Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

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

July 21, 2016

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:

The Partnership for Quality Home Healthcare (the "Partnership"), a national coalition of skilled home healthcare providers dedicated to ensuring the quality, efficiency, and integrity of the Medicare home healthcare benefit for homebound seniors and disabled Americans, 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)).[1]

According to the Notice, CMS seeks to develop and implement a Medicare demonstration project, which CMS believes will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among home health agencies (HHAs) providing services to Medicare beneficiaries. CMS seeks OMB approval of the relevant information collection to effectuate this demonstration.

As discussed below, the Partnership has serious concerns with both the intent and design of the underlying demonstration, and therefore strongly questions the necessity and utility of the proposed information collection for the proper performance of the agency's functions. We also have very serious concerns with the accuracy of the estimated burden provided by CMS. For these reasons, we urge OMB to decline to approve the proposed Form Number: CMS-10599.

Necessity and Utility of the Proposed Information Collection

CMS notes that the PCRD would "help assure that payments for home health services are appropriate before the claims are paid, thereby preventing fraud, waste, and abuse."[2] Specifically, as justification

[1] CMS, *Agency Information Collection Activities: Submission for OMB Review; Comment Request*, 81 Fed. Reg. 40308 (June 21, 2016).
[2] 81 Fed. Reg. at 40309.

for the need and legal basis of the PCRD, CMS cites section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)(J)), which authorizes the Secretary to "develop or demonstrate improved methods **for the investigation and prosecution of fraud** in the provision of care or services under the health programs established by the Social Security Act (the Act)." (Emphasis added.)

However, as we have discussed with CMS on numerous occasions, the actual underlying issue that the agency seeks to address is a high *improper payment rate*, not fraud. Our ongoing work – both independent analyses and through discussions with CMS – strongly indicates that this improper payment rate is not a strong indication of fraud. Instead, this improper payment rate is primarily driven by the lack of clear guidance provided by CMS, the lack of appropriate physician education, the lack of objectively standardized submission requirements, the correspondingly subjective assessments on the part of Medicare Administrative Contractors (MACs), and the ongoing difficulty that HHAs face in trying to obtain accurate and complete information from physicians with whom they necessarily coordinate – but not necessarily with whom they contract. As a result of these factors, HHAs are frequently determined by MAC reviewers to have submitted incomplete or improperly completed paperwork when seeking payment for Medicare claims. In fact, CMS acknowledges in the CMS-10599 Supporting Statement that a full 90% of the errors that comprise the current improper payment rate consist of "Insufficient Documentation Errors."[3]

Furthermore, we understand that the improper payment rate identified by CMS represents the rate of improper payments identified in the pre-appeal stage of claims adjudication. Our members' experience suggests that HHAs frequently appeal findings of improper payment and are ultimately successful in overturning the vast majority of MACs' initial denials. Anecdotally, some HHAs report an average overturn rate in excess of 90% to 95% during the course of appeals. We believe this suggests that CMS is relying on an inaccurate measure of improper payment rates to justify the demonstration.

Given that the problem CMS seeks to address is ultimately not the prevention of ***fraud***, but the minimization of first-level review claim denials based almost exclusively on subjective determinations of insufficient documentation, we strongly believe that the proposed PCRD is an overly broad, overly aggressive, and potentially harmful approach that will not address the root causes of the existing improper payment rate. To that end, we have called on CMS to delay and, ultimately, withdraw the proposed demonstration; we similarly urge OMB to decline to approve the proposed information collection in favor of an approach that better targets actual causes and perpetrators of fraud.

Inaccuracy of the Estimated Burden

As part of the PCRD, CMS proposes to perform – through these same MACs – pre-claim reviews before processing claims for *all* home health services in: Florida, Texas, Illinois, Michigan, and Massachusetts. Furthermore, despite public pronouncements to the contrary, CMS acknowledges in the Supporting Statement that "CMS as a whole does not collect the information in any existing

[3] Supporting Statement, at 2.

format. With the exception of basic identifying information such a beneficiary name, address, etc., there is no standard form or location where this information can be gathered."[4] As such, this information collection request represents both a wide-reaching and entirely new task for HHAs to undertake.

As CMS notes, the burden associated with this prior authorization is based on the time and effort necessary for the submitter to locate and obtain the supporting documentation for the Medicare claim and to forward the materials to the Medicare contractor for review. CMS "expects that this information will generally be maintained by providers as a normal course of business and that this information will be readily available."[5] What CMS fails to acknowledge is that the information being collected – including a "face-to-face narrative", a physician-signed and dated plan of care, and other medical records – are generally not collected by HHAs prior to the start of care or even within the first days or weeks during which care is provided. This is due, in large part, to the unique nature of the interactions between HHAs and ordering or certifying physicians. These physicians are largely non-contracted with respect to the HHAs with which they work, meaning HHAs have no "stick" to assist in the pursuit of necessary documentation. These physicians are also not reimbursed under Medicare for generating and supplying the relevant documentation, leaving no "carrot", either. What's more, CMS has not yet sufficiently and appropriately educated physicians about the impact that their delays or errors in documentation can have on HHAs.

With respect to the financial burden of this demonstration, CMS estimates that average time for office clerical activities associated with this task will be 30 minutes, equivalent to that for prepayment review. Based on Bureau of Labor Statistics (BLS) information, CMS further estimates an average hourly rate of $15.89 with a loaded rate of $31.78. This equates to a cost of $21.6 million for 3 years. In total, CMS estimates that nearly one million responses will be collected across these five states each year, requiring close to half a million hours of work, and totaling roughly $7.2 million in additional expenses to HHAs annually. This estimate excludes the cost of mailing medical records, which could increase the total costs to HHAs by an additional $4.5 million annually. CMS goes on to note that the impact of this financial burden will be allocated across providers and nationwide[6] without acknowledging that some providers will be significantly more impacted than others – namely, those providing higher volumes of care in the five demonstration states.

As noted above, the Partnership has serious concerns about the accuracy of CMS' burden estimate. First, while CMS projects a 0.5 hour investment related to each submission, we believe each submission will comprise upwards of between 0.75 hours and 1.0 hours, based on various factors. We expect that this would be the minimum time investment at the outset of the demonstration in each state, but anticipate that this could decrease slightly over the course of implementation. We note that the prepayment review to which CMS likens the PCRD is a distinct process, not subject to the myriad document organization, claims processing, and product requirements that have been proposed for the PCRD. Specifically, the MAC providing the most current guidance around implementation (Palmetto GBA) has indicated that documentation specific to seven (7) separate

[4] Supporting Statement, at 4.
[5] Supporting Statement, at 5.
[6] Supporting Statement, at 6.

tasks will be required and must be submitted in a precise order, with separator pages or specified file names.

We note that the average timeframe identified above represents an initial request for pre-claim review at the start of care for a new episode. Submissions for a recertification of a subsequent episode of care may be somewhat shorter. The average time will also be longer for resubmissions (which require additional time to research and gather "missing" documentation). Additional time beyond this estimated average would also be necessary in cases wherein a patient's status changes over the course of an episode, warranting the provision of additional services – and requiring additional pre-claim review request submission(s). Our members are strongly concerned that these changes in status could result in the full duplication – or more – of time associated with submissions.

Therefore, the time investment necessary to comply with this new program will include, among other things, at least the following activities:

- Initial review of each patient's electronic or paper record as received from the referring provider (the format(s) of which can vary by provider);
- Retrieving and organizing documentation necessary for pre-claim review submission;
- Engaging in follow-up communications with the referring provider regarding any missing or incomplete documentation;
- Compiling newly received and/or updated documentation;
- Finalizing and submitting final pre-claim review request documentation package;
- Attending to potential system failures;
- Reviewing and responding to MAC communications regarding provisional approval or non-approval of a pre-claim review request (*i.e.*, resubmissions);
- Compiling and submitting additional documentation in instances where there is a change in the patient's condition such that additional services are required (and subject to separate and additional MAC review); and
- Attention to documentation of pre-claim review status on final claim filings.

Second, CMS estimates the work will be performed by individuals who are paid at an hourly rate of $15.89 – what appears to be the BLS-estimated hourly wage for medical secretaries.[7] Such individuals are not licensed medical professionals. This suggests that CMS does not expect HHAs to hire or utilize clinicians for this task, but views it as a mere clerical endeavor. However, CMS has confirmed publicly that the applicable MACs ***will*** be hiring and utilizing clinicians for purposes of reviewing and approving or denying all pre-claim review requests. We therefore anticipate that the vast majority of HHAs will similarly use clinicians for purposes of reviewing, compiling, and submitting pre-claim reviews to best ensure accuracy, completeness, and anticipate what issues MAC reviewers may be looking for.

As a result, we estimate that the associated average hourly rate will be much closer to (if not greater than) a base rate of $21.76 per hour – the most recent median hourly rate for licensed practical

[7] See BLS, *May 2015 National Occupational Employment and Wage Estimates United States*, available at: http://www.bls.gov/oes/current/oes_nat.htm

nurses (LPNs). As a result, we anticipate that the actual costs associated with the PCRD will far exceed CMS' burden estimate. When the increased time and wages are taken together, rather than costing HHAs a total of $7.2 million per year, we anticipate the actual costs will more than double this amount, reaching or exceeding $14,830,636.80 per year. CMS has also failed to consider the additional upfront costs associated with educating and training HHA providers and staff on the PCRD or the system changes necessary to allow for electronic submission of the information. Given the highly abbreviated timeframe for this demonstration, our members have not had sufficient to fully estimate these upfront costs, but anticipate that they will be significant.

We also reiterate that these costs will *not* be spread evenly across providers nationwide, but will be concentrated among those HHAs that have higher densities of patient populations located in the five demonstration states.

Conclusion

Given that the underlying demonstration has not been shown by CMS to be necessary for the stated purposes (*i.e.*, to reduce fraud) and is anticipated to nearly double the estimated burden on HHAs, we urge OMB to decline to approve the Information Collection request for OMB Control Number: 0938-NEW in favor of an approach that better targets the actual causes and perpetrators of fraud without unnecessarily adding such a significant burden on these critical health care providers. We appreciate your consideration of these comments. Please do not hesitate to contact me at 202.239.3436 or colin.roskey@alston.com if we can provide anything more.

Sincerely,

Colin Roskey
Executive Vice President
Partnership for Quality Home Healthcare