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July 23, 2018

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: OMB Control Number 0938-1311
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern,

RE: Comments, Home Health Review Choice Demonstration

On behalf of our 27,163 employees and 32,389 clients, BAYADA Home Health Care appreciates the opportunity to provide comments on the home health review choice demonstration. BAYADA strives to provide the highest quality of nursing, rehabilitative, therapeutic, hospice, habilitation, and assistive care services to children, adults, and seniors in the comfort of their homes. We believe our clients and families deserve home health care delivered with compassion, excellence, and reliability; BAYADA's core values.

As an active participant in state and federal health care policy, BAYADA appreciates that the Centers for Medicare & Medicaid Services (CMS) is seeking input on this proposal from a variety of stakeholders. We understand this document is a small part of a long process. BAYADA is happy to be a valuable partner to CMS. Working together will ensure that all parties' concerns are heard and, if properly addressed, that CMS will reach its goal of addressing Medicare fraud and improper payments without creating significant disruptions to home healthcare services for thousands of Medicare beneficiaries in need of care at home.

We commend CMS for its desire to strengthen the integrity of the Medicare program, and for recognizing that the previous demonstration was too limited and inflexible for providers. However, while the newly proposed program represents modest improvements and greater choice for providers, BAYADA has three major concerns that prevent us from supporting the demonstration as currently proposed:

1. CMS has not yet released information from the previous demonstration that was halted in Illinois. This information should be released and used to create a dialogue among stakeholders regarding lessons learned and the potential structure and approach for any future demonstration projects.

2. The new proposal's sweeping approach misses the opportunity to strategically target bad actors and instead forces all home healthcare providers, the majority of which are committed to functioning with honesty and integrity, to take on additional burdens within an already heavily regulated payment system.

3. The current proposal is overly burdensome for Medicare home health providers and will force providers in the five affected states to take on such enormous costs that many providers may have to shut their doors. This will not only create potential access to care issues, but it also limits providers' ability self-fund innovations that will improve Medicare beneficiaries' care.

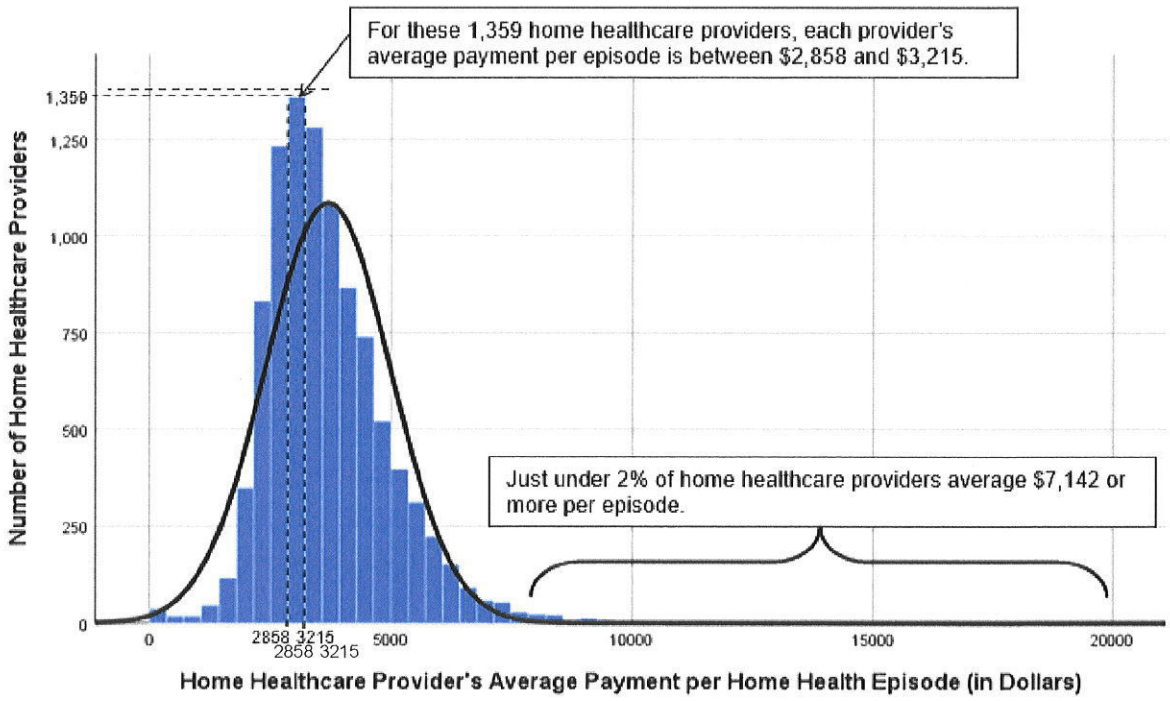
First, BAYADA is concerned that CMS has not yet taken steps to disseminate the results and lessons learned from the previous Pre-Claim Review demonstration in Illinois. The data from the Illinois demonstration was never released, which means that home care providers do not have access to the complete data and information necessary to compile their thoughts about the new proposal and form questions to ensure that they are as ready as possible for implementation. It would be prudent for CMS to release data from the original project, work with providers and stake holders to evaluate the outcomes and the best alternatives that can address any deficiencies uncovered through the project, and institute appropriate corrective measures that do not needlessly increase administrative burdens and costs to deliver care. Creating an environment in which an open and inclusive dialogue about future proposals would benefit CMS, home health care providers, and ultimately beneficiaries.

The current CMS Targeted Probe and Educate (TP&E) process, which has been underway across the industry for the past two years, is appropriately increasing scrutiny across all providers. As a result, the education provided by Medicare Administrative Contractors (MACs) has helped reveal several gaps in documentation which are being actively addressed by a broad array of home health providers. This work has created demonstrated success toward improving documentation and more effectively justifying the amount and type of care that is being delivered to Medicare beneficiaries at home. This essential TP&E work should continue in order to help achieve CMS's stated goal of "protecting the Medicare Trust Fund from fraudulent actions and the resulting improper payments."

Second, the home health review choice demonstration proposal should proceed by strategically targeting providers with demonstrated abnormal billing practices, many of whom are likely bad actors. A 100 percent review process makes sense for providers that are suspected of committing fraud. However, mandating a 100 percent review across an entire category of providers does not weed out likely bad actors as much as it creates a burdensome environment for all providers across the board.

Home health care providers and the industry at-large have proposed other ways that CMS can better target home health care providers with abnormal billing patterns without

using a broad-brush approach to address the issue. Medicare claims data drawn from the 4Q16 to 3Q17 Avalere Medicare Claims Database supports this conclusion. As the graph below illustrates, a minority of home healthcare providers is responsible for the costliest home health episodes. Eighty-five percent of providers average $5,000 or less per episode, and 95% of providers average $6,000 or less. Just 5% of providers average over $6,000 per episode, and just under 2% average over $7,142 per episode.



To accomplish the proposal's intent without burdening providers with demonstrated normal billing patterns, CMS should target higher cost providers directly for further scrutiny. One approach CMS could pursue is collaborating with home healthcare providers to establish an appropriate cut point for agencies and requiring agencies with an average bill rate above this cut point to provide further documentation on their billing.

We share CMS's concern about the improper payment rate and its commitment to protecting taxpayer funds while also improving program integrity. Yet we are concerned that the current proposal may not fully address the root cause of these errors. We believe there are simple changes that can be implemented to achieve the goal of reducing improper payments, including the identification of the nature and cause of documentation errors and implementing targeted changes to underlying policy. Should CMS subsequently choose to move forward with the Home Health Review Choice Demonstration, we encourage you to consider a scaled-down approach that would achieve CMS' desired outcomes without disrupting providers' ability to deliver high-quality patient care.

Finally, the new proposal does not address the administrative burdens that providers experienced and expressed concern about during the previous demonstration. These enormous burdens stand to severely impact the home healthcare industry and Medicare beneficiaries. As it is currently proposed, CMS has estimated that to be in compliance with pre-claim or post-payment review, the initial demonstration states (Illinois, Ohio, North Carolina, Florida, and Texas) must take on an estimated $24 million per year in additional administrative burden, which would be allocated across providers in the affected states. If expanded to the entire Palmetto/JM jurisdiction, the cost would rise to roughly $40 million annually according to CMS' estimates.
It is important to note that CMS came up with its estimates under the presumption that submissions and resubmissions would only take 30 minutes to complete and that employees to provide the support necessary to manage this additional paperwork would be paid an average hourly rate of $16.00. While the $24-$40 million estimate does take training and benefits into account, it does not include recruitment and on-boarding costs.

Additionally, it is important to note that while CMS does acknowledge that the $24-$40 million cost burden will be allocated amongst all home healthcare providers, it fails to acknowledge that agencies that choose to hire and utilize medical professionals to perform the added administrative tasks will be significantly more impacted than others. CMS estimates that providers will pay employees who perform the added administrative tasks an hourly wage of $16.00, which indicates that CMS believes that these tasks will be performed by non-medical professionals. However, BAYADA and many other providers anticipate hiring and utilizing clinicians for the purposes of reviewing, compiling, and submitting the necessary documents to comply with this mandate, which is consistent with plan for the MACs to use "trained, nurse reviewers" for their reviews. As a result, the median hourly rate will likely be closer to $21.65 per hour, the 2017 median rate for licensed practical nurses (LPNs), according to the Bureau of Labor Statistics (BLS). This could significantly increase CMS' estimated cost burden on home healthcare providers that opt to use clinical rather than clerical support to manage this mandate.

This proposed demonstration puts undue pressure on providers in an industry that is already heavily regulated and administratively burdensome, often at both the state and federal level. Given the shortage of nurses in many states across the US, this demonstration puts additional strain on providers to incur high administrative costs and possibly divert limited clinical resources to paperwork management. Additionally, the increased cost burden may force providers to stifle their self-investment in technology and programs that improve care delivery. For example, BAYADA and other home care providers have prioritized investing in telehealth technology, for which there is currently no reimbursement. BAYADA has seen how such innovations have improved care for Medicare beneficiaries, but added administrative costs associated with the demonstration may force us and other providers to divert these resources from care delivery innovation into care administration.

Effectively, the new proposal asks providers in affected states to either take on additional costly administrative burdens or face a 25 percent rate cut for each Medicare service it

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provides. Thus, the new proposal forces providers into the unappetizing choice of reduced reimbursements or incurring major new administrative costs to submit records, withstand payment delays, and defend claims. This lose-lose situation will likely lead to bankruptcies and closings throughout the industry, in which case affected states may witness an access to care issue for Medicare beneficiaries.

It is crucial that CMS consider the three major concerns outlined in these comments while deciding on the program's parameters and the timeline for implementation. As illustrated above, while BAYADA and many other home health care providers do not object to measures that will punish bad actors that commit Medicare fraud, our primary concern is that the current proposal forces agencies that already operate in a burdensome regulatory environment to take on additional duties and costs despite their record of functioning with honesty and integrity. Additionally, mandating that all providers choose between a costly administrative burden or a 25 percent reduction in Medicare payments threatens major disruption to business and beneficiary care. We urge CMS to delay the Home Health Review Choice Demonstration until all stakeholders and Congress have the opportunity to evaluate and understand the impact of the demonstration in Illinois and collaborate to create a program that will address these concerns.

The advantages of keeping Americans in their homes and in their communities are well known by CMS and it is of utmost importance that federal regulations continue to support a robust and efficient home healthcare system. Many of the issues that states faced while implementing pre-claim review in Illinois stemmed from CMS' lack of solicitation of comments and feedback from external parties, and we appreciate that with this demonstration CMS has specifically reached out to providers for comment. We believe there are several ways to meet the goal of addressing Medicare fraud and improper payments without creating significant disruptions to home healthcare services for thousands of Medicare beneficiaries in need of care at home.

Please do not hesitate to contact us for additional feedback or resources, and please continue to communicate with BAYADA and other providers throughout this process. Thank you for allowing us to submit comments and for considering our position. We look forward to continuing to be a valuable partner to CMS.

Thank you,

David J. Totaro
Chief Government Affairs Officer

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Document Identifier CMS-10599 / OMB # 0938-1311
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