

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,



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U.S. Senator



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U.S. Senator

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