ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

September 12, 2011

Donald Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW Room 445-G
Washington, DC 20201

RE: CMS 2348–P; Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health

Submitted electronically: http://www.regulations.gov

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) appreciates the opportunity to comment on the proposed rule that would establish a face-to-face encounter requirement for home health services covered under the Medicaid program. ACAP is an association of 58 nonprofit, safety net plans in 28 states dedicated to serving approximately 8 million publicly insured individuals.

ACAP and our member plans are strong supporters of improving and ensuring access for individuals enrolled in Medicaid and CHIP, while also ensuring the integrity of the Medicaid program. However, we do have issues with the compliance-focus associated with the requirement for the face-to-face encounter and do not believe it will ultimately support the aspects of the triple aim of improving care and reducing costs.

We are concerned that the face-to-face requirement will impede access and provide marginal benefit as a tool to eliminate ordering of questionable services. Currently, the capacity of primary care providers is strained in many areas of the country. This is an issue that could become more pronounced with the critical and needed expansion of Medicaid that will occur in 2014. Therefore, it seems ill-advised to add requirements that will further strain primary care capacity for a visit that may be solely for the purposes of meeting a compliance mandate. While the allowing telehealth as a means of meeting the requirement is certainly appreciated, we are concerned that it will not be enough.

Moreover, travel is often very difficult for individuals with health care needs that necessitate home health care services. This will result in an added burden to those individuals and significantly increase the cost associate with a face-to-face encounter that may have little clinical value.

Instead of requiring a physician visit, we would recommend that more productive emphasis be placed on training physicians in the home health assessment process so that physicians are held accountable for ordering appropriate services, whether done based on a face-to-face encounter or telephonic ordering process. Physicians who have ordered home health services should also be required to assess the need for the service as part of every visit, while not requiring an encounter for the sole reason of ordering a home health or home health related service such as DME. Alternatively, we would recommend that a process be put in place to audit home health services and, if a home health agency is abusing the system by providing questionable services, then a heightened authorization system be put in place for those identified high-risk agencies, similar to the targeted anti-fraud and abuse focus of the new provider enrollment requirements.

In addition, there is an increased emphasis throughout the health care system on improving transitions in care. If a need for home care services is identified as part of post discharge assessment, we are concerned that the face-to-face requirement could impede timely access to necessary home care services. Therefore, if the regulation goes forward, we believe there needs to be a clearer discussion of a hold harmless provision that would allow temporary services to be put into place pending the face-to-face encounter.

While we do not support the face-to-face requirement, there are other issues that must be addressed if the regulation moves forward. First, the regulation should clarify whether the face-to-face encounter is only required for the initial visit or for recertifications as well. Second, according to the proposed rule, the face-to-face encounter only applies to home health related services. However, many states also provide personal care assistance as an optional service, although though this service is not part of the Medicare benefit package. Since there is often little distinction between the services of a personal care attendant (PCA) and a home health aide and PCA services have been known to be abused as well, we are concerned that more services will be shifted to PCA resulting in potential Medicare savings at the expense of state Medicaid budgets. Third, given the increased cost associated with the face-to-face encounter requirements, CMS should query states as

to how they will be adjusting rates paid to managed care plans to adjust for these increased costs in an actuarially sound manner.

Finally, we do support the ability of Medicaid-enrolled individuals to receive home health services without an artificial barrier based on their homebound status. However, because this requirement does not apply to the Medicare program and the ongoing lack of integration between the Medicare and Medicaid programs, we are concerned about how this will be implemented for those that are dual eligibles. While the Office for the Dually Eligibles is working to improve integration and alignment between the two public programs, this is another potential misalignment that will result in increased confusion and potential cost shifting.

In closing, we would like to thank you for giving ACAP this opportunity to comment on this important proposal to assure access for vulnerable populations.

Sincerely,

Deborah Kilstein

Deborah Kilstein
Vice President Quality Management
and Operational Support