

ONE HUNDRED FOURTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
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**MEMORANDUM**

**September 29, 2015**

**To: Subcommittee on Health Democratic Members and Staff**  
**Fr: Committee on Energy and Commerce Democratic Staff**  
**Re: Hearing on “Examining Potential Ways to Improve the Medicare Program”**

On Thursday, October 1, at 10:00 a.m. in room 2322 of the Rayburn House Office Building, the Subcommittee will hold a legislative hearing on three bills regarding the Medicare program.

The first bill, H.R. 556: The Prevent Interruptions in Physical Therapy Act of 2015, allows for physical therapists to enter into locum tenens arrangements for Medicare reimbursement. The second bill, H.R. 1934, the Cancer Care Payment Reform Act of 2015, would establish a five-year Medicare oncology medical home demonstration project. The third bill is draft legislation that would alter documentation requirements for providers of home health services.

**I. BACKGROUND**

Medicare was enacted in 1965 to provide acute, chronic and preventive health services to elderly and disabled Americans.<sup>1</sup> The program is divided into 3 core parts: Part A which covers inpatient hospitalizations, Part B which covers outpatient treatment and Part D which covers prescription drugs. Medicare Advantage, sometimes referred to as Part C, is an option to obtain their Medicare benefits through a private health maintenance organization or preferred provider organization. In 2014, approximately 53.8 million Americans were enrolled in Medicare.<sup>2</sup>

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<sup>1</sup> Cubanski, J, Boccuti C, *Medicare Coverage, Affordability, and Access*, Journal of the American Society on Aging (2015) 39(2): 26-34.

<sup>2</sup> Congressional Research Service, *Medicare Financial Status: In Brief* (August 10, 2015) (online at <http://www.crs.gov/Reports/R43122?source=search>).

Medicare financing comes from a variety of sources. Most notably, the Medicare trust fund is financed by a payroll tax and from general revenues.<sup>3</sup> In addition, beneficiaries are responsible for some premium and cost-sharing requirements. Part A and B are subject to a deductible. Part D enrollees are also subject to cost-sharing provisions, with a coverage gap (the so-called “donut hole”) that requires a larger beneficiary contribution.

In general, Medicare beneficiaries have broad access to physicians, hospitals and other health care providers.<sup>4</sup> Although it is optional for physicians to participate in the Medicare program, nearly all do given the large patient population from which to draw. Less than 1 percent of physicians have elected to opt out of the Medicare program. From the patient perspective, when surveyed, beneficiaries report strong access to primary care with 95 percent of beneficiaries reporting a usual source of care.<sup>5</sup>

## **II. H.R. 556, the Prevent Interruption in Physical Therapy Act of 2015**

### **A. Medicare Coverage of Physical Therapy**

Physical therapy (PT) treatments are designed to relieve symptoms, improve function or prevent further disability in individuals suffering from either an injury or disability.<sup>6</sup> PT can be used for a variety of health conditions ranging from back pain to stroke rehabilitation to diseases such as Parkinson’s. PT services are covered under Medicare Part B benefits. To be eligible these services must be medically necessary, provided while the beneficiary is under the care of a physician, and directed by a written care plan provided by an appropriate medical professional.<sup>7</sup>

The Medicare program spends a significant annual amount on outpatient PT services. In 2011, Medicare spent \$4.1 billion on PT services for 4.3 million Medicare beneficiaries.<sup>8</sup> For

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<sup>3</sup> Cubanski, J, Boccuti C, *Medicare Coverage, Affordability, and Access*, Journal of the American Society on Aging (2015) 39(2): 26-34.

<sup>4</sup> *Id.*

<sup>5</sup> Center for Disease Control and Prevention, *National Health Interview Survey* (2015) (online at [www.cdc.gov/nchs/nhis.htm](http://www.cdc.gov/nchs/nhis.htm)).

<sup>6</sup> United States Government Accountability Office (GAO), *Medicare Physical Therapy: Self Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary* (2014) (online at <http://www.gao.gov/assets/670/662860.pdf>).

<sup>7</sup> 42 CFR §§ 424.24(c)(1)(iii), 410.61(c).

<sup>8</sup> GAO, *Medicare Physical Therapy: Self Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary* (2014) (online at <http://www.gao.gov/assets/670/662860.pdf>).

the individual beneficiary, Medicare imposes an annual cap of \$1,940 for therapy services.<sup>9</sup> In the event that a beneficiary requires services above and beyond the cap, certain exceptions could apply, provided a physician establishes and documents that the added therapy is reasonable and necessary. If a physician recommends treatment above the annual total limit, a manual medical review is triggered for any amount greater than \$3,700.<sup>10</sup> With the passage of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), certain exceptions were made to certain claims that previously underwent the manual medical review.

## **B. Recent Reports on Medicare Coverage for Physical Therapy**

Over the last decade, Medicare expenditures for physical therapy have risen rapidly. Between the years 2006 and 2009, Medicare reimbursement for PT increased 28 percent.<sup>11</sup> This increase has drawn some scrutiny. In 2010, the Health and Human Services Office of Inspector General (OIG) identified several questionable billing practices for Medicare outpatient therapy services.<sup>12</sup> In compiling the report, the OIG identified significant geographic variability in billing practices for outpatient therapy services. Specifically, they found that outpatient therapy in high-utilization counties was 72 percent greater than the national average.

The OIG identified six characteristics that raise suspicions for fraudulent billing.<sup>13</sup> The characteristics included services for which the annual cap is exceeded, beneficiaries whose providers indicated that the annual cap would be exceeded on the first day of service, payments for beneficiaries who may receive outpatient therapy from multiple providers, payments for therapy services provided throughout the year, payments that exceeded the annual cap, and providers who were paid for more than 8 hours of outpatient therapy in a single day.

In addition, the US Government Accountability Office (GAO) examined whether certain referral patterns in Medicare led to inappropriate payments for PT.<sup>14</sup> Prior research has demonstrated that in areas of medicine outside of PT, self-referral patterns tend to increase risk

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<sup>9</sup> The Department of Health and Human Services (HHS), *Medicare Limits on Therapy Services* (2015) (online at <https://www.medicare.gov/Pubs/pdf/10988.pdf>).

<sup>10</sup> The Centers for Medicare and Medicaid Services (CMS), *Therapy Services* (2015) (online at <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/therapyservices>).

<sup>11</sup> *Id.*

<sup>12</sup> HHS, Office of the Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services* (December 2010) (online at <http://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>).

<sup>13</sup> *Id.*

<sup>14</sup> GAO, *Medicare Physical Therapy: Self Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary* (2014) (online at <http://www.gao.gov/assets/670/662860.pdf>).

of inappropriate billing. Because of this, the GAO examined self-referral vs non-self-referral patterns for PT. Although the report found that the majority of the recent growth in the PT marketplace was due to non-self-referral services, they did find significant differences between providers who self-refer vs those who do not. Specifically, PT service referrals increased the year after a provider began to self-refer at a higher relative rate than non-self-referring providers in the same specialty.

**C. H.R. 556: The Prevent Interruptions in Physical Therapy Act of 2015**

*Locum Tenens* is a designation that allows a health care provider to continue to bill for patient care while another licensed provider actually cares for the patient. Typically, this is used when the original provider is away due to illness, vacation, pregnancy, educational conferences or a variety of other purposes. Under this arrangement, the substitute provider is paid by the original physician as an independent contractor. Under current Medicare law, physicians, dentists, podiatrists, optometrists, and chiropractors are allowed to utilize this structure. Physical therapists, however, are not allowed to use locum tenens arrangements. H.R. 556 would change Medicare law to add physical therapists to the list of eligible locum tenens providers.

Physical therapists argue that they should be eligible locum tenens providers because they operate as solo practitioners or in small group practices in many parts of the country. For patients, it becomes an access to care issue where patients rely on a physical therapist for care, that therapist is absent from a practice, and there is a lack of other providers. Patients in these circumstances may have breaks in care, which could be harmful.

H.R. 556 was introduced by Rep. Bilirakis (R-FL) and Rep. Lujan (D-NM) and currently maintains bipartisan support with 77 co-sponsors (44 Republicans, 33 Democrats).

***i. Recent Senate Action***

The Senate-passed version of this bill (S.313) was modified to apply locum tenens to PT treatments only in rural, health professional shortage areas, or medically underserved areas. The Senate bill was reported favorably from the Senate Finance Committee on July 30<sup>th</sup> after an amendment to limit the scope to rural areas, medically underserved areas and health professional shortage areas. The bill passed out of the committee on a voice vote. CBO believes that expanding the locum tenens designation will increase the marketplace for locum tenens staffing, and thus increase utilization and spending in the Medicare program. The Senate bill received a CBO score of \$18 million.<sup>15</sup>

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<sup>15</sup> The Congressional Budget Office (CBO), *Cost Estimate, S. 313: Prevent Interruptions in Physical Therapy Act of 2015* (July 16, 2015) (online at <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/s3133.pdf>).

### III. H.R. 1934, the Cancer Care Payment Reform Act of 2015

#### A. Cancer Care in the United States

Cancer care in the United States is a significant driver of health care costs. In the Medicare program alone, treatment of cancer accounts for approximately 10 percent of all spending.<sup>16</sup> Recent spending estimates show that in 2010, the US spent approximately \$125 billion in cancer care.<sup>17</sup> By 2020, this amount is expected to increase by 39 percent to \$173 billion. These estimates are based on population change alone. If new diagnostic tests are developed, drugs are approved or other measures that improve survival are developed, these estimates can be expected to increase.

Despite a proliferation of clinical guidelines, research shows wide variations in the costs of cancer care for Medicare beneficiaries.<sup>18</sup> These variations exist on multiple levels of cancer care, including use of chemotherapy, advanced imaging, hospital admissions, procedures and drug usage. As a result, in 2012, when comparing the top quarter spending oncology practice to the bottom quarter spending, a per-patient difference existed of \$3,866 for chemotherapy, \$1,872 for hospitalizations and \$439 for advanced imaging. Another study of regional variations in cancer care shows similar spending differences with no appreciable improvement in patient survival.<sup>19</sup>

Some have pointed to the fee-for-service reimbursement structure in Medicare for the disconnect between reimbursement and quality for oncology care in the United States.<sup>20</sup> Researchers have maintained that it promotes delivering high volumes of high-cost services while oftentimes discourages cost-effective, evidenced based treatments. Because of this, policymakers have proposed a variety of approaches towards oncology reimbursement outside of the traditional fee for service model.

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<sup>16</sup> Lisa Potetz, et al., *Cancer: A Chartbook*, American Cancer Society Cancer Action Network (2009).

<sup>17</sup> Angela B. Mariotto et al., *Projections of the cost of cancer care in the United States: 2010-2020*, *Journal of the National Cancer Institute* (2011) 103: 117-128.

<sup>18</sup> JD Clough et al., *Wide variation in payments for Medicare beneficiary oncology services suggests room for practice-level improvement*, *Health Affairs* (2015) 34 (4): 601-608.

<sup>19</sup> GA Brooks et al., *Regional variation in spending and survival for older adults with advanced cancer*, *Journal of the National Cancer Institute* (2013) 105 (9): 634-642.

<sup>20</sup> K. Patel et al., *Transforming oncology care: Payment and delivery reform for person-centered care* (2015) (online at <http://www.brookings.edu/research/articles/2015/05/19-oncology-payment-delivery-reform-patel>).

A recent Brookings Institute article examined the success of alternative payment models in oncology.<sup>21</sup> Specifically, the article examined clinical pathways, oncology patient-centered medical homes, bundled payments and oncology accountable care organizations. Although evidence thus far is limited, preliminary studies have thus far showed success in reducing hospitalization, emergency department utilization, symptom management and decreasing high-cost drug overutilization from the spectrum of alternative payment models. The authors hypothesize that the better care is received by using case management fees to offer patients additional support services such as expanded office hours, team-based care, improved care coordination and other services.

## **B. H.R. 1934, the Cancer Care Payment Reform Act of 2015**

H.R. 1934, the Cancer Care Payment Reform Act of 2015 would direct the Secretary to establish a five-year Oncology Medical Home Demonstration project. The demonstration would involve up to 1,500 oncologists that come from a variety of geographic locations and practice sizes. It would provide oncologists with a per-month care coordination management fee for each Medicare patient treated. The demonstration would measure a variety of outcomes such as the percentage of patients who receive guideline concordant chemotherapy regimens, emergency department and hospital admission utilization rates, survival rates and end-of-life care measures. At the end of the demonstration, the bill requires the GAO to submit a report to Congress evaluating the success of the demonstration project.

This bill was introduced by Reps. McMorris Rodgers (R-WA) and Israel (D-NY) and has five bipartisan co-sponsors.

### *i. Similar CMMI Model*

The Center for Medicare and Medicaid Innovation (CMMI) has announced that it will begin a five-year Oncology Care Model in the spring of 2016.<sup>22</sup> The Oncology Care Model aims to improve care and to lower costs by giving providers episode-based fees, quality bonuses, and a monthly per-beneficiary care management payment. Participants are charged with treating patients using nationally recognized guidelines, documenting care plans in accordance with Institute of Medicine recommendations, providing access to care regardless of time of day or day of the week, and instituting continuous quality improvement.

H.R. 1934 shares many similarities to CMMI's oncology care model, but it is not housed within CMMI. Passage of this bill would either require CMMI to stop its similar model so that

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<sup>21</sup> *Id.*

<sup>22</sup> CMS, *Oncology Care Model* (2015) (online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-02-12.html>).

this bill could be implemented, or result in duplicative efforts on account of two similar demonstration projects running concurrently.

#### **IV. Medicare Home Health Face-to-Face Documentation Requirements**

##### **A. Background**

Under current law, Medicare beneficiaries who remain confined to their homes are eligible for home health services.<sup>23</sup> These services can include nursing care, home health aide, social work, or physical, occupational or speech therapy. In 2013, 3.5 million Medicare beneficiaries received home health services from 12,613 agencies at a cost of \$17.9 billion.<sup>24</sup> Home health services have seen a significant increase in spending in recent years, having doubled since 2001.

With this increase in spending has come increased scrutiny of the appropriateness of reimbursements. During the last two decades, a variety of OIG reports have emerged, which document high levels of reimbursement for claims not meeting Medicare requirements for reimbursement, patient homebound eligibility standards, or documentation that the billed service had even been provided.<sup>25</sup> One such survey showed that in 2008, 22 percent of claims were made in error resulting in \$432 million in improper Medicare payments.<sup>26</sup> Additionally, home health agencies were found to upcode on approximately 10 percent of claims, resulting in \$278 million in inappropriate reimbursements. As a result of these concerns, substantial changes to the home health payment and service verification methodology were made.

##### **B. Affordable Care Act Reforms to Home Health Certification**

In order to address fraud concerns in home health, the Affordable Care Act (ACA) included Medicare home health program integrity provisions. Specifically, the ACA mandated that as a condition of payment, physicians must engage in a face-to-face encounter with the

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<sup>23</sup> Social Security Act, § 1835(a)(2)(A).

<sup>24</sup> The Medicare Payment Advisory Commission (MedPAC), *2015 March Report to Congress* (online at [http://www.medpac.gov/documents/reports/chapter-9-home-health-care-services-\(march-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-9-home-health-care-services-(march-2015-report).pdf?sfvrsn=0)).

<sup>25</sup> *Id.*

<sup>26</sup> OIG, *Documentation of coverage requirements for Medicare home health claims* (2012) (online at <http://oig.hhs.gov/oei/reports/oei-01-08-00390.pdf>).

beneficiary and certify the patient's eligibility for the home health benefit.<sup>27</sup> Other providers, such as nurse practitioners, clinical nurse specialists, and physicians' assistants are also eligible to perform the face-to-face evaluation. The required documentation is generally brief and requires the physician or alternative provider to include an explanation of the need for home health services, documentation indicating that the patient encounter is the primary reason for the necessitated home health services, and a dated physician's signature.<sup>28</sup>

Following implementation of the rule, the OIG performed a review of provider compliance with face-to-face documentation requirements.<sup>29</sup> In general, they found widespread deficiencies and noncompliance. Specifically, 32 percent of home health claims did not meet the required documentation, resulting in \$2 billion in unsubstantiated claims. To remedy this, they recommended CMS create a standardized form to ensure compliance, increase communication with physicians and to develop an oversight mechanism for the face-to-face requirement. CMS concurred with the three recommendations and set forth a plan to enact them.

To address the OIG recommendations, CMS enacted rules to simplify the certification requirements on January 1, 2015.<sup>30</sup> While engaging with stakeholders, CMS heard from the home health industry of difficulties faced when relying on physicians to provide the face-to-face certification. Specifically, agencies expressed that the narrative portion of certification was unnecessary, as it was duplicative of information already contained in a patient's medical record. As a result, CMS removed the narrative portion of the certification documentation, so a physician simply must attest that the patient meets the criteria for home health care.

In addition, CMS is currently developing a standardized form that physicians may fill out in order to document the need for home health care.<sup>31,32</sup> CMS has been hosting Open Door

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<sup>27</sup> CMS, *Medicare Home Health Face to Face Requirement* (online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/downloads/face-to-face-requirement-powerpoint.pdf>).

<sup>28</sup> CMS, *Safeguarding Your Medical Identity* (2013) (online at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf>).

<sup>29</sup> OIG, *Limited Compliance with Medicare's Home Health Face to Face Documentation Requirements* (2014) (online at <http://oig.hhs.gov/oei/reports/oei-01-12-00390.pdf>).

<sup>30</sup> HHS, *Federal Register Vol.79 No. 215* (November 6, 2014) (online at <http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf>).

<sup>31</sup> CMS, (2015) (online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/Downloads/eclinicaltemplatev44.pdf>).

<sup>32</sup> CMS, (2015) (online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HomeHealthPaperClinicalTemplatev22.pdf>).



Forums in which stakeholders can ask questions and voice concerns about the standardized form. In addition, CMS has set up an inbox specifically to field stakeholder comments regarding the form: [HomeHealthTemplate@cms.hhs.gov](mailto:HomeHealthTemplate@cms.hhs.gov).

Although CMS has significantly simplified the certification and documentation requirements, many home health agencies still find the documentation requirements to be overly burdensome. For example, in a January, 2015 letter to CMS by Rhode Island's Congressional delegation, they documented concern over high levels of payment denials to home health agencies.<sup>33</sup> In the letter, they specifically point to CMS' high-levels of document requests and a backlog in the payment denial appeals process as being problematic for home health agencies.

### **C. Home Health Discussion Draft**

The bill that is at issue for this hearing is a discussion draft, authored by Rep. Walden (R-OR). The intent of the bill is to address some of these documentation concerns.<sup>34</sup> Its major provision develops a single, standardized document for physicians to fill out in order to fulfill the requirements of the face-to-face encounter. The document would simply require the physician to list the date of the face-to-face encounter and check-boxes for each type of skilled service ordered with a brief explanation. In addition, it waives the face-to-face requirement for patients who had been discharged from either a hospital or a skilled nursing facility within the last 14 days. Finally, the legislation requires CMS to both reopen and revise all home health claims that were denied due to face-to-face requirements on or after January, 2011 and to set up a voluntary process for home health agencies to enter into a settlement agreement with HHS in lieu of reprocessing claims that were denied due to face-to-face documentation compliance issues.

#### *i. Analysis*

The face-to-face requirement was in the ACA in order to prevent and detect over-utilization and fraud in Medicare home health care. There are concerns that this bill, if passed, would present serious program integrity concerns for Medicare, as it severely limits the face-to-face requirement.

After removing the narrative requirement, auditors are more focused on the supporting documentation. Thus, stakeholders have asked for a template, which CMS is now developing,

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<sup>33</sup> Letter from Senators Reed and Whitehouse and Representatives Langevin and Cicilline to CMS Administrator Marilyn Tavenner (January 7, 2015) (online at <http://www.vnaa.org/files/2015-01-07%20RI%20Delegation%20Ltr%20to%20CMS%20re%20Home%20Health%20Concerns.pdf>).

<sup>34</sup> S.\_\_\_\_, 114<sup>th</sup> Cong. (2015) (online at <http://www.vnaa.org/files/F2F%20bill%20Menendez%20June%202015.pdf>).

which could be added to medical record for this purpose. Notably, this bill seems to require CMS to develop a form that the agency is already in the process of developing.

In addition, this bill allows home health agencies to fill out the form and procure a physician's signature. However, as the home health agency did not perform the physician's face-to-face visit, it is unclear how it could determine the physician's thought process at that encounter—i.e. that the encounter was related to the primary reason the beneficiary needs home health care—as is required by law. The bill would also “deem satisfaction of requirements” if a home health agency completes the form and gets it signed by a physician. This provision could lead to over-utilization and fraud as it puts the home health agency in charge of whether a beneficiary receives home health care.

Though CBO has not issued a formal score, reopening four years of denied claims would have a high cost and be incredibly difficult to administrate. It is also not clear that CMS would be able to distinguish the home health denials as a result of face-to-face encounter as opposed to for other reasons, making the effort more difficult and costly.

## **V. WITNESSES**

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