July 24, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: A Letter to Doctors

Dear Administrator Verma,

The Home Care Alliance of Massachusetts (HCA of MA) - on behalf of our 100 home health agencies serving more than 110,000 Medicare patients annually – commends you for writing such a thoughtful and heartfelt correspondence, "A Letter to Doctors" on July 17, 2018, acknowledging physicians' administrative paperwork burden and its negative impact on physician time for patient care. We wish you much success with the endeavor of "patients over paperwork" and will strongly support CMS in removing regulatory obstacles that get in the way of all providers spending time with patients.

Under the umbrella of the "patients over paperwork" agenda, the home health industry would request that CMS consider revisions - from the physician's perspective - of the confusing and onerous Face to Face regulation. While the requirement that a patient must have a F2F encounter with a physician as a condition of payment became a statutory requirement with the Affordable Care Act of 2010, the fact is that the intent of the statute could have been met by a the inclusion of simple and concise signed and dated statement of the encounter in the same plan of care document the physician signs to order the home health services. Instead we have in place a complicated set of requirements relative to the documentation that must be both in the home health and physician's record, requiring that the physician medical record must document to the standard outlined by Medicare in

Chapter 7 *Home Health Services* coverage manual. This has resulted in excessive, time consuming and frustrating documentation 'back and forth' between agencies and physicians, as well as, medical review denials for "insufficient documentation" for care that clearly meets medically necessary standards.

Rather than acknowledge that this rule has been made overly complex, CMS just recently released for comment a second version of a complicated and lengthy documentation framework. The proposed CDE Drafts and Templates for the Plan of Care, Certification,; Face-to-Face Encounter Requirements is the very embodiment of your *"complicated and redundant processes …. documenting lines of text that add no value to a patient's medical record*." This form requires items to be documented that are not required by CMS regulation or policy; it would essentially be another form that is redundant with what is in the physician's record and could more simply be found and signed off on in the plan of care.

Since the faulty implementation of the F2F rule in 2011, there has been a large gap between the reality of how physicians view and document diagnosis and symptoms leading to a referral for home health and what reviewers acting on behalf of CMS have deemed sufficient. Another form is not going to change that fact. Such a form not only ignores how physician practice and document, it fails to take into account the movement toward consolidated electronic health records and how more support for a single record, that connects the home health agency, would simplify the task of documenting coverage determinations.

Physician burden would further be relieved if the rule allowed that a non-physician practitioner could perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

The Home Care Alliance of MA appreciates your consideration of these comments and stands ready to assist in any way possible.

Sincerely,

Patricia M Kelleher
Executive Director