group's episode payment was raised to the national average, providing an incentive to select low-cost regimens when appropriate. Second, the oncology practices did not realize any gains by switching to higher priced drugs. Third, the metastatic episode payments continued every 4 months even if the patient was no longer receiving chemotherapy. This policy was intended to compensate the oncologist for the additional work of palliative care. All of these incentives encouraged lower drug expenses.

Can this pilot be generalized? The operational work for this project was substantial. Early identification of the patients was essential to ensure the correct treatment regimen and to explain the unusual claim payments. Claims had to be adjusted by both the payer and the physician's office to conform to the episode payment methods. Claim adjudication was done manually for the same reason. The work load required dedicated time and resources for both payer and medical groups. However, automation of enrollment and claims payment is possible and essential to further generalization.

The episode payment project yielded significant savings for the treatment of patients with cancer without any measurable effect on quality outcomes or toxicity. This study challenges the assumption that any reduction of resources results in worse outcomes for cancer. Further, this approach allowed each medical group to seek the solutions that worked best for their environment. Although the pilot should be replicated to answer the questions about generalization, this study proves the essential concept that the cost of care for future generations can be reduced without sacrificing quality.

Acknowledgment

We thank the following oncology medical group participants: Scott Parker, Northwest Georgia Oncology, Atlanta, GA; Barry Russo, Tammy Chambers, Center for Cancer and Blood Disorders, Fort Worth, TX; Marcus Neubauer, MD, John Hennessy, Kansas University, Kansas City, KS; Charles Bane, MD, Josh Cox, Robert Baird, Dayton Physicians, Dayton, OH; Lee Schwartzberg, MD, Jamie Chandler, West Clinic, Memphis, TN; Leonard Kalman, MD, Maggy Pons, Advanced Medical Specialties, Miami, FL.

Authors' Disclosures of Potential Conflicts of Interest

Although all authors completed the disclosure declaration, the following author(s) and/or an author's immediate family member(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a "U" are those for which no compensation was received; those relationships marked with a "C" were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

Employment or Leadership Position: Lee N. Newcomer, UnitedHealthcare (C); Sheila A. Donelan, UnitedHealthcare (C); Monica Perkins, UnitedHealthcare (C) **Consultant or Advisory Role:** None **Stock Ownership:** Lee N. Newcomer, UnitedHealthcare; Sheila A. Donelan, United Health Group; Monica Perkins, UnitedHealth Group **Honoraria:** None **Research Funding:** None **Expert Testimony:** None **Patents, Royalties, and Licenses:** None **Other Remuneration:** None

Author Contributions

Conception and design: Lee N. Newcomer, Bruce Gould, Ray D. Page, Sheila A. Donelan, Monica Perkins

Collection and assembly of data: All authors

Data analysis and interpretation: Lee N. Newcomer, Sheila A. Donelan, Monica Perkins

Manuscript writing: All authors

Final approval of manuscript: All authors

Corresponding author: Lee N. Newcomer, MD, UnitedHealthcare, 9700 Health Care Lane, Mail Route MN017-W700, Minnetonka, MN 55343; e-mail: Lee_newcomer@uhc.com.

DOI: 10.1200/JOP.2014.001488; published online ahead of print at jop.ascopubs.org on July 8, 2014.

References

1. Young RA, DeVoe JE: Who will have health insurance in the future? An updated projection. Am Fam Med 10:156-162, 2012
2. Jacobson M, Earle CC, Price M, et al: How Medicare's payment cuts for cancer chemotherapy drugs changed patterns of treatment. Health Aff (Millwood) 29:1294-1402, 2010
3. Bach PB, Mirkin J, Luke J: Episode-based payment for cancer care: An opportunity for medicare to cut costs without hurting quality. Health Aff (Millwood) 30:1-10, 2011
4. Newcomer LN: Changing physician incentives for cancer care to reward better patient outcomes instead of use of more costly drugs. Health Aff (Millwood) 31:780-785, 2012
5. Hawthorne effect: http://www.merriam-webster.com/dictionary/hawthorne%effect

COME HOME

Innovative Oncology Business Solutions, Inc.

The COME HOME Program – External Evaluation, Evolving Outcomes

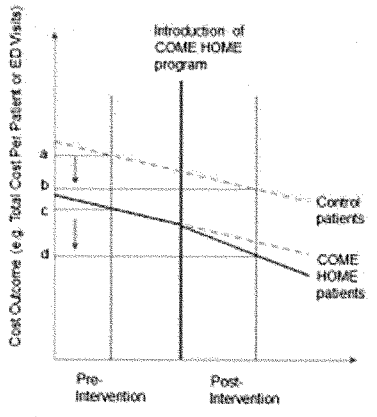
September 2015

Barbara McAneny, MD

www.comehomeprogram.com

Pre-Post Difference-in-Differences Analysis

- Comparing utilization and cost outcomes for patients at COME HOME practices before and after introduction of the new model to those observed for matched patients from non-COME HOME practices
- Normalized to patients' utilization pre-intervention (i.e. pre cancer diagnosis).
- Includes Data for 50% of evaluation period, through December 2014.



DID Impact = (Outcome$_d$ – Outcome$_c$) – (Outcome$_b$ – Outcome$_a$)

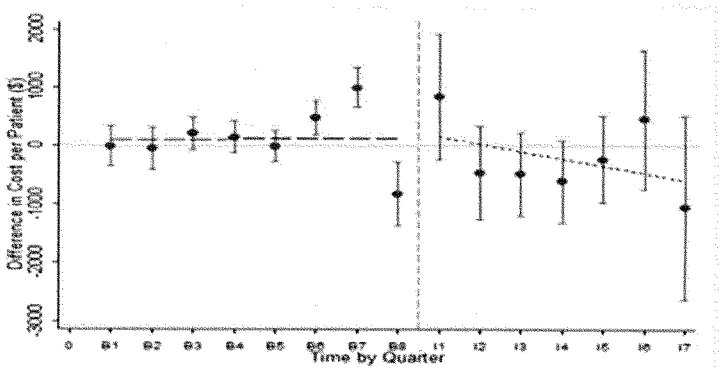
Patient Characteristics

	COME HOME	Controls
Number of Pts	3,488	3,488
Cancer Type		
Breast	42.3%	42.3%
Colorectal	13.2%	13.2%
Lung	25.6%	25.6%
Other	18.9%	18.9%
Cancer Tx		
Surgery	48.4%	49.8%
Radiation	31.9%	32.5%
Chemotherapy	58.1%	58.9%
Severity		
% Metastatic	33.4%	33.9%

*HCC: Heirarchical Condition Categories
** p<0.05
***p<0.01

	COME HOME	Controls
Demographic		
< 65 yrs	9.3%	9.3%
65 – 74 yrs	49.6%	50.0%
75 – 84 yrs	31.3%	31.1%
≥ 85 yrs	10.0%	9.6%
White	90.0%	89.6%
Female	69.1%	69.1%
Dually Eligible**	15.7%	13.7%
Comorbidity and Disability		
HCC* Score (SD)	2.61 (2.29)	2.62 (2.35)
Disability	16.5%	16.6%
Utilization and Cost in Prior Year		
Medicare Cost	17,101	16,644
IP Admits/1000	509	550
ED Visits/1000***	836	674

Difference in Adjusted Total Cost of Care per Patient for COME HOME by Quarter



COME HOME
Innovative Oncology Business Solutions, Inc.

How COME HOME Practices Compare to Controls, pre- and post-intervention

	Pre-Intervention	Post-Intervention	Difference In Differences (95% CI)
Hospitalizations per 1,000 Patients	CH patients have 3 fewer than controls	CH patients have 10 fewer than controls**	-7 (-9, 3)
ED Visits per 1,000 Patients	CH patients have 17 more than controls	CH patients have 11 more than controls**	-6 (-16, 3)
30-day Readmissions per 1,000 Patients Hospitalized	CH patients have 10 more than controls	CH patients have 23 fewer than controls	-33 (-66, -1)**
ACS Hospitalizations per 1,000 Patients	CH patients approximately equal to controls	CH patients have 3 fewer than controls	-3 (-7, 0.4)
Total Cost of Care per Patient	CH patients $167 higher than controls	CH patients $139 lower than controls	-$306 (-938, 227)

***p<0.01; **p<0.05; *p<0.1

Innovative Oncology Business Solutions, Inc.

Conclusions

- COME HOME patients show a statistically significant reduction in 30 day readmissions, compared with matched controls.
- COME HOME patients show trends toward reduction across all other reported utilization measures, including:
  - Hospitalization Rate
  - ED Visit Rate
  - ACS Hospitalization Rate
  - Total Cost of Care

COME HOME
Innovative Oncology Business Solutions, Inc.

Mr. PITTS. Thank you.

Sorry to rush you here. We are going to do one more opening statement. No time left, but 290 people still haven't voted.

So, Ms. Norby, you're recognized for 5 minutes for your opening statement.

STATEMENT OF SANDRA NORBY

Ms. NORBY. Chairman Pitts, Ranking Member Green, and members of the committee, thank you for holding today's hearing highlighting these important legislative issues.

My name is Sandra Norby, and I appreciate the opportunity to discuss my strong support for H.R. 556, the Prevent Interruptions in Physical Therapy Act of 2015.

I would like to especially thank Congressmen Bilirakis and Luján for their sponsorship of this legislation.

I am a physical therapist and a member of the American Physical Therapy Association and its private practice section. My small business consists of five clinics in Iowa in communities with populations ranging from 500 to 9,000.

One of APTA's policy priorities is to improve access to care by physical therapists through the elimination of regulatory, legal, and payment policy barriers that impede patient care. Physical therapy is part of the comprehensive care model; therefore, it is high time that access to PT also receives the same protections against unavoidable absences by the therapy provider.

H.R. 556 would improve access to care by providing needed regulatory relief with a simple technical fix. This bill would allow PTs to enter into locum tenens arrangements with other qualified therapists on a temporary basis in cases such as illness, pregnancy, or jury duty. This arrangement is available to numerous Medicare providers, but physical therapists were overlooked and are not included in the law that permits locum tenens.

This means PTs in private practice are unable to be absent from the clinic, even in an emergency, without interrupting a Medicare patient's episode of care. Such interruption results in potential regression in the patient's condition. When care is resumed, the Medicare patient is likely to require more visits to achieve the original therapy goals, than what would have been realized sooner, had a locum tenens therapist been allowed. Thus, not allowing a locum tenens for PTs has the potential to increase costs to the Medicare program.

It is currently possible to hire a substitute for a planned leave by arranging for a PT to be added to the practice's Medicare certification. However, such an arrangement is not realistic for emergencies or a short-term option. The certification process is complicated and time consuming, taking 2 to 3 months under the best of circumstances, and includes an on-site visit. This cumbersome time requirement is certainly a reason that numerous other Medicare providers are permitted to use locum tenens arrangements. It only makes sense that PTs are afforded the same options.

Practicing in rural communities, as I do, my colleagues and I are often the only physical therapists in town. When we have to be gone from our clinic, our practice must turn away our Medicare patients or take extraordinary measures for them to continue their

care. During a recent maternity leave for one of my therapists, I spent 12 weeks driving from my home 3 hours away, sleeping at the clinic most nights, in order for our Medicare patients to receive their care.

Under locum tenens, a clinic like mine would be allowed to bill and receive payment for the replacement therapist services. Built-in safeguards control fraud and abuse as all locum tenens arrangements must meet regulatory standards that includes identification of services on the Medicare claim form and a 60-day limit to use the provider.

Senator Charles Grassley recently received a letter stating quote: "CMS does not have evidence indicating that locum tenens, as used by physicians under current law, has led to a general increase in utilization of services; or that industry practices generally lead to the provision of unnecessary services related to the use of locum tenens; or that the use of locum tenens under current law in the Medicare program is generally inappropriate, wasteful, or fraudulent" close quote. Preventing the disruption of Medicare patients' therapy, as this bill will do, would likely result in lower costs to the Medicare program.

I truly appreciate the committee's interest in addressing this regulatory burden that impacts access to care. I am hoping that this simple technical correction can be achieved and that Medicare patients will be allowed to continue to access medically necessary PT services without disruption.

I look forward to working with the committee, and I am happy to answer any questions you may have.

[The prepared statement of Ms. Norby follows:]

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

OFFICIAL STATEMENT

Testimony of Sandra Norby, PT, AT
Owner, HomeTown Physical Therapy, LLC

House Energy and Commerce Committee
Subcommittee on Health
on Examining Potential Ways to Improve the Medicare Program

October 1, 2015

Chairman Pitts, Ranking Member Green, and Members of the Committee:

Thank you for holding today's hearing highlighting these important legislative issues. My name is Sandra Norby, and I appreciate the opportunity to discuss my strong support for H.R. 556, the Prevent Interruptions in Physical Therapy Act of 2015. I would like to especially thank Congressman Bilirakis and Congressman Lujan for their sponsorship of this legislation. I'm a physical therapist and a member of the American Physical Therapy Association (APTA) and its Private Practice Section. I own 5 clinics in Northwest and North Central Iowa, located in towns with populations fewer than 10,000 and serving members of the community from children to senior adults. We are part of the rural health network of providers that ensure access to care and keep our communities healthy and economically viable. As physical therapists in these communities we diagnose and manage the health of individuals who have conditions that limit their ability to move or function in their daily lives. We also work with patients to prevent the loss of mobility before it occurs so they can enjoy healthier and more active lifestyles.

One of APTA's policy priorities is to improve access to care by physical therapists through the elimination of regulatory, legal, and payment policy barriers that impede patient care. Recognizing the value of access to care, the locum tenens program has been around since the early days of Medicare. Now that medicine has evolved to fully recognize physical therapy as part of a comprehensive care model, it is high time that access to physical therapy also receive the same protections against delays due to unavoidable absences by their standard provider. H.R. 556, the Prevent Interruptions in Physical Therapy Act of 2015, would improve access to care by providing needed regulatory relief from an impediment caused by a simple technical issue. This fix will keep clinics open to provide our communities with medically necessary services. H.R. 556 would amend section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) by adding a section that would allow physical therapists to enter into locum tenens agreements with other qualified physical therapists. This arrangement, common in medical practice, allows a health care provider to bring in another qualified provider on a temporary basis in cases of vacancy, illness, pregnancy, jury duty, or other temporary lack of adequate staffing in the clinic. This arrangement is available to other Medicare providers, but physical therapists in private practice are not included in the law that permits locum tenens.

The process currently works as follows: the patient's regular physician may submit a claim and, if the assignment is accepted, would receive the Part B payment for covered visit of a locum tenens physician who is not an employee of the regular physician and

whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- the regular physician is unavailable to provide the visit services,
- the Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician,
- the regular physician pays the locum tenens for his services on a per diem or similar fee-for-time basis,
- the substitute physician does not provide the visit services to Medicare patients over a continuous period of more than 60 days, and
- the regular physician identifies the services as substitute physician services by entering the HCPCS modifier Q6 (service furnished by a locum tenens physician) after the procedure code in Item 24d on the CMS-1500 claim form or electronic equivalent.

The regular physician must keep a record of each service provided by the substitute physician on file, with the substitute physician's UPIN/NPI, and it must be available to Medicare upon request.

For many physical therapists in private practice, this means we are unable to be absent from the clinic, even in an emergency, without interrupting a Medicare patient's care. Such an interruption in a Medicare beneficiary's care results in gaps in treatment and potential regression in the patient's condition. When care is resumed, the Medicare patient is likely to require more care to achieve the therapeutic goals than would have been required had a locum tenens therapist been allowed to step in and continue the

treatment plan. Not allowing locum tenens arrangements for PTs has the potential to increase costs to the Medicare program, and delay the patient's full recovery.

It is currently possible to hire a substitute for planned leave by arranging in advance for a Medicare-enrolled physical therapist to be added to the practice's CMS certification. However, such an arrangement is not realistic for emergencies or a short-term option. The process is lengthy, complicated, and time-consuming, taking 2 to 3 months under the best of circumstances and requires an onsite visit, typically duplicating a visit the practice already would have received. Further, the process must be repeated for every provider absence, since Medicare certification lapses after a physical therapist has no associated billing with a practice for a certain period of time. This unwieldy time requirement is certainly a reason the majority of other Medicare providers are permitted to use locum tenens arrangements; it only makes sense that physical therapists are afforded the same option.

This limitation has real-world impact. Practicing in small rural communities, my colleagues and I are often the only physical therapists in the local area. When we are pulled away from the clinic for health reasons, which can range from caring for children or parents to personal health issues, the clinic has to shut down or take extraordinary measures to ensure patients maintain access to care. During a recent maternity leave, of one of my partners, I spent 12 weeks driving from my home, 3 hours away, sleeping at the clinic most nights, in order to help maintain patient loads at that clinic. This not only challenges the clinic operations but also begins to disrupt care. Locum tenens would

allow us to bring in licensed, qualified physical therapists to help meet these short-term needs and provide uninterrupted health care services in our communities.

This is an issue all across the country, but rural areas where I work are disproportionately impacted since there are shortages of other physical therapists in these areas. A locum tenens provider would be able to keep a small practice like mine open to serve rural patients who otherwise would have to travel long distances or forgo care. Locum tenens arrangements ensure that patient care does not lapse and that appointments continue as designated in the Medicare plan of care.

Under locum tenens, a clinic like mine would be allowed to bill and receive payment for the replacement therapist's services. This arrangement saves considerable time compared with hiring a new employee for the practice, especially for absences that are unexpected. Built-in safeguards control fraud and abuse as all locum tenens agreements must meet regulatory standards, including the identification of these services on the Medicare claim form and a 60-day limitation on the use of the provider. A substitute provider would likely be safer than bringing in an enrolled therapist. An enrolled therapist would bill under his or her own supplier number, and thus have access to all patient information. This information could, feasibly, be used for fraudulent payments in the future. A substitute therapist would simply see the patient and provide services without access to any payment information. Furthermore, a recent letter from the Centers for Medicare and Medicaid Services to Senator Charles Grassley highlighted that locum tenens as used by physicians under current law does not lead to an increase in utilization of services or to

unnecessary services, nor is the use of locum tenens generally inappropriate, wasteful, or fraudulent.

A 2015 survey shows how healthcare executives, physicians, and other health care professionals are using locum tenens arrangements at greater frequencies every year. The *2015 survey of Temporary Physician Staffing Trends*[i], issued by Staff Care, suggests that the physician shortage is one major reason there is robust use of locum tenens providers. The top reasons for using locum tenens providers were filling in until a permanent doctor was hired, to fill in for someone that left, or to fill in for doctors that are on vacation or pursuing medical education. With the Bureau of Labor Statistics estimating that the employment of physical therapists projected to grow at 36 percent between 2012 and 2022[ii], it is essential that current physical therapists can not only continue to cover patient load, but also to bring in help to bridge the gap that every clinic faces during the hiring process, just as our physician counterparts are able to do.

Having been involved in APTA's policy committee for several years, I am acutely aware of the scrutiny placed on legislation and its impact on the budget. In my experience, I cannot see how this would cost money; if anything, it should reduce costs in the long run. These are the same patients who would receive the same services regardless of which provider they see, and so utilization should be consistent. Moreover, preventing disruption of a Medicare patient's care should result in lower costs to the Medicare program.

I truly appreciate the committee's interest in addressing this regulatory burden that impacts access to care. I am hopeful this simple technical correction can be achieved, and that Medicare beneficiaries will be allowed to continue to access medically necessary physical therapist services without disruption. I look forward to working with the committee, and I am happy to answer any questions you may have.

---

[i] Staff Care, 2015 Survey of Temporary Physician Staffing Trends. Locum tenens. Staff Care, 2015. http://www.staffcare.com/uploadedFiles/2015-survey-temporary-physician-staffing-trends.pdf. Accessed September 28, 2015.

[ii] Bureau of Labor Statistics. *Occupational Outlook Handbook, 2014-15 Edition.* Physical Therapists. US Department of Labor; 2014. http://www.bls.gov/ooh/healthcare/physical-therapists.htm. Accessed September 28, 2015.

Mr. PITTS. Thank you very much.

I appreciate your patience due to the votes on the floor. We are going to have to take a brief recess. We will reconvene immediately after the votes. There are still 160 people who haven't voted, so we have time.

So, without objection, the subcommittee stands in recess.

[Recess.]

Mr. PITTS. The time for the recess having expired, the subcommittee will come to order. I will begin the questioning and recognize myself for 5 minutes for that purpose. Can I get staff to come over here and operate this clock? One of you. I am sorry, that is OK.

We will start with you, Dr. Gould. One thing this committee focused on during the SGR debate, the sustainable growth rate—you are familiar with that I am sure——

Dr. GOULD. Yes.

Mr. PITTS [continuing]. Was creating a new framework for alternative payment models, and the goal was to encourage specialties to develop their own best practices that could ultimately lead to more coordinated care and better patient outcomes. How do you see H.R. 1934 conforming to this goal?

Dr. GOULD. Well, I see H.R. 1934 fitting like a hand in a glove with that mandate. As medical specialists, we all want to be judged on the quality of our work, and we want to be judged on measures that are relevant to our specialty, and we want to be judged on how satisfied patients are with the care they receive from us.

In addition, we understand in these days that costs are important, and we also want to take responsibility for our part of the rising health care costs. So the alternative payment model, H.R. 1934, meets all those needs in terms of payment reform, in which I applaud Medicare in terms of their moving from paying for the volume of services utilized to the quality of the services rendered to the patient.

Mr. PITTS. Thank you. Ms. Norby, what safeguards and fraud and abuse controls, if any, are built into locum tenens agreements?

Ms. NORBY. As I indicated in my testimony, we have to identify who the provider was on the claim form by reporting their NPI number, and also, there is the 60-day limit that they can be utilized as a locum tenens as well.

As the letter from CMS had indicated, that these were physicians, they have not seen any problems with any kind of fraud or abuse when the locum tenens physician is in, so we assume the same would happen with physical therapists.

Mr. PITTS. Thank you. Ms. Myers, in your testimony you discuss how vulnerable a population the home health beneficiaries are. Can you elaborate on that a little bit?

Ms. MYERS. Absolutely. In a number of cases that we provide services to Medicare homebound beneficiaries, some of them are wheelchair bound, many of them are in very rural areas with very little access to community and/or family support systems. There are certainly a number of patients that we serve that are severely homebound, and without assistance, truly cannot get out of the home, even to simply get to a physician's office for a visit. So there

are many cases where we are dealing with highly functionally impaired individuals.

Mr. PITTS. So it is very important in a rural setting?

Ms. MYERS. Absolutely. Most specifically, we have a lot of patients in Congressman Walden's district who have very little access to care. They may live 60 miles, 100 miles from the nearest hospital, and it is very difficult, not only for clinicians to reach them due to the rural conditions and the areas in which they live, but also, certainly, very difficult for those patients to get out to basic health care so that they may continue to be independent.

Mr. PITTS. Ms. Norby, how long does it take to hire a substitute provider for planned leave by arranging in advance for a Medicare-enrolled physician therapist to be added to the practice's CMS certification?

Ms. NORBY. As I understand, you are asking how long it would take for me to hire someone to replace the therapist? In the case of my story where I covered a maternity leave for a therapist that was leaving, I did reach out to some traveling companies to see if I could hire someone to fulfill that role. They could not guarantee me that I would know who the provider was more than 30 days in advance. And with Medicare's requirement for the certification enrollment, that can take 2 to 3 months or longer. So if I had brought that person in, I would not be able to actually bill for their services for a significant duration of time, which then would put a financial hardship on our clinic because we still have payrolls to pay and those types of things as well.

Mr. PITTS. I have just one more question for you, how does Medicare save money if PTs in private practice are allowed to enter into locum tenens arrangements?

Ms. NORBY. That is a great question. So right now, without locum tenens, if I had to be gone from my clinic, my Medicare patients are not receiving the care they need. And if someone had, for instance, a total knee replacement, any interruption in physical therapy to regain, for instance, their knee range of motion, is going to be very, very detrimental to the progress of their care. And so what would happen is they are going to create joint stiffness, and so then when I come back and they can get physical therapy, they are literally going to have to have more visits to achieve that goal that we set up in the first place, because they were put behind because of the absence.

Mr. PITTS. All right, my time has expired. The Chair recognizes Mr. Schrader for 5 minutes for questions.

Mr. SCHRADER. Thank you very much, Mr. Chairman. A couple of questions for Ms. Myers, if I could. You said that the current home health documentation requirements aren't working as needed. There have been a lot of denials that seem odd or problematic, to put it nicely. Could you give us some real-world examples of some of the ridiculous things you have incurred from CMS in denial?

Ms. MYERS. Absolutely, and I thank you for the question. A lot of the examples that we are seeing on claims and denials and requests for additional documentation from the reviewers include things such as a missing date, a missing signature. One denial, in particular, was due to the fact that the reviewer could not read the

handwriting of the physician, and in particular, could not read the physician's signature itself, which I find to be terribly odd because the record requires us to provide an NPI number to validate that the physician is actively billing Medicare and the system. And so it is a little bit of an oddity.

The other denials that we do see are related to the status of the clinical condition of the patient and the homebound status. Some of the denials we have seen involve the description by the physician and how he or she may describe the patient's condition. For example, one physician described the patient and their need for skilled care as a double leg amputee. To me, that is pretty clear that that patient is not going to be able to get out of bed, into a wheelchair and to do the general things that we take for granted every day. But certainly, that particular instance did require some additional documentation on the part of the physician.

Mr. SCHRADER. Very good. And as a veterinarian whose signature also is very illegible on a regular basis, yes, I think most people should assume that is the case.

CMS has apparently recently released a draft form, a little different new form documenting patient eligibility. I wonder how that compares to what the current form is and if you think that is a step forward?

Ms. MYERS. Well, we have certainly have been working extensively as a stakeholder in that group, and with our national association through that process. And I think that we are seeing some movement forward, but I think that, to the extent that it goes far enough in order to avoid the thousands of denials we are seeing, we don't believe that it currently does. I think there are sections in the proposal for that new form that still require such documentation that could be subjectively denied by a reviewer and determined to be insufficient.

Mr. SCHRADER. Very good, very good. Thank you for your testimony, and thank you for making the trip.

Ms. MYERS. Thank you.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes the gentleman from Texas, Dr. Burgess, for 5 minutes for questioning.

Mr. BURGESS. Thank you, Mr. Chairman. And thank you for the bills that we have got under consideration today. They are certainly worthy of discussion and certainly provide, I hope, some commonsense relief to people who are having difficulty with the agencies in trying to deliver care for their patients.

I am a cosponsor of H.R. 556, which is to prevent interruptions in physical therapy. This does seem like a commonsense approach to allow physical therapists providing outpatient physical therapy services to use specified locum tenens arrangements.

I have a constituent who wrote me, and this was a quote, "I am a contract therapist, and this bill directly affects my business and the therapists for whom I work. One private practice owner asked me 5 months in advance to cover her vacation. Although I am fully credentialed with Medicare, I have to submit paperwork to the Center for Medicare & Medicaid Services for reassignment of benefits to the clinic. By the time of the vacation, the paperwork was still not finalized.

In lieu of denying the patient's care for the week, the business owner opted to have me proceed with providing the care her patients needed. I worked an entire week and she was not able to bill Medicare for the services I provided during that time. A significant loss of revenue for what is, after all, a small business."

So Mrs. Norby, for the record, can you explain why physical therapists weren't included in the first place? And why can't the payer, the agency, Center for Medicare & Medicaid Services, just simply pay the physical therapists through regulation?

Ms. NORBY. That is a great question. The language that included the physicians is over 40 years old. And at that time, there was not a prevalence of physical therapists in private practice, and so that is one of the reasons that they were overlooked, because there was not a need. The landscape today is completely different.

In our State of Iowa alone, we have numerous physical therapists in small communities. In three of my clinics, we have one PT, including the clinic that I am currently practicing out of as well.

We understand CMS has been approached many times by our association and asked can we correct this, and they have said that it requires legislation to correct the technical fix for it.

Mr. BURGESS. So it requires an act of Congress. Well, Mr. Chairman, I am grateful that we are stepping up to that challenge. Not that there aren't other challenges out there, but this is one that needs to be fixed.

The face-to-face issue, man, oh, man, I have got a situation similar to what we just heard from Dr. Schrader, but we all agree it is important to combat fraud, we want to ensure patients are getting the care from the physician that was ordered. But then to deny them the care or delay it because the contractor, not anyone else in the equation, but a contractor, determined that the physician didn't do enough to meet the requirement; of course that burdens the doctor, of course it burdens the person who is the provider of the home health service, and I guess the main thing is it really does hurt the patient.

Now, again, my question is going to be very similar to Dr. Schrader's, but in the answer to his question, you said that sometimes handwriting was hard to read. I am a physician, guilty as charged, but everybody has electronic health records now, so why is handwriting even an issue any longer?

Ms. MYERS. Well, I would argue that most of the documentation is done by hand. There are so many different electronic health record systems out there, they don't speak to each other, at least not as consistently as they could.

Mr. BURGESS. So with all of these billions of dollars we paid for electronic health records, we are now disrupting every private practice across the country with ICD–10 starting today, the system still doesn't work?

Ms. MYERS. And home health agencies, for the most part, do have some form of electronic record, but in rural communities, there is no capital funding for that. So, for example, in some of the areas where we have experienced issues with, for example, Veterans Administration, and a lot of our rural providers who provide care to patients who are serviced through the VA across the border, they are finding that the VA electronic records are not even being

accepted by the contractors and reviewers, and they were previously approved. So there are some problems.

Mr. BURGESS. Let me just share with you, I asked a provider back home, Do you have any thoughts on this? And her quote to me is, "This policy, as implemented, has cost my business almost $1 million. I have no issue with the requirement for a physician to visit in 99 percent of the cases, and there are great and respectable physicians across the country. Not all the time do they have time to hand documents over and over and over again for Medicare contractor employees, who, themselves, have little or no medical expertise to determine whether they have adequately described, according to very loosely fitting terms."

And I suspect this is something that people all over the country are encountering. Mr. Chairman, I hope today we are finally going to get that fixed. I will yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman. The Chair now recognizes the ranking member of the subcommittee, Mr. Green, for 5 minutes for questioning.

Mr. GREEN. Thank you, Mr. Chairman. I want to thank our witnesses for joining us today. I know that home health care services are critically important for Medicare beneficiaries who are confined to their homes. I have a very urban area that it is important for. However, over the last two decades, a variety of the Office of Inspector General reports have found high levels of improper payments in Medicare reimbursement for home health care.

Ms. Myers, can you describe any recent fraud reduction efforts, or any proposals underway at your agency or across the country?

Ms. MYERS. With respect to fraud reduction efforts, I might want to consult one of my national colleagues about that. Certainly with the Oregon Association for Home Care, we work with all of our providers to make sure they are knowledgeable about the laws and regulations, and to make sure that they understand what the guidance is relative to implementing that, those laws. And certainly, the physicians are subject to many antifraud laws, and so it is important—a critical piece of the process.

Mr. GREEN. OK. Dr. Gould, thank you for your testimony. I think your testimony helped confirm something we in the committee have long thought, traditional fee-for-service has not done a great job of incentivizing care coordination. That is why we started moving towards alternative payment models in the Affordable Care Act, and then we built upon the reforms of the ACA in the recently passed Medicare Access and CHIP Reauthorization Act of 2015 for its repeal of the flawed sustainable growth rate formula, and replaced it with incentives that switched alternative payment models that put value and quality care over volume.

Alternative payment models in cancer care have a lot of potential, both to improving care, coordination, and quality and reduced cost. It sounds like you are doing some of the work in cancer care, both through public and private partnerships to test payment reforms. Specifically, you testified you have successfully been able to reduce costs through alternative payment models. Can you talk a little bit about how you were able to achieve these lower costs?

Dr. GOULD. Yes, sir. I fully agree with your remarks. Basically, it comes down to the physicians within a practice making the com-

mitment that they want to transform their practice from the old way of doing things to the new way of doing things, which is not only taking care of the patient medically, but being more thoughtful in terms of the resources utilized to take care of that patient in making sure that whatever we do for that patient is going to have a meaningful impact on their health. And our national societies have put out the Choosing Wisely program, which outlines things that physicians calmly do that do not add value to the care of the patients, and there are certainly many more examples than what is put out by our national societies. So in our practice, for instance, as I mentioned, one of the things that we did was to implement treatment guidelines to make sure that all patients got state-of-the-art care that was appropriate.

Secondly, we talk at length about end-of-life care to make sure that the patient gets the appropriate end-of-life care, sometimes doing less is better than doing more.

Thirdly, we have made a big investment in the infrastructure of our practice by hiring almost a 1-to-1 ratio of physician extenders to physicians so that we have plenty of room in the office schedule to take in patients who need to be seen urgently as opposed to sending them to the emergency room.

A lot of times when patients get to the emergency room, they are seen by an ER doctor who doesn't have the level of comfort that we do in terms of treating these patients as an outpatient, and then these patients automatically get admitted.

And then, finally, in the development of our treatment guidelines, we always put the interests of the patient first in terms of what is the most effective treatment and the least toxic, and we do not take economics into the equation. So, all of those practice processes have made us a leader in the oncology medical home. And then, I have been a leader, personally, in terms of helping educate and in disseminating this model across the country.

Mr. GREEN. Well, obviously, I appreciate it and I know it is difficult for physicians to go between paper and electronic medical records, but also, with a lot of the things that are changing in the practice of medicine, and it affects Members of Congress, too. My staff finally told me I can't get a new—my old BlackBerry back because they don't have screens anymore, so I have to go to a new model. You know, change is tough for folks, how they do it. But again, electronic medical records and the coordination, and they need to talk to each other from practices. And it sounds like what you all have done has been able to do that, because I have a very urban district, but I have a group of physicians in the area that all go to one hospital, and they were able to do that and with their practices, and so, they could share, because they share their patients all the time with each other.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. Mr. Bucshon, you don't want to question?

The Chair recognizes the vice chair, Mr. Guthrie, for 5 minutes of questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you for yielding.

Dr. Gould, my first question is, we are talking about the payment model established in the bill. How large is your practice? And

I guess my question is, do you think this payment model would work for different-size practices and would hospitals be able to participate in the demonstration project created by the bill?

Dr. GOULD. Yes, sir. So, my practice has 21 physicians, and we have a pretty sophisticated management team. But at the end of the day, as I mentioned in my earlier remarks, it really takes the commitment of the physicians to want to change and do a better job in controlling costs.

We all recognize that healthcare costs are spiraling out of control, and for us to get a handle on things is going to require that each stakeholder that has a hand in rising healthcare costs take responsibility. And the oncology medical home is the attempt by the community oncologists to control those things that they can, such as hospital utilization, making sure drug therapy is being used appropriately, doing a better job at the end of life where a lot of times treatments are not impactful in terms of the patient's quality and quantity of life.

So obviously, it is going to be a little easier for larger practices to make the transformation, but there are a lot of well-run, smaller practices that should be able to make the transition as well.

Mr. GUTHRIE. I believe you understand, or know, that CMS is in the process of developing an oncology care payment model. How does the model established in this bill, H.R. 1934, different to what CMS is trying to accomplish, and why is the bill better?

Dr. GOULD. So it is not like one is better than the other. First of all, both programs have, as their heart and soul, the oncology medical home. I, personally, along with a lot of my community oncology colleagues, gave input to the Brookings Institute which helped craft the oncology care model. But the big difference between the two programs, and I can say we applied for the oncology care model, by the way, is the number of physicians that the programs touch. In the oncology care model, it is only open to 100 practices, whereas the H.R. 1934, that opens this new payment, alternative payment model, to up to 1,500 physicians. So, the impact of H.R. 1934 potentially is going to be much larger than the OCM.

Mr. GUTHRIE. We always appreciate when groups come forward, and this is an opportunity for us to help you save money within our field, because if it is bottom up, or driven up and brought to us and people are invested in it, and so they really make it work. So, I guess the question is, we all focus on saving money in the spiraling health care costs. But how does this benefit—how would the medical home benefit patients specifically?

Dr. GOULD. Sure. Great, great point. Obviously, in my work as the chairman of the co-oncology medical steering committee, the first group that we interviewed to get their perspective on what is quality and value in terms of cancer care was the patients and the patients' advocacy groups. We interviewed a slew of patients and patient advocacy groups, and basically, kind of consolidated their needs, so to speak. And then, along with other providers we helped develop processes to make sure that those patient stakeholder needs are met. And as part of H.R. 1934, the oncology practices are not only required to report on quality measures that are driven by medical good care, but as part of that program, there is a patient satisfaction survey.

Mr. GUTHRIE. I just have about a minute, and I want to ask one more question. I appreciate your—I think we got what we needed.

Dr. GOULD. So anyway, there is a patient satisfaction survey built into——

Mr. GUTHRIE. So Ms. Norby, in the piece of legislation that you are here to testify, if it is passed, how would this legislation affect your business and businesses of other small PT clinic owners.

Ms. NORBY. It is critical for the continued longevity of our businesses, and really, critical for the Medicare patients in those communities. As I said, three of our five clinics have only one physical therapist in that clinic. When I go back to the maternity leave that I personally covered for—our only options were to either hire a substitute to come in, or to close the clinic for that length of time. Closing the clinic was not an option. We had a commitment to the community to bring our practice there and to treat the patients and provide them access to care that was local and convenient for them. So that was our first and foremost.

To hire a substitute, as I indicated, we would have to enroll them in Medicare provider, and that can take up to 3 months, which then we can't bill Medicare. Now, granted, we have had to do that when we hire new therapists, and we always bank locally in the communities that we do, and they have been very gracious to offer me a short-term line of credit to cover salaries and pay rent while we are waiting for Medicare enrollment, but this is a clinic in a town of 500, small margins, that was not an option either.

Mr. GUTHRIE. Thanks, my time has expired. I appreciate the answer. My time has expired. I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the gentleman from New Mexico, Mr. Luján, for 5 minutes for questions.

Mr. LUJÁN. Thank you, Mr. Chairman. Mr. Chairman, in June, the Congressional Budget Office provided a score to the Senate companion of the Prevent Interruptions to Physical Therapy Act as amended by the Senate Finance Committee. In determining the cost for the bill, CBO raised questions about increased utilization and suggested that locum tenens would result in a cottage industry. Fortunately, Senators Grassley and Casey, who are the lead sponsors of the Senate bill, wrote a letter to the Centers for Medicare & Medicaid Services asking if there was data to support CBO's assumptions.

CBO responded, "CMS does not have evidence indicating that locum tenens, as used by physicians under current law, has led to a general increase in utilization of services, or that the industry practices generally lead to provision of unnecessary services relating to the use of locum tenens, or that the use of locum tenens under current law in the Medicare program is generally inappropriate, wasteful or fraudulent." I would like to ask unanimous consent to enter into the record the letter from Senators Grassley and Casey to the Secretary of Health and Human Services and the response from HHS to both Senators Grassley and Casey.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. LUJÁN. Thank you very much, Mr. Chairman.

Ms. Norby, you know, I had the honor, I guess you could call it, of getting to see firsthand the work of physical therapists and the benefit of therapy. In the early 1990s, I was sadly the victim in a head-on car accident with a drunk driver, and it was physical therapists who once the docs on the other side gave me the release that really put me back together, if you will, from being able to move, and being able to just walk around. So I just want to say thank you to you and to everyone we had the honor of working with.

As you know, the locum tenens agreement is a longstanding and widespread practice for physicians to retain substitute positions in the professional practices when they are absent due to illness, pregnancy, maternity or paternity leave, jury duty, vacation or working to continue their medical education. This makes it acceptable for the regular physician to bill and receive payment for the substitute physician services as if they performed themselves. Physical therapist practices are similar to physician practices and like physicians, there are times when a physical therapist practice owner must be away for a short period of time. Under current law, physicians, osteopaths, dental surgeons, podiatrists, optometrists, and chiropractors can navigate these circumstances easily by entering into a locum tenens agreement with a qualified substitute provider.

What options do physical therapy private practitioners currently have when they need a physical therapist to fill in? And I think you went over this quite substantially. You have already addressed the timeframe that it takes. Do you feel there is an opportunity for fraud and abuse if physical therapists in private practice are included as providers at locum tenens?

Ms. NORBY. No, I don't feel that there is a potential for fraud and abuse. The locum tenens physical therapist would be seeing the patient that I would have been seeing if I was in the clinic. And we would be reporting their services on the claim form by utilizing their NPI number reporting who provided that care. I feel very strongly that they don't have the access to their Medicare provider enrollment number to take after they leave, they are just being paid for services that they are providing at that time.

Mr. LUJÁN. I appreciate that. You addressed the other questions that I had which are, what are the potential setbacks to patients and clients? I can attest that if there was an interruption of me being able to go to the therapist at that time, I can't imagine what would have occurred. So when we are talking about our parents, our grandparents, loved ones, constituents, it is important that they have the continuity of care. So thank you for being here today.

Dr. Gould, I want to thank you for sharing a little bit of the unfortunate loss of your parents to cancer. I sadly lost my father to cancer a few years ago, but what you are testifying to today is very important, the legislation that both Congressman McMorris Rodgers and Congressman Israel have put forth is something that I am definitely very interested in. And I appreciate what you said when asked the question about the two programs: One is not necessarily better than the other, they both have different trajectories, different projects, different approaches, to making sure that we can provide the best care.

Is there, in your mind, a professional opinion, sir, that maybe both programs could operate parallel to one another because of the focuses that they would both bring?

Dr. GOULD. Yes. I mean, I think they are designed to do exactly that. A lot of practices did not apply for the OCM because they just felt that the application was a bit onerous and opted not to apply, and if every practice in the country applied to OCM, it is only limited to 100 practices. So there has got to be another pathway, so to speak, that runs parallel to the OCM, and that is what H.R. 1934 is designed to fulfill.

Mr. LUJÁN. I appreciate that, sir. And Mr. Chairman, I know my time has expired, but Ms. Myers, for traveling all the way from Oregon, thank you so much for taking the time. New Mexico, like Oregon, is a very rural State. It takes 8 ½ hours to drive across my congressional district. And so it is not just a matter of the testimony that you are bringing today of the information being on paper, it is the sheer geography with physicians driving 2 and 3 hours to get into some of these communities. So thank you very much for what you are doing. I appreciate the work of Mr. Walden in this area, and I look forward to working with him and yourself, Mr. Chairman, and our members on this issue. Thank you very much for the time, sir

Mr. PITTS. The Chair thanks the gentleman and agrees with his last statement. Thank you very much for coming.

The Chair now recognizes Mr. Bilirakis from Florida 5 minutes for questioning.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman.

Ms. Norby, in your testimony, you very briefly talked about the challenge your practice faced when one of the therapists was away. So, again, it is the geography, but also, the small practice that has difficulties. Can you elaborate more on what happened with your business? What problems this created? And how badly this inconvenienced both patients and physical therapists, please? Thank you.

Ms. NORBY. Yes, I sure will. Thank you for the question. So, like I had indicated, we have made our mission to provide physical therapy care in communities that don't have access to care. And so when a therapist has to be gone for any type of reason, the Medicare patients within that community have been afforded to have local convenient care, and they are happy about that—physical therapists, we develop our relationship with our patients. They don't necessarily want to see anybody else.

In the particular instance that I had, the next closest physical therapy clinic was 45 miles away, and it was winter. And so the Medicare patients, they were not going to drive to those clinics to be able to receive their care. So it was imperative and our commitment was to provide that. So that is why I went in and covered that maternity leave.

When we set up a clinic, I have the flexibility at that time to be a substitute provider, and so I was an enrolled Medicare provider for that clinic. That situation has changed now, and I am currently practicing full-time in one of our clinics as the solo PT.

So in the future, if this happens again, which it will, they will have more children, we do not have the opportunity for me to actu-

ally be the one to physically go there. So this is extremely important for the communities that we serve, and for our small business as well. As I had indicated, because we have to wait, we have to hold claims before we get the Medicare provider enrollment, that puts a significant hardship on our small business financially. And we have had local bankers that have been very generous to literally offer us a short-term line of credit to be able to continue to pay salaries, and pay rent and that type of thing. That is not an ideal situation, so locum tenens is crucial.

Mr. BILIRAKIS. Thank you so much. Ms. Norby, will giving physical therapists the ability to use locum tenens arrangements increase waste, fraud and abuse in the system or cause excess utilization of services? Is there any evidence that locum tenens arrangements leads to these problems? I know that Ben and others have touched on this, but I want to give you the opportunity, and I have something to submit for the record as well.

Ms. NORBY. OK, awesome. No, the therapist would see my patients in my absence, and so that would be indicated on the Medicare claim form by their NPI number, so the visits that would have been scheduled for the patients to see me are now just rescheduled to see the substitute therapist.

Mr. BILIRAKIS. Thank you. Mr. Chairman, I ask unanimous consent to submit this letter from CMS which states that CMS doesn't have evidence locum tenens leading to increased utilization, or that locum tenens leads to fraud.

Mr. PITTS. Without objection so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BILIRAKIS. Thank you. If a physical therapist is out for an extended period of time, their patients may have to cancel or reschedule or may forget to reschedule future appointments. Can you talk about how important it is for seniors to maintain their physical therapy regimen?

Ms. NORBY. It is very important. Physical therapists, we are movement specialists, and we help people be able to stay functional in their homes, and to stay longer in their homes as well. And so when a patient, a Medicare patient accesses physical therapy, they have a problem with their movement. And when we determine our plan of care and start to treat that patient, we are progressing them through to be able to get their goals to move better, or to regain function.

Postsurgical care is very, very critical to be able to have consistent physical therapy. Otherwise, stiffness of the joint can occur that then becomes very painful to try to regain that motion, and it does take longer for them to do that. I know two patients, in particular, that they had to interrupt their care because one had a gall bladder attack in surgery, the other their spouse died unexpectedly. And they came back after those incidences with very stiff joints, and it literally doubled the amount of visits that they needed to have to get to their original goal, because they were without care for a period of time. And so if I had to be absent and I couldn't have a substitute come in, that would be bad as well.

Mr. BILIRAKIS. Thank you. I guess I have 3 seconds. Can I ask one more question, Mr. Chairman—actually, I am over.

Mr. PITTS. You may proceed. Go ahead.

Mr. BILIRAKIS. One more? Thank you.

Can you describe how locum tenens works, and why a physical therapist can't just pick up a substitute for a physical therapist during staffing shortages? Does private insurance also allow for locum tenens? I just want you to have an opportunity to elaborate.

Ms. NORBY. No. A great question. Private payers do offer locum tenens, all of our commercial payers in Iowa do, and across the country. But in order, in a private practice setting, to be able to see a Medicare patient, as a physical therapist, I have to be provider-enrolled under that tax I.D. Number and that location. So I cannot just have another substitute come in and see my patients legally, because I cannot locum tenens without them going through that process.

Mr. BILIRAKIS. I thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questioning.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I want to apologize to the panel for missing your testimony, but I did have an important question to ask. But first, I just wanted to say, Ms. Norby, I am a happy user of physical therapy. I have very weird feet that I would like to keep working for another couple of decades, who knows, and so I am, right now, taking physical therapy and can see its results. So I just wanted to tell you that.

So I wanted to talk about the staggering cost of prescription drug prices in this country and the burden this places on patients and families. Sadly, I am well aware of that. My precious daughter-in-law passed away from cancer, but it put a tremendous strain on the family financially, in terms of having a 5-year-old and a 3-year-old also left to my son.

So it is an issue that I think we really have to be discussing more, and I know a majority of Americans agree. In fact, 73 percent of the public think that the cost of prescription drugs is unreasonable. Cancer treatments, in particular, are increasingly bankrupting patients. The average cost of new cancer drugs and other specialty drugs continue to increase each year at an unsustainable rate. We saw this dramatic example of the $13.50 pill that the hope of the owner of the company was to raise it to $750 a pill. But even less dramatic, a recent study from the American Economic Association's Journal of Economic Perspectives showed that cancer drug prices increased 10 percent every year from 1995 to 2013. And Mr. Chairman, I would like unanimous consent to place that study in the record.

Mr. PITTS. Without objection, so ordered.[1]

Ms. SCHAKOWSKY. So while the average American family makes about $52,000 a year, there are cancer drugs on the market that cost more than $100,000 per year. Even those fortunate enough to have insurance can face out-of-pocket expenses that add up to more than half of the family's income.

---

[1] The information has been retained in committee files and also is available at *http://docs.house.gov/meetings/IF/IF14/20151001/104006/HHRG-114-IF14-20151001-SD006.pdf.*

I think we can all agree that drugs only work if patients can actually afford to take them. And I worry that if we don't act soon, these skyrocketing prices will leave the majority of Americans literally priced out of a cure.

So, Dr. Gould, I am sure you have seen firsthand how difficult it can be for a patient to pay for their treatment. I am wondering if you have any experiences as to how the rising drug costs have affected the patients that you are treating?

Dr. GOULD. What you are describing is a new concept in medical oncology that we hadn't talked about until a few years ago, and that is called the financial toxicities of our therapies, and not just the medical toxicities. Clearly, that is a concern to us at the Community Oncology Alliance, and we meet regularly with the pharmaceutical companies, and we make the points that you just made loud and clear.

Unfortunately, at this point, we have got limited ability to influence how the manufacturers price.

Ms. SCHAKOWSKY. Let me ask you this: I am wondering if you can discuss how the alternative payment methods, such as the Center for Medicare Medicaid Innovation, Oncology Care model, might address this issue?

Dr. GOULD. Yes, that is exactly where I was going.

Ms. SCHAKOWSKY. Thank you.

Dr. GOULD. So as I was saying, to contrast, we don't have a lot of control over how the manufacturers price their drugs, but what we do have control over is, one, how we utilize those drugs and making sure that those drugs are being utilized with the right patients at the right time for the right disease.

Secondly, we do control a large part of the healthcare dollars such as hospital utilization, emergency room utilization, and radiation therapies and radiology therapies. As community oncologists, we are imploring our colleagues to take more ownership of the health dollars that we do control, and the alternative payment models, such as the oncology care model and H.R. 1934, really not only give extra incentives to the practices to do a better job in controlling those dollars, because if they do a good job controlling the dollars, then there is a financial reward associated with that better utilization of the healthcare dollar, only if the quality of care is maintained.

Ms. SCHAKOWSKY. Thank you so much. I just wanted to point out the oncology care model was part of, and CMMI, part of the Affordable Care Act that I think can help us all deliver better care, and do it at a better price. So thank you and I yield back.

Mr. PITTS. The Chair thanks the gentlelady. I now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. I am very happy that we are having this hearing today on ways to improve our Medicare program. In a couple of the bills that are up for discussion are very important, including H.R. 556, the Prevent Interruptions in Physical Therapy Act, which was introduced by my good friend, Mr. Bilirakis, and I am a proud cosponsor of that bill. That bill came to my attention because of the significant number of physical therapists in my district, western New York, very rural, who reached out to my office, and pretty much articulated the same

problem we have heard discussed already, finding someone else to take care of their patients if the PT needs to go out of town for any variety of reasons.

Mark Howard, the owner and chief therapist of a very small private PT practice in Depew, New York, western New York again, recently wrote to me, and he said when he goes out of town, either to attend a seminar or perhaps getting the continuing education units that he would need to stay compliant with our State regulations, his wife, who is also a PT, takes over for him. So in that case, he doesn't have a problem. But he said there are times he and his wife travel together, and at that point, there is a problem. That is when they have to find a replacement therapist, assign their payments, which can take several weeks, and a lot of advanced planning, as you very well already discussed. If they didn't do this, the elderly patient care would be interrupted, obviously, as you again explain, setting back their treatment schedules.

So I really think, Ms. Norby, you handle that very well, and Mr. Bilirakis covered that in a lot of detail which we, I suppose, could go back over, but I think that has been discussed. So I would like to maybe switch, and even though today, while we are primarily talking about patient payment plans, Dr. Gould, I would like to also talk about patient access, because they are kind of related. But in particular, in reading through your testimony, I noticed you reference that there is a large number of community oncology practices that have closed or have been forced or have chosen to merge with various hospitals. And certainly my concern in this regard is on the access piece.

I just wondered if you could discuss any of the reasons, perhaps unintended or otherwise, but some of the reasons that have caused so many, especially oncology practices, to merge under hospitals?

Dr. GOULD. Yes, sir. I would say that there are two forces in play here, we have what I like to call a push, then we have the pull. The push forces I would characterize as four major forces. We have increase in cost of doing business. Our costs go up just like everybody else, including for health care.

Secondly, we have had declining reimbursement, particularly from Medicare. And I mentioned one example, which was the sequestration cut.

Thirdly, we have the increased cost of doing business, particularly with the increasing regulatory environment. And then fourthly, we have the uncertainty of future Government programs and how that is going to impact Medicare reimbursement and so forth.

So on the other hand is the other force that I call the pull, which is that many hospitals have access to the 340B program, and for those hospitals to be able to access that program, they have to have contracted physicians, either directly employed or contracted through what we call a physician service agreement, or a PSA. And so, you know, with the increasing challenges in trying to run a practice, a lot of physicians are saying heck with it, I don't want to be bothered with all of this, I just want to be able to take care of my patients. And so the hospitals are singing a siren song, and these physicians are going to work for the hospitals and not worrying about the management of a practice.

Mr. COLLINS. So let me interrupt there, because I heard this before. Is it safe to say a private oncology practice would not have 340B pricing?

Dr. GOULD. That is correct, sir.

Mr. COLLINS. So in this case, if I have this right, a 340B hospital, and we are talking about very expensive oncology drugs, I mean, these could be $100,000-type drugs. So in the 340B setting, there is a private oncology practice, they treat a patient, there is a $100,000 pharmaceutical, they are covered by Blue Cross/Blue Shield, it is prescribed, Blue Cross/Blue Shield pays it and we move on. But now, if the same practice merges under a hospital, the same drug is given, the same reimbursement is made by Blue Cross/Blue Shield, to give an example, but then that hospital turns around and gets a discount from the drug company and get that drug for $20,000.

Dr. GOULD. That is correct, I mean——

Mr. COLLINS. In which case that $80,000 goes to the bottom line of the hospital, which actually, in a profit-motivating world, would allow them to pay a lot of money for private oncology practice. The primary financial driver of that is nothing more than telling the pharmaceutical companies they are going to take it on the chin, have to pass this discount on because it a 340B situation, but nothing else has changed. I know my time has expired, but is my understanding of that fairly accurate?

Dr. GOULD. Yes, sir. And what happens is, those hospital practices now have more monies to compete for employees and doctors than what I have in private practice, and so, I go out of business and have to partner with hospitals as well.

Mr. COLLINS. I know my time has expired, but that goes back to picking winners and losers, and we are not supposed to be doing that. With that, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman. I now recognize Mrs. Brooks from Indiana for 5 minutes of questions.

Mrs. BROOKS. Thank you, Mr. Chairman. I want to commend the chairman on continuing to tackle this complex and important issue by bringing up these bipartisan bills today and ensure that we keep moving forward to ensure that seniors get the access to the care that they need. And I think the bills before us today will strengthen existing programs and build upon the momentum that we started in the field with SGR reform.

I am particularly happy and want to focus on Mr. Walden's bill before us today addressing the issue with CMS's current face-to-face rule. I have long said that these rules initially put forward by CMS are imposing crushing burdens on home health agencies rules and impair their ability to provide seniors the home health services that they deserve.

Complicated, confusing, inconsistently enforced, the current face-to-face regulations have exceeded the intent of the law, and I believe has hindered the work of caregivers at home health agencies. And it is having three real-world implications for three home healthcare agencies operating within my district.

The survey actually found that 52 percent of face-to-face claim denials resulted mainly from Medicare's determination that physician's documentation was insufficient, even though medically nec-

essary care was provided. I believe this is creating an access-to-care crisis, particularly in rural parts, not only in my district, but across the country. And it is preventing providers from delivering vital services to those most in need. Speaking of, home health patients are more likely to be women, more likely to be older, more likely to be sicker, poorer, and minorities. And I think Mr. Walden's bill makes commonsense reforms to bring the CMS rule into the scope of the intent of the law.

So I would like to just ask you, Ms. Myers, a few questions. Can you give us any real-world examples of issues about the current documentation requirements that aren't working as intended?

Ms. MYERS. Absolutely. Thank you for that question. We have spoken a little bit about some of the examples of claim denials. In one additional example that I have, an orthopedic surgeon was treating an 82-year-old patient and referred them to home health care following a total knee arthroplasty, which had to do with the knee itself. Certainly this woman was wheelchair bound.

It took five attempts from the home health agency in working with the physician's office to get confirmation and documentation back from the physician. So that is one example where the physicians are extremely fed up with the documentation requirements and the difficulty.

We have talked also about the fact that there are other issues related to things like signatures, dates, missing documentation, or descriptions of documentation that have fallen under that insufficient and subjective mode from the reviewers.

Mrs. BROOKS. Can you tell me whether or not the impact of these denials, or the problems with the documentation, how is it affecting the small and the rural agencies?

Ms. MYERS. Well, certainly, we have a number of small and rural agencies on the east side of Oregon, which comprises most of Congressman Walden's district. In those cases, there are certainly less staff, less ability to be competitive, to hire good clinical nurses and physical therapists to provide the care for the patients that is needed at home. So it has both an impact on the agency in terms of attempting to spend less time on paperwork, and chasing documentation, and more time in patient care.

Mrs. BROOKS. Do you have to, what I suspect, the agencies have to often hire extra administrative staff to take care of all of the documentation? Is that what you are seeing? Or is it actually the providers that are trying to do what is administrative work?

Ms. MYERS. It is a little of both. In the case of smaller and rural agencies, they have less of an ability to hire additional staff. I have one particular example of a provider in Wheeler County, and the agency is the only provider in that county, and faced closure this year. She is a nurse, she provides care in the community, she is traveling 60 miles to treat farmers, ranchers all over the county. And her inability to manage both patient care and handle denials and paperwork related to all of this documentation are really making that agency struggle significantly.

Mrs. BROOKS. Do you have any idea roughly how many patients she cares for?

Ms. MYERS. I think it is between 5 and 10 in the entire county.

Mrs. BROOKS. Can you talk to me a little bit more about the issues between how is the face-to-face requirement straining the relationship between the physicians and the home health providers? What is happening with that?

Ms. MYERS. It has created a relationship of almost antagonism, and it is as if the home health agency is the antagonizer, but certainly, we are just the bearer of the regulation and the rule and the requirement. So it is straining that relationship in ways that it normally wouldn't be.

Mrs. BROOKS. Thank you. My time is up.

Mr. PITTS. The Chair thanks the gentlelady, and now recognizes the gentleman from Oregon, Mr. Walden, for 5 minutes of questioning.

Mr. WALDEN. I thank the Chair for this hearing, and our witnesses for their testimony. I am going to follow up on what Ms. Myers said, Ms. Brooks, because when she talks about four or five patients being served in Wheeler County, there are only about 1,700 people in the entire county. And if you drove from Fossil, Oregon, the county seat to the nearest hospital, it would be 142 miles each way. These are enormous areas, and my colleague from New Mexico, Mr. Luján, talked about the size of his district and everybody kind of gasped. His is 47,271 square miles. Mine is 69,341.

So when we are talking about providing basic services in these remote areas, this is life and death, literally life and death. That is why this matters so much that when some contractors, some bureaucrats, some rule writer comes up with one of these things back here in Washington, they don't have a clue what they are doing in real life out on the ground, and that needs to change, and it needs to change now.

Let me go to Ms. Myers. The original requirements for a physician face-to-face encounter were intended as a program integrity measure to protect waste, fraud and abuse. Do you think this bill that we have before us eliminates or dilutes that protection against fraud and abuse?

Ms. MYERS. Absolutely not. The requirement for the face-to-face encounter with the patient is still fully maintained with the proposed bill. And it further is required, and a condition for payment under the Medicare home health benefit. The physicians still must certify the patient's eligibility for coverage, and the bill provides for a cleaner, more standardized process by which we would be able to operate and be able to focus more on patient care rather than chasing paperwork.

Mr. WALDEN. I had a very positive discussion with Mr. Luján during the break, when we went to vote on the House floor and come back, and he and I intend to work closely on this legislation.

Mr. Griffith and I had a very good conversation. I imagine he won't talk about this, I won't steal his thunder, but I will give him full credit that is, perhaps, within the context of this legislation, we should allow face-to-face to qualify over electronic devices.

Again, if I could take my phone into the home and have the doctor on the other side, which we all know can be done today, why should we have to transport a patient 142 miles over icy, foggy roads for a face-to-face so they can go back home?

Ms. MYERS. Absolutely, and in the case of my father, right before he passed away, I was attempting to get home care for him, but he couldn't stand up, literally, or make it to the car and have my mother help him to get into the car to make it into a physician's office. So it is very challenging, and that may present an opportunity.

Mr. WALDEN. We went through the same sort of event with my mother-in-law, who had severe rheumatoid arthritis, who was in very bad shape, and they would have to transport her by ambulance or the equivalent, and they'd have to do the blood pressure test before she left, which drove excruciating pain throughout her body, and then as soon as she got to the hospital or whatever, they had to do it again.

I mean, there are so many stupid things in delivery of care right now, driven by either litigation or regulation that we need to get past so we put the patients first.

I ask unanimous consent, Mr. Chairman, to enter into the record a statement written by Jeffrey Weil, who is Division Vice President for Operations in the northwest for LHC Group. Jeff is responsible for the operations of Three Rivers Home Care in Grants Pass, in Medford, Oregon.

He says that, just for 2014 and 2015, his company has had more than 393 claims denied for inadequate face-to-face documentation. Each and every one of these claims had documentation signed by a physician. However, in most cases, the Medicare administrative contractors denied the claims because they deemed the physician's narrative to be inadequate. Many of these denials were reversed, but they currently have more than $1.5 million of denied face-to-face encountered claims tied up in appeals at various stages.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. WALDEN. Oh, thank you, Mr. Chairman.

Ms. Myers, can you describe in more detail the impact that claim denials and the subsequent appeals associated with the home health face-to-face requirement has on patient care and home health agency operations, particularly in these small and rural areas?

Ms. MYERS. Absolutely, and as Jeffrey Weil indicated, you know, many of the agencies across the State are experiencing very similar situations with thousands of dollars pending.

Certainly, the impact to patients occurs where the physicians these days are getting, you know, arguably, very fed up with the documentation requirements and that they simply have said to some of our providers, "Forget it." The documentation is too much. It takes too much time and too much time away from patient care. And unfortunately, in some cases where the physician is struggling with this documentation to make a referral for home health care, they are just simply saying no. So the patient gets caught in the middle.

And, as I have said previously, the denials are, you know, plentiful on a lot of technicalities and semantic issues, and, certainly, that needs to be fixed, and we think that this bill would help tremendously to do that.

Mr. WALDEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. I didn't realize I was next, but I am very happy.

Thank you to our panel for being here and for this particular subcommittee hearing. It is so important. I would like to associate myself with the gentleman from Oregon and his comments about the importance of us moving forward with good legislation so that we can take care of these patients in the way they need to be taken care of and stop having to jump through the hoops and put these patients and their families through this.

I do want to ask a couple of questions. As far as, you know, the beneficiaries of Medicare—I mean, I know you have probably answered this a million times, but isn't that the effect—and it is really a "yes" or "no" answer for all three of you. The impact will be tremendous if we can change the legislation and move forward with much more—giving our physicians, our physical therapists much more control over this situation and payment and reimbursement. I mean, this will move mountains, do you agree?

OK. You are all indicating "yes." I agree with that as well. It is definitely something we have needed.

And physical therapists in our rural communities, especially, are just vital, absolutely vital. Whether we are talking about physicians or whether we are talking about physical therapists in a home health setting, it is incredibly important to be able to allow the individuals to stay in their homes. We know that that has an impact on their health care.

As far as locum tenens, how would this affect reimbursement or payment for locum tenens when—I know you were discussing how you would have had to have closed if you didn't have someone that could take that space and keep your operation going. What would you like to say about that, Ms. Norby?

Ms. NORBY. That is a great question. So, it affects payment because I would be able to bring in, under locum tenens, a licensed, qualified physical therapist to continue the care with my patients, and then we would submit the claims under my Medicare provider enrollment number to Medicare, so——

Mrs. ELLMERS. And it would all, basically, go under your Medicare number——

Ms. NORBY. Right.

Mrs. ELLMERS [continuing]. But that person would be fully qualified, able to do it, all checked out ahead of time——

Ms. NORBY. Yes.

Mrs. ELLMERS [continuing]. And would just fit into that space.

So that is a very convenient and sensible way of dealing with that issue and is definitely something that I think is so important. Because, seriously, what are you doing? I mean, you really have no alternative right now the way the system is set up.

Ms. NORBY. That is correct. I am gone from my clinic 2 days this week to be here——

Mrs. ELLMERS. Yes.

Ms. NORBY [continuing]. With you, and it took creative scheduling. Now, my Medicare patients know I am very much an advocate for this, and they all know about this bill.

Mrs. ELLMERS. Good.

Ms. NORBY. So they were very supportive and willing to come at 7:00 at night or at 10:00 on Saturday morning.

Mrs. ELLMERS. To accommodate so you could be here.

Ms. NORBY. Yes, so I could be here, so——

Mrs. ELLMERS. Oh, that is awesome.

See, this is what our health care providers do. I mean, the commitment that our health care providers have for their patients, for their families, and the role—that is why, I mean, I am so passionate about health care, being a nurse and being in that space and knowing what goes on behind the scenes that people are completely unaware of; and so, I am there with you.

I do want to ask a little bit about the cumbersome nature of the paperwork, the documentation that our health care professionals—right now, especially, is the most difficult time; and I am probably making more of a comment than I am asking a question, but I think you are going to agree with me, so I am going to assume that, and I will ask if you agree.

Right now, our health care professionals are dealing with electronic health records, meaning meaningful use. They are moving forward with stage three, which I think is a big mistake. We have a very important letter with, gosh, well over 120 cosponsors—bipartisan—asking them to step back from moving forward; and now we have ICD–10 that is added into the mix on top of the difficulties that are being experienced, especially in the home health setting. One "i" that isn't dotted, one "t" that isn't crossed can mean the difference between reimbursement for a health care professional or not.

Do you agree that right now is just an incredibly difficult time for any health care provider when it comes to the documentation? And, mind you, we are all supposed to be going paperless. I will just throw that in there. Do you agree?

Ms. NORBY. And regulatory burden, too.

Mrs. ELLMERS. Yes, and the regulatory burdens.

And that is what this legislation is about. We are trying to make things better. We are really trying to work behind the scenes, and I am just excited to be a part of it because I have been out in the real world. I know what it is like, and I know the commitment that our health care providers have. I know the dedication that the families of those patients have and the meanings. They will never forget the things that you have done for them ever, and any way we can make that better is exactly what we need to do.

So, again, I thank you for your time. Thank you for really taking away from your back-home patients and care and families of your own to be here for this important, important subcommittee hearing. Thank you so much.

And thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady. That concludes the questions from the members present. We will have written questions and follow-up from other members who weren't able to attend sent to you. We ask that you please respond promptly.

Ms. MYERS. Absolutely.

Mr. PITTS. Thank you. And I will remind members that they have 10 business days to submit the questions for the record, so they should submit those questions by the close of business on Thursday, October 15.

A very informative, excellent hearing. Thank you for coming all the way to this hearing. We really appreciate it. Thank you for your expert testimony. These are very important, bipartisan, noncontroversial bills. We expect them to move very soon, and you have had a great part in that. So thank you very much.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 11:59 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

For years we have been warned of the looming insolvency of Medicare. Those alarm bells cannot be ignored. To allow the program to fall into bankruptcy would be to abandon the solemn promise we have made to seniors in Michigan and across the Nation. As the committee of primary jurisdiction over much of the Medicare program, we cannot, and we will not let that happen. As the population ages with Baby Boomers entering retirement and the potential for provider shortages to increase in the near future, it is our duty to identify opportunities to improve the program. Today, we will examine bipartisan solutions to help put us back on track.

H.R. 556, the Prevent Interruptions in Physical Therapy Act of 2015, introduced by Representatives Bilirakis and Luján, would ensure that Medicare patients receiving therapy services do not have to delay care in the event their treating provider gets sick or married.

H.R. 1934, the Cancer Care Payment Reform Act of 2015, is sponsored by Representatives McMorris Rodgers and Steve Israel. The legislation would build off of the promise in the SGR repeal legislation—also known as MACRA—by promoting innovative payment reforms designed to increase the quality of care delivered to Medicare seniors and reduce costs to the program.

Finally, we will examine a discussion draft authored by Representative Greg Walden that would streamline documentation requirements related to home healthcare delivery.

We will continue our work to keep the promise to seniors and improve the Medicare program.

I

114TH CONGRESS
1ST SESSION

H. R. 556

To amend title XVIII of the Social Security Act to add physical therapists to the list of providers allowed to utilize locum tenens arrangements under Medicare, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 2015

Mr. BILIRAKIS (for himself, Mr. BEN RAY LUJÁN of New Mexico, Mr. TONKO, Mr. KELLY of Pennsylvania, Mr. POMPEO, Mr. KING of Iowa, and Mr. MEEHAN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to add physical therapists to the list of providers allowed to utilize locum tenens arrangements under Medicare, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Prevent Interruptions in Physical Therapy Act of 2015".

SEC. 2. ALLOWING PHYSICAL THERAPISTS TO UTILIZE LOCUM TENENS ARRANGEMENTS UNDER MEDICARE.

(a) IN GENERAL.—The first sentence of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking "and" before "(H)"; and

(2) by inserting before the period at the end the following: ", and (I) in the case of outpatient physical therapy services furnished by physical therapists, subparagraph (D) of this sentence shall apply to such services and therapists in the same manner as such subparagraph applies to physicians' services furnished by physicians".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished after the date of the enactment of this Act.

○

I

114TH CONGRESS
1ST SESSION

H. R. 1934

To amend title XVIII of the Social Security Act to establish a national Oncology Medical Home Demonstration Project under the Medicare program for the purpose of changing the Medicare payment for cancer care in order to enhance the quality of care and to improve cost efficiency, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 22, 2015

Mrs. MCMORRIS RODGERS (for herself and Mr. ISRAEL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to establish a national Oncology Medical Home Demonstration Project under the Medicare program for the purpose of changing the Medicare payment for cancer care in order to enhance the quality of care and to improve cost efficiency, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Cancer Care Payment Reform Act of 2015".

SEC. 2. ESTABLISHING AN ONCOLOGY MEDICAL HOME DEMONSTRATION PROJECT UNDER THE MEDICARE PROGRAM TO IMPROVE QUALITY OF CARE AND COST EFFICIENCY.

Title XVIII of the Social Security Act is amended by inserting after section 1866E (42 U.S.C. 1395cc–5) the following new section:

"SEC. 1866F. ONCOLOGY MEDICAL HOME DEMONSTRATION PROJECT.

"(a) ESTABLISHMENT OF DEMONSTRATION PROJECT.—Not later than six months after the date of the enactment of this section, the Secretary shall establish an Oncology Medical Home Demonstration Project (in this section referred to as the 'demonstration project') to make payments in the amounts specified in subsection (f) to each participating oncology practice (as defined in subsection (b)).

"(b) DEFINITION OF PARTICIPATING ONCOLOGY PRACTICE.—For purposes of this section, the term 'participating oncology practice' means an oncology practice that—

"(1) submits to the Secretary an application to participate in the demonstration program in accordance with subsection (c);

"(2) is selected by the Secretary, in accordance with subsection (d), to participate in the demonstration program; and

"(3) is owned by a physician, or is owned by or affiliated with a hospital, that submitted a claim for reimbursement in the prior year for an item or service for which payment may be made under part B.

"(c) APPLICATION TO PARTICIPATE.—An application by an oncology practice to participate in the demonstration program shall include an attestation to the Secretary that the practice—

"(1) furnishes physicians' services for which payment may be made under part B;

"(2) coordinates oncology services furnished to an individual by the practice with services that are related to such oncology services and that are furnished to such individual by medical professionals (including oncology nurses) inside or outside the practice in order to ensure that each such individual receives coordinated care;

"(3) meaningfully uses electronic health records;

"(4) will, not later than one year after the date on which the practice commences its participation in the demonstration project, be accredited as an Oncology Medical Home by the Commission on Cancer, the National Committee for Quality Assurance, or such other entity as the Secretary determines appropriate;

"(5) will repay all amounts paid by the Secretary to the practice under subsection (f)(1)(A) in the case that the practice does not, on a date that is not later than 60 days after the date on which the practice submits an application to the Secretary under subsection (b)(1), submit an application to an entity described in paragraph (4) for accreditation as an Oncology Medical Home in accordance with such paragraph;

"(6) will, for each year in which demonstration project is conducted, report to the Secretary, in such form and manner as is specified by the Secretary, on—

"(A) the performance of the practice with respect to not less than ten of the measures described in subsection (e), as selected by the practice; and

"(B) the level of satisfaction of individuals who are provided with oncology services by the practice for which payment may be made under part B, as measured by a patient satisfaction survey based on the Consumer Assessment of Healthcare Providers and Systems survey or by such similar survey as the Secretary determines appropriate;

"(7) agrees not to receive the payments described in subclauses (I) and (II) of subsection (f)(1)(B)(iii) in the case that the practice does not report to the Secretary in accordance with paragraph (6) with respect to performance of the practice during the 12-month period beginning on the date on which the practice submits the application described in this subsection to the Secretary;

"(8) will, for each year of the demonstration project, meet the minimum performance requirements developed under subsection (e)(4)(B) with respect to each of the measures on which the practice has agreed to report under paragraph (6)(A); and

"(9) has the capacity to utilize shared decision-making tools that facilitate the incorporation of the patient needs, preferences, and circumstances of an individual into the medical plan of the individual and

that maintain provider flexibility to tailor care of the individual based on the full range of test and treatment options available to the individual.

"(d) SELECTION OF PARTICIPATING PRACTICES.—

"(1) IN GENERAL.—The Secretary shall, not later than six months after the date of the enactment of this section, select oncology practices that submit applications to the Secretary in accordance with subsection (c) to participate in the demonstration program.

"(2) MAXIMUM NUMBER OF PRACTICES.—In selecting an oncology practice to participate in the demonstration program under paragraph (1), the Secretary shall ensure that the participation of such practice in the demonstration project does not, on the date on which the practice commences its participation in the demonstration project, increase the total number of oncologists who participate in the demonstration program to a number that is greater than 1,500 oncologists.

"(3) DIVERSITY OF PRACTICES.—In selecting oncology practices to participate in the demonstration project under paragraph (1), the Secretary shall, to the extent practicable, include in such selection—

"(A) small-, medium-, and large-sized practices; and

"(B) practices located in different geographic areas.

"(4) NO PENALTY FOR CERTAIN OPT-OUTS BY PRACTICES.—In the case that the Secretary selects an oncology practice to participate in the demonstration project under paragraph (1) that has agreed to participate in another model, under section 1115A or otherwise, for payment under this title for oncology services, such practice may not be assessed a penalty for electing not to participate in such other payment model if such practice makes such election—

"(A) prior to the receipt by the practice of any payment under such model; and

"(B) in order to participate in such demonstration project.

"(e) MEASURES.—

"(1) DEVELOPMENT.—The Secretary shall use measures described in paragraph (2), and may use measures developed under paragraph (3), to assess the performance of each participating oncology practice, as compared to other participating oncology practices.

"(2) MEASURES DESCRIBED.—The measures described in this paragraph, with respect to individuals who receive treatment for cancer from a participating oncology practice, are the following:

"(A) PATIENT CARE MEASURES.—

"(i) The percentage of such individuals that receives documented clinical or pathologic staging prior to initiation of a first course of cancer treatment.

"(ii) The percentage of such individuals that is undergoing advanced imaging and has been diagnosed with stage I or II breast cancer.

"(iii) The percentage of such individuals that is undergoing advanced imaging and has been diagnosed with stage I or II prostate cancer.

"(iv) The percentage of such individuals that, prior to receiving cancer treatment, had its performance status assessed by the practice.

"(v) The percentage of such individuals that—

"(I) is undergoing treatment with a chemotherapy regimen provided by the practice;

"(II) has at least a 20-percent risk of developing febrile neutropenia due to a combination of regimen risk and patient risk factors; and

"(III) has received from the practice either GCSF or white cell growth factor.

"(vi) With respect to such individuals who receive chemotherapy treatment from the practice, the percentage of such individuals so treated that receives a treatment plan prior to the administration of such chemotherapy.

"(vii) With respect to chemotherapy treatments administered to such individuals by the practice, the percentage of such treatments that adhere to guidelines published by the National Comprehensive Cancer Network or such other entity as the Secretary determines appropriate.

"(viii) With respect to antiemetic drugs dispensed by the practice to individ-

uals as part of moderately or highly emetogenic chemotherapy regimens for such individuals, the extent to which such drugs are administered in accordance with evidence-based guidelines or pathways that are compliant with guidelines published by the National Comprehensive Cancer Network or such other entity as the Secretary determines appropriate.

"(B) RESOURCE UTILIZATION MEASURES.—

"(i) With respect to emergency room visits in a year by such individuals who are receiving active chemotherapy treatment administered by the practice as of the date of such visits, the percentage of such visits that is associated with qualified cancer diagnoses of the individuals.

"(ii) With respect to hospital admissions in a year by such individuals who are receiving active chemotherapy treatment administered by the practice as of the date of such visits, the percentage of such admissions that is associated with qualified cancer diagnoses of the individuals.

"(C) SURVIVORSHIP MEASURES.—

"(i) Survival rates for such individuals who have been diagnosed with stage I through IV breast cancer.

"(ii) Survival rates for such individuals who have been diagnosed with stage I through IV colorectal cancer.

"(iii) Survival rates for such individuals who have been diagnosed with stage I through IV lung cancer.

"(iv) With respect to such individuals who receive chemotherapy treatment from the practice, the percentage of such individuals so treated that receives a survivorship plan not later than 45 days after the completion of the administration of such chemotherapy to such individuals.

"(v) With respect to such individuals who receive chemotherapy treatment from the practice, the percentage of such individuals that receives psychological screening.

"(D) END-OF-LIFE CARE MEASURES.—

"(i) The number of times that such an individual receives chemotherapy treat-

ment from the practice not later than 30 days prior to the death of the individual.

"(ii) With respect to such individuals who have a stage IV disease and have received treatment for such disease from the practice, the percentage of such individuals so treated who have had a documented end-of-life care conversation with a physician in the practice or another health care provider who is a member of the cancer care team of the practice.

"(iii) With respect to such an individual who is referred to hospice care by a physician in the practice or a health care provider who is a member of the cancer care team of the practice, regardless of the setting in which such care is provided, the average number of days that the individual receives hospice care prior to the death of the individual.

"(iv) With respect to such individuals who die while receiving care from the practice, the percentage of such deceased individuals whose death occurred in an acute care setting.

"(3) MODIFICATION OR ADDITION OF MEASURES.—

"(A) IN GENERAL.—The Secretary may, in conjunction with appropriate stakeholders, modify or add to the measures described in paragraph (2).

"(B) APPROPRIATE STAKEHOLDERS DESCRIBED.—For purposes of subparagraph (A), the term 'appropriate stakeholders' includes oncology societies, oncologists who provide oncology services to one or more individuals for which payment may be made under part B, allied health professionals, health insurance issuers that have implemented alternative payment models for oncologists, patients and organizations that represent patients, and biopharmaceutical and other medical technology manufacturers.

"(4) ASSESSMENT.—

"(A) IN GENERAL.—The Secretary shall, for each year in which the demonstration project is conducted, assess—

"(i) the performance of each participating oncology practice for such year with respect to the measures on which the prac-

tice has agreed to report to the Secretary under subsection (c)(6)(A), as compared to the performance of other participating oncology practices with respect to such measures; and

"(ii) the extent to which the practice has, during such year, used breakthrough or other best-in-class therapies.

"(B) MINIMUM PERFORMANCE REQUIREMENTS.—The Secretary shall, in conjunction with the appropriate stakeholders described in paragraph (3)(B), develop minimum performance requirements with respect to—

"(i) each of the measures developed under this subsection; and

"(ii) the level of satisfaction on which practices agree to report to the Secretary under subsection (c)(6)(B).

"(f) PAYMENTS FOR PARTICIPATING ONCOLOGISTS.—

"(1) CARE COORDINATION MANAGEMENT FEE.—

"(A) IN GENERAL.—Subject to subparagraphs (D) and (E), the Secretary shall, in addition to any other payments made by the Sec-

retary under this title to a participating oncology practice, make payment of a care coordination management fee to each such practice.

"(B) TIMING OF PAYMENTS.—The care coordination management fee described in subparagraph (A) shall be paid to a participating oncology practice at the end of each of the following periods:

"(i) The period that ends 6 months after the date on which the practice submits the application described in subsection (c) to the Secretary under subsection (b)(1).

"(ii) The period that ends 12 months after the date on which the practice submits such application to the Secretary.

"(iii) Subject to subsection (c)(7)—

"(I) the period that ends 18 months after the date on which the practice submits such application to the Secretary; and

"(II) the period that ends 24 months after the date on which the practice submits such application to the Secretary.

"(C) AMOUNT OF PAYMENT.—The amount of the care coordination management fee described in subparagraph (A) shall be determined by the Secretary in conjunction with oncologists who provide oncology services for which payment may be made under part B.

"(2) PAYMENT IN SUBSEQUENT YEARS.—

"(A) IN GENERAL.—Subject to subparagraphs (C) and (D), the Secretary shall make payments of an ongoing management fee to each participating oncology practice.

"(B) TIMING OF PAYMENTS.—The ongoing management fee described in subparagraph (A) shall be paid to a participating oncology practice at the end of the third, fourth, and fifth years of the demonstration project.

"(C) AGGREGATE AMOUNT OF PAYMENTS.—With respect to each of the dates of payment described in subparagraph (B), the aggregate amount of payments to participating oncology practices on such date shall be determined by—

"(i) determining the amount by which the aggregate expenditures that would have been expended for the previous year

under this title if the demonstration project had not been implemented exceeds the aggregate expenditures under this title for such previous year;

"(ii) calculating the amount that is half of the amount determined under clause (i); and

"(iii) subtracting from the amount calculated under clause (ii) the total amount of payments made under paragraph (1) that have not, in a prior application of this clause, previously been so subtracted from a payment determination made under this subparagraph.

"(D) AMOUNT OF PAYMENTS TO INDIVIDUAL PRACTICES.—

"(i) MINIMUM PERFORMANCE REQUIREMENTS.—The Secretary may not make payments to a practice under subparagraph (A) at the end of a year of the demonstration project described in subparagraph (B) unless the practice meets or exceeds the minimum performance requirements developed under subsection (e)(4)(B) for such year with respect to—

"(I) the measures on which the practice has agreed to report to the Secretary under subsection (c)(6)(A); and

"(II) the level of satisfaction on which the practice has agreed to report to the Secretary under subsection (c)(6)(B).

"(ii) CONSIDERATION OF PERFORMANCE ASSESSMENT.—The Secretary shall, in conjunction with the appropriate stakeholders described in subsection (e)(3)(B), determine the amount of a payment to an individual oncology practice under subparagraph (A) for a year. In making a determination under the preceding sentence, the Secretary shall take into account the performance assessment of the practice under subsection (e)(4)(A) for the previous year, as compared to the performance assessment of other participating oncology practices under such subsection for such previous year.

"(3) ISSUANCE OF GUIDANCE.—Not later than the date that is six months after the date of the en-

actment of this section, the Secretary shall issue guidance detailing the methodology that the Secretary will use to implement subparagraphs (C) and (D) of paragraph (2).

"(g) SECRETARY REPORTS TO PARTICIPATING ONCOLOGY PRACTICES.—The Secretary shall inform each participating oncology practice, on a quarterly basis, of—

"(1) the performance of the practice during the prior quarter with respect to the measures on which the practice has agreed to report to the Secretary under subsection (c)(6)(A); and

"(2) the amount by which the expenditures that would have been expended for the prior quarter under this title by a typical oncology practice if the demonstration project had not been implemented exceeds the actual expenditures by the participating oncology practice under this title for such quarter.

"(h) APPLICATIONS FROM ENTITIES TO PROVIDE ACCREDITATIONS.—Not later than the date that is six months after the date of the enactment of this section, the Secretary shall establish a process for the acceptance and consideration of applications from entities for purposes of determining which entities may provide accreditation to practices under subsection (c)(4) in addition to the entities described in such subsection.

"(i) GAO REPORT.—Not later than June 1, 2019, the Comptroller General of the United States shall submit a report to Congress evaluating the success of the demonstration project that includes an assessment of the impact of the project upon the quality and cost-efficiency of oncology services furnished to individuals under this title, including an assessment of the satisfaction of such individuals with respect to such services that were furnished under such project. Such report shall include recommendations regarding the possible expansion of the demonstration project, as well as any possible reforms that are based on the demonstration project that can be made to the program under this title with respect to payment for cancer care.".

○

[DISCUSSION DRAFT]

114TH CONGRESS
1ST SESSION

H. R. _____

To amend title XVIII of the Social Security Act to make changes to the Medicare home health face-to-face encounter requirements.

IN THE HOUSE OF REPRESENTATIVES

Mr. WALDEN introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to make changes to the Medicare home health face-to-face encounter requirements.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Home Health Documentation and Program Improvement Act of 2015".

SEC. 2. DEVELOPMENT OF A SINGLE FORM OR DOCUMENT TO SATISFY THE HOME HEALTH CERTIFICATION REQUIREMENT.

(a) PART A.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(1) in subsection (a)(2)—

(A) by inserting "(in the case of home health services, in the manner described in subsection (m)(4))" before "(and recertifies"; and

(B) in subparagraph (C), by striking "has had a face-to-face encounter" and inserting "has, subject to subsection (m)(5), had a face-to-face encounter"; and

(2) by adding at the end the following new subsection:

"(m) IMPLEMENTATION OF REQUIREMENT FOR CERTIFICATION FOR HOME HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary shall develop a single form or document to be used by a physician to satisfy the documentation requirements necessary to fulfill the requirement of a face-to-face encounter and other criteria for home health eligibility under subsection (a)(2)(C) (otherwise known as the certification for home health services).

"(2) STAKEHOLDER INPUT.—In developing the form or document under paragraph (1), the Sec-

retary shall seek input from stakeholders, including physicians and other non-physician providers (such as nurse practitioners or clinical nurse specialists (as those terms are defined in section 1861(aa)(5))), home health agencies, hospitals, patients or representatives of patients, and other entities (such as electronic medical record vendors) the Secretary determines appropriate. The Secretary shall provide the opportunity for such stakeholders to offer input on the form or document during its initial development as well as the opportunity to make comments on a proposed version prior to its finalization. The Secretary shall also set up a process to educate physicians and non-physicians on how to appropriately fulfill the requirements related to the form or document in this section prior to implementation.

"(3) CONTENT OF FORM.—The Secretary shall accept the following content as documentation of an individual's eligibility for home health services:

"(A) With respect to the face-to-face encounter requirement, the date of the encounter.

"(B) With respect to the need for skilled services, a selection, via checkbox, of the types of skilled services required by the individual and

a statement with the clinical basis for each type of skilled service ordered.

"(4) DEEMED SATISFACTION OF REQUIREMENTS.—The requirements for documentation of a face-to-face encounter and other criteria for certification of home health eligibility under subsection (a)(2)(C), **[**section 1815, and section 1833**]** **[***review: sections 1815 and 1833 are broad payment provisions that don't go into specifics of certifications, etc. Is the Secretary is using that broad authority to implement certifications? Or are other references perhaps intended here?***]** shall be deemed satisfied with respect to an individual if a home health agency completes the form or document under paragraph (1) and the ordering physician signs or attests to the contents of the form or document.

"(5) EXCEPTION TO FACE-TO-FACE ENCOUNTER REQUIREMENT.—The Secretary shall waive the requirement for a face-to-face encounter under subsection (a)(2)(C) related to home health services provided to an individual if the individual has been discharged from a hospital (including from the emergency department) or skilled nursing facility on a date that is not greater than 14 days prior to the

date on which such home health services are initiated.

"(6) GUIDANCE.—

"(A) IN GENERAL.—The Secretary shall provide notification, guidance, and education regarding the application of the form or document under paragraph (1) as it pertains to satisfying the documentation requirements for home health services under subsection (a)(2)(C) to the following:

"(i) CONTRACTORS.—Medicare administrative contractors (as defined in section 1874A) and recovery audit contractors (as defined in section 1893(h)).

"(ii) HEALTH CARE PRACTITIONERS.—Physicians, [practitioners (as described in section 1842(b)(18)(C)], and home health agencies.

"(iii) OTHER ENTITIES.—Any other entity which the Secretary determines appropriate.

"(B) NATIONAL APPLICABILITY.—The Secretary shall ensure that all medicare administrative contractors, recovery audit contractors, and any other entity which the Secretary deter-

mines appropriate apply the guidance under this paragraph in a nationally consistent and uniform manner and that all audit activities, policies, and practices regarding documentation for home health services are likewise applied in a nationally consistent and uniform manner.

"(C) STUDY.—Not later than 18 months after the date of the enactment of this paragraph, the Secretary shall submit to Congress a report on—

"(i) the adherence of medicare administrative contractors, recovery audit contractors, and any other entity which the Secretary determines appropriate to nationally consistent and uniform audit activities, policies, and practices as described in subparagraph (B); and

"(ii) the rate of appeals for denial of payment based solely on the face-to-face encounter requirements for home health services under this section and the rate of such appeals that are ultimately successful.".

(b) PART B.—Section 1835 of the Social Security Act (42 U.S.C.1395n) is amended—

(1) in subsection (a)(2)—

(A) by inserting "(in the case of home health services, in a manner consistent with the requirements of subsection (f))" before "(and recertifies"; and

(B) in subparagraph (A), by striking "has had a face-to-face encounter" and inserting "has, subject to subsection (f), had a face-to-face encounter"; and

(2) by adding at the end the following new subsection:

"(f) APPLICATION OF DOCUMENTATION, GUIDANCE, AND TREATMENT OF CERTAIN HOME HEALTH CLAIMS PROVISIONS UNDER PART A.—The provisions of section 1814(m) shall apply with respect to the application of documentation requirements for home health services under subsection (a)(2)(A) in the same manner as such provisions apply with respect to the application of the documentation requirements for home health services under section 1814(a)(2)(C).".

SEC. 3. EFFECTIVE DATE; TREATMENT OF CERTAIN HOME HEALTH CLAIMS.

(a) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by section 2 shall apply with

respect to home health services furnished on or after October 1, 2016.

(2) [EXCEPTION TO FACE-TO-FACE ENCOUNTER REQUIREMENT].—Subsection (m)(5) of section 1814 of the Social Security Act (42 U.S.C. 1395f), as added by section 2, shall apply with respect to home health services furnished [or or after the date of the enactment of this Act.] Notwithstanding any other provision of law, the Secretary may implement such subsection (m)(5) by program instruction or otherwise.

(b) TREATMENT OF CERTAIN HOME HEALTH CLAIMS.—

(1) DENIED CLAIMS.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall—

(i) through guidance, develop and implement processes to reopen and review claims that were denied on or after January 1, 2011, and before the date of the enactment of this Act, due solely to the face-to-face documentation requirements under section 1814(a)(2)(C) of the Social Secu-

rity Act (42 U.S.C. 1395f(a)(2)(C)) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(A)); and

(ii) issue revised decisions of such denials as if the narrative requirements of section 424.22(v) of title 42, Code of Federal Regulations, did not apply at the time such services were furnished.

(B) SETTLEMENT AGREEMENTS FOR DENIED CLAIMS.—In addition to the processes under subparagraph (A), not later than 60 days after the date of the enactment of this Act, the Secretary shall establish a voluntary process for home health agencies to enter into a settlement agreement with the Secretary of Health and Human Services in lieu of reprocessing claims for payment which are required to be paid by reason of subparagraph (A)(ii).

(2) OTHER CLAIMS.—In the case of a claim for home health services furnished on or after January 1, 2011, and before October 1, 2016, that is not described in paragraph (1)(A), such claim shall be determined and processed as if the explanation or narrative requirements of section 424.22(a)(1)(v) and the documentation requirements of 424.22(c) of title

42, Code of Federal Regulations, did not apply at the time such services were furnished.

Partnership for Quality Home Healthcare
THERE'S NO PLACE LIKE HOME

FOR IMMEDIATE RELEASE
October 1, 2015

Contact: Emily Adler
703-548-0019

Partnership for Quality Home Healthcare Applauds Lawmakers for Exploring Ways to Improve the Medicare Program

Home health leaders strongly support enactment of common-sense improvements to preserve patient access and strengthen program integrity by improving face-to-face documentation rules

WASHINGTON – The Partnership for Quality Home Healthcare – a coalition of home health providers dedicated to improving the integrity, quality, and efficiency of home healthcare for our nation's seniors – today joined other home healthcare advocates in thanking the House Energy & Commerce Subcommittee on Health for hosting a Congressional hearing to examine potential ways to improve the Medicare program, including legislation that would streamline current "face-to-face" documentation requirements in order to secure patient access to clinically advanced, cost effective, and patient preferred Medicare home healthcare services.

Under current Medicare policy, home health agencies are forced to contend with inconsistently administered Medicare documentation rules in order to meet Centers for Medicare & Medicaid Services' (CMS) requirements and receive appropriate reimbursement for physician-prescribed home healthcare services. Too often, this overly complicated process leads to delays in patient care and denial of coverage for skilled home healthcare.

Legislative reform now under consideration would resolve these problems by updating face-to-face (F2F) documentation rules, reducing the paperwork burden on physicians and home health agencies, and minimizing the risk of inappropriate denials of care. The legislation achieves these important outcomes by directing CMS to utilize a standardized form, developed in consultation with stakeholders, to document beneficiaries' eligibility for home health services. Importantly, this reform will also eliminate the burden on physicians by enabling home health agencies to prepare the documentation for their review and by eliminating duplicative documentation for beneficiaries who have been discharged from a hospital or skilled nursing facility within 14 days prior to the initiation of home healthcare. This common-sense reform would also establish a process for review of inappropriately denied claims, ensure educational outreach to key players, and provide for a study and report to Congress on the effectiveness of this streamlined process.

"We proudly support the efforts of Representative Walden and the U.S. Congress to reform overly burdensome documentation requirements that are putting patient access at risk," said Eric Berger, CEO of the Partnership for Quality Home Healthcare. "This legislation will significantly improve a flawed process that is unworkable, administratively burdensome, and resulting in coverage delays and denials."

Current policy is endangering access to care for the most vulnerable patient population in the Medicare program. Indeed, Medicare's home health beneficiaries are documented as older, sicker, poorer and are more likely to be female, a minority, and disabled than all other beneficiaries in the Medicare program combined.

The Partnership previously expressed support for the *Home Health Documentation and Program Improvement Act of 2015* (S. 1650) – introduced by Senators Robert Menendez (D-N.J.) and Pat Roberts (R-Kan.) – which would similarly help to ensure that homebound Medicare beneficiaries have access to clinically-necessary home healthcare services.

Today, nearly 3.5 million homebound Medicare beneficiaries receive skilled home healthcare to treat illnesses related to acute, chronic or rehabilitative needs.

####

The Partnership for Quality Home Healthcare was established to assist government officials in ensuring access to skilled home healthcare services for seniors and disabled Americans. Representing more than 2,000 community- and hospital-based home healthcare agencies across the U.S., the Partnership is dedicated to developing innovative reforms to improve the quality, efficiency and integrity of home healthcare. To learn more, visit www.homehealth4america.org. To join the home healthcare policy conversation, connect with us on Facebook, Twitter and our blog.

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Denise Schrader, RN MSN NEA-BC
Chairman of the Board

Val J. Halamandaris, JD
President

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."

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.

VNAA
Visiting Nurse Associations of America

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
Thursday, October 1, 2015
By
Tracey Moorhead, President and CEO
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.

United States Senate

WASHINGTON, DC 20510

May 17, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

Dear Dr. Berwick,

This letter is in follow up to the December 17, 2010 bipartisan Senate letter urging the Centers for Medicare and Medicaid Services (CMS) to delay implementation of the final rule for section 6407 of the Patient Protection and Affordable Care Act (P.L. 111-148), requiring documentation of face-to-face encounters prior to certification for home health services. Thank you for your recognition of the burden that the January 1, 2011, implementation of this provision would have created both for providers and Medicare home health recipients, especially those in rural and underserved areas. CMS subsequently set an implementation date of April 1, 2011, for this provision.

We write in follow up to implementation of this provision to express concerns about burdens these rules impose, especially the documentation requirements, and the potential negative impact of these rules on access to home health services for Medicare recipients. The documentation requirements imposed by these rules go beyond the certification requirement in section 6407 of the Affordable Care Act.

Specifically, we are concerned about the documentation requirements in the rule placed upon ordering physicians, which are burdensome, duplicative, and impractical for many doctors, especially those in rural and underserved areas. For instance, CMS requires that physicians complete narratives describing how the patient's clinical condition observed during the encounter supports the patient's qualification for Medicare-covered home health services. The physician who conducts the encounter and certifies the patient's eligibility for home health services must record and sign a detailed face-to-face narrative directly on the home health certification or review and sign required encounter information extracted from his or her record by his or her own staff. Furthermore, only the physician may document the required narrative for face-to-face encounters made by non-physician practitioners. Failure to complete this narrative results in non-payment for the home health services. Physicians with multiple potential home health patients would be especially burdened by this requirement, which is also time consuming.

In addition, this documentation requirement is duplicative. Physicians record patient's homebound status and condition on multiple forms, including the patient's medical records as well as the patient plan of care. While we understand that CMS allows the physician to attach existing documentation to the certification, this approach still inordinately increases paperwork burdens for already overstretched physicians.

In consideration of the burden this requirement places upon physicians, we ask that you consider eliminating the narrative requirement and accept the physician's sworn certification of the patient's need for home health services in lieu of this, or alternatively, permitting the use of the model Physician Certification and Plan of Care (formerly Form 485) to meet the documentation requirements in lieu of the narrative. Alternatively, we ask for your consideration that non-physician practitioners and home health agency health professionals be allowed to complete the form for patient history and need for services, provided the physician acknowledges the clinical finding and certifies the need for home health services with his or her signature.

CMS allows physician staff, hospital staff, nursing home personnel, and virtually everyone else to transpose physician assessments and other clinical information for the physician to sign off on. Further, in all other care settings there is no requirement that prohibits a professional health care provider such as a nurse or therapist from working in collaboration with the doctor on patient care and documentation. These professionals put their licenses on the line if they improperly document. There is no evidence that these professionals breach their responsibilities to a degree that warrants prohibiting them from the same allowances afforded to other providers.

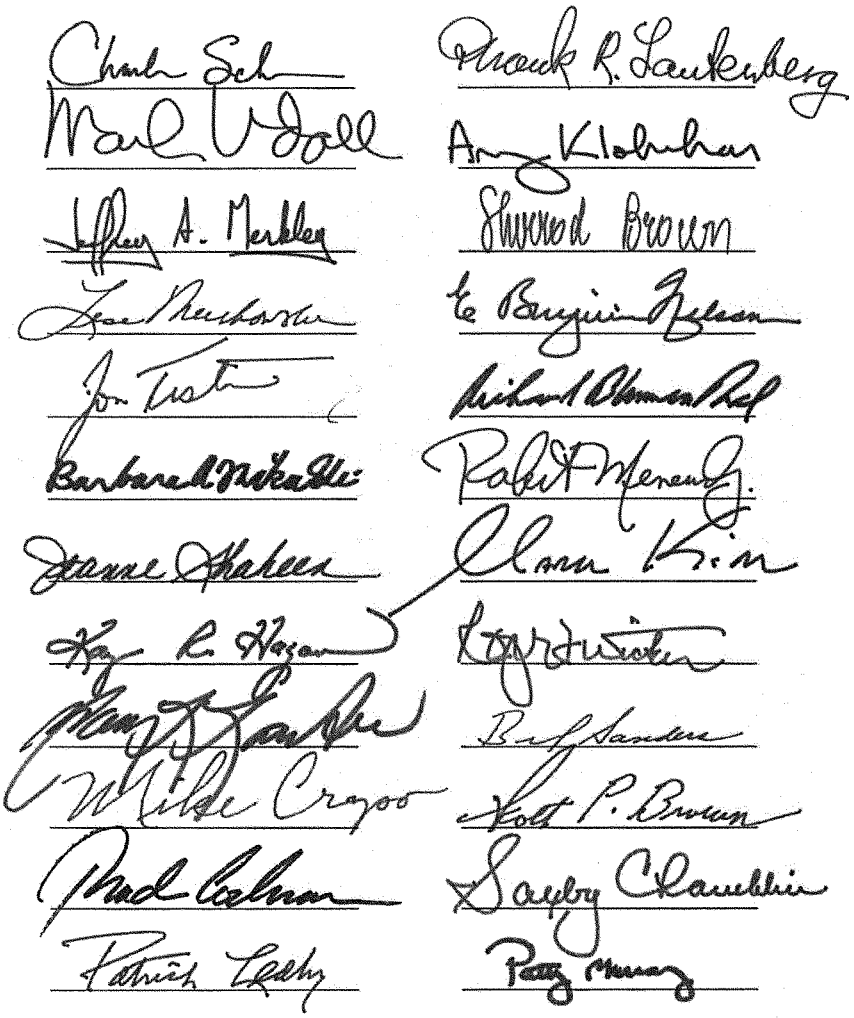
Without the easing of these documentation requirements, there will be a negative impact on home health recipients' access to home health providers and home health care. Physicians will be discouraged from accepting home health patients, and therefore, hospital discharges will be delayed and/or patients will be sent to post-acute institutions, which entail higher costs for the patients and Medicare. Some patients in rural and underserved areas may be unable to access providers to certify their eligibility for home health services, therefore, going without the needed home health services that several surveys have shown that the majority of seniors prefer over institutional care. In addition, small home health agencies and non-profits will be disproportionately impacted by these requirements. According to a recent survey, home health agencies report that after educating physicians on the requirement, 46 percent have indicated that they will refer patients to other care settings instead of home health care. This means patients will be steered to more costly institutional care that would result in poorer clinical outcomes for the patients.

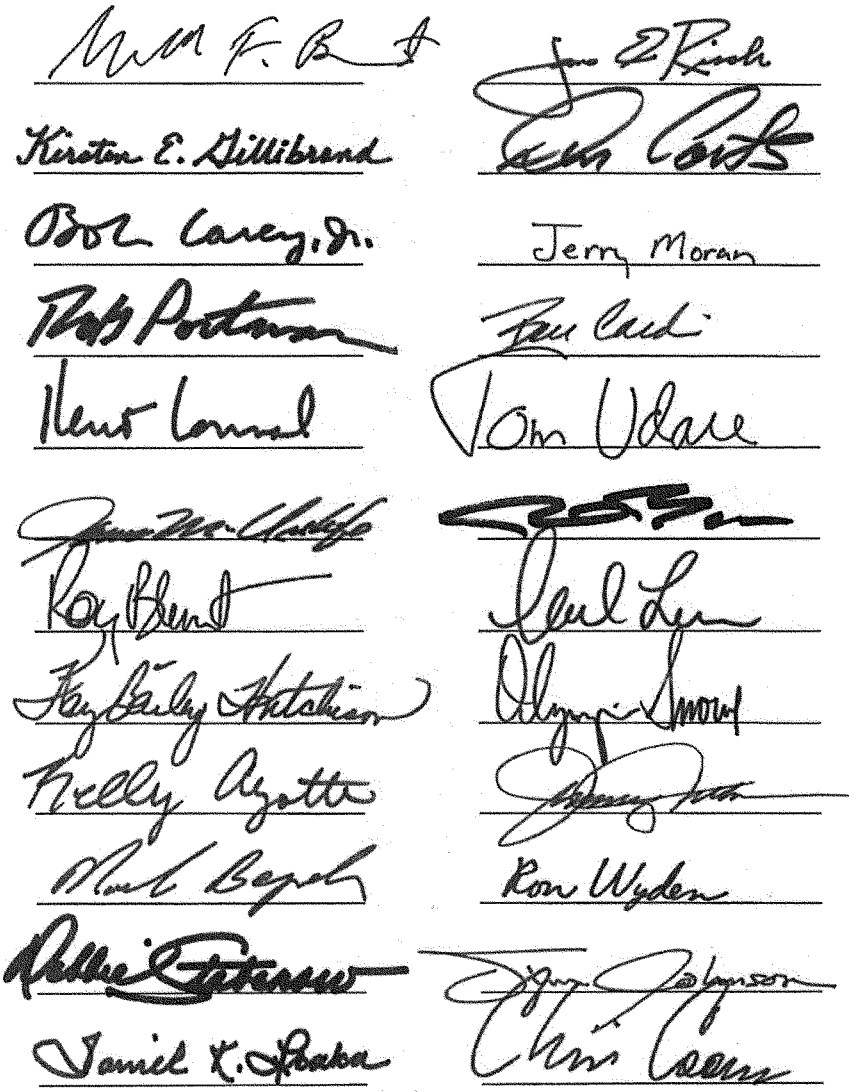
These requirements place a disproportionate impact on vulnerable patients and perpetuate the bias towards institutional care. We ask that CMS consider the above-mentioned alternatives to the burdensome and duplicative requirements of section 6407 and encourage continued access to home health services for Medicare recipients. Thank you for your consideration.

Sincerely,

Maria Cantwell
U.S. Senator

Susan Collins
U.S. Senator





Congress of the United States
Washington, DC 20515

September 17, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner:

On behalf of the home health provider community in our respective states, and the millions of elderly and disabled individuals that receive vital home health services from these mission-driven providers, we write to ask for your involvement as we address an expensive and unnecessary regulatory burden that is a barrier to patients receiving home care services.

As you know, under the Affordable Care Act (ACA), Congress included a provision aimed at increasing collaboration between home health agencies and physicians. This provision, implemented by the Centers for Medicare and Medicaid Services (CMS), is known as the Face-to-Face (F2F) Encounter Requirement. While we support the need for direct encounters between patients and physicians to occur, the current regulations contain complicated, confusing, and overlapping documentation requirements that exceed the intent of the law passed by Congress. These requirements have imposed a significant burden on home health providers and physicians in our districts.

As implemented by CMS, physicians are now required to document, sign and date an additional form with a narrative of the patient's condition in order to justify home care services. Home health agencies must obtain this signed form prior to billing for Medicare home health services. We are uncertain why this method for implementing the F2F requirement was chosen. Prior to billing for Medicare home health services, home health agencies already must obtain a signed and dated form from the physician which outlines the full plan of care for the patient. This comprehensive form, known as the 485 form, includes the complete plan of care outlined by the physician (for nursing, therapy, aide and all other services needed by the patient), which will be delivered by the home health agency. We have heard from home health agencies that believe as a consequence, these new forms are counterproductive to the underlying F2F intent.

Across the country providers are reporting that the net effect of the current regulatory scheme has been to increase the paperwork burden and cost to home health agencies which are struggling to comply with this regulation; possibly even adding a disincentive for physicians to recommend home health services.

Within all relevant rules and regulations we ask that CMS consider modifying this requirement to allow that the F2F mandate is met through the completion and collection of the

separately signed and perhaps modified 485 form. Given the importance of this issue, and our shared commitment to fostering the increased use of cost-effective Medicare home health services, we look forward to working with you on this.

Sincerely,

Tom Reed
Member of Congress

Paul Tonko
Member of Congress

Christopher Smith
Member of Congress

Robert Andrews
Member of Congress

Jim Gerlach
Member of Congress

Joe Crowley
Member of Congress

Tim Griffin
Member of Congress

James McGovern
Member of Congress

Michael Burgess
Member of Congress

Charles Rangel
Member of Congress

Ralph Hall
Member of Congress

Allyson Schwartz
Member of Congress

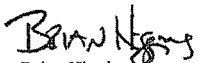
Peter King
Member of Congress

Kathy Castor
Member of Congress

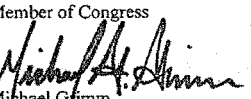
Glenn Thompson
Member of Congress

Ben Ray Luján
Member of Congress

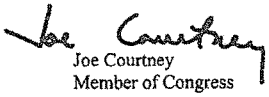
Todd Rokita
Member of Congress



Brian Higgins
Member of Congress

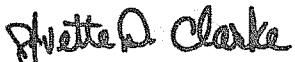


Michael Grimm
Member of Congress



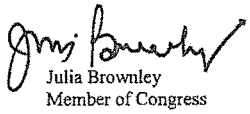
Joe Courtney
Member of Congress

Doug Lamborn
Member of Congress

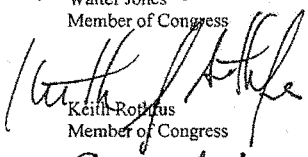


Yvette Clarke
Member of Congress

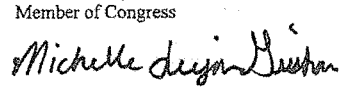
Walter Jones
Member of Congress



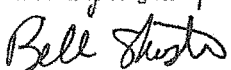
Julia Brownley
Member of Congress



Keith Rothus
Member of Congress

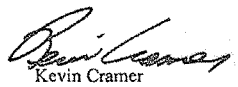


Michelle Lujan Grisham
Member of Congress



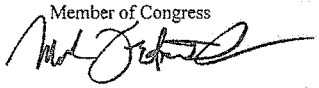
Bill Shuster
Member of Congress

Bill Owens
Member of Congress

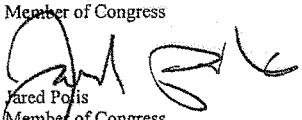


Kevin Cramer
Member of Congress

Tim Bishop
Member of Congress

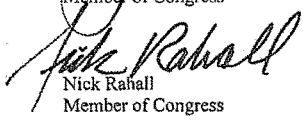


Michael Fitzpatrick
Member of Congress



Jared Polis
Member of Congress

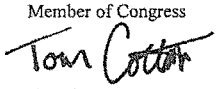
Alan Nunnelee
Member of Congress



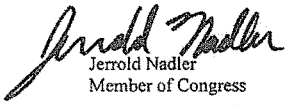
Nick Rahall
Member of Congress

Lou Barletta
Member of Congress

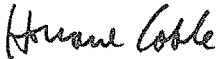
Ann M. Kuster
Member of Congress



Tom Cotton
Member of Congress

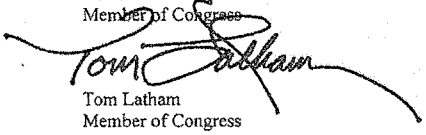


Jerrold Nadler
Member of Congress

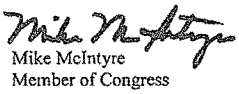


Howard Coble
Member of Congress

Gerald Connolly
Member of Congress

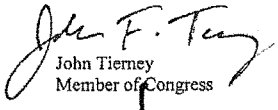


Tom Latham
Member of Congress

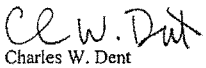


Mike McIntyre
Member of Congress

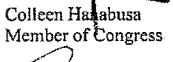
Patrick Meehan
Member of Congress



John Tierney
Member of Congress



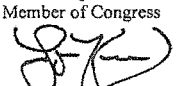
Charles W. Dent
Member of Congress



Colleen Hanabusa
Member of Congress

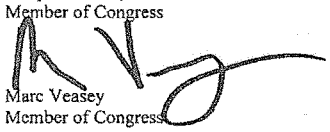
Niki Tsongas
Member of Congress

Albio Sires
Member of Congress

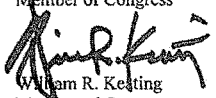


Joseph Kennedy
Member of Congress

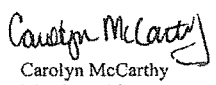
Donald M. Payne, Jr.
Member of Congress



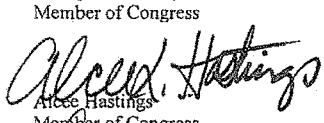
Marc Veasey
Member of Congress



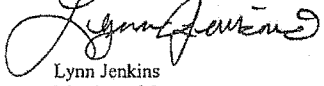
William R. Keating
Member of Congress



Carolyn McCarthy
Member of Congress

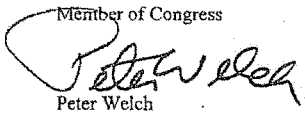


Alcee Hastings
Member of Congress



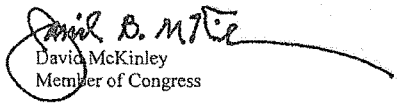
Lynn Jenkins
Member of Congress

Richard Hudson
Member of Congress



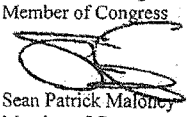
Peter Welch
Member of Congress

Eliot Engel
Member of Congress



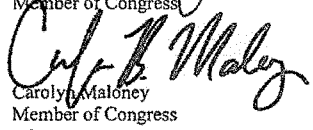
David McKinley
Member of Congress

Matthew Cartwright
Member of Congress

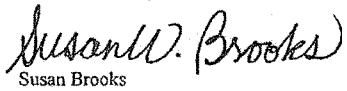


Sean Patrick Maloney
Member of Congress

Raul Grijalva
Member of Congress

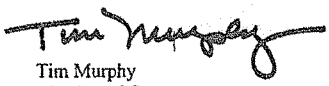


Carolyn Maloney
Member of Congress

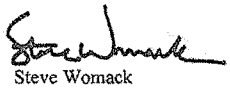


Susan Brooks
Member of Congress

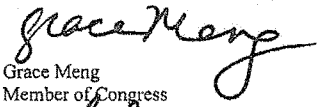
Jon Runyan
Member of Congress



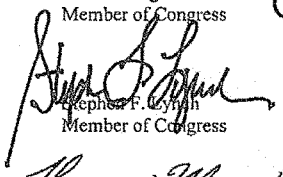
Tim Murphy
Member of Congress



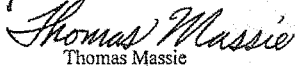
Steve Womack
Member of Congress



Grace Meng
Member of Congress

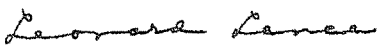


Stephen F. Lynch
Member of Congress



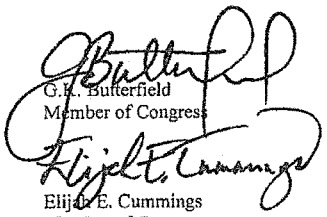
Thomas Massie
Member of Congress

Frank LoBiondo
Member of Congress



Leonard Lance
Member of Congress

Robert Pittenger
Member of Congress



G.K. Butterfield
Member of Congress

Elijah E. Cummings
Member of Congress

Congress of the United States
Washington, DC 20515

August 11, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Tavenner:

The availability of home healthcare services is important to millions of frail elderly and disabled patients across our nation. It is important that laws set by Congress and rules and regulations administered by the executive branch take proper care of the issues which affect the access to care for this community. As such, we write to express our comments on the 2015 proposed Home Health Prospective Payment System (HHPPS) rule by the Centers for Medicare and Medicaid Services (CMS) which will be finalized in the coming months and take effect on January 1, 2015.

We acknowledge that progress was made towards eliminating the required physician narrative as part of the Face-to-Face (F2F) requirement in the 2015 proposed HHPPS rule and support the inclusion of this provision in the final rule. However, concerns remain over the providers and patients whose claims are still being denied due to an insufficient physician narrative while they wait for the rule to be finalized. CMS signaled with the proposed rule that it intends to no longer enforce the physician narrative requirement. Therefore, we urge CMS to suspend audits related to the physician narrative beginning with the date that the 2015 proposed HHPSS rule went on display (July 1, 2014). Similarly, in light of the changes announced in the proposed rule, we urge CMS to establish a process that would allow providers to receive full reimbursement if a claim was previously denied for an "insufficient physician narrative."

As Representatives concerned about the impact that the final 2015 HHPPS rule from CMS will have on the ability of the elderly and disabled to receive proper care and treatment through home healthcare services, we appreciate your attention to this matter.

Sincerely,

Tom Reed
Member of Congress

Paul Tonko
Member of Congress

Greg Walden
Member of Congress

John B. Larson
Member of Congress

Jim Gerlach
Member of Congress

Doris Matsui
Member of Congress

Tim Murphy
Member of Congress

Charles B. Rangel
Member of Congress

Lynn Jenkins
Member of Congress

Bill Pascrell, Jr.
Member of Congress

Diane Black
Member of Congress

Allyson Y. Schwartz
Member of Congress

Mike Kelly
Member of Congress

Alcee Hastings
Member of Congress

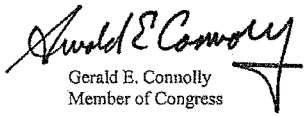
Tim Griffin
Member of Congress

Albio Sires
Member of Congress

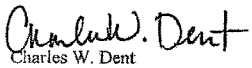
Bill Shuster
Member of Congress

Brian Higgins
Member of Congress

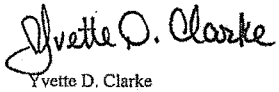
Chris Gibson
Member of Congress



Gerald E. Connolly
Member of Congress

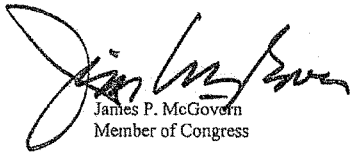


Charles W. Dent
Member of Congress

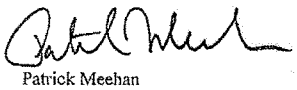


Yvette D. Clarke
Member of Congress

Peter King
Member of Congress

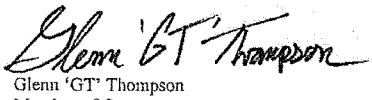


James P. McGovern
Member of Congress

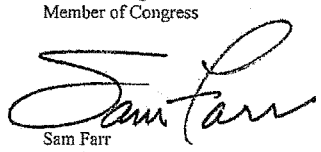


Patrick Meehan
Member of Congress

Matt Cartwright
Member of Congress



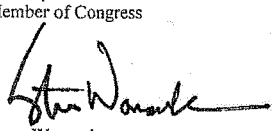
Glenn 'GT' Thompson
Member of Congress



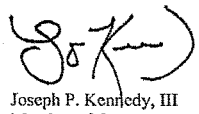
Sam Farr
Member of Congress

Christopher H. Smith
Member of Congress

William L. Owens
Member of Congress

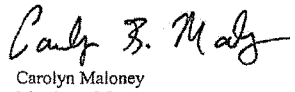


Steve Womack
Member of Congress



Joseph P. Kennedy, III
Member of Congress

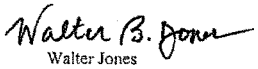
Mike Coffman
Member of Congress



Carolyn Maloney
Member of Congress

Michael G. Fitzpatrick
Member of Congress

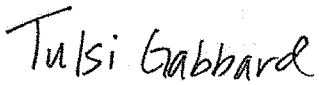
Ann M. Kuster
Member of Congress



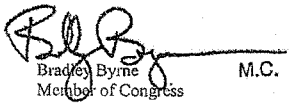
Walter Jones
Member of Congress

André Carson
Member of Congress

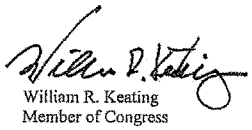
Keith Rothfus
Member of Congress



Tulsi Gabbard
Member of Congress

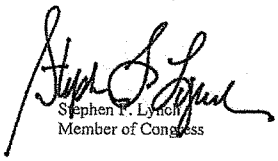


Bradley Byrne M.C.
Member of Congress

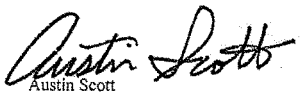


William R. Keating
Member of Congress

Lou Barletta
Member of Congress

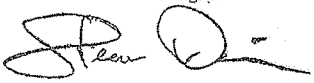


Stephen F. Lynch
Member of Congress

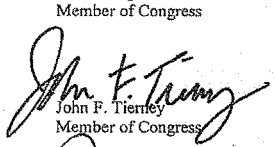


Austin Scott
Member of Congress

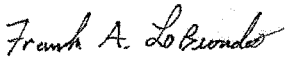
Niki Tsongas
Member of Congress



Steve Daines
Member of Congress

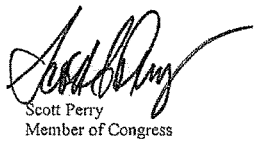


John F. Tierney
Member of Congress



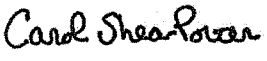
Frank A. LoBiondo
Member of Congress

Chaka Fattah
Member of Congress



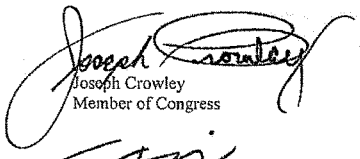
Scott Perry
Member of Congress

Colleen W. Hanabusa
Member of Congress



Carol Shea-Porter
Member of Congress

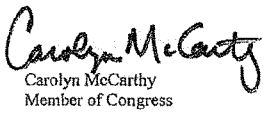
Chellie Pingree
Member of Congress



Joseph Crowley
Member of Congress

Timothy H. Bishop
Member of Congress

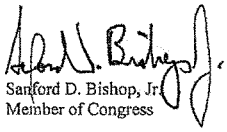
Steve Israel
Member of Congress



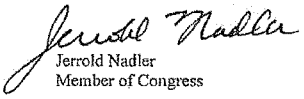
Carolyn McCarthy
Member of Congress

Theodore E. Deutch
Member of Congress

David Loebsack
Member of Congress



Sanford D. Bishop, Jr.
Member of Congress



Jerrold Nadler
Member of Congress

United States Senate
WASHINGTON, DC 20510

June 25, 2015

Andrew Slavitt, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Slavitt:

The locum tenens arrangement is a longstanding and widespread practice for physicians to retain substitute physicians in their professional practices when they are absent due to illness, pregnancy, vacation or continuing medical education. It is also acceptable for the regular physician to bill and receive payment for the substitute physician's services as if he/she performed them him/herself.

Under locum tenens, the patient's regular physician may submit a claim and (if assignment is accepted) receive the Part B payment for a covered visit of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- the regular physician is unavailable to provide the visit services,
- the Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician,
- the regular physician pays the locum tenens for his services on a per diem or similar fee-for-time basis,
- the substitute physician does not provide the visit services to Medicare patients over a continuous period of more than 60 days, and
- the regular physician identifies the services as substitute physician services by entering the HCPCS modifier Q6 (service furnished by a locum tenens physician) after the procedure code in Item 24d on the CMS-1500 claim form or electronic equivalent.

Section 1842(b)(6) of the Social Security Act allows locum tenens for practitioners identified as "physicians" under Medicare. Specifically, the following providers may utilize locum tenens arrangements (when all other conditions are met and within their same authorized scope of practice):

- Doctors of Medicine
- Doctors of Osteopathy
- Doctors of Dental Surgery (or of dental medicine legally authorized by the state)
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Doctors of Chiropractic

Physical therapists in private practice, especially those who are in small rural practices through America, have considerable difficulty arranging for substitute care when they need to be away from the office for health, family matters, or other reasons. Extending the locum tenens authorization to physical therapists may alleviate this difficulty and enable improved patient access to therapy services. We introduced a bill, S.313, to allow physical therapists who furnish outpatient physical therapy services to use locum tenens arrangements for payment purposes in the same manner as such arrangements are used for physicians.

In the process of determining the cost for the bill, the Congressional Budget Office raised questions about the utilization of the arrangement under current law. Further, questions were raised about the development of a 'cottage industry' in locum tenens under current law. So given the importance of the issues raised, we would like to ask you the following:

1. Given that all participating Medicare practitioners are required to have a National Provider Identifier (NPI), does CMS have any evidence that locum tenens as used by participating Medicare practitioners under current law have led to an increase in utilization of services?

2. Does CMS have any evidence of the development of a 'cottage industry' relating to the use of locum tenens under current law by participating Medicare practitioners? If so, does CMS have any evidence that this is leading to the provision of unnecessary services?

3. Does CMS have any evidence that the use of locum tenens under current law by participating Medicare practitioners is in any way inappropriate, wasteful or fraudulent?

4. Does CMS lack the authority to properly respond to the use of locum tenens under current law by participating Medicare practitioners if such utilization was found in any way to be inappropriate, wasteful or fraudulent?

5. Does CMS have any evidence of currently covered physical therapy services under Medicare that are not being accessed by beneficiaries because locum tenens arrangements are not authorized physical therapists?

Thank you for your attention to this request. Please provide a response no later than Thursday, July 2. Should you need any further information, please contact Rodney Whitlock (Grassley) at 202 224 3744 or Gillian Mueller (Casey) at 202 224 6324.

Sincerely,

Charles E. Grassley
United States Senator

Robert P. Casey, Jr.
United States Senator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

JUL 10 2015

Administrator
Washington, DC 20201

The Honorable Charles Grassley
United States Senate
Washington, D.C. 20510

Dear Senator Grassley,

Thank you for your recent letter regarding the use of locum tenens arrangements in the Medicare program and the focus of S. 313 to extend such arrangements to physical therapists to improve outpatient access and add flexibility to physical therapy provider arrangements.

We appreciate your questions about the use of locum tenens arrangements, the provision of unnecessary services, the potential for fraudulent or wasteful behaviors and CMS's authority to address inappropriate utilization.

CMS does not have evidence indicating that locum tenens as used by physicians under current law has led to a general increase in utilization of services or that industry practices generally lead to the provision of unnecessary services relating to the use of locum tenens, or that the use of locum tenens under current law in the Medicare program is generally inappropriate, wasteful, or fraudulent.

We appreciate your interest in assuring CMS maintains the proper authority to respond to any abuses of locum tenens. To further that, CMS has solicited comments on the policy for substitute physician billing arrangements in the 2015 Physician Fee Schedule proposed rule, and we are still in the process of considering comments received on some specific issues.

Thank you again for your letter and please contact me should have you have any additional questions. I will also provide this response to the cosigner of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator

September 30, 2015

The Affordable Care Act included a provision which simply required that a physician document that the physician or a non-physician practitioner had a face-to-face encounter with a patient in order for the patient to qualify for Medicare home health services. The Centers for Medicare and Medicaid Services greatly expanded the face to face encounter requirements in its implementation of the regulations, and imposed an additional requirement that the physician also include a narrative of the face to face encounter in the documentation explaining why the patient is homebound and why skilled services are necessary to treat a patient's clinical condition. CMS also required that the physician's documentation be a separate and distinct section of the physician's certification for home health services. CMS changed this regulation in 2015 to remove the narrative requirement but now requires that the physician's records contain enough evidence that the patient is homebound and in need of skilled services.

The face to face requirement has been a challenge since its inception in 2011. Despite recent changes which alleviated the narrative portion by physicians it continues to create a hardship for home health agencies but also for patient care. Absolute profit margins in home health are razor thin and likely going down again in 2016. The administrative burden associated with obtaining a valid face to face document stretches even the most efficient of home health providers. The burden falls almost exclusively on the home health agency to educate the physicians and navigate i.e. chase this paperwork.

Nowhere is this more challenging, administratively burdensome and potentially catastrophic than in the post acute care discharge arena. As originally conceived, the face to face requirement was meant to reduce fraud in the billing of home health episodes; so to require this documentation when the patient has been in the hospital clearly runs counter to the original concept. When the patient is seen in an acute facility by many health care providers, none of them are likely have a post-acute role in that patient's care and are less inclined to assist an agency obtain the face to face document. Often these patients are not only the most vulnerable but they are the least likely to be able to obtain the necessary visit with a physician.

We see patients in their home and one of the primary conditions of participation is that the patient has to be "homebound". While there is absolutely an allowance for medical visits to that rule often these patients are unable to make that physician visit. To therefore require them to go out of the home to obtain a face to face visit makes no logical sense and in too many cases is impossible, so that patient suffers at home with no care because of a paperwork burden that benefits no one.

We have examples of this burden daily in our agencies across the west coast and here are a few short stories.

Salem Oregon: Patient is referred to us as she is discharging from a nursing home. The facility MD writes the order for home health but is not willing to sign the face to face documentation nor is he willing to "follow" the patient. The patient has no primary care provider but we find one willing to accept the patient. The patient is willing to try this new doctor as well and we set an appointment. Based on the plan we accept the referral and start to see the patient based on the

original order and plan of care. In this case the patient does not make it to the MD appointment inside of the 30 day window for various reasons that generally boil down to no clinical reason to go and the functional and physical burden to go is too much. Our only choice then is to continue to see this patient pro bono or discharge based on the fact that we do not have a face to face thus cannot bill the episode.

Alamosa Colorado: Patient is referred to home health but has not seen his doctor in many months. The patient has agoraphobia and simply cannot get out comfortably. He agrees to make an MD appointment but is simply unable to keep and make that appointment. The result is he is not able to get home health because the face to face document cannot be obtained. In this case he had significant lower extremity pain and needed nursing and therapy guidance but was not able to obtain it. This is a very rural town and there are no home visits MDs.

Moses Lake Washington: Patient is in a great deal of pain and is generally not mobile. The patient's family who has an established relationship with a primary care doctor visits the doctor and obtains a Home Health referral. We start care based on that referral but need a face to face document signed. No face to face exists. The patient is not able to go to the doctor without ambulance transport which he cannot afford and simply cannot agree to. We tried for some weeks to get this but ultimately the result once again is we have to discharge this patient. In this case there are home visiting Nurse practitioners in this very rural town here again we face a barrier because NPs cannot independently write for home health and complete the face to face.

In 2014 and 2015 our company has had over 393 claims denied for inadequate face to face documentation. Each and every one of these claims had face to face encounter documentation that was signed by a physician. In most cases, the Medicare Administrative Contractors denied the claim because they deemed the physician's narrative inadequate under the regulations. We have appealed each of these denials and have had many of the denials reversed. To date we have had only one denied claim upheld at the Administrative Law Judge level of appeal. At present we have over $1.5 million tied up in appeals of denied face to face encounter claims in various stages of appeal, many of which are at the Administrative Law Judge level of appeal.

These unfortunate examples take place on a near daily basis in the seven states that I oversee and across the country. I appreciate you reading my stories and would be happy to have any further conversation on the topic.

Regards,

Jeff Weil, PT
Division VP
LHC group - Western states
Based in Portland, Oregon