PRE-CLAIM REVIEW DEMONSTRATION PROJECT

Dear CMS Desk Officer,

Thank you for the opportunity to submit comments regarding the home health Pre-Claim Review Demonstration project. I am an IT Director in the Home Health and Hospice industry. I have served this industry for 15 years but been around it most of my life as my mother is an RN who performed direct patient care for most of my childhood. I have had many friends and relatives that have benefited from Home Health and Hospice services. Because of the amount of time I have been around the industry, I have seen a lot of changes as should be expected in any industry. The problem with most of the changes in this industry (in particular home health) is that the patient is rarely thought of. I do understand that any business must be able to provide a financially viable service so there is always a delicate balance between the best interest of the customer being served and the cost of the service itself. One of the major problems in home health over the years I have served is over regulation without proper justification paired with decreased payment. The combination of those two factors threatens the survival of this vital service. Not only to the patients we serve but to the healthcare system as a whole. Home Health, Hospice along with preventative care programs are the final link in the continuum of care. Without these services, there will be more hospital visits, more re-hospitalizations, more physician visits and more emergency care required. Not to mention a decrease in quality of life for a population we owe our lives to…literally.

With all that said, this particular demonstration is another example of the government not listening to the home health and hospice industry and its patient population in regards to what will and will not work. There are so many regulations that in this case, many are overlapping and contradicting each other making it seem that the end goal is not to remove fraud but to simply but agencies across the board out of business.

Below is a list of statements that point out some of the contradictions and realities of implementing this "demonstration." I appreciate your consideration in repealing any proposed or current laws that put the pre-claim review process into effect based on the following points.

- While I support all efforts to prevent fraud and abuse in the home care industry, such efforts should target abusive providers and not decrease access to care for our most vulnerable population at home.
- One of the basis for this demonstration project is an increasing improper payment rate for home health claims. The 90% of errors due to insufficient documentation is evidence of unclear F2F documentation requirements. Despite CMS education while the F2F requirements evolved, undue confusion resulted for home care agencies.
- As currently proposed, this project conflicts with existing CMS regulation. Examples:

    - F2F documentation is not required until 30 days after the start of care. Because F2F is now required to be submitted with the PCR, the allowed 30-day timeframe will be effectively reduced.
    - Physician orders, including the Plan of Care, are currently required to be signed by the physician prior to the agency's submission of the End of Episode (EOE) claim. Because the POC must be signed prior to submitting a PCR, the timeline for obtaining physician signatures has significantly decreased.
- Despite an agency's best efforts to prepare for a PCR submission, external issues beyond their control (e.g. timely receipt of physician signatures) will further delay agency submission and subsequent response of an affirmed/non-affirmed decision.
- The proposed submission of a subsequent PCR for changes in plans of care during an episode effectively changes the PCR project to a prior authorization process. The only difference is the PCR process places financial liability on the home care agency while the prior authorization process delays and limits access to medically necessary home care services.
- This PCR project requires CMS to invest substantial resources into the procedures and personnel that is not an efficient or effective use of taxpayer dollars.
- This PCR project is not sufficiently targeted to the fraud or abuse of concern. It fails to distinguish between fraud and unintentional noncompliance with documentation requirements.
- Current state and federal anti-fraud enforcement agencies have the resources and have been successful in targeting fraud and abuse among specific home care agencies.
- While home care reimbursement is proposed to decrease yet again next year, agencies will incur additional costs to implement this project.
- This project results in additional administrative costs and operational burdens on home care agencies.
- While agencies strive to achieve higher quality care with increased efficiencies and less reimbursement, the added administrative costs of the pre-claim review process are an additional financial burden on home care agencies.
- This demonstration project unduly targets compliant agencies instead of targeting cities where known fraud exists.
- While I appreciate no delay in the provision of medically necessary care for Medicare beneficiaries, this project poses an undue financial burden on an agency who will not receive reimbursement for a non-affirmed PCR.
- Agencies will incur the cost for skilled services provided in the event a pre-claim review is non-affirmed.
- Agency requirements for this project are evolving and not fully defined.
- Medicare Administrative Contractors (MACs) are not ready for implementation of this project.
- While a non-affirmed PCR allows the opportunity for appeal, such appeals will further increase the catastrophic backlog of Medicare appeals pending review by an Administrative Law Judge (ALJ.)

- Although this is a demonstration project, Medicare Administrative Contractors (MACs) have not been allowed sufficient time to test the process. Similarly, home care vendors have not had time to update their software.
- This project causes potential for adverse consequences to Medicare beneficiaries due to the financial and administrative burden placed on the provider.
- This project is a potential for barrier to home care. Patients requiring high levels of care may be declined by home care agencies due to the financial risk of a non-affirmed PCR decision. Further, home care agencies will discharge Medicare beneficiaries from skilled services when a PCR is returned non-affirmed. Such barriers may result in increased hospital stays and increased re-hospitalizations.
- The cost to the federal government to reimburse MACs for this project is excessive. These same funds could be used more effectively in targeted review.
- MACs' pre-claim review of all episodes results in excessive volume with doubt that PCR requests will be processed on a timely basis.
- Without the development and distribution of clear guidelines for this project, the PCR affirmation is subject to the reviewer and/or the MAC's interpretation. We have learned from our experience with the F2F requirement, how easily misinterpretation results in denial.
- CMS currently performs targeted edits of home care agencies through Additional Documentation Requests (ADRs.) However, the PCR project essentially places all agencies on 100% pre-claim ADR review without proper cause.
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Suggestions:

- I suggest CMS, in conjunction with the home care community, develop a less burdensome approach to fraud and abuse.
- Rather than using this project to remedy non-compliance with documentation requirements, I recommend CMS provide clarified and consistent standards with education to the home care community and MACs. (e.g. F2F)
- Because the home care agency provides medically necessary services in good faith of receiving reimbursement, I recommend CMS provide reimbursement for services provided until the date of the non-affirmed PCR decision.
- Rather than create this broad-spectrum project, I recommend CMS utilize data to identify high risk situations and target program integrity measures.
- Rather than targeting all agencies within the demonstration states, CMS should target specific agencies and/or cities where known fraud and abuse occur.

Thank you again for your consideration.
Jeremy Combs