

August 26, 2008

Acting Administrator Kerry N. Weems  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1403-P  
P. O. Box 8013  
Baltimore, MD 21244-8013

Dear Acting Administrator Weems:

The American Academy of Home Care Physicians, representing over 1,300 organizations and individuals who make house calls or serve as Medical Directors of Home Care agencies to the frailest and sickest of Medicare's elderly welcomes the opportunity to comment on the 2009 proposed Medicare payment rule.

**1. OTHER ISSUES—PHYSICIAN  
CERTIFICATION/RECERTIFICATION**

We agree with CMS, OIG and others who over the years have argued for the need for greater physician involvement in home care. With home health agencies caring for patients many of whom are as sick as those found in nursing homes and in hospice programs, we have always been disturbed by the striking difference between these settings both in terms of the requirements and compensation for physicians that work with home health agencies. This lack of incentives discourages physician engagement that would improve quality of care for many of our most frail and vulnerable patients when they are treated in the least costly setting —the home.

We do not think CMS should be surprised by the current circumstance in which there exists a great variability in physician involvement in the care of patients with complex chronic diseases and disabling conditions. As a result, many homebound patients receive only a cursory review of home care documents by a physician, and are not seen by a physician at all unless they are hospitalized.

First, CMS effectively eliminated paid Medical Directors who existed in home care agencies prior to the 1997 BBA, when agencies paid physicians under the cost cap. The home health agency payment arrangement prior to 1997 was inflationary and poorly structured, but many home health agency medical directors were making valuable contributions. The BBA dramatically curtailed agency payments and medical directors were among many costs that were immediately

eliminated, along with staff education budgets, and most personal care aide services.

Second, the inadequate supply of primary care physicians has left many office practices swamped, and unable to spend much time on home care patients who represent less than 5 percent of a typical primary care office practice. As the pressure on primary care grows, time for home care work will shrink unless there is a sound incentive.

Third, while payments for house calls increased in 1998, there have been subsequent cutbacks and physicians are choosing other more lucrative, less time consuming alternatives to primary care and house call medicine, such as hospitalist medicine. We now face a workforce crisis in primary care. Among the primary care practices of medicine that has declined relative to the population need, is the availability of physician home visits.

We believe there are two alternatives, both of which should be pursued. First, instead of cutting back of certification and recertification payment, these payments should be restructured to provide incentives for greater physician involvement, including personally seeing the patients. Second, the ability to pay Medical Directors should be restored to home care agencies, along with requirements for their education, and a definition of their role.

For the future, we believe that, within three years all home health agencies except those in HPSA areas should be required to have patients seen by a physician or a qualified non-physician provider as a condition of certification and recertification. This could be done through employment or contract, and would mirror the expected practice in hospices and nursing homes. The final date of such action should reflect trends in primary physician supply.

## **Recommendations:**

**Restructuring Certification and Recertification Payment:** We believe current payments should be graduated in the same way that E and M office visit codes are graduated. There should be three levels of payment. The first, and least, should be for just signing the 485 form (certification). The second, middle payment level should be for providing a definitive quality assurance role by electronic connection to the HHA and performing medication reconciliation. The third level of payment should be for seeing the patient within the first two weeks of the current 60-day episode of care, and subsequently advising the home health agency more fully on the plan of care during the episode.

**Medical Director Job Description, Training and Certification:** Our experience in developing a curriculum for Medical Directors, and training and certifying them in the 1990's leads us to believe that there needs to be some specification of role, and also some qualification requirements. On the role, home health agencies need to pay

Medical Directors to have a substantive role and achieve a result, not just to “show up.” At a minimum, the job description should include

1. Acting as liaison with the practicing physician community, helping the nurse problem-solve patient care issues.
2. Commenting on clinical policies and procedures;
3. Leading and/or participating in quality assurance activities;
4. Seeing or providing for patients to be seen who do not have or cannot access their own primary care physician;
5. Providing for 24/7 on-call telephone medical direction in emergent or urgent care situations

On background and training, Medical Directors who do not have previous training, should receive a required 25 hours of CME credit in home care medical direction of home care agencies every three years, and an examination opportunity to demonstrate competence as a condition of employment/contracting.

**Timing:** We understand that CMS has referred the certification/recertification issue to the RUC for study and a recommendation at the October meeting. We believe CMS should delay a decision on this matter until after this meeting. We have requested and been granted the right to provide input to the primary care societies assigned the task of developing the recommendations to the RUC.

## **2. POTENTIALLY MISVALUED SERVICES UNDER THE PHYSICIAN FEE SCHEDULE**

In this section, CMS is seeking comments on approaches to re-valuing overvalued procedures which disadvantage primary care physicians and distort the PFS. No mention is made, however, of the opposite problem as it affects primary care physicians—the failure of CMS or the RUC to establish valuations for services not valued by the Harvard study, even when CMS officials had indicated plans to do so.

Such is the fate of reimbursement for travel expenses during house calls, which is required by federal statute and which the AAHCP has brought to the attention of CMS on numerous occasions during the past 15 years. From its 2007 Medicare Payment Rule letter:

“Mobile medical care services have always been at risk. Despite successful efforts to address work values in the mid-1990s, the codes were never fully valued because travel time was never addressed. Travel is inherent to the home visit service and it is a cost, estimated by member survey at 20 minutes door-to-door between house calls (includes driving, parking, getting in and out of buildings, locating patients within buildings). CMS promised to address this issue in 1996, saying it was a practice expense issue rather than a physician work issue, and then later refused to include this element in the practice expense calculation, saying it should have been a work expense. Thus, travel time became orphaned. “

We made a specific, practical proposal which we re-submit:

**Recommendation:**

**“2. Establish travel as a separate and covered code.**

The PE methodology used by CMS penalizes home care physicians in 3 ways: 1) clinical staff time is not included (often a physician working in the home must also do work that an office nurse would do in an office practice setting); 2) indirect costs were characterized as minimal and omitted some that are specific and unique to the service; 3) travel time, which is integral to the service, is not paid at all.

In 1997 when the code values for home visits were initially determined, AAHCP was told by the leadership of the CMS Part B payment group that travel time would later be included either as a work or practice expense value. Travel costs are an included expense under Part A Home Health and is a recognized, substantial cost for other mobile services such as mobile x-rays (e.g. CPT R0070). Because home visits cannot be provided without travel, we believe the travel time and expense must be a covered **routine** component, and not a matter of carrier discretion.

We presented a legal opinion in 2000 which held CMS accountable for addressing this issue, and have presented two possible methodologies to the CPT committee. No action has been taken. As a matter of public policy, we believe action must be taken now.

To address the concern that many providers other than those making home visits would seek to use travel codes, we suggest that a specific travel payment be made available using a G-code (under the HCPCS process) with a modifier that restricts travel billing to home visit codes.”

Our specific proposal regarding travel is as follows: Based on a specific question added to our RUC survey, respondents have indicated that the average time spent in travel is 20 minutes between visits. We propose that the reimbursement be based on a multiple of the work component of code 99211, the lowest level office based service, which entails 5 minutes of low complexity physician work. Therefore, travel would be valued at 4 times the 99211 Work RVU. In this scenario, the PE and malpractice or vehicular liability components would not be counted. Travel time would be paid as a G-code applicable only to each “stop” in a physician’s house call practice. Carrier instructions should include the bundling into one application of this code made to rest home patients receiving E/M services on the same day. The alternative is to treat this as a practice expense applicable only to house calls.

With the price of gas making increasing numbers of house call providers have to limit the number of patients they can see because of their inability to pass on the increased costs, we believe action on this issue—19 years after it was required in OBRA89 and 12

years after it was promised—is now mandatory to maintain at least existing access to care for some of Medicare’s sickest, and frailest home-limited patients.

### **3. EDUCATIONAL REQUIREMENTS FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS**

The AAHCP has many nurse practitioner members who provide house call services to patients. We agree with the recommendation made by CMS, but suggest using the more generic terminology “master’s in nursing” rather than MSN.

### **4. PHYSICIAN AND NONPHYSICIAN PRACTITIONER (NPP) ENROLLMENT ISSUES**

We join with the many other physician organizations who at the CMS briefing at the AMA, felt this section represented an unjustified swing too far toward physician punishment. We join with others in believing that no change should be made to the “effective date of Medicare billing” until the PECOS system is in place, and there is actual data to confirm that applications are indeed being processed within 30-45 days. Additionally, we are particularly concerned about the “Denial of Enrollment in the Medicare program” section.

Under this section, CMS will start imposing a payment suspension when “we possess reliable information that an overpayment or fraud, or willful misrepresentation exist, or that payments to be made may not be correct.” Amazingly, providers and suppliers can submit a rebuttal to such payment suspension but do not have formal appeal rights.

This section seems to assume that CMS contractors always make correct determinations, and that providers are always at fault. In fact, the reverse is often the case when post-payment computer reviews based on office practices are used to investigate full-time housecall clinicians. Our physician members can cite hundreds of instances in which contractors and their agents made unintentional, yet repetitive mistakes which were later overturned by subsequent ALJ rulings. (Specific documentation available upon request). We emphasize that these cases are not unique or even unusual in housecall practices. Audits and defense of audit-related difficulties have become an expected “cost of doing business” for unaffiliated small housecall physician practices which appear to Medicare carriers as suspicious statistical anomalies and are subjected to under regulatory burden as a result of being “different.”

At the least, CMS contractors can educate their staff adequately about house calls, rather than forcing physicians to spend long hours educating carrier staff.

Medicare Carrier policies have had adverse effects severely impacting access to care, leading to higher costs. In one case, 500 home-limited Medicare patients were effectively abandoned to 911 as their only means of accessing regular care when the only three doctors who made house calls in Riverside, California, went out of business after unjustified payment denials. In more than 25 consecutive medical reviews of this

group, representing thousands of claims, 100 percent of the instances were overturned by the Fair Hearing Officers or the ALJ. There are too few doctors serving the needs of the frail home-limited elderly as it is. It is contrary to BIPA98 anti-harassment provisions and poor use of the taxpayer's money to discourage legitimate and beneficial medical services in this manner.

**Recommendation:**

At the very least, **current rights of appeal should be preserved for all proposed denials**. Most importantly, CMS should actively research the performance of its contractors in auditing clinicians who make "all or substantially all of their clinical encounters in the patient's home," and give provider feedback a defined role in the evaluation and subsequent award of contracts to intermediaries.

## **5. INCENTIVE PAYMENT AND SHARED SAVINGS PROGRAMS**

Hospitals are not the only organizations where incentive payment and shared savings programs are being used to provide needed incentives for service. Soon, the Academy expects to see introduced the Independence at Home Act, which would offer one such program to providers of medical care in the home as an incentive to provide medical care services that would mandate saving the Medicare program substantial dollars. This bill has numerous endorsements and bipartisan support in the House and Senate. While we await the outcome of the political process it is important that we do not eliminate the core of the experienced workforce by way of regulatory burden and underpayment. Home and community-based services are one way to reduce the reliance on costly ER visits, inpatient hospitalizations, and nursing home placement.

**Recommendation:**

We recommend that CMS explicitly provide a means for non-hospital providers, specifically home and community-based medical service providers to seek exemption from Stark restrictions for proposed programs. One example of an arrangement that can have beneficial effects is physician ownership of home health agencies.

## **6. PQRI PROGRAM**

The AAHCP represents clinicians who make "all or substantially all" of their clinical encounters in the patient home or residences. As of these comments, the vast majority of PQRI measures do not allow for the use of codes for home (99343-99350) and residential care facilities (99326-993379) treatment in the denominator of the measure. All other measures are unavailable to our members, who arguably provide care to the most complex, frail and costly patients in the Medicare/Medicaid systems.

We understand that this was a simple oversight by the many and diverse groups of sponsoring organizations who proposed the various measures from an office-based practice perspective. However, the lack of available codes for home care providers may

result in reduced bonus income, a reduced number of quality of care indicators, and publication of report cards excluding an entire group of clinicians simply because of the lack of available screening codes using their E/M code qualifiers in the denominator.

**Recommendation: the home visit and domiciliary care families of codes be added to the denominator eligibility for the measures below which are not currently eligible for use by home care practitioners:**

- 41. Osteoporosis: pharmacologic therapy
- 46. Medication Reconciliation
- 50. Plan of care for urinary incontinence in women aged 65 or older
- 57. Assessment for oxygen saturation for CAP
- 77. Assessment of GERD symptoms in patients receiving medication for GERD
- 110. Influenza vaccination for patients 65 years and older
- 124. HIT-adoption/use of HIT (EHR)
- 130. Universal documentation and verification of current medications in the medical record
- 133. Screening for cognitive impairment
- 134. Screening for clinical depression

We are heartened by the consideration being given to inclusion of home and domiciliary care facilities in the denominator of several of these codes by the AMA, and hope that CMS will support the eventual extension of denominator status for home and domiciliary care facilities to all applicable codes.

**7. PROPOSED AMENDMENT TO THE EXEMPTION FOR COMPUTER-GENERATED FACSIMILE TRANSMISSION FROM THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP) SCRIPT STANDARD FOR TRANSMITTING PRESCRIPTION AND CERTAIN PRESCRIPTION-RELATED INFORMATION FOR PART D ELIGIBLE INDIVIDUALS.**

The AAHCP represents physicians in a unique site of practice, the patient's home or residence, which mandates certain elements of internet connectivity which should be considered in the Final Rule. Since e-prescribing regulations will need to reflect the provisions of the new law, we want to provide general background to CMS at this time to inform decisions not just on this section, but on the issue generally as it applies to medical providers in the home.

In our invited presentation to the Office of the National Coordinator for HIT we were privileged to present these issues, which resulted in the formulation of national Strategy 1.3.9:

***“Remove technical, financial, workflow, and other barriers to diagnosing, treating, and communicating with patients outside the boundaries of traditional healthcare settings.”***

We agree with the ONC-HIT that “Many technical, legal, financial and workflow barriers...prohibit widespread adoption of technologies that support improved communication, diagnosis and treatment outside of the clinical setting.” Specifically, e-prescribing is unique subset of communication standards formulated for handheld devices which are “constantly on-line” and using the SCRIPT standard, which is not HL-7 compatible, nor compatible with any usable EMR in our randomly disconnected or non web-based environment.

For example, the current CCHIT requirements for DUR (drug utilization review), online attestation of each specific patient’s Medicare D insurance plan in real-time, and drug/disease incompatibility alerts cannot be performed by any known device in a patient home where internet access over cabled modem speeds is unavailable.

Many house call patients live in poor socio-economic sectors of society and have few resources in the home to provide broadband connectivity, so clinicians must carry their own. Since 802.11x access is likewise difficult in many patient’s homes, this leaves the connectivity to a wireless wide area network standard, currently fastest over the 3G, EVDO, version A modems. It is not commonly known that these modems seldom provide upload speeds to the internet faster than 50-200 kilobytes per second, which cannot support the intense data synchronization and searching of all current DUR methodologies.

There is precedent for exemption of full-time home care providers from regulations based upon the office practice model in the exemption of house call medical groups from meeting the “in the building” practice standards.

### **Recommendations:**

1. As per the ONC-HIT national strategy 1.3.9 we recommend exemption for clinicians who provide “all or substantially all” of their clinical encounters in the patient home or residence (not skilled nursing facilities) from those e-prescribing functionalities which are not compatible with 802.11x internet upload connection speeds of less than 1MB/sec until the year 2012.
2. Clinicians should be eligible for the PQRI e-prescribing proposed bonus plan and exempted from the penalty when using a defined, but limited e-prescribing functionality meeting specifications compatible with less than a 1MB/sec upload wireless connection speed.
3. The standard of instantaneous transfer at the time of third-party, validated signatures for controlled substances as recommended in the May 28, 2008 DEA Proposed Rule should likewise be altered to reflect this reality of home based e-prescribing at the point-of-care.
4. With regard to the specific section on fax transmissions, we recommend that when prescriptions written at the point of care in a patient home or residence

which are required to protect the patient's health that day, the e-facsimile options shall be retained until the year 2012 when wireless broadband upload connectivity speed is less than 1MB/sec.

Thank you for the opportunity to provide comments on this rule.

Sincerely,

Joe W. Ramsdell, MD  
President