PUBLIC SUBMISSION

As of: January 10, 2013
Received: December 13, 2012
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Comments Due: February 11, 2013
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Docket: CMS-2012-0155
Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131)

Comment On: CMS-2012-0155-0001
Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131)

Document: CMS-2012-0155-0002
UT

Submitter Information

Name: Timothy Coleman
Address:
Salt Lake City, UT, 84116
Organization: Weber State University

General Comment

I support this proposal for simplification of ABN's. One of the main challenges that health care providers face today when trying to comply with Medicare regulations is confusion when it comes to the necessity of paperwork. By reducing different forms of paperwork this may help alleviate this confusion. I have found in my own personal health care management experience that health care employees perform more efficiently with reduced errors if their process is simplified. If multiple processes or rules can be condensed into one, there is less chance for human error.

PUBLIC SUBMISSION

As of: February 11, 2013
Received: January 22, 2013
Status: Draft
Category: Home Health Facility - HPA25
Tracking No. 1jx-8399-poql
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Submission Type: Web

Docket: CMS-2012-0155
Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131)

Comment On: CMS-2012-0155-0001
Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131)

Document: CMS-2012-0155-DRAFT-0002
NY

Submitter Information

Name: Sue DUnnigan
Address:
Albany, NY, 12203
Organization: Living Resources Certified Home Health Agency

General Comment

Regarding ABN (Form CMS-R-131 (3/11) Section G Options - I think that there will be confusion with the "You" and "I"s referenced in Option 1 and 2. Also, confusion use of word "paid".

This is my recommendation for clearer wording-
Option 1. I want the D_____ listed above. I may be asked to pay for D_____ now, but I also want Medicare billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN).....

Option 2. I want the D._____ listed above, but do not bill Medicare. I may be asked to pay for D_____ now as I am responsible for payment.

Re listing Estimated cost- Can we list cost of service by visit vs cost for projection of total number of visits in 60 day episode?
Example: "PT - $150 per visit" (One visit example) or are you asking for documentation that reflects "PT - Between $600 and $750 per 60 day period" (projecting episodic reimbursement based on a fee for service reimbursement model and not on episodic model)
As a provider, it is more accurate and easier to discuss costs with client and caregiver by listing a fee for service or cost per visit/test/treatment projection vs a cost based on a range of time in which frequency of service and proportionally the price would fluctuate. (Base fee for service price would be the same, but frequency of use of that service would define cost.)

Re ABN Form Instructions-
Overview - paragraph 3- Second sentence - The ABN must be delivered far enough in advance that the beneficiary has time to ..... Not sure "as far enough in advance" really means. Sometimes it may be necessary to deliver notice on day of change, other times there may be ability to give predicable notice of change in coverage earlier in time.

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

February 6, 2013

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room c4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-10280 and CMS-R-131

Dear Sir/Madam:

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 175,000 Medicare patients in New York State. HCA's members include Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCP) providers, Licensed Home Care Services Agencies (LHCSAs), providers of various waiver programs, Managed Long Term Care plans, hospices and others. HCA's home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

Our membership of CHHAs gives us an important perspective on changes to the Home Health Advance Beneficiary Notice (HHABN) and we appreciate the opportunity to provide comments. When prior changes were made to the HHABN, we advocated that the form be simplified to make it easier to complete by home health staff and made more understandable for patients and their families.

In general, we support CMS's effort to simplify the HHABN three options by utilizing a different notice, such as the existing Advance Beneficiary Notice of Noncoverage (ABN), for the current HHABN Option Box 1, and the new Home Health Change of Care Notice (HHCCN). However, the ABN was not designed for home care cases and the form, along with the accompanying instructions, need many revisions before they will be appropriate for home health patients. Though the HHCCN is an improvement over the current HHABN Option Box 2 and Option Box 3 forms, we seek clarification on its use and certain revisions.

ABN

Options Section

In the Options section, the choice of words like "You," "I" and "Paid" are confusing and should be changed. Our recommendation for Option 1 is:

- I want the _____listed above. I may be asked to pay for _____ now, but I also want Medicare billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice . . . .

For Option 2, we recommend the following language:

- I want the _____ listed above, but do not bill Medicare. I may be asked to pay for _____ now as I am responsible for payment.

Medicaid and Other Insurance

Even though the ABN instructions (page five) indicate that "Beneficiaries who need to obtain an official Medicare decision in order to file a claim with secondary insurance should choose Option 1," such language should be included on the ABN so that it is clear to both providers and patients. The existing ABN language, "Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this," is very confusing and should be removed.

We suggest adding text to Option 1 on the ABN similar to that on the current HHABN Option Box 1, whereby the patient can check off a box to request that a claim be submitted to other insurance. We would also add Medicaid to the language so that it would read, "Send the claim to Medicaid or my other insurance." This additional language is very important, as New York State and some other states have a very large number of individuals dually eligible for Medicare and Medicaid.

Delivery

The ABN instructions (page one, paragraph three) state that "the ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice." We request clarity on "far enough in advance." Sometimes the home health agency conducts the initial assessment on the first visit and determines that Medicare will not cover services. Thus, the agency would deliver the ABN on this visit. In this case, the agency cannot meet the "advance" criteria and should not be penalized. We recommend that the "advance" language be revised to recognize that providing advance notice is not always feasible.

Service Reductions

The ABN instructions (page three, last bullet) indicate that the ABN is used for service reductions. This is confusing, as the new HHCCN would be used for reductions, such as reducing the number of therapy visits due to a change in the physician's order. If the ABN also is used for home health reductions, then clearer guidance is needed to explain when it is used and how this differs from when the HHCCN is used.

Reasons that Medicare May Not Pay

The reasons indicated on the ABN instructions (page four) for Medicare not paying are not appropriate for home health cases. We suggest giving some examples specific to home health as outlined in the CMS Manual HHABN Instructions (Transmittal 2362, December 1, 2011). These include:

- "Medicare does not pay for care that is not medically reasonable and necessary;"
- "Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit;" and
- "Medicare does not usually pay for custodial care, except for some hospice services."

For cases where the same reason for noncoverage applies to each service, the ABN instructions also need to indicate if the home health agency has to write the same reason for every service or can indicate that the same reason(s) applies to all services. We support allowing the agency to write that the same reason(s) applies to all services.

Non-covered Services

The ABN instructions (page three, third bullet from bottom of page) indicate that it is used for non-covered care. This needs clarification so that home health agencies know if the ABN should be used for services that Medicare never covers, such as waivered services under a state's home and community-based waiver program (i.e. personal emergency response system) or for home health services covered by Medicare only under certain circumstances (i.e. patient must require skilled care and be homebound).

Cost Estimates

The ABN instructions (page four) need to explain whether home health agencies can list the cost of a service per visit or if they are expected to project the total number of services that will be part of the 60-day episode of care. For example, can the agency indicate that physical therapy costs $150 per visit or does the agency have to estimate that physical therapy will cost between $600 and $750 per 60-day period?

HCA prefers that agencies be allowed to list the fee per service instead of a cost based on a range of time in which frequency of service (and thus the cost) would fluctuate.

Signature

The ABN instructions (page six) should indicate if the term "representative" refers to "authorized" representatives and, if so, who can be such a representative and what documentation the home health agency should request to confirm such an appointment.

Burden Estimate

The burden estimate for the ABN (page seven of ABN Supporting Statement) is very confusing: seven minutes to deliver each notice, and the hourly burden is 4.79 hours per notifier. We request clarification on this burden and ask that the estimate be revised to include completion of the form, delivery to the patient and explanation of its contents to the patient and family so that the estimate is more realistic.

HHCCN

Box Language

The language at the top of the second box, "Your home health agency has decided to stop giving you the home care listed above," is misleading and should be replaced with: "Your home health agency is unable to continue giving you the items/services listed above." The current language seems to indicate that the

home health agency has decided on its own to stop care when in actuality it is due to reasons beyond the agency's control, such as an unsafe environment.

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The HHCCN instructions (page two under Applicability) state that the HHCCN is required for covered and non-covered services listed in the plan of care. As stated in our comments on the ABN, we request clarification so that home health agencies know if the HHCCN should be used for services that Medicare never covers, such as waivered services under a state's home and community-based waiver program (i.e. personal emergency response system) or for home health services covered by Medicare only under certain circumstances (i.e. patient must require skilled care and be homebound).

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Though the form informs the patient that "You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed," this explanation is inadequate. We suggest removing it or providing a lengthier explanation in the instructions so that the appropriate home health agency representative can answer any patient-related questions.

Notice of Medicare Non-coverage Form

The HHCCN instructions (page two, Triggering Events) indicate that "If a termination involves the end of all Medicare covered care and no further care is being delivered, the only notice issued would be a Notice of Medicare Non-coverage (NOMNC)." This section should be expanded to address whether the HHCCN (or ABN) is needed if all Medicare covered services are ending but non-Medicare covered services will continue.

Thank you for the opportunity to provide comments and feel free to call me if you have any questions or need additional information. I can be reached at (518) 810-0662.

Sincerely,

Andrew Koski
Vice President, Program Policy and Services

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

February 6, 2013

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Division of Regulations Development
Room c4-26-05
7500 Security Boulevard
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Sincerely,

Andrew Koski

Andrew Koski
Vice President, Program Policy and Services

Andrea L. Devon, MSN, MBA, RN
Chairman of the Board

HOMECARE & HOSPICE

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

February 11, 2013

Re: CMS-10280 and CMS R-131

To Whom It May Concern:

The National Association for Home Care & Hospice (NAHC), the largest trade association representing providers of health care services in the home appreciates the opportunity to comment on proposed changes to the Home Health Advance Beneficiary Notice (HHABN). NAHC applauds the Centers for Medicare & Medicaid Services (CMS) for taking steps to clarify and simplify the process for informing Medicare beneficiaries of reductions in their care, and for differentiating between notification of Medicare non-coverage as required by the Social Security Act and notification of reductions for other reasons as required by the *Lutwin v. Thompson* decision.

NAHC realizes that CMS plans to provide detailed instructions for the use and completion of the proposed forms and thanks CMS in advance. However, we do wish to offer the following suggestions for revisions to the forms.

CMS-R-131 Advance Beneficiary Notice

We agree that home health agencies should use the Advance Beneficiary Notice of Noncoverage (ABN) as required of other providers. However, we request consideration of two amendments to the form:

1. The letter phrase "D_____listed above" be deleted with from the language in all three Options (1, 2, and 3) and replaced with "services and/or supplies as listed above"
2. Replace MSN in the statement under Option 1 and change it to read "...I can appeal to Medicare by following the directions on the Medicare Summary Notice."

CMS-10280 Home Health Change of Care Notice (HHCCN)

In order to reduce misunderstanding and eliminate repetitive language, we request consideration the following amendments to the form:

1. Replace the single "Items/services and "Reasons for change" box with two separate "Items/services" and "Reasons for change" box below each check boxes (i.e. bellow both "Your doctor's orders..." and "Your home health agency has decided...").
2. Remove the word "provider" from all places where it appears on the form since only physicians may order home health.
3. Amend the first sentence in the second box to read: "You can look for care from a different home health agency if you still need care and your doctor agrees." Remove the statement "If you get care..., you can ask it to bill Medicare" since this notice is unrelated to Medicare coverage.
4. Remove the statement "If you have questions about these changes, you can contact your home health agency and/or the doctor/provider who orders your home care" as it is repetitive of advice included in both of the checkboxes.
5. Since none of the services addressed in this form are appealable, either remove the statement: "You cannot appeal to Medicare about payment for the items/services listed above..." or amend ending of the sentence to read: "...because you they are not related to Medicare coverage."

Thank you for consideration of our comments. If you wish to discuss these further, please feel free to contact me at (202) 547-7424 or by e-mail at mts@nahc.org

Mary St. Pierre, RN, BSN, MGA

Mary St. Pierre

Vice President for Regulatory Affairs