



July 20, 2016

OMB
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

Re: CMS-10599; OMB Control Number: 0938-NEW

Dear Sir/Madam:

The Home Care Association of New York State (HCA) appreciates the opportunity to comment on the proposed Information Collection Request for the “Pre-Claim Review Demonstration. For Home Health Services.”

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 300,000 Medicare and Medicaid 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.

While we support efforts by the U.S. Centers for Medicare and Medicaid Services (CMS) to address billing, payment and service integrity in the Medicare program, we strongly object to the proposed “Pre-Claim Review Demonstration For Home Health Services” and call for it to be rescinded.

General Comments

While CMS has revised the Medicare Prior Authorization of Home Health Services Demonstration to now become a Pre-Claim Review Demonstration, we believe the revised Demonstration would still create unnecessary obstacles to care, increase system wide costs, and jeopardize the quality of care that patients receive.

The following is a detailed description of our concerns about this misguided proposal.

Access to Care

The demonstration requirement that signed physician orders, face to face (F2F) encounter evidence and other documentation must be submitted as part of the pre-claim review process will lead to long delays in HHAs utilizing the pre-claim review process and obtaining a pre-claim determination on home care cases.

Currently, home health agencies (HHAs) have up to 12 months after a patient is admitted to an agency or prior to billing, whichever is sooner, to submit **signed** physician orders (prior to final billing they can obtain verbal orders). HHAs encounter numerous roadblocks to acquiring signed physician orders and often spend countless hours and staff resources in contacting physician offices for signatures.

HHAs have also encountered endless problems in having physicians submit the necessary documentation to meet the F2F requirement as there are unclear guidelines from CMS and the Medicare Administrative Contractors (MACs). Our experience is that CMS's "probe and educate" reviews, which are pre-claim reviews of five selected cases, have resulted in the majority of cases being denied due to inadequate documentation.

In some "probe and educate" cases, we have heard that agencies had some claims approved and others denied that had the same circumstances and documentation.

CMS should conclude from these reviews and other home care claims experience that there is a major issue with the requirements for documenting home health eligibility, as opposed to an indication of fraud and abuse in home health. Also, there seems to be little consistency among the MAC staff and we fear that this will carry over into the pre-claim review demonstration.

The expectations put on doctors regarding their written records to show that their patients are eligible for Medicare-covered home health are unreasonable, unrealistic and overwhelming. Until CMS simplifies the documentation requirements, we expect that the pre-claim review demonstration will result in many "non-affirmed" requests.

Requiring that all this documentation be submitted with the request for a pre-claim review will delay agencies in requesting a pre-claim review decision and leave the agency in limbo as to whether their final claim will be approved. Secondly, requiring agencies to utilize this process for **every** 60-day episode of care will create an unreimbursed and tremendous paperwork burden on agencies. We expect that HHA staff will have to spend countless hours in obtaining and submitting documents multiple times to the MACs as the HHAs are told that their pre-claim review was not affirmed and they are told to send additional evidence.

An additional burden is placed on those HHAs that have the capacity to submit information electronically, but encounter MACs that only want paper documents.

In addition, we question how the MACs will be able to issue a decision on a pre-claim review request within 10 business days for an initial request and 20 business days for a resubmitted request following an adverse decision.

Pre-claim review and RAP

While CMS confirmed on the June 28 Open Door Forum that the Request for Anticipated Payment (RAP) will be paid regardless of the pre-claim review determination, it needs to issue a clarification in writing on this issue. If the RAP will not be paid until after a favorable pre-claim review, this will put agencies at risk of providing services for a period of time without payment. HHAs will be unable to await payment until they receive a favorable pre-claim review determination, and patients will face major problems in accessing home care services.

Pre-claim review is counter to CMS's stated goals

In the June 21, 2016 *Federal Register* Information Collection Notice of the proposal, CMS states that this demonstration will help assure that payments for home health services are appropriate before the claims are paid, thereby preventing fraud, waste and abuse.

CMS justifies the demonstration by pointing to a high improper payment rate (59 percent in 2015) for home health services, and states that a large proportion of the improper rate was due to insufficient documentation.

However, many of these errors were due to insufficient documentation, predominantly in the F2F requirement, which is the subject of intense provider and policymaker discussion regarding its efficacy and necessity. Pre-claim review will not address this major driver of denials at a time when the required documentation of F2F remains mired in dispute, due to conflicting information and direction by MACs, inadequate physician education and engagement.

While a large number of payments have been retrospectively disallowed on the basis of F2F, these disallowances are technical and bureaucratic in nature, rather than resulting from evidence that services were not needed or provided. These findings aside, the major areas of HHA fraud are not documentation issues, but billings for "phantom" patients and referral kickbacks conducted by a few bad actors in the system; none of these cases would be addressed by a pre-claim review system.

Pre-claim review is duplicative of existing CMS audit activities and controls

CMS already has many existing tools and auditing entities at its disposal to address Medicare integrity issues, including Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), state-level surveillance agents (targeting Conditions of

Participation adherence), third-party liability payment auditors, the Office of the Inspector General, the MACs' "Probe and Educate" reviews and others.

In an environment where audit and integrity programs are already robust, this new Demonstration is even less discriminating in its targeting. The initiative unfairly and arbitrarily scrutinizes all HHAs in the selected states, even those who have a long established record of compliance with existing rules and regulations and may already be scrutinized by retrospective audits from other entities.

The pre-claim review proposal would burden all providers equally, regardless of the individual HHA's compliance record and regardless of other factors such as patient diagnosis and age that is currently on Outcome and Assessment Information Set (OASIS) and claims data that is available to CMS with which targeted, case-specific, risk-based reviews could be performed under the Additional Documentation Request (ADR) process. Under ADRs, Medicare already performs post-billing audits of provider cases which provide CMS with a similar oversight process to pre-claim reviews.

CMS's time and resources would be better allocated targeting those specific HHAs, regions, or utilization bands suggesting fraudulent activity, rather than punishing all agencies with a time-consuming and costly pre-claim review process.

Pre-claim review jeopardizes and contradicts the design of existing CMS innovations and goals

Regrettably, this demonstration works in direct opposition to the current orientation of our health care environment, where CMS's "Triple Aim" and associated programs are focused on delivering services in the most appropriate care setting at the lowest cost.

The bottleneck and burdens created by pre-claim review contradicts the very goals, procedures and technical designs of CMS's own innovations, be it value-based payment, bundling initiatives, Accountable Care Organizations or other specific new pilots like the Comprehensive Care for Joint Replacement (CJR) program – all of which rely on the smooth, expeditious and flexible assignment or discharge of patients.

Pre-claim review takes care-planning decisions away from professionals in the field who have direct knowledge of urgent care demands and consequences

This demonstration process redirects care-planning decisions from the patient's care team to the Medicare contractors. These government contractors are not directly liable for the timely initiation of care at the clinical level and they are not intimately involved in urgent clinical decisions where time is of the essence, especially during discharge from hospitals on weekends and evening hours and in other critical circumstances.

Pre-claim review increases costs to Medicare, its providers, its contractors and will worsen an already massive backlog of appeals

By requiring agencies to submit multiple documents for the pre-claim review, it will take nursing staff away from patient care, worsen an already shortage of nursing staff and threaten the ability of HHAs to respond to timely hospital referrals.

This proposal has the potential to drive longer inpatient stays in facilities and increase costs to Medicare (be it prolonged hospital stays or incentives for admission to other post-acute facilities) while nurses spend additional time on obtaining burdensome records rather than on providing services at home. In many cases, home care is the most cost-effective and preferred type of post-acute care and delays to accessing home care will increase Medicare costs.

Statistical models bear this out. According to a 2012 study by Dobson DaVanzo and Associates, home care accounts for nearly 40 percent of hospital discharge episodes to a post-acute setting; yet these episodes represent less than 30 percent of Medicare episode payments (costs). In contrast, skilled nursing facilities represent 50 percent of post discharge episodes and approximately 50 percent of episode payments (costs).

This demonstration will also significantly raise administrative costs for agencies tasked with new paperwork requirements. HHAs and referring physicians will be forced to redirect staff time away from the beneficiary's clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. As it stands, providers are already stretched thin in the "paper chase" for signed physician orders, face-to-face encounter documentation, and physician validation under the Provider Enrollment Chain and Ownership System (PECOS). This demonstration offers a duplicative process of oversight that will only add to the paper chase that already plagues providers.

One of our home care members has estimated that such a demonstration would require it to hire two full time employees to keep up with gathering all of the information, tracking it and filing any necessary appeals.

Meanwhile, HHAs are subject to devastating rebasing reductions and other reimbursement cuts that already underpay these existing cost obligations, not to mention the new cost obligations of a pre-claim review process, which has a direct impact on the initiation of services. HHAs need to develop electronic health records and connectivity with other health care providers, including physicians and hospitals, to participate in new models of care supported by CMS and their states. Unfortunately, however, they have not been eligible for the billions of federal dollars available for technology upgrades to other sectors, and have little resources to pay for these necessary investments.

The pre-claim review process will significantly increase the workload of MACs as they will be required to review more than one million claims per year, as opposed to the approximate 25,000 claims currently being reviewed annually. We are very concerned that the MACs do not have the appropriate qualified workforce to properly manage this demonstration to ensure that HHAs providing clinical care can be assured of timely payment for their services.

Lastly, the demo will result in many additional requests for administrative appeals from beneficiaries, further increasing an already massive backlog of appeals. The Congressional Budget Office has noted that there is currently a delay of about five months in entering new appeals cases into the Administrative Law Judge docket and the average processing time for an appeal in fiscal year 2015 was about 550 days.

In Conclusion

On behalf of New York State's entire home care community, we strongly urge CMS to rescind this proposed Demonstration and solicit feedback from the provider community on other, more appropriate ways to address Medicare integrity issues. Given that documentation is the key area of alleged noncompliance, CMS should instead opt for education, clear guidelines and compliance standards, and provider support in place of this pre-claim review proposal, which will have many adverse and unintended consequences including the jeopardizing of access to care, the increase of system and operational costs, and is contrary to current CMS innovations and projects.

Thank you for the opportunity to offer our comments. If you have any questions or need additional information, we can be reached at (518) 426-8764.

Sincerely,



Andrew Koski
Vice President for Program Policy & Services



Alexandra Blais
Director of Public Policy