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NATIONAL ASSOCIATION FOR HOME CARE

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May 22, 2006

Centers for Medicare & Medicaid Services,
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-B
Attn: William N. Parham, III
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Home Health Advance Beneficiary Notice Form Number: CMS-R_296
(OMB # 0938-0781)

Dear Mr. Parham:

The National Association for Home Care & Hospice (NAHC) is the largest national trade association representing home health care providers. As such, NAHC provides information and educational opportunities on regulatory and policy requirements for home health agencies and monitors the impact of these requirements on the industry. We recognize that the Home Health Advance Beneficiary Notice (HHABN), in its current form, was mandated by the *Lutwin v. Thompson* decision by the U.S. Court of Appeals (2nd Circuit). However, NAHC does not believe that the true impact and burden of the new HHABN requirements has been accurately reflected. Although we appreciate the efforts of the Centers for Medicare & Medicaid Services (CMS) to minimize the burden of the new HHABN requirements, we believe that the impact analysis must be recalculated and further work be carried out to reduce the complexity of notice requirements.

Burden Estimate

The new HHABN requirements mandate that an HHABN must be delivered to Medicare beneficiaries each time a reduction or termination of coverage and/or services occurs that was not predicted in the initial plan of care. The number of Medicare covered home health episodes in 2002 was 4.2 million, 40% of which are recertification episodes.

William N. Parham

During the course of an episode of home care services a beneficiary could receive from 1 to 6 different Medicare covered services (nursing, physical therapy, occupational therapy, speech language pathology, home health aide, medical social worker) and medical supplies, as well as a variety of non-covered services (homemaker, telehealth, dietician, respiratory therapy). An initial plan of care is developed for a 60 day period at the start of care. In light of the unpredictable nature of illness and recovery, home health agencies report that most beneficiaries have a minimum of one reduction of each service during a 60 day episode that was not predicted in the original plan of care. In addition, a majority of the 1.68 million recertification episodes reflect a reduction or termination of services. Therefore, we believe that CMS has underestimated the number of HHABNs that will be required.

Assuming that each of the 4.2 million Medicare episodes results in only a single unexpected change to the original plan of care (a gross underestimate) a minimum of 4.2 million HHABNs will be delivered annually. This number does not include HHABNs to notify beneficiaries of Medicare non-coverage and excluded services, or reductions or terminations of services when a beneficiary is self pay.

At 4.2 million notices, even if completion of each HHABN takes only 6 minutes as projected by CMS, the actual burden is significantly higher than reported.

Number of notices:	4.2 million
Time for completion:	6 minutes
Total time:	25,200,000 minutes
Total annual hours:	420,000

HHABNs are routinely completed and delivered by home health agency clinicians, primarily nurses. Although the Paperwork Reduction Act is limited to the burden of completing a form, additional agency professional time is needed to evaluate each situation in which a reduction of service occurs, consult with agency management, and deliver and explain the notice to the beneficiary. CMS policy states that a notice is not considered delivered until it is understood by the beneficiary. Therefore, a minimum of 10 minutes per notice, or national annual average of 700,000 hours, of clinicians' time will be spent on notices. This, in addition to the 420,000 annual hours for form completion, is a huge burden on clinicians, especially in light of the current shortage of nurses and therapists across the country.

Comments and Recommendations

Issue: The current HHABN is required even when reductions and terminations are due to physician orders. However, neither Option Box 1 nor Option Box 2 language is appropriate for notifying a beneficiary that changes to their plan of care are due to physician orders. Nor does either Option Box advise the beneficiary that he/she is not entitled to receive these services without physician orders. CMS has instructed agencies to use and annotate Option Box 1, explaining that services cannot be provided without physician orders. However, we believe that this will only serve to confuse beneficiaries since, when completing Option Box 1, the beneficiary is offered the choice of continuing the reduced or terminated services.

Recommendation: Develop an additional HHABN Option Box for use exclusively when services are reduced or terminated based on physician orders. Language similar to the following would serve that purpose: "We _____ are not allowed to provide home health services without orders from your physician. Your physician has instructed us to reduce/terminate (circle one) the following services _____." The new plan for your care is _____. If you do not agree with this change, have your physician contact us."

Rationale: A separate Option Box that explains that home health care cannot be provided without physician orders will decrease confusion on the part of clinicians and beneficiaries and will eliminate the need for annotations.

Issue: Home health agencies have long provided services, especially since the advent of the Prospective Payment System (PPS), for which they are not reimbursed. Costs for these services have traditionally been considered as part of agency administrative overhead. Included, but not limited to, are such services as dietitian, respiratory therapy, and telehealth. CMS instructed agencies that they must deliver an HHABN for non-coverage on initiation and at reduction or termination of all services, even for these no-charge services.

Recommendation: Eliminate the requirement to deliver an HHABN when services are initiated, reduced, or terminated if the cost of these services is absorbed by the agency in its administrative overhead.

Rationale: These services are being provided gratis. There is no Medicare or patient financial liability, nor would a no-pay bill be required for third party payment.

Issue: The required explanatory phrases for Section B, the body, are limited to “will not provide you” or “will no longer provide you.”

Recommendation: Expand the allowable phrase in Section B to include the following:

- Believe that Medicare will not provide payment for
- Believe that Medicare will no longer provide payment for
- Will only provide

Rationale: The phrases currently provided in the HHABN instructions are not appropriate for situations when Medicare coverage and qualifying criteria are not met but services are to be delivered and a third party is available to pay for continued services or the patient wishes to pay. The statement about Medicare payment will resolve this problem. In other cases, the words “Will only provide” may allow the agency to present the changed plan in a more positive and understandable manner.

Thank you for the opportunity to comment. If you have any questions or wish to discuss our recommendations I can be reached at (202) 547-7424 or by e-mail at mts@nahc.org.

Sincerely,

Mary St. Pierre
Vice President for Regulatory Affairs