July 21, 2016

VIA E-MAIL: OIRA_submission@omb.eop.gov

Attention: CMS Desk Officer
Office of Management and Budget (OMB)
Office of Information and Regulatory Affairs
725 17th Street, NW
Washington, DC 20503

RE: Agency Information Collection Activities: Submission for OMB Review; Comment Request (OMB Control Number: 0938-NEW)

To Whom It May Concern:

Amedisys, Inc. ("Amedisys"), a national home health and hospice provider delivering care in 36 states through more than 400 Medicare-certified home health and hospice agencies, appreciates the opportunity to comment on the Notice entitled *Agency Information Collection Activities: Submission for OMB Review; Comment Request* (the "Notice") published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register on June 21, 2016, regarding the Pre-Claim Review Demonstration (PCRD) For Home Health Services (Form Number: CMS-10599 (OMB Control Number: 0938-NEW)).

Amedisys reiterates its opposition to any prior authorization or PCRD for the home health benefit for an entire state as a basis to combat fraud. As stated in our comments to OMB and CMS on the initial Paperwork Reduction Act (PRA) Notice announcing the then "Prior Authorization Demonstration for the Medicare Home Health Benefit", we believe CMS has many other options in targeting and rooting out fraud and combating the improper payment rate for home health claims. Furthermore, Amedisys is a member of the Partnership for Quality Home Health Care (the Partnership), and we join the Partnership in its comments submitted in response to this burden estimate request and the previous comments submitted on prior authorization.

The burden estimate associated with the implementation of the Pre-Claim Review (PCR) is necessarily incomplete and continues to evolve based on the constant updating of information from CMS and the Medicare Administrative Contractors (MACs). Within the 48 hours prior to this submission, representatives from Amedisys participated in CMS and MAC sponsored webinars and Open Door Forums directed at both Home Health Agencies (HHAs) and the physician community. During each of these sessions, new information has been passed along that will result in additional resources and time not originally contemplated

in the burden assessment analysis performed in response to the publication of the aforementioned Notice. We urge OMB, CMS and others to cautiously approach this demonstration with an understanding that the burden on beneficiaries, HHAs, physicians, CMS, MACs, the Medicare Trust Fund, and taxpayers can in no way be accurately ascertained at this time. Real-time information from CMS and the MACs and the provisional affirmation and non-affirmation rates will be required to further detail the burden of this demonstration, along with specific and detailed information about why the claim is being non-affirmed.

Moreover, it is impossible for an HHA to estimate the burden for compiling the necessary information needed for claims that are initially non-affirmed and required to be resubmitted an unknown number of times, or partially provisionally affirmed/partially non-affirmed.[1]

Based on the criteria presented by CMS and its MACs during the last few weeks and the specific tasks that have been itemized by the MACs that will be required to be completed by submission, Amedisys estimates that it will take 55 minutes to submit a Start of Care (SOC) for pre-claim review and 50 minutes for a recertification episode. For an HHA completing 50 new admissions and 25 recertifications each month, this would result in approximately 67 additional working hours per month (17 hours/week), which is the equivalent of .43 full time equivalent (FTE) employee. Obviously this workload would increase for larger agencies, and the work is unlikely to be able to be absorbed by current staff levels. In addition, note that this estimate does not include potential resubmissions, because we have no way to estimate what percentage of pre-claim reviews will be non-affirmed and require resubmission. We arrived at the 55 and 50 minute estimates based on the tasks outlined by Palmetto GBA (PGBA), the MAC for three of the demonstration states (Illinois, Florida and Texas). PGBA has stated its preferred method of correspondence for this pre-claim review is its portal. The task list that PGBA has outlined is as follows:

After accessing the portal and entering required demographic data, the HHA will need to submit documentation based on a "dynamic tree" model.

- Task 1: Upload the actual FTF clinical encounter note used by the certifying physician to justify the referral for Medicare HH services
- Task 2: Upload the HHA generated records that have been signed, dated and incorporated into the certifying physician's medical record

[1] HHAs only recently learned through a MAC webinar that during PCR a claim may be partially provisionally affirmed and non-affirmed at the same time for the same episode of care, as the affirmation does not apply to the entire episode, but to the individual Healthcare Common Procedural Coding System (HCPCS) Codes that are included on the claim.

- Task 3: Upload the plan of care established and periodically reviewed by an authorized physician
- Task 4: Upload the signed and dated physician's certification of patient eligibility
- Task 5: Upload medical documentation that meets the First Criteria for Confined to the Home
- Task 6: Upload the documentation to support the normal inability to leave the home
- Task 7: Upload the documentation to support the considerable and taxing effort

Please note that PGBA has specified that, even if a particular portion of the medical documentation provides evidence for more than one of the tasks, it must be named and uploaded separately for each task.

HHA staff will need to scan, upload and name documents, some of them multiple times, to follow this process. This duplication makes an already burdensome process even more complex.

To arrive at our time estimates, we assume the following:

1) Start of care documentation: 55 minutes
    a. 25 minutes to gather, scan, name and save documents
    b. 20 minutes to complete data entry and uploads to the portal
    c. 10 minutes to do internal tracking
2) Resubmission for non-affirmed decisions: additional 60 minutes
    a. 5 minutes to review the decision letter detailing missing elements
    b. 25 minutes to gather missing elements, scan, name and save documents
    c. 20 minutes to complete data entry and uploads to the portal
    d. 10 minutes to do internal tracking
3) Recertification documentation: 50 minutes
    a. We assume 5 minutes less because the FTF documentation will already be scanned, named and saved
    b. All other requirements are the same

Moreover, the amount of additional documentation PCR will require from HHAs cannot be overstated. Currently, an HHA submits RAPs and final claims to the appropriate jurisdictional MAC through Direct Data Entry (DDE), providing required billing codes and details but no paper documentation. At certain times, MACs will make an Additional Development Request (ADR) to an HHA requiring the production of documentation necessary to support a claim. This request

typically requires the HHA to submit the signed Plan of Care, documentation of the Face-to-Face encounter, visit notes and other pertinent documentation. ADRs account for approximately five (5) percent of all claims submitted and typically result in the HHA submitting approximately 200+ pages of documentation. One can easily extrapolate the figures and arrive at an astronomical increase in the documentation required for 100% of all claims in a given state to be subject to pre-claim review. CMS has neither acknowledged nor projected this burden; but instead has consistently contended this demonstration presents no additional documentation requirements for HHAs. This is an inaccurate representation of the administrative burden that will be undoubtedly be borne by HHAs if the PCR demonstration proceeds as planned.

Finally, in addition to the significantly deficient time estimate and the non-existent estimate on the HHAs burden for documentation, CMS also estimates work will only be required of non-medical clerical staff in order to complete the necessary tasks associated with PCR. We disagree with this assumption. Clerical staff may do the actual data entry in the portal, but a clinical staff person will need to review all records to be sure the documentation meets the specified criteria. Thus, the hourly wage figures utilized by CMS from the Bureau of Labor and Statistics (BLS) is low and does not accurately project the costs of the PCRD to HHAs.

* * * * *

Amedisys appreciates the opportunity to address the burden estimate presumptions presented by CMS in the PRA Notice. As stated previously in prior comments and as noted by the Partnership in its comments, this demonstration is unnecessary to fulfill its stated aim of decreasing fraud and abuse of the Medicare Home Health benefit. We are supportive of CMS' desires to root out fraud and abuse and believe the agency can continue to pursue these efforts and fulfill the Triple Aim through a more targeted approach to combat fraud. We also believe that the "improper payment rate" that is attributable to insufficient documentation can be addressed by clarifying and simplifying the documentation requirements necessary to demonstrate full compliance with certification and eligibility requirements. Amedisys knows CMS shares its goal of providing the highest quality of care to Medicare beneficiaries in the most cost effective setting – which is the home. If you have any questions, feel free to contact me at 615.928.5468.

Sincerely,

Kate Jones, MSN, RN, CCM
Senior Vice President, Public Policy and Research
Amedisys, Inc.