HCA's Recommendations

HCA urges Congress to repeal the F2F provision and develop more constructive ways to secure physician involvement in home health care. If repealing the F2F regulations is not possible, we strongly urge Congress to require CMS to do the following:

- Revise the requirements to eliminate or significantly modify the physician documentation requirements so that physician must no longer spell out why the patient's clinical condition requires Medicare covered home health services, nor maintain sufficient documentation in their own files.
- Have CMS modify this requirement so the F2F mandate can be met through the completion and collection of the separately signed and perhaps modified 485 form.
- Establish F2F exceptions for patients who have been recently discharged from an inpatient setting, individuals in rural areas where access to a physician or non-physician practitioner is limited, and individuals unable to leave home or have a physician perform a home visit.
- Provide financial protection to home health agencies that admit a patient in good faith with the reasonable expectation that a qualified F2F encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event of noncompliance through no fault of the home health agency.
- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

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CMS Fails to Fix Face-to-Face Requirement with Home Care Providers Bearing Financial Losses

Repeal or reform of the physician Face-to-Face encounter is a prerogative, as CMS's own data proves the requirement simply does not work

The Problem

Since 2010, specific Medicare rules for physician documentation, called the Face-to-Face requirement (F2F), have been virtually conditioned for provider error while delaying access to patient care and unfairly denying payment to home health providers in stunning sums.

The F2F rule, while laudable in theory, is duplicative, costly and confusing. Most of the so-called "improper" payments to home care providers (those audited for compliance) have nothing to do with Medicare eligibility or necessity of home care … substantial blame falls squarely on one rule: F2F.

In fact, CMS's own contractors find that **90 percent of home health billing errors are documentation-related**. Fixing F2F is a prerogative. It would bring integrity to the billing system for Medicare contractors, it would reduce costs, and it would protect home care providers from unnecessary financial vulnerability, assuring access to care for Medicare beneficiaries.

The solutions are simple and we appreciate Congressional support in the past for these solutions, but action is urgently needed now.

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Additional Background

Under F2F, home care providers must obtain excessive paperwork from physicians documenting that the physician has had a face-to-face (F2F) encounter with the home health patient within certain timeframes. Home care providers must also obtain explicit records that document the patient meets Medicare eligibility criteria for home health services. While this rule has been revised several times, the U.S. Centers for Medicare and Medicaid Services (CMS) repeatedly fails to get F2F right, as the requirement remains a major source of confusion and unnecessary claim denials.

F2F is a condition of payment under Section 6407 of the Affordable Care Act (ACA). It establishes that the F2F encounter – with the patient seeing a physician or other approved practitioner – must occur within 90 days prior to the start of home care services or within 30 days. Regardless of who actually sees the patient for F2F encounter purposes, the patient's physician must still certify that the encounter occurred and prepare the documentation.

F2F Duplicates Longstanding and Already Sufficient Documentation Requirements

Home health agencies have long been required to obtain a signed and dated form, known as the 485, from physicians who outline the full plan of care prior to billing. A separate face-to-face documentation process is largely duplicative of this existing plan-of-care procedure. If CMS would like additional documentation (i.e., for F2F), all CMS needs to do is refine or update the plan-of-care form.

CMS Fails to Implement Sensible Changes

CMS's implementation of the F2F rule is confusing to all involved, including physicians, home health agencies, and hospitals. CMS has tried to mitigate the confusion in various ways, but those solutions fail to provide basic clarity, ease of application or sensible application. As a result, the rule is creating an access-to-care barrier: practitioners find that it is easier to care for patients in alternative settings to home health care.

Following a 2014 lawsuit, CMS eliminated one specific component of F2F that drew objections from home care providers – a requirement that physicians complete a "narrative." But CMS did not eliminate the rule itself and, in many ways, made the documentation requirements even more fragmented, onerous and confusing.

Now, in place of the physician narrative, CMS is requiring that physicians have sufficient documentation in their own files to support the certification of a patient's homebound status and skilled care need. Yet CMS has not issued adequate guidance on how home health agencies are to comply with this new requirement.

HCA has worked in good-faith with our state's Medicare contractor, New York's physician association and hospital representatives to educate all practitioners about the rule, but the rules remain so opaque, so procedurally complicated, and so cumbersome that a complete overhaul of the rule is essential. When 90 percent of "improper claims" are for documentation errors, we believe that the requirements are themselves in error and need to be revised.

Home Care Providers and Patients Bear All The Risk

Under both the original standard (requiring a physician narrative) as well as the new standard, the home health agency is not in control of the documentation, yet it suffers the risk of a payment denial. Further, the subjectively technical requirements on documentation pose the likelihood of claim denials on patients who are, in fact, homebound and in need of skilled care.

Medicare beneficiaries who are homebound – or, even worse, bedbound – have faced additional access-to-care burdens, especially in rural or remote areas. Many have not been able to travel to their doctor's offices to satisfy the face-to-face requirement.

CMS has currently implemented a series of "probe-and-educate" audits as it ramps up review of F2F documentation. The audits involve a review of claims, denials of claims that do not meet the technically onerous F2F standards, and education of providers as to why the standards aren't met. This audit regime follows more than half-a-billion dollars in claims denials for F2F across the country. No other CMS regulation requires such an extensive "probe-and-educate" function, and the very nature of its existence is proof that the rules must change.

CMS's Missed Opportunity for Sensible Changes

CMS recently had an opportunity to repair F2F in its proposed 2017 Home Health Prospective Payment System Rule (HHPPS). This rule establishes payment and regulatory requirements for the coming year. The 2017 proposal is silent on F2F, even as CMS's own "probe-and-educate" audits and error reports are evidence that change is needed.

HCA is preparing comments on the proposed 2017 HHPPS, urging changes to F2F among other aspects of the HHPPS rule, but our past calls have either been dismissed or resulted in equally onerous changes.

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