American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
www.apta.org

July 18, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-10599
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments in response to the Centers for Medicare and Medicaid Services' (CMS) Notice: Pre-Claim Review Demonstration for Home Health Services. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

While APTA supports efforts by CMS to address payment, billing, and service integrity in the Medicare program, we strongly object to the revised Pre-Claim Review Demonstration for Home Health Services, now referred to as the Review Choice Demonstration for Home Health Services. The Review Choice Demonstration will allow home health agencies (HHAs) the choice of 3 options: Pre-claim review, postpayment review, or minimal review with a 25% payment reduction for all home health services.

APTA has serious concerns that the Review Choice Demonstration will impose access barriers to timely, medically necessary home health services; will increase costs to patients, providers, and taxpayers; does not sufficiently target fraudulent behavior; and is excessively burdensome. We respectfully request that you consider our more detailed comments and concerns provided below.

Recommendations

- **APTA recommends that CMS allocate its time and resources to target specific HHAs whose behavior suggests fraudulent activity, rather than penalizing all agencies with a time-consuming and costly pre-claim or postpayment review, or minimal review with 25% penalty processes.**
- **APTA urges CMS to exempt agencies that receive a 90% affirmation rate from any form of audit for a minimum period of 12 months.**
- **APTA encourages CMS to solicit input and engage in meaningful dialogue with stakeholders, including APTA, through roundtables, open-door forums, conference calls, and meetings, to discuss how to better identify and prevent Medicare fraud.**
- **APTA recommends that CMS increase its education efforts at the local, regional, and national levels to better ensure compliance with home health documentation requirements, and offer tools and resources that will help HHAs obtain the requisite documentation from other providers involved in the delivery of care to Medicare beneficiaries. We also recommend that CMS require Palmetto to institute ongoing education for its medical reviewers.**
- **Finally, we recommend that CMS not move forward with implementation until the agency can ensure that all HHAs are adequately prepared to successfully participate.**

Review Choice Demonstration Hinders Beneficiary Access to Care

Due to the administrative and financial burdens associated with complying with the Review Choice Demonstration, APTA has serious concerns that the demonstration will obstruct beneficiary access to care and jeopardize the quality of care that beneficiaries receive. Requiring all HHAs in the selected states to engage in the pre-claim or postpayment review process, or suffer a 25% reduction in payment, will likely hinder many agencies from being able to furnish high-quality, effective care to patients with the most critical clinical conditions due to the overwhelming administrative and financial costs associated with complying with the demonstration's requirements. HHAs, referring physicians, and other clinicians on the beneficiary's care team 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. We particularly are concerned about the impact on beneficiary access in rural areas, as agencies in more remote areas, operating with razor-thin margins, will be forced to reduce wages or eliminate positions altogether to compensate for the increase in administrative costs.

Specifically regarding physical therapy services, HHAs may not be able to afford to employ full-time physical therapists or physical therapist assistants, further reducing the breadth of services the agencies can furnish and, in turn, decreasing their potential reimbursement rates. As a result

of this demonstration, smaller agencies will be forced to either drastically reduce essential staff or close their doors.

Implementing the demonstration as currently proposed could have deleterious effects on beneficiary care and outcomes. Before moving forward, APTA urges CMS to fully assess how the demonstration may impact the ability of agencies to deliver person-centered, clinically efficient care that meets the needs of the Medicare patient population. We also recommend that CMS discuss in future guidance how it intends to ensure continued beneficiary access to high-quality home health services, irrespective of geographic location.

Review Choice Demonstration Imposes Administrative and Financial Burden on Providers

Administrative Burden

APTA notes that HHAs are already under pressure to comply with various complex and burdensome Medicare pilot programs and demonstrations, including the new Medicare Conditions of Participation and the Home Health Value-Based Purchasing (VBP) Program, in effect in 9 states. HHAs also are facing changes to their payment methodology effective January 1, 2020. Imposing another program, the Review Choice Demonstration, will further increase the administrative and financial burdens on HHAs. Accordingly, APTA does not support the implementation of this demonstration as currently proposed and we request that CMS withdraw this demonstration proposal.

However, should CMS proceed with the demonstration, implementation should not occur until CMS can ensure that all stakeholders are adequately prepared to successfully participate. Although HHAs in Illinois have some experience with pre-claim review, having achieved a 91.7% of pre-claim review requests receiving provisional affirmation, including both fully affirmed or partially affirmed decisions, by Week 24 of the demonstration, HHAs located in Ohio, Texas, North Carolina, and Florida have not. It is likely to take these agencies 6 months, if not longer, to successfully participate in the pre-claim review program. While we recognize that CMS has expanded the options for participating providers—pre-claim review; postpayment review; or minimal review with a 25% payment reduction—this is unlikely to offset the burden on HHAs.

Furthermore, the demonstration duplicates oversight that will only add to the administrative burdens that already plague agencies, without producing savings for Medicare. 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), Unified Program Integrity Contractors (UPICs), Supplemental Medical Review Contractor (SMRC), and Medicare Administrative Contractors (MACs), among others. CMS contractors use the medical review program to prevent improper payments in the Medicare fee-for-service program. The demonstration would merely replicate these contractors' efforts, increasing the administrative and financial burden on providers and patients while also failing to preserve the Medicare trust funds.

The demonstration also is likely to result in many additional requests for administrative appeals from HHAs and beneficiaries, which will not only increase the administrative burden on HHAs and delay payment, but also expound upon the already significant backlog of appeals pending with the US Department of Health and Human Services (HHS) Office of Medicare Hearings and

Appeals, thereby further increasing the administrative and financial burden on HHS.[1] We urge CMS to consider how the demonstration will harm HHS's stated commitment to improve the Medicare appeals process.

As CMS has acknowledged, the majority of improper payments to HHAs are due to documentation errors or omissions, as opposed to fraudulent behavior. The 2017 Comprehensive Error Rate Testing report states that improper payment within HHAs is primarily due to insufficient documentation.[2] Additionally, CMS specifically notes within its CMS-10599 Revised Supporting Statement that the high rates of improper payments in home health are "primarily due to instances when documentation in the medical record did not meet Medicare's face-to-face encounter requirements." These documentation errors are largely due to the numerous roadblocks that HHAs encounter to acquire signed physician orders and complete face-to-face documentation. Compliance with these documentation requirements is labor and resource-intensive for HHAs; further, the requirements are inconsistently applied by medical reviewers.

Instituting 100% pre-claim or postpayment review will not address the current vulnerabilities of the home health payment system, which include billing for services not furnished; billing that appears to be deliberate for duplicate payment; and altering claims or medical records to obtain a higher payment amount. These systemic issues and failures are what should be addressed and corrected, rather than the imposition of an additional burdensome process on agencies caring for some of the nation's most vulnerable patient populations. The Review Choice Demonstration is contradictory to CMS's top priority—to put patients first. HHS Secretary Azar recently touted CMS's Patients over Paperwork initiative, stating that he was aware of the burden regulations put on providers, and the initiative's goal is to streamline those rules and improve the beneficiary experience. We fail to see how the Review Choice Demonstration aligns with the goals of the Patients over Paperwork initiative.

Financial Burden

CMS estimates that the revised demonstration will cost the federal government $392.9 million over the 5-year demonstration period, whereas it will cost providers $24 million in the first year and $39 million in subsequent years, assuming the demonstration is expanded beyond the initial selected states. APTA has concerns that the cost obligations associated with complying with the pre-claim or postpayment review process will harm many HHAs, which will directly impact the initiation and continued delivery of home health services. Preparing and submitting documentation to comply with pre-claim or postpayment review requires a substantial commitment of time, energy, and resources. The demonstration effectively ensures payments to HHAs will decline while failing to eliminate fraud, abuse, and waste from the home health system. Moreover, requiring agencies to put forth thousands of dollars in technology upgrades to comply with the demonstration will significantly harm their financial and clinical viability. Many HHAs have not yet adopted and implemented electronic health records and interoperability with other health care providers. These HHAs have few resources to pay for these necessary

[1] Office of Medicare Hearings and Appeal's Fiscal Year 2018 budget request indicated there is currently a backlog of more than 650,000 appeals pending at Level 3 of the Medicare appeals process.

[2] 2017 Medicare Fee-for-Service Supplemental Improper Payment Data, page 16: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf Accessed June 4, 2018.

investments, as they have not been eligible for the billions of federal dollars available for technology upgrades to other sectors.

The demonstration falls short of what it takes to be an effective program integrity tool sufficient to offset the downside risks to Medicare beneficiaries and HHAs. The demonstration would equally burden all providers, regardless of each HHA's compliance record and other factors. It 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. Given the significant financial obligations associated with the demonstration, we request that CMS clarify in future guidance the anticipated savings to the federal government over the 5-year demonstration period.

Most HHAs currently exert a sincere effort to comply with Medicare's laws, regulations, and standards. Therefore, rather than institute a demonstration that assesses compliance with documentation, CMS should allocate its time and resources to target specific HHAs whose behavior suggests fraudulent activity, such as fraudulent billing, false cost reports, credit balances, non-compliance with Stark law, billing for services not furnished to beneficiaries who are homebound, etc., rather than penalizing all agencies with a time-consuming and costly pre-claim or postpayment review.

Review Choice Demonstration Overrides Clinicians' Clinical Judgment

One of CMS's primary goals is ensuring that providers deliver patient-centered care, allowing patients to share in the decision-making related to their care. However, the demonstration effectively overrides the judgment of the provider, redirecting the decision-making process to Palmetto's medical review staff—individuals who frequently make medical denial decisions without consideration of the beneficiary's total condition and individual need for care. The beneficiary's care team strives to ensure that the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the clinician, such as the physical therapist, to make judgments that are in the best clinical interests of the beneficiary. Affording Palmetto significant clinical decision-making authority is unjustifiable, given it is the professional judgment of the *clinician* to decide which combination of home health services is most appropriate to treat the beneficiary in accordance with Medicare coverage guidelines.

Ensuring Compliance with Pre-claim Response Timeline

Within the notice, CMS indicates that Palmetto will have 10 days to provide either an affirmative or nonaffirmative decision on an initial HHA's pre-claim review. If the decision is non-affirmative, the HHA may resubmit a pre-claim review request, after which Palmetto will have 20 days to provide a decision. APTA appreciates CMS's flexibility in permitting a HHA to resubmit a pre-claim review request as many times as necessary to receive an affirmed decision. We request, however, that CMS clarify the mechanisms it will employ to ensure that Palmetto responds within the prescribed timeframe, as it is unclear whether Palmetto has a sufficiently qualified workforce to properly manage the demonstration's requirements. We also question how CMS will ensure Palmetto's medical reviewers consistently apply Medicare regulations and guidance when assessing documentation, as the application of documentation standards significantly varies among reviewers.

Conclusion

APTA encourages CMS to be mindful, as it pursues new program integrity initiatives, that these programs must be supplemented by meaningful and carefully crafted policies and regulations that reduce redundancies, eliminate administrative burden, and increase efficiency. While we acknowledge CMS's efforts to develop and improve procedures for the identification, investigation, and prosecution of Medicare fraud, the demonstration will merely result in increased paperwork, financially crippling many agencies. As stated above, APTA opposes implementation of this demonstration and we request that CMS withdraw this demonstration proposal. Should CMS choose to move forward, we encourage the agency to consider the following recommendations: (1) allocate its time and resources to target specific HHAs whose behavior suggests fraudulent activity, rather than all HHAs within the selected states; (2) exempt agencies that receive a 90% affirmation rate from any form of audit for a minimum period of 12 months; (3) solicit input and engage in meaningful dialogue with stakeholders, including APTA, through roundtables, open-door forums, conference calls, and meetings, to discuss how to better identify and prevent Medicare fraud; (4) increase its education efforts at the local, regional, and national levels to better ensure compliance with home health documentation requirements, and offer tools and resources that will help HHAs obtain the requisite documentation from other providers involved in the delivery of care to Medicare beneficiaries; (5) require Palmetto to implement immediate, ongoing education to improve the knowledge and expertise of its medical reviewers; and (6) not move forward with implementation until CMS can ensure that all stakeholders are adequately prepared to successfully participate.

We thank CMS for the opportunity to comment on the Review Choice Demonstration. If you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS_FRDOC_0001-DRAFT-11113
Current Document ID: CMS-2018-0071-0002
Title: TX
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Document Subtype: Public Comment
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1

Submitter Info

Comment: Pre Claim review is a huge burden to home health agencies. We already have new regulations for the year 2018 under new Conditions of Participation. Why does CMS continue to target the home health industry. There is less fraud in home health than in other areas. There is a tremendous amount of fraud, waste and abuse in the disability program MEDICAID than any other but yet these folks that don't have to work and stay home every day to get their free check in the mail but yet they have nicer phones and cars than I do. And you see them out working in their yards everyday.....they are not disabled.

You call and report it and nothing ever gets done. Yet, you never see them being look at before they receive their next check. The Provider assistance program is full of waste and fraud. People that have been on medicaid all their life qualify for a free housekeeper. Individuals such as myself that have worked and paid into the system and do not qualify for medicaid receive less help from the govt and have to depend on home health services. Now your department of our government is threatening the good working people again. THIS IS SO UNFAIR!!!! And why President Trump was elected because Americans are TIRED OF IT!! Registered Nurses and physicians that work in the home health industry worked hard for our professional license and have no desire to commit fraud for a patient's benefit and get in trouble. We are good american citizens working hard everyday to prevent hospitalizations and prevent nursing home placement to save CMS money but yet your department of the government continues year after year to target the home health workers. We have lost good nurses that will not work home health because of the tremendous amount of red tape and regulations that we work under everyday. I traveled four hours this year to hear Charles Cannon speak for four hours to stay abreast and current with PGBA policies for our documentation. We received one deficiency on our state survey this year. The Pepper reports have not been taught enough and the home health industry has not had a fair chance to clean up the Pepper reports. I just learned this spring when I heard Charles speak, that the Pepper reports is what Administrators should be looking at and correcting within their agencies. My last comment is your department of our government should do more teaching and creating less havoc for working Americans. A good example is the devastating havoc and confusion over the face to face encounter. And all the money lost to agencies because your department of the government changed the law with the narrative component without any teaching to the home health industry....just making the rules up as you go. I would like to see your department investigated and send some authority to advise what is your true purpose for placing a target on home health's back again. How is it, you continue to get away with the havoc you create and seem to delight in year after year. I intend to contact President Trump's office and try to get him involved in this comment period. A copy of this will be mailed and emailed to his office.

First Name: Anonymous
Last Name: Anonymous
City:

Country: United States
State or Province: Texas
ZIP/Postal Code: 75901
Email Address:
Organization Name: ABC home health
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS_FRDOC_0001-DRAFT-11111
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Document Type: PUBLIC SUBMISSIONS
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Comment on Document ID: CMS-2018-0071-0001
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Submitter Info

Comment: Home Health Agencies have endure strict scrutiny more than any other healthcare industry in the past 20 years or more! It is more difficult to provide the amount of necessary care each patient needs with half of the reimbursement rate per episode. Pre-Claim Review is another avenue to reduce payments to Home Healthcare Agencies. Most HHA provide the very best quality care to patient as possible, but more are moving away from Medicare and more towards private insurance. This is because of the reduced reimbursements, over imposed guidelines and the pre-claim review program! Physicians are doing just that. If

all healthcare providers move away from Medicare and more or completely to private insurance, where would that leave millions of Medicare recipients? That would leave them without healthcare coverage!
First Name: Anonymous
Last Name: Anonymous
City: Houston
Country: United States
State or Province: Texas
ZIP/Postal Code: 77071
Email Address:
Organization Name: NA
Category:
Cover Page:

Document Optional Details

Submitter Info

Comment: Home Health Agencies have endure strict scrutiny more than any other healthcare industry in the past 20 years or more! It is more difficult to provide the amount of necessary care each patient needs with half of the reimbursement rate per episode. Pre-Claim Review is another avenue to reduce payments to Home Healthcare Agencies. Most HHA provide the very best quality care to patient as possible, but more are moving away from Medicare and more towards private insurance. This is because of the reduced reimbursements, over imposed guidelines and the pre-claim review program! Physicians are doing just that. If all healthcare providers move away from Medicare and more or completely to private insurance, where would that leave millions of Medicare recipients? That would leave them without healthcare coverage!
First Name: Anonymous
Last Name: Anonymous
City: Houston
Country: United States
State or Province: Texas
ZIP/Postal Code: 77071
Email Address:
Organization Name: NA
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
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Number of Attachments: 0
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Number of Submissions: 1

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1

Submitter Info

Comment: Why do we need more review of claims if we are currently under review of Probe and educate of records. How many times do we have to pass before we are trusted ?
First Name: Jerry
Last Name: Harney
City: Lubbock
Country: United States
State or Province: Texas
ZIP/Postal Code: 79423
Email Address: jerry@chhsi.com

Organization Name: Caprock Home Health Services, inc.
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Tracking Number: 1k2-93t6-54bw
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Submitter Info

Comment: Having gone through Pre Claim Review in Illinois, all I can say is that it was a disaster. Documentation would be rejected by one reviewer and the same documentation resubmitted would be approved by a different reviewer at Palmetto. The fact is, even if all of the documentation is pristine and 100% by the book, preparing and submitting it for PCR approval takes time. And in this industry, as most others, time equals money. There is no increased reimbursement for this added work. So, CMS is effectively cutting payments to providers by putting new administrative burdens on agencies. The biggest issue that no

one seems to understand, is that PCR does not stop fraud. It hurts honest agencies that might have clerical errors on their documentation or difficulty getting an MD to properly sign and fill out documents. If you are an agency already engaged in fraudulent activity, then manufacturing CMS compliant documentation is not a problem. Why would it be, if you are already cheating the system? What CMS won't say, is that it saves them money not by catching fraudulent claims, but through rejecting claims from honest agencies for what amounts to clerical errors or uncooperative doctors and hospitals. Common sense and experience shows that correcting a home health plan of care or face to face, which might be a month or more old, is very low on a doctor's list of priorities. By going after home health agencies, CMS is squeezing the little guy while refusing to go after the big fish. The fact is, CMS would save exponentially more money by going after hospitals throwing away unused supplies, medications being packaged in a way that purposely causes excess, which must be paid for and dumped, and a general refuse to place basic price controls drugs. Think of the lobby CMS has to face from big pharma, the AMA, and major hospital systems vs home health. Does anyone really think the national association of home care and hospice, NAHC, has the pull and influence of a Pfizer or Community Health Systems?

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60091
Email Address:
Organization Name:
Category:
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Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
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Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0034
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Submitter Info

Comment: Pre Claim review is very time consuming and costly to home health agencies, especially smaller agencies with limited resources. I think this should be stopped before another tragedy (like in Illinois) takes place. Texas agencies are going through probe and educate ADRs again, this was fruitless the first go around as the educator seemed to have little knowledge of the regulations they were attempting to educate on. I feel that CMS collects massive amounts of data on agencies and CMS should be able to target outliers to investigate, instead of punishing all the agencies who happen

to operate in a high fraud state. As a small agency near Houston, I am made to feel like I am a criminal on an ongoing basis. When in fact, we do our best to follow the regulations and still give superior patient care. Please reconsider this project. I am sure it will also be very expensive for CMS to put into place and to manage.

First Name: Susan
Last Name: Rhodes
City: Magnolia
Country: United States
State or Province: Texas
ZIP/Postal Code: 77354
Email Address: hhspecialists@sbcglobal.net
Organization Name: Susan Rhodes Enterprises, LLC
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0035
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Title: OH
Number of Attachments: 0
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Submitter Info

Comment: Given how unsuccessful the pre-claim review demonstration was the first time, I am surprised to see it back. Pre-Claim review does nothing but slow the whole system down. We have agencies in the probe and educate and those agencies who passed the very first time should now be trusted to continue their good work. I would rather see a probe and educate every year or so to ensure compliance is continued. Plus, if it is still in the plan to implement HHGM, most home health agencies are going to see a drastic reduction in reimbursement. Pre-claim review just adds to the burden...not only to the

provider but for the MACs as well.
First Name: Anonymous
Last Name: Anonymous
City: London
Country: United States
State or Province: Ohio
ZIP/Postal Code: 43140
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0036
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Document Type: PUBLIC SUBMISSIONS
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Submitter Info

Comment: June 21, 2018 Seema Verma, MPH Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 445-G Attn: CMS-10599 Hubert Humphrey Building 200 Independence Ave, SW Washington, DC 20201 Submitted electronically RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services' (CMS) Review Choice Demonstration for Home Health

Services. I have had the privilege to serve our aging population for 15 years in the home healthcare environment. As a Home Health Care Administrator, I was able to work one on one with patients to ensure that their specific needs were met. This was a very positive experience, as you could really see the difference that our practice made for these patients on a day to day basis. Most recently, I have worked within our Quality team to take our clinical and quality practices to the next level for those that we serve. As the Revenue Recovery Manager, I have several concerns with the Review Choice Demonstration. My concerns include: Review Choice Demonstration Will Obstruct Beneficiary Access Instituting 100% pre-claim or postpayment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the increase in administrative and financial costs associated with complying with the Demonstration's requirements. HHAs, referring physicians, and other clinicians on the beneficiary's care team will be forced to redirect staff time away from clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns the Demonstration will erode beneficiaries' access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired patients. Review Choice Demonstration Will Impose Undue Administrative and Financial Burden on Providers CMS is disproportionately subjecting HHAs to complex and burdensome Medicare pilot programs and demonstrations. This demonstration is a duplicative process of oversight that will only add to the administrative burdens that already plague HHAs. The Demonstration 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. Additionally, this Demonstration is contradictory to CMS's top priority - to put patients first. Review Choice Demonstration Will Take Care Planning Decision Away from HHA Clinicians The beneficiary's care team strive to ensure the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the provider, such as the physical therapist, to make judgments that are in the best clinical interests of the beneficiary. However, the Demonstration effectively overrides the judgment of the clinician, redirecting the care decision-making process to Palmetto's medical review staff, individuals who frequently make medical

denial decisions without consideration of the beneficiary's total condition and individual need for care. Affording Palmetto significant clinical decision-making authority is unjustifiable, given it is the professional judgment of the clinician to decide which combination of home health services is most appropriate to treat the beneficiary in accordance with Medicare coverage guidelines. Conclusion I do not believe CMS's efforts to identify, investigate, and prosecute Medicare fraud is supported by the proposed Demonstration. Therefore, I recommend that CMS not move forward with the Review Choice Demonstration. I appreciate the opportunity to comment on the Review Choice Demonstration for Home Health Services. Thank you for your consideration. Sincerely, David Kastner Revenue Recovery Manager

First Name: David
Last Name: Kastner
City: Holt
Country: United States
State or Province: Michigan
ZIP/Postal Code: 48842
Email Address: dkastner@pinnaclesenior.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0038
Current Document ID: CMS-2018-0071-0039
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Submission Type: Web
Number of Submissions: 1

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File Code:
Tracking Number: 1k2-93ui-3k21
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Total Page Count Including Attachments:
1

Submitter Info

Comment: The Review Choice Demonstration will 1. increase costs to the already burdened health care system, 2. do nothing to support CMS goals to shift toward rewarding value-based care. The administrative and financial costs associated with complying with the demonstration's requirements threaten the financial and clinical viability of home health agencies (HHAs), particularly low-volume and rural agencies. Agencies will be forced to reduce wages or eliminate positions altogether to compensate for the increase in costs required to comply with the demonstration's requirements. Consequently this will have

a negative affect promoting poor clinical outcomes and diminished quality of life due to financial burdens of this demonstration. CMS continues to subject HHAs to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program, the Review Choice Demonstration, will further increase the administrative and financial burdens on HHAs without addressing the home health system's vulnerabilities. The demonstration is a DUPLICATIVE process of oversight that will only add to the burdens that already plague providers. CMS should allocate its time and resources to target specific HHAs whose behavior suggests fraudulent activity, rather than penalizing agencies that have established records of compliance with existing rules and regulations. Such as the CERT program and existing ADR review.

First Name: Dan
Last Name: Willson
City: Tyler
Country: United States
State or Province: Texas
ZIP/Postal Code: 75701
Email Address: willsond@paradigmrehab.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0039
Current Document ID: CMS-2018-0071-0040
Title: IL
Number of Attachments: 0
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/22/2018
Date Posted: 07/10/2018
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Submission Type: Web
Number of Submissions: 1

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Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93uv-fisq
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1

Submitter Info

Comment: The regulatory burden along with the reimbursement cuts have caused the homecare industry of healthcare to be unfairly targeted leading to a mandated consolidation of providers. This has illustrated that government intervention has allowed and supported large corporate takeovers of smaller providers of care leading to less choices in care for beneficiaries. The 25% penalty is a strong incentive for submission to this additional scrutiny and is again unjustly and unfairly targeted to burden smaller businesses than larger corporations. This is unfair and indicative to a government

preference toward big business. Please consider the Americans under your care that they should have the best choices for their healthcare and they should not be forced toward care choices with Big Business.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60614
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0040
Current Document ID: CMS-2018-0071-0041
Title: MD
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: Web
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Component:
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1

Submitter Info

Comment: Seema Verma, MPH Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 445-G Attn: CMS-10599 Hubert Humphrey Building 200 Independence Ave, SW Washington, DC 20201 Submitted electronically RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. I

am a physical therapist for over fifty years and am presently the owner of a private practice Physical Therapy Consults with a both a clinic and a contract with a home health agency. I participate in both Medicare part A and Medicare part B and while I appreciate CMS attempting to prevent fraud and abuse I would suggest that efforts should be directed at the abusers and not add more administrative burdens. I was hearted with CMSs hashtag of Patients over Paperwork but Choice Review Demonstration for Home Health Services hardly fits into that sentiment or slogan. I have several concerns with the Review Choice Demonstration. My concerns include: Review Choice Demonstration Will Obstruct Beneficiary Access Instituting 100% pre-claim or postpayment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the increase in administrative and financial costs associated with complying with the Demonstrations requirements. HHAs, referring physicians, and other clinicians on the beneficiarys care team will be forced to redirect staff time away from clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns the Demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired patients. Review Choice Demonstration Will Impose Undue Administrative and Financial Burden on Providers CMS is disproportionately subjecting HHAs to complex and burdensome Medicare pilot programs and demonstrations. This demonstration is a duplicative process of oversight that will only add to the administrative burdens that already plague HHAs. The Demonstration 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. Additionally, this Demonstration is contradictory to CMSs top priority to put patients first. Review Choice Demonstration Will Take Care Planning Decision Away from HHA Clinicians The beneficiarys care team strive to ensure the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the provider, such as the physical therapist, to make judgments that are in the best clinical interests of the beneficiary. However, the Demonstration effectively overrides the judgment of the clinician, redirecting the care decision-making process to Palmettos medical review staff, individuals who frequently make medical

denial decisions without consideration of the beneficiarys total condition and individual need for care. Affording Palmetto significant clinical decision-making authority is unjustifiable, given it is the professional judgment of the clinician to decide which combination of home health services is most appropriate to treat the beneficiary in accordance with Medicare coverage guidelines. Conclusion I do not believe CMSs efforts to identify, investigate, and prosecute Medicare fraud is supported by the proposed Demonstration. Therefore, I recommend that CMS not move forward with the Review Choice Demonstration. I appreciate the opportunity to comment on the Review Choice Demonstration for Home Health Services. Thank you for your consideration. Sincerely, Carol Zehnacker, PT, DPT Physical Therapy Consult, LLC 7918 River Run Court Frederick, Maryland 21701

First Name: carol
Last Name: zehnacker
City: frederick
Country: United States
State or Province: Maryland
ZIP/Postal Code: 21701
Email Address: doctorcz@comcast.net
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0041
Current Document ID: CMS-2018-0071-0042
Title: AZ
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/24/2018
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93wg-b7st
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I am actively and adamantly opposed to such a change that has been recommended by CMS. As a licensed physical therapist I believe the result of this new legislation would be to further decrease accessibility of Medicare beneficiaries to the TIMELY service they deserve and require. It will further handicap licensed professionals in their goals to decrease patient burden and reliance on opiod medications, hospital and ED utilization, and impact change in poor lifestyle choices and home safety. I understand the position of CMS on the reasons for implementing this change, however I do not agree that this

will be the avenue to achieve the desired outcome.
First Name: Preston
Last Name: Collins
City: GILBERT
Country: United States
State or Province: Arizona
ZIP/Postal Code: 85233
Email Address: PRESTON.COLLINS22@GMAIL.COM
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0042
Current Document ID: CMS-2018-0071-0043
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/25/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93x1-yape
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I can understand the rationale to move forward with this. I know you are choosing Palmetto, however their user interface to upload and send documentation was not efficient. If you have any control of how they set up the UI that would be great. Also, consider not having to supply F2F encounter documentation for any patient discharged from an ED, observation or acute care stay. They had a F2F encounter.
First Name: Stacy
Last Name: Ragogna
City: Peoria

Country: United States
State or Province: Illinois
ZIP/Postal Code: 61615
Email Address: stacy.l.ragogna@osfhealthcare.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0043
Current Document ID: CMS-2018-0071-0044
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Component:
File Code:
Tracking Number: 1k2-93x7-wo3g
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: This demonstration project has great potential to negatively impact a patient access to timely and effective home health services. It will definitely have a negative effect on the financial stability of the providers by requiring increases in staffing to meet the cumbersome requirement and slowing down payment. The addition of the post claim review option provides no relief. It would be foolish for an agency to pay staff to provide services that might be denied later. I believe CMS's claims that fraud is prevalent in home health is quite inflated. The F2F probe and educate data used to illustrate

their claims of fraud are actually an illustration of the poor job CMS did when they rolled out the F2F requirement. The subsequent CMS revision to the F2F requirement only exacerbated the problem. Had CMS initially done proper training regarding F2F, this so called widespread "fraud" would not have been an issue. Providers want to be compliant. When provided with adequate training, they can be. But the implementation of the F2F requirement has been tragically flawed from the start and now CMS want to use that data against home health. It almost seems as if it was the plan from the very beginning. Give the industry a new regulation, poorly educate the industry, do no education with the physicians (that's the poorly educated industry's job, right?}, change the regulation, do a really poor job of educating about the change, sit back a few years, look at the data and identify the industry as fraud riddled. There is no other healthcare entity that endures 100% claim audit. This is an industry killer, targeted at states that do not have certificate of need requirements. CMS ADRs are not identifying the level of fraud that this demonstration project is citing to justify its existence. Supposedly, the F2F regulation was intended to ensure that the physician's were involved in the home health patient's care. Instead it has become some technicality that a claim can be denied for. The physician is seeing the patient and is involved in their care. But if the documentation verbiage is not exactly right.....FRAUD!!!!! How about we spend our national healthcare resources taking care of our patients....instead of wasting them on these types of projects that are not patient centered.

First Name: johanna
Last Name: ray
City: fort worth
Country: United States
State or Province: Texas
ZIP/Postal Code: 76116
Email Address: jrayrn1982@yahoo.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0044
Current Document ID: CMS-2018-0071-0045
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93xr-50fn
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I have several concerns about this iteration of pre-claim review. 1. A 100% pre-claim review does place an additional burden on home health agencies. While your assertion that agencies are already collecting this documentation is true, it is the review of the documentation, the identification of which documents satisfy which requirements, the scanning and ensuring legibility and completeness of those scans, and tracking to ensure that 100% of all beneficiary paperwork is submitted and approved that takes time. Not to mention technology is not infallible and must be monitored, adjusted

and repaired from time to time. Increased use creates increased wear and tear which also adds to administrative burden. 2. Then, once you have submitted your pre-claim review, documentation can be arbitrarily denied by some reviewers. Whether this is a lack of education or lack of attention to detail is uncertain. However, when we went through pre-claim review in Illinois, I ended up writing a cover letter on each of our pre-claim reviews to point out where certain pieces of information were because it was so frustrating to get a denial when you knew that the information was there. Toward the end of the Illinois program, the reviewers were calling when they were going to deny a pre-claim review. I then had to review my submitted documentation and sometimes identify the very items I was told were not submitted. Several potential denials were addressed in this manner. As the program is extended into more states, the burden on reviewers can only be anticipated to increase. Where does this leave their attention to detail? What kind of quotas will you be imposing on them to ensure you don't receive bad press about delays in decisions? What kind of pressure will they be under to justify their positions and create enough denials to keep the home health fraud facade up in the media? 3. Though CMS has developed some physician education and resources, I think you underestimate the already increased time burden you place on agencies to re-enforce that education and ensure compliant face-to-face documentation. Physicians are given no incentive to cooperate with agencies. Agency staff continue to go back and forth with them on the content of their progress notes. 4. As others have stated, this will not deter the bad actors in the home health field. This is a mechanism to give you a manufactured "win" and justify the existence of all of your audit agencies. Four out of five of the top denial reasons from January - March were for paperwork technicalities. Only one reason code actually addresses the reasonableness and necessity of care. If you're being truly honest with yourselves, you're catching administrative errors and not identifying true fraud and abuse. The fraudsters will just manufacture compliant paperwork. This is truly a disappointing time to be working in home health. Administrative burdens continue to increase while payments decrease. What is the aim of the pre-claim review? You say it is to identify fraud but all you are doing is exposing paperwork deficiencies. How many agencies did you identify during pre-claim review that were actually performing widespread fraud and abuse? How many agencies did you close because of blatant illegal activities? Any program that does

little to improve patient care has no place in today's healthcare environment.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60053
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0045
Current Document ID: CMS-2018-0071-0046
Title: MD
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Component:
File Code:
Tracking Number: 1k2-93xs-nne5
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: 06-26-2018 Seema Verma, MPH Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 445-G Attn: CMS-10599 Hubert Humphrey Building 200 Independence Ave, SW Washington, DC 20201 Submitted electronically RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. My

name is Hema Venkata N Rajesh Vemuri, licensed Physical Therapist working in Home Health setting in my community in Charles County, MD, have have several concerns with the Review Choice Demonstration. My concerns include: Review Choice Demonstration Will Obstruct Beneficiary Access Instituting 100% pre-claim or postpayment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the increase in administrative and financial costs associated with complying with the Demonstrations requirements. HHAs, referring physicians, and other clinicians on the beneficiarys care team will be forced to redirect staff time away from clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns the Demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired patients. Review Choice Demonstration Will Impose Undue Administrative and Financial Burden on Providers CMS is disproportionately subjecting HHAs to complex and burdensome Medicare pilot programs and demonstrations. This demonstration is a duplicative process of oversight that will only add to the administrative burdens that already plague HHAs. The Demonstration 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. Additionally, this Demonstration is contradictory to CMSs top priority to put patients first. Review Choice Demonstration Will Take Care Planning Decision Away from HHA Clinicians The beneficiarys care team strive to ensure the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the provider, such as the physical therapist, to make judgments that are in the best clinical interests of the beneficiary. However, the Demonstration effectively overrides the judgment of the clinician, redirecting the care decision-making process to Palmettos medical review staff, individuals who frequently make medical denial decisions without consideration of the beneficiarys total condition and individual need for care. Affording Palmetto significant clinical decision-making authority is unjustifiable, given it is the professional judgment of the clinician to decide which combination of home health services is most appropriate to treat the beneficiary in accordance with Medicare coverage guidelines. Conclusion I do not believe

CMSs efforts to identify, investigate, and prosecute Medicare fraud is supported by the proposed Demonstration. Therefore, I recommend that CMS not move forward with the Review Choice Demonstration. I appreciate the opportunity to comment on the Review Choice Demonstration for Home Health Services. Thank you for your consideration. Sincerely, Hema Venkata N Rajesh Vemuri, MS PT DPT CCI. Licensed Physical Therapist

First Name: Hema Venkata
Last Name: Vemuri
City: Waldorf
Country: United States
State or Province: Maryland
ZIP/Postal Code: 20601
Email Address: vemurirajesh7@gmail.com
Organization Name:
Category:
Cover Page:

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Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0046
Current Document ID: CMS-2018-0071-0047
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93xt-iwjg
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: PCR has its Pros and Cons. Our organization had 100 percent success rate in PCR. The number 1 benefit was that we had a strategic advantage that caused an increased marketshare because competition did not understand PCR or was busy complaining Our complaints include the following: + PCR staff is unqualified: We learned that many of the staff were LPN's or less and were stationed remotely. I remember vividly that our TV in the Lobby had the Peoples Court and we can hear the PCR representative watching the same channel as we can hear the television voice over the phone My Fears: + I welcome PCR

in my Market because it will force the closure of my competition however, with HHGM around the corner, PCR with HHGM will increase healthcare costs by increased hospitalizations, ineffeficient home health case management that will lead to longterm healthcare consequences (increased hospitalizations with rising healthcare costs). + PCR is a mindshare in business operations that takes away from efficient cost cutting therapies that will benefit CMS. Home Health agencies will be more focused on financial matters and less focused on clinical outcomes. This is time well spent on CMS already mandated Clinical Quality Improvement Projects Business Model Impact: Medicare healthcare access has always been democratized, patients have full access to care and freedom to choose providers. PCR is a barrier to access of care. Home Healthcare Agencies will alter their business models to delay care. CMS, please look at data between hospital and home healthcare days during PCR and with no PCR. You will see a time lage of at least 1 day before a home health nurse can visit a patient with PCR. Delayed home health visits will cause patient harm and immediate financial reprecussion. PCR model makes sense in theory, however the design, oversight, and CMS staff should be outsourced at a minimum, otherwise there are a myriads of managed care designs that can help curb waste in the post acute care setting My recommendation is to share the economic model that justifies cost savings, improved care, and reducing wastage to the public at a minimum. There seems to be no financial justification for the model implementation just a theoretical concept that worked in commercially funded for profit organizations backed with investors.

First Name: Iqbal
Last Name: Shariff
City: Chicago
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60605
Email Address: iqbal@bhhcare.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0047
Current Document ID: CMS-2018-0071-0048
Title: CA
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/28/2018
Date Posted: 07/10/2018
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Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93z3-gt6h
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: comment
First Name: Wesley
Last Name: Ether
City: Long Beach
Country: United States
State or Province: California
ZIP/Postal Code: 90802
Email Address: wesley.either@gmail.com
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0050
Current Document ID: CMS-2018-0071-0049
Title: MO
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/29/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93zp-oihx
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Re-instituting the failed pre-claim review, with two other alternatives which are also disastrous for home health agencies, will result in home care being unavailable to many seniors as more agencies are forced to close due to delayed or lower revenue. Considering that several of the demonstration states are already dealing with Value-Based Purchasing, this is an unreasonable burden for agencies in these states. It seems that home health, which is one of the most cost effective methods of providing health care, is being targeted with the most efforts at reducing Medicare expenditures. When

agencies are forced out of business, the only alternative will be inpatient care for many of the seniors served by home health. Targeted Probe and Educate has also impacted many of the agencies in these demonstration states, as well as in other agencies across the nation. This past year, agencies were faced with dealing with so many regulatory changes, many are still reeling from the efforts of implementing new policies and practice in order to be in compliance. We are an industry that has been unduly burdened in recent years, and we are seeing a large number of our competent, skilled staff leave home health to go to other areas of health care because of this. Home Health is already subject to a number of audits to review fraud and abuse, including MACs, ZPICs, RACs, OIG, etc. If these are inadequate to solve problems related to fraud and abuse, there is no reason to think that the Review Choice Demonstration is going to improve matters any. Adding the Review Choice Demonstration on top of the many other challenges the industry has faced may well be the breaking point for a number of agencies and professionals in the industry. This will negatively impact many seniors across the nation who should be able to stay in their homes to receive the care they need. Review Choice Demonstration should be reconsidered, and more reasonable alternatives introduced.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Missouri
ZIP/Postal Code: 64116
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0051
Current Document ID: CMS-2018-0071-0050
Title: MO
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Received Date: 06/29/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93zp-rsf8
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: CMS-10599 Re-instituting the failed pre-claim review, with two other alternatives which are also disastrous for home health agencies, will result in home care being unavailable to many seniors as more agencies are forced to close due to delayed or lower revenue. Considering that several of the demonstration states are already dealing with Value-Based Purchasing, this is an unreasonable burden for agencies in these states. It seems that home health, which is one of the most cost effective methods of providing health care, is being targeted with the most efforts at reducing Medicare expenditures. When

agencies are forced out of business, the only alternative will be inpatient care for many of the seniors served by home health. Targeted Probe and Educate has also impacted many of the agencies in these demonstration states, as well as in other agencies across the nation. This past year, agencies were faced with dealing with so many regulatory changes, many are still reeling from the efforts of implementing new policies and practice in order to be in compliance. We are an industry that has been unduly burdened in recent years, and we are seeing a large number of our competent, skilled staff leave home health to go to other areas of health care because of this. Home Health is already subject to a number of audits to review fraud and abuse, including MACs, ZPICs, RACs, OIG, etc. If these are inadequate to solve problems related to fraud and abuse, there is no reason to think that the Review Choice Demonstration is going to improve matters any. Adding the Review Choice Demonstration on top of the many other challenges the industry has faced may well be the breaking point for a number of agencies and professionals in the industry. This will negatively impact many seniors across the nation who should be able to stay in their homes to receive the care they need. Review Choice Demonstration should be reconsidered, and more reasonable alternatives introduced.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Missouri
ZIP/Postal Code: 64154
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0052
Current Document ID: CMS-2018-0071-0051
Title: MO
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Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93zp-81q3
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: CMS-2018-0071 Re-instituting the failed pre-claim review, with two other alternatives which are also disastrous for home health agencies, will result in home care being unavailable to many seniors as more agencies are forced to close due to delayed or lower revenue. Considering that several of the demonstration states are already dealing with Value-Based Purchasing, this is an unreasonable burden for agencies in these states. It seems that home health, which is one of the most cost effective methods of providing health care, is being targeted with the most efforts at reducing Medicare

expenditures. When agencies are forced out of business, the only alternative will be inpatient care for many of the seniors served by home health. Targeted Probe and Educate has also impacted many of the agencies in these demonstration states, as well as in other agencies across the nation. This past year, agencies were faced with dealing with so many regulatory changes, many are still reeling from the efforts of implementing new policies and practice in order to be in compliance. We are an industry that has been unduly burdened in recent years, and we are seeing a large number of our competent, skilled staff leave home health to go to other areas of health care because of this. Home Health is already subject to a number of audits to review fraud and abuse, including MACs, ZPICs, RACs, OIG, etc. If these are inadequate to solve problems related to fraud and abuse, there is no reason to think that the Review Choice Demonstration is going to improve matters any. Adding the Review Choice Demonstration on top of the many other challenges the industry has faced may well be the breaking point for a number of agencies and professionals in the industry. This will negatively impact many seniors across the nation who should be able to stay in their homes to receive the care they need. Review Choice Demonstration should be reconsidered, and more reasonable alternatives introduced.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Missouri
ZIP/Postal Code: 64116
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0053
Current Document ID: CMS-2018-0071-0052
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/29/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-93zp-s2hv
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I would like to take this opportunity to explain some of the challenges faced by our agency during the previous pre-claim review in Illinois. I hope that this helps CMS to better understand the burden placed on agencies, as well as opportunities to improve the program moving forward. Our agency is a mid-size agency with an average census of around 500 patients and less than 50% of our patients with traditional Medicare coverage. During the PCR demonstration, we sent a total of 1,113 submissions. Of these submissions, 1,042 were fully or partially affirmed upon the first

submission which gave us an overall 93.6% affirmation rate upon initial submission. All of our cases were eventually affirmed after as many as four re-submissions. During PCR, there were cases that we chose to self-deny and not submit for payment as we were aware that we were missing necessary documentation. We have continued auditing all Medicare charts utilizing the knowledge we gained during PCR and ensure that our documentation meets all standards before billing. In order for our agency to complete PCR submissions, we dedicated an average of 100 hours per week to this task. This is the equivalent of 2.5 FTEs of nursing, medical records, and billing staff time. Our agency is affiliated with the largest Medicaid provider in the State of Illinois and our office services the Chicagoland area. Therefore, we serve a large number of patients with Medicaid payment sources. This requires us to be particularly efficient with our costs so that we can continue to serve our community with decreased revenues as compared to other agencies with more lucrative payer mixes. Due to these financial constraints, we were unable to hire additional staff to help manage this burden. Therefore, we had to re-allocate resources that might otherwise have been spent on improving our patient experience or quality of services to administrative tasks. With an affirmation rate that consistently exceeded 90%, the PCR program seemed not only to place unnecessary strain on our staff members, but it also took resources away from patient-focused work and moved those resources to paperwork. Like many of the commenters, we experienced challenges with the PCR process that I would like to share with you in the hopes that these issues may be addressed in future programs. Especially at the beginning of the demonstration, we felt a lack of clarity about what documentation would be required to receive affirmation. We experienced a wide variation between reviewers about what was considered acceptable documentation. In fact, there were multiple instances in which we received a non-affirmation from one reviewer, and (due to our lack of understanding about what was missing from the original submission) when we submitted the exact same documentation again, we received an affirmation from a different reviewer. There were times when a reviewer was evaluating our submission, and would call the office for clarification; if the staff member who entered the submission was not available to answer the call, we were not provided with a direct call back number to speak with the reviewer and therefore missed out on opportunities to discuss any deficiencies together or provide education to someone who may not be familiar with the

formatting of our documentation. We also experienced a significant delay in receiving logon credentials to sign in to the PCR website so we could submit clinicals and receive affirmation/non-affirmation letters electronically. This resulted in wasted resources required to print large volumes of documents from our electronic medical record. We hope that you will consider beginning the new Review Choice Demonstration in another state as Illinois has already demonstrated the ability to comply with the expectations of the PCR demonstration and our agency has continued to ensure that our documentation on all Medicare patients meets the standards of PCR. If CMS chooses to move forward with initiating RCD in Illinois, we ask that: you are transparent with the guidelines provided to reviewers; all reviewers are adequately trained prior to the start of the demonstration, previous success with the PCR demonstration will be considered as an option for opting high-performing agencies out of the demonstration; all agencies are provided with appropriate logins and training for the website where documents can be submitted prior to the start of the demonstration. Thank you for your consideration.

First Name: Angi
Last Name: Bollinger
City: Des Plaines
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60016
Email Address: angela.bollinger@presencehealth.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0054
Current Document ID: CMS-2018-0071-0053
Title: MD
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/30/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-9409-caui
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: June 30, 2018 Seema Verma, MPH Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 445-G Attn: CMS-10599 Hubert Humphrey Building 200 Independence Ave, SW Washington, DC 20201 Submitted electronically RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. I

have been a physical therapist for 32 years and have worked in a variety of settings including home health. As a physical therapist I have several concerns with the Review Choice Demonstration. My concerns include: CMS is disproportionately subjecting HHAs to complex and burdensome Medicare pilot programs and demonstrations. This demonstration is a duplicative process of oversight that will only add to the administrative burdens that already plague HHAs. The Demonstration 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. Additionally, this Demonstration is contradictory to CMSs top priority to put patients first. Instituting 100% pre-claim or postpayment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the increase in administrative and financial costs associated with complying with the Demonstrations requirements. HHAs, referring physicians, and other clinicians on the beneficiarys care team will be forced to redirect staff time away from clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns the Demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired patients. Conclusion I do not believe CMSs efforts to identify, investigate, and prosecute Medicare fraud is supported by the proposed Demonstration. Therefore, I recommend that CMS not move forward with the Review Choice Demonstration. I appreciate the opportunity to comment on the Review Choice Demonstration for Home Health Services. Thank you for your consideration. Sincerely, Carolyn Chanoski, PT, DPT Physical Therapist

First Name: Carolyn
Last Name: Chanoski
City: Bel Air
Country: United States
State or Province: Maryland
ZIP/Postal Code: 21014
Email Address: c_chanoski@yahoo.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0055
Current Document ID: CMS-2018-0071-0054
Title: MD
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 06/30/2018
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-940a-4rs0
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: June 30, 2018 Seema Verma, MPH Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 445-G Attn: CMS-10599 Hubert Humphrey Building 200 Independence Ave, SW Washington, DC 20201 Submitted electronically RE: Request for Information Regarding Physician Self-Referral Law. Dear Administrator Verma I am writing in response to the request for comments on Request for Information Regarding Physician Self-Referral Law. I have been a physical therapist for 32 years and have worked in the public schools as well as long term care and out-patient

physical therapy clinics. Patients have direct access to physical therapy services in some manner in all fifty states except those patients covered by Medicare. Todays physical therapists are educated with an entry-level doctorate of physical therapy. We have been trained evaluate and treat a wide variety of diagnoses. We have also been trained to refer patients whose ailments we determine are not appropriate for our services. Long gone are the days when physical therapists required physician oversight. Why then do physicians own physical therapy clinics? Certainly it is not because they need to supervise physical therapists. Many clinics are open when the physicians are not there. Physicians no longer need to prescribe physical therapy treatment since physical therapists are trained in modalities and techniques which physicians are not. Physicians own physical therapy clinics as another source of income. This constitutes a referral for profit. When a physician owns a physical therapy clinic it allows him/her to interfere with the treatment plan determined by the physical therapist by limiting the number and types of treatments the may patient receive. Researchers Jean M. Mitchell, PhD, James D. Reschovsky, PhD, and Elizabeth Anne Reicherter, PT, DPT, PhD, examined whether the course of physical therapy treatments received by patients who undergo total knee replacement (TKR) surgery varies depending on whether the orthopedic surgeon has a financial stake in physical therapy services, often called physician self-referral. After reviewing 3,771 TKR patients, the study investigators concluded that physical therapists not involved with physician-owned clinics saw patients for fewer visits and provided more individualized care at a lower out-of-pocket cost, according to a news story by Joint Motion Physical Therapy. Specifically, the study found that TKR patients who were treated in a clinic owned by their orthopedic surgeon received an average of 8.3 more (or twice as many) physical therapy visits than those who were treated in a clinic in which their orthopedic surgeon had no financial stake, the news story continues. The article further suggests that the rehab program in a physician self-referral clinic may often be heavily focused on group therapy sessions. In such a setting, the PT may not be able to observe and address each patients deficits. However, the article adds, patients treated in an individualized physical therapy program may recover sooner and receive better care. The study was published in the journal Health Services Research. [Source: Joint Motion Physical Therapy] Increasing the number of treatments also increases the direct cost of therapy services and also related costs to

the patients such as assistance with housekeeping, etc. This also prolongs the time that a patient is unable to return to their prior level of function. Conclusion Thank you for the opportunity to comment on the Request for Information Regarding Physician Self-Referral Law. If you have any questions or would like to contact me, I can be reached at 410-879-3796 or c_chanoski@yahoo.com Sincerely, Carolyn E. Chanoski, PT, DPT Physical Therapist

First Name: Carolyn
Last Name: Chanoski
City: Bel Air
Country: United States
State or Province: Maryland
ZIP/Postal Code: 21014
Email Address: c_chanoski@yahoo.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0056
Current Document ID: CMS-2018-0071-0055
Title: NJ
Number of Attachments: 1
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/01/2018
Date Posted: 07/10/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-941a-vf70
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services, and to explain two reasons why I think this proposed Demonstration is problematic. I am a physical therapist with over 30 years of home care experience, and I currently work for home care agency within a faith-based, not-for-profit health system.
First Name: Cindy
Last Name: Moore
City: Hamilton

Country: United States
State or Province: New Jersey
ZIP/Postal Code: 08620
Email Address: cmoore@holyredeemer.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0057
Current Document ID: CMS-2018-0071-0056
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/10/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-941s-i643
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: The Review Choice Demonstration will take care planning decisions away from HHA clinicians. The beneficiarys care team strives to ensure the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the provider, such as the physical therapist, to make judgments that are in the best clinical interests of the beneficiary. However, the demonstration, in effect, overrides the judgment of the provider, redirecting the care decision-making process to Palmettos medical review staff, individuals who frequently

make medical denial decisions without consideration of the beneficiarys total condition and individual need for care. In essence, this demonstration is contradictory to CMSs top priorityto put patients first. The Review Choice Demonstration Will Hinder Patient Access. Instituting 100% pre-claim or post-payment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the increase in administrative and financial costs associated with complying with the demonstrations requirements. HHAs, referring physicians, and other clinicians on the beneficiarys care team will be forced to redirect staff time away from the beneficiarys clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns that the demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired beneficiaries. I believe the demonstration falls short of being sufficient as a program integrity tool to offset the downside risks to Medicare beneficiaries and HHAs. As your constituent, I request that you contact CMS on my behalf and strongly urge them not to move forward with the Review Choice Demonstration for Home Health Services unless and until CMS can ensure that beneficiaries access to home health care services will not be threatened. Sincerely, Carol Tankersley

First Name: Carol
Last Name: Tankersley
City: Amarillo
Country: United States
State or Province: Texas
ZIP/Postal Code: 79109
Email Address: ctankersley@chhsi.com
Organization Name: Caprock Home Health Services, Inc.
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0058
Current Document ID: CMS-2018-0071-0057
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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Submission Type: Web
Number of Submissions: 1

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Component:
File Code:
Tracking Number: 1k2-941u-c3mk
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: There does not seem to be a concrete set of guidelines that the Reviewer and Agency can refer to as a common resource. Reports during the original PCR demonstration period noted that many denials were based on simple paperwork errors. Resubmission for a denial would again encounter the denial of a different section by the next reviewer. CMS should include the wisdom and experience of home health leaders into the development of any new guidelines. Addressing the issue of fraud jointly to come up with a solution will not only help reduce fraud, it will improve the greatly needed home health

service for our patient's benefit. The goal to provide better care is of course the goal of many in CMS and the Home Health Care industry.

First Name: Lillie
Last Name: Ralph
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 75149
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0059
Current Document ID: CMS-2018-0071-0058
Title: MO
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

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Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-942d-gu6z
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: OMB CMS 2018-0071 Re-instituting the failed pre-claim review, with two other alternatives which are also disastrous for home health agencies, will result in home care being unavailable to many seniors as more agencies are forced to close due to delayed or lower revenue. Considering that several of the demonstration states are already dealing with Value-Based Purchasing, this is an unreasonable burden for agencies in these states. It seems that home health, which is one of the most cost effective methods of providing health care, is being targeted with the most efforts at reducing Medicare

expenditures. When agencies are forced out of business, the only alternative will be inpatient care for many of the seniors served by home health. Targeted Probe and Educate has also impacted many of the agencies in these demonstration states, as well as in other agencies across the nation. This past year, agencies were faced with dealing with so many regulatory changes, many are still reeling from the efforts of implementing new policies and practice in order to be in compliance. We are an industry that has been unduly burdened in recent years, and we are seeing a large number of our competent, skilled staff leave home health to go to other areas of health care because of this. Home Health is already subject to a number of audits to review fraud and abuse, including MACs, ZPICs, RACs, OIG, etc. If these are inadequate to solve problems related to fraud and abuse, there is no reason to think that the Review Choice Demonstration is going to improve matters any. Adding the Review Choice Demonstration on top of the many other challenges the industry has faced may well be the breaking point for a number of agencies and professionals in the industry. This will negatively impact many seniors across the nation who should be able to stay in their homes to receive the care they need. Review Choice Demonstration should be reconsidered, and more reasonable alternatives introduced.

First Name: Rebecca
Last Name: Murrell
City: North Kansas City
Country: United States
State or Province: Missouri
ZIP/Postal Code: 64116
Email Address: Rebecca.Murrell@nkch.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0060
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Document Optional Details

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1

Submitter Info

Comment: WellCare Health Plans, Inc. (WellCare) is pleased to submit comments in response to the Pre-Claim Review Demonstration for Home Health Services information collection request (CMS10599; OMB control number: 09381311). WellCare supports CMS initiative to mitigate fraud, waste, and abuse in the home health services industry. The supporting statement notes that CMS will conduct a revised demonstration in select states, as the current demonstration ends in June 2019. We ask CMS to confirm the start date of that revised demonstration. WellCare asks that the provider specific data that is collected by CMS

be made available to Medicare Advantage (MA) plans to help MA plans mitigate fraud, waste, and abuse in their networks. Specifically, we are asking that the names of participating agencies and their claim approval results be made available for MA plans use. On page 2 of the supporting statement, CMS states that providers who do not wish to participate in either 100 percent pre-claim or post-payment reviews have the option to furnish home health services and submit the associated claim for payment without undergoing such reviews. However, CMS notes that these providers will receive a 25 percent payment reduction on all claims submitted for home health services and may be eligible for review by the Recovery Audit Contractors. WellCare asks for clarification on whether MA plans can enforce the 25 percent payment reduction if their providers in the demonstration area choose to opt out of the program.

First Name: Camille
Last Name: Heard
City: Tampa
Country: United States
State or Province: Florida
ZIP/Postal Code: 33634
Email Address: camille.heard@wellcare.com
Organization Name: WellCare Health Plans, Inc.
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0061
Current Document ID: CMS-2018-0071-0060
Title: MO
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/05/2018
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Submission Type: Web
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Component:
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Submitter Info

Comment: Please reconsider the impact to the intended recipients and the home care providers as you think about re-instituting the pre-claim review. Bringing this review back is detrimental to the home health industry. This is an unnecessary burden to the agencies. A surveyor once commented to our agency that the home health industry is about as highly regulated as the nuclear industry. We have already absorbed a significant increase in the work load with the new COP's and other ongoing regulatory changes. Many agencies find themselves forced to shut down their operations which in turn means there is either

no access or less access for the patients in that area. Seems home care is such a target for decreasing your expenses--yet home care is the most cost effective setting to provide care AND is where the beneficiaries wish to receive their care. As you force agencies to close--unfortunately, in some cases, you leave patients no choice except to seek their care in the ER or the hospital--something again that home care has been tasked to help reduce. Seems this is counter productive. Seems your only solution is to add yet another layer of targeting home health with more audits. There is already the very burdensome face to face requirement. Then, there are ADR's, CERT's, RAC's, MAC's, ZPIC's, OIG, the target P&E and now this! It seems there are plenty of layers of audits/over sight of the home health industry. It perplexes me to think that if these are not enough and are not working--why keep trying the same thing--thinking this next audit is going to be the answer. Layering us with yet another burdensome task is not your solution. I have been in home care for over 35 years. I stay in this industry because I believe in our mission. I have been in it long enough to remember when home care was fun. Unfortunately--you have driven our industry to so much of nothing more than meeting the regulations, that we have a tremendous challenge in attracting and retaining talented staff. There are so many options for nurses now that are more attractive. They can go to work for IT companies making much larger salaries, have regular hours and work in an office rather than 100 plus summer temps and dealing with slick, icy roads in the winter. The ones who come and stay are here for the patients--but they become so frustrated with the ongoing new additions to their work load due to regulations they will at times, out of frustration lay their head on my desk--almost in tears and ask--when do I get to be a nurse? This is just one more burden. Many of us seasoned nurses who are die-hard committed to home health will soon be retiring--you see that in the stats now. The younger staff are much better at setting limits and establishing a work-life balance. if they can't find that in home health--back to the hospital they go where they can give report and punch out on the time clock or off to an IT company they go. Bringing the same pre-claim review back with a new name--Review Choice Demonstration is not your answer. Please reconsider.
First Name: Sarah
Last Name: Kerr
City: Platte City
Country: United States
State or Province: Missouri

ZIP/Postal Code: 64079
Email Address: Sarah.Kerr@nkch.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0062
Current Document ID: CMS-2018-0071-0061
Title: UT
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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1

Submitter Info

Comment: I am a home health physical therapist, previous owner of a Home Health Agency,and prior executive director / now board member for utah association for home care. I have spent many, many years arguing with Medicare reviewers regarding the review process and have overturned 99 percent of the improperly denied reviewed claims. I have spent many many years arguing with Insurance companies to assure medically necessary services are delivered in timely fashion to meet a patient's unique medically necessary issues, while services are simply delayed due to overburdened systems from pre-claim

review. I have witnessed people die, return to the hospital, be institutionalized, and any other number of unnecessary added complexities due delay of services or no services at all. And the added costs to care when spending so much time arguing with reviewers who cannot begin to understand the home issues (mostly because they aren't clinically competent to adjudicate a claim) are made worse when they do it from some place other than the home setting. Preclaim review demonstrations have already shown how poorly it deals with urgent medically necessary services in the home. The key issue is a majority of complicating issues, including rehospitalization occur when there is insufficient services in the the home during the transition. This is well-documented in Medicare's stats. The shear volume of requests to be reviewed has proven to be impossible to respond timely for approval, let alone a reviewer being able to review the documentation submitted adequately to make the correct decisions on approval of what services. Even now, in post claim review, the reviewers are unable to properly review claims to make correct decisions regarding payment. This is why there are so many appeals. And this is why it would actually be expected to INCREASE appeals that need to be made much faster, or risk people dying, in order to safely carry out such a onerous task as preclaim review. Bottom line, stats show problems occur during the transitions. Preclaim is a stall of services during the most vital transition time of entering into home health. Additionally, it is poor logic to believe that preclaim review will successfully fight fraud. In an evidence based society, I would ask where IS the evidence? If a person wishes to game any system, they have and will figure out how to do it. And simply making it preclaim review will not stop them. But the worst thing is that there is just no way for us in the home health setting to have a full understanding of these medically complex, multifactoral chronic problems, fragile, and vulnerable adults' full functional and medical status in one evaluation. And when you try to convey that to a person sitting in an office somewhere, it just does not translate. And, it just makes no sense that it will "prevent fraud, waste, and abuse." If anything, it will add to it as we watch the reviewers' wasteful and abusive behavior of inappropriately denying patients medically necessary services that they just can't understand... at least they haven't shown it yet. Further, the denial of medically necessary benefits by insurers of medadvantage plans has only served to take care back in time by about 30 years. The plans have literally thrown away the innovative ideas processes for a stricter

reign from a disconnected person in an office because they don't trust the provider to do the right job. Let's focus our energy on results, not more ineffective and burdensome rules. Let's get back to where the patient is the critical factor rather than compliance being primary over the patient. Let's not take us back in time on handling these critical processes, but move forward with best practices. preclaim review is not a best practice and cannot meet any of the ends of improved quality, improved outcomes, improved efficiencies, improved transitions, decreased institutionalization, decreased unnecessary medical complications, or fraud, waste, and abuse.

First Name: Edward
Last Name: Dieringer
City: Millcreek
Country: United States
State or Province: Utah
ZIP/Postal Code: 84109
Email Address: egdieringer@gmail.com
Organization Name: Utah Association for Home Care
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0063
Current Document ID: CMS-2018-0071-0062
Title: FL
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Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Component:
File Code:
Tracking Number: 1k2-946i-i0o1
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Please do not allow the pre claim review to go into place. We are a small family run home health agency and you will be putting us out of business. We love treating patients and we do it honestly. Please allow us to continue to do what we do best!! We are inspected atleast every 3 years and are performing up to par. I feel unless a survey brings on mandatory authorizations or pre claim review please let us do our job and take care of our patients. We cant afford to hire more staff (which is what it is going to require) if this goes through and takes affect. Our nurses and therapist have plenty

of paperwork as it is with new and changed Medicare rules, this would just make less time for patient care and more time for paperwork. There is only so many hours in the day. I feel if we (as in home health agency owners) have given privileges to see patients and have not been cited for not following guidelines, then let us be and do what we love= TREAT PATIENTS. Thank you!

First Name: Kelli
Last Name: Davis
City: Jacksonville
Country: United States
State or Province: Florida
ZIP/Postal Code: 32221
Email Address: Kddavis14@yahoo.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0064
Current Document ID: CMS-2018-0071-0063
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/10/2018
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Submission Type: Web
Number of Submissions: 1

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Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-9476-zu2a
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: This additional responsibility on Florida is another straw that could break many of our backs. We are dealing with HHVBP that became active Jan 2018 and will change each year going forward. This makes budgeting for operations difficult since our reimbursement can vary from year to year. Pre-claim review will cause us to increase our staffing since we would want to participate with 100% pre-claim and it would require a specific person being responsible for tracking the necessary documents, loading them on the portal and monitoring the approval process from CMS. Seems to me that if our 4.5 star

quality rating and 5 star patient satisfaction rating should exempt us from being included in this probe. The quality management of our outcomes and patient satisfaction drains our available staff to maintain our high performance level. Adding more layers of compliance just drains more resources. We have not given any cost of living increases to our staff for over 6 years because of reimbursement variances and unknowns. Keeping good employees costs money and all we've seen are cuts. Home care professionals come with a lot of experience and high skill levels - they deserve to be paid for their worth. Please do NOT implement this requirement and if it must be initiated; don't penalize those of us who have established and maintained outstanding perfomance.

First Name: Louise
Last Name: Stewart
City: Naples
Country: United States
State or Province: Florida
ZIP/Postal Code: 34103
Email Address: lstewart@americareinc.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0225
Current Document ID: CMS-2018-0071-0064
Title: MN
Number of Attachments: 1
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Received Date: 07/16/2018
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Posting Restriction: No restrictions
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Component:
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Page Count: 1
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1

Submitter Info

Comment: Dear Ms. Verma: On behalf of Allina Health, I appreciate the opportunity to comment on the changes proposed in the Pre-Claim Review Demonstration Request, published by CMS. Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin. A not-for-profit health care system, Allina Health cares for patients from beginning to end-of-life through its 90+ clinics, 13 hospitals, 14 retail pharmacies, specialty care centers and specialty medical services that provide home

care, senior transitions, hospice care, home oxygen and medical equipment, and emergency medical transportation services Allina Health appreciates the opportunity to provide comments on the proposed demonstration, and we hope that CMS will take our concerns into consideration. If CMS opts to move forward with this demonstration, we believe that the agency needs to share with providers the rationale for implementing this burdensome process. If you have any questions, please feel free to contact me at 612-262-4908. Sincerely, Allyson Hammer, MPH Manager, Compliance & Regulatory Affairs

First Name: Allyson
Last Name: Hammer
City: Minneapolis
Country: United States
State or Province: Minnesota
ZIP/Postal Code: 55407
Email Address: allyson.hammer@allina.com
Organization Name: Allina Health
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0224
Current Document ID: CMS-2018-0071-0065
Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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File Code:
Tracking Number: 1k2-94b2-lzcj
Page Count: 1
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1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Lloyd
Last Name: Ohlinger
City: Baltimore
Country: United States
State or Province: Ohio
ZIP/Postal Code: 43105
Email Address: denpsey.ohlinger@caregiverusa.com
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0278
Current Document ID: CMS-2018-0071-0066
Title: OH
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File Code:
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1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Peggy
Last Name: Carnahan
City: Van Wert
Country: United States
State or Province: Ohio
ZIP/Postal Code: 45891
Email Address: peggy_carnahan@comhealthpro.org
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0277
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Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Submission Type: Web
Number of Submissions: 1

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Component:
File Code:
Tracking Number: 1k2-94cf-rt3w
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Jayne
Last Name: Monk
City: Galion
Country: United States
State or Province: Ohio
ZIP/Postal Code: 44833
Email Address: j-monk@live.com
Organization Name:
Category:

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Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0276
Current Document ID: CMS-2018-0071-0068
Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/18/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-94ce-1sz2
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Robert
Last Name: Mason
City: Columbus
Country: United States
State or Province: Ohio
ZIP/Postal Code: 43209
Email Address: robert@dhmcorp.net
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0275
Current Document ID: CMS-2018-0071-0069
Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/18/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-94ce-uazq
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Gretchen
Last Name: Lammers
City: Ottawa
Country: United States
State or Province: Ohio
ZIP/Postal Code: 45875
Email Address: glammers@pchh.net
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0274
Current Document ID: CMS-2018-0071-0070
Title: VA
Number of Attachments: 1
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/18/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-94ce-2bi6
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: On behalf of the American Physical Therapy Association, thank you for the opportunity to provide comments on the Review Choice Demonstration for Home Health Services. Our comment letter is attached.
First Name: Kara
Last Name: Gainer
City: Alexandria
Country: United States
State or Province: Virginia
ZIP/Postal Code: 22314

Email Address: karagainer@apta.org
Organization Name: American Physical Therapy Association
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0273
Current Document ID: CMS-2018-0071-0071
Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/18/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-94cd-sbaf
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Nicole
Last Name: Waddell
City: Cincinnati
Country: United States
State or Province: Ohio
ZIP/Postal Code: 45230
Email Address: nicolewaddell@superiorcareplus.com
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0272
Current Document ID: CMS-2018-0071-0072
Title: VT
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/18/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-94cd-5xyz
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for providing the opportunity to comment on the CMS-10599Pre-Claim Review Demonstration for Home Health Services. While I work at an agency that is not located in a participating state for this project I have several concerns to bring forth. 1) This seems to be a duplication to the Probe and Educate audit which, in my opinion, is a less punitive approach to determining the efficacy of claims sent to CMS for payment. This method of pre or post payment review, or the option to take a 25% payment reduction with "minimal review" (I did not see a definition for "minimal") implies guilt

before review. 2) Including any agency within these states in the audit due to the data reflective of higher incidence of fraudulent claims or waste punishes those agencies who are not identified as being in this category and who work diligently to remain in compliance. The result is an undeserved hardship on a compliant agency that will lead to additional operating income losses due to the increased administrative burden. 3) The option of a 25% reduction in payment is not a viable option, especially to a compliant agency. A more compliant agency likely already has additional quality/compliance/education staff in place in order to meet guidelines. This limits your operating margin to begin with. Imposing the additional administrative burden on these agencies could result in reduced quality rather than improved or equal quality/compliance and may lead to closure of compliant agencies. 4) I would advocate for the continued use of Probe and Educate to determine poor practice patterns and fraud within the industry. Agencies who are identified as highly non-complaint would then be appropriately placed in a full pre or post payment review category rather than punished before the crime is identified.

First Name: Catherine
Last Name: Cullen
City: Norwich
Country: United States
State or Province: Vermont
ZIP/Postal Code: 05055
Email Address: cullcath@gmail.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0065
Current Document ID: CMS-2018-0071-0073
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947s-cco6
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I have been working in home healthcare for 22 years and take great pride working with our elderly. The new process that is pending will only hurt and not help the elderly. New process would greatly increase admin cost to manage the new process and place burden on the HHA companies. This will take away from the funds we have to care for the patients. I understand there are companies out there that attempt to cheat the system and have a pattern of abuse and waste. Please turn the focus to those companies and don't punish us who work very hard caring for our patients and follow the rules. Homecare's

number 1 purpose/goal is to help the elderly safely remain in their homes for as long as they are able. In doing this we cut the cost of medical cost for the elderly by reducing the hospital and rehab stays. Thank you

First Name: Amy
Last Name: Fraboni
City: Middleburg
Country: United States
State or Province: Florida
ZIP/Postal Code: 32068
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0066
Current Document ID: CMS-2018-0071-0074
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947s-s8kf
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: By imposing this rule, the demonstration will increase Administrative cost and increase the burden on home health agencies who are trying to take care of patient's in their homes who deserve this care. There will be additional cuts which will directly impact nurses who care for these patients and some agencies will not survive the cuts and the agencies who does survive will have added burden to care for these patient's without the needed funding. Stop punishing the majority of ETHICAL, hard-working agencies and clinicians and go after those agencies that through data analysis show a

pattern of WASTE and ABUSE. Finally, don't jeopardize providers solvency and beneficiary's access to services when home care can keep patients at home longer and thus reduces more costly forms of care. Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has. --Margaret Mead

First Name: Sue
Last Name: Wetherington
City: Orange Park
Country: United States
State or Province: Florida
ZIP/Postal Code: 32073
Email Address: swetherington@drschoicehh.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0067
Current Document ID: CMS-2018-0071-0075
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947s-5e3h
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: We found our experience with PCR to be beneficial for our organization. It helped us to identify our shortcomings and were able to modify several of our processes in preparation for a great survey. There were however several flaws with the overall system that have us concerned with the new proposal. One, is in regards to not being able to resubmit claims we had several instances when we received a Non-Affirmed decision due to reviewer error. After the reviewer would call to inform us of this decision, wed ask them to review attachment 2 (or whichever attachment was in question) and the decision would

be reversed. Also, many reviewer decisions were subjective. Almost identical charts were Affirmed or Non-Affirmed if a reviewer did not like how our MD electronic signatures were printed on our orders but once we provided a copy of our Interdoc software agreement it would then be Affirmed as well. These were easy fixes, but without the ability to resubmit at least once to correct the reviewers standpoint it would be difficult to obtain as high of score as we did last time.
Thank you for allowing us to share these experiences with you.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60803
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0068
Current Document ID: CMS-2018-0071-0076
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947s-z9yx
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Pre-claim review sounds like a good idea but will cause increased administrative cost that will take away our ability to secure additional resources used to take high quality care of our patients. It seems a waste of resources. Rather than impose another strategy to reduce payment to all agencies, focus on those that raise red flags. We are already working diligently to meet HHVBP metrics.
First Name: Kelly
Last Name: Garvin
City: Palm Coast

Country: United States
State or Province: Florida
ZIP/Postal Code: 32164
Email Address: kgarvin@drschoicehh.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0069
Current Document ID: CMS-2018-0071-0077
Title: OK
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947u-9vkx
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: To institute the Pre-Claim Review Demonstration either by choice or by regulation will be disastrous to our industry. We are already burdened with various layers of audits that require extra personnel without additional reimbursement. We already struggle with paperwork burdens like Face to Face that cause us to not get timely reimbursement. Due to industry cuts that we have been subjected to in the last several years we are not able to hire enough staff or able to even give cost of living increases to our staff presently. Costs, burdens, benefits all continue to rise in addition to the rise in the

burden of "proof" that we must provide every single day to remain compliant and operate with integrity and according to regulations. Organizations that choose to operate with integrity are the ones that are really burdened by this. If you make a choice to reduce your burden in pre-claim review, your also choosing a 25% reduction in already strapped payments. So, you either accept the 25% reduction or have your funds tied up in pre or post claim review and still suffer a financial crunch in regards to how we operate our organizations. There are many other alternatives to this process that would be far more successful. This will only serve to close more agencies and increase the hardship on many already fragile patients that are needing services. Please reconsider this option and choose something more budget neutral that will allow compliance to be ensured. Thank you

First Name: Carla
Last Name: Lyles
City: Oklahoma City
Country: United States
State or Province: Oklahoma
ZIP/Postal Code: 73116
Email Address: carla@alphahomehealthcare.com
Organization Name: Alpha Home Health Care
Category:
Cover Page:

RCDcomments1

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0071
Current Document ID: CMS-2018-0071-0079
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947u-jeti
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: How will this effect unconscious/ financial incentive to reduce patient care. Especially with regard to therapy cases.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 78758
Email Address:
Organization Name:

Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0072
Current Document ID: CMS-2018-0071-0080
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947v-2wgk
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: The home health industry has gone through a brutal number of changes and added burdens with the additional requirements of the Conditions of Participation, Emergency Preparedness, the Probe an Educate and CERT audits just in the last year. Agencies struggle with the low reimbursement rate and annual cuts and are burdened with all the requirements to comply with state and federal regulations. This proposed audit, pre or post payment, will require more staff to be able to comply with providing and submitting the charts of 100% of claims, delay payments to agencies, hurt the cash flow needed to keep

agency open, may hurt staff relying on their timely income, and put additional burden on staff complying with all the paperwork requirements. This Pre-Claim Review will only burden the honest Agency and add to CMS costs. It seems that CMS should attempt to find alternate ways to locate the agencies that are not compliant with all the regulations and rules or committing fraud. CMS knows what the target areas are. Why not just review the agencies with red flags and targeted areas: Excessive length of stay, coding that is obviously not accurate / upcoding, high rate of claims with visits that are slightly higher than a LUPA, and others that CMS is fully aware. It would be a crisis to see small agencies close and patients lose their home health benefits. In the end, if patients are admitted to hospitals, it will be more costly to CMS.

First Name: Anonymous
Last Name: Anonymous
City: Sunset
Country: United States
State or Province: Texas
ZIP/Postal Code: 76270
Email Address: Sher.johnson@jcctexas.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0073
Current Document ID: CMS-2018-0071-0081
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Status Set Date: 07/18/2018
Current Assignee: NA
Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947w-xeti
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Dear Administrator Verma, Thank you for the opportunity to submit comments regarding the Medicare Review Choice Demonstration. As a physical therapist employed by a home care agency which serves rural communities, I am concerned about the negative impact of this Demonstration on our patients. While I support all efforts to prevent fraud and abuse in the home health care industry, such efforts should target abusive providers and not decrease access to care for our most vulnerable population at home. This Demonstration unduly targets compliant agencies. CMS continues to subject home

health agencies to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program will further increase the administrative and financial burdens on agencies without addressing the home health systems vulnerabilities. Further, CMS has not fully implemented what was learned from the previous pre-claim review demonstration in Illinois. Nor has CMS considered alternatives suggested by the home care industry. As it has been previously suggested by the home care industry, CMS should work collaboratively with the home care community to develop a less burdensome and more effective approach to fraud and abuse. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. Because the established documentation review processes did not solve the home care industrys fraud and abuse, I propose a review of the accuracy and effectiveness of these current processes instead of adding this unreasonable Demonstration of further documentation review. Rather than using this Demonstration to remedy non-compliance with documentation requirements, I recommend CMS provide clarified and consistent standards with education to the home care community and MACs. This Demonstration does nothing to support our agencys goals to shift toward rewarding value-based care. Instead, this Demonstration will force clinicians on the patients care team to redirect staff time away from clinical care and toward compliance with arduous and duplicative documentation and clinical records requests. As a clinician, it is my responsibility to exercise professional judgment to treat the beneficiary in accordance with Medicare coverage guidelines. However, this Demonstration effectively overrides my clinical judgment and redirects the care decision-making process to Palmettos medical review staff. Although I appreciate the proposal to not delay the provision of medically necessary care for Medicare beneficiaries, this Demonstration poses an undue financial burden on an agency who will not receive reimbursement for a non-affirmed pre-claim review. 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 pre-claim review decision for those agencies who select to participate in the pre-claim review process. Otherwise, this Demonstration will be a potential 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 pre-claim review decision, which will result in an erosion of beneficiaries access to

home care services. Further, home care agencies will discharge Medicare beneficiaries from skilled services when a pre-claim review is returned non-affirmed. Such barriers may result in increased hospital stays and increased re-hospitalizations.
Thank you for your consideration of my comments and recommendations.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 79528
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0074
Current Document ID: CMS-2018-0071-0082
Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
Date Posted: 07/18/2018
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947w-hw98
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Mindy
Last Name: Cicero
City: Parma
Country: United States
State or Province: Ohio
ZIP/Postal Code: 44129
Email Address: mcicero@rxprn.com
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0094
Current Document ID: CMS-2018-0071-0102
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Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/11/2018
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Submission Type: API
Number of Submissions: 1

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Status Set By: Hill, Jamaa (CMS)
Component:
File Code:
Tracking Number: 1k2-947w-knbs
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I disagree with the implementation of the Review Choice Demonstration until the process is successfully tested with a small sample of agencies in each of the states. When it is implemented, I agree with the proposed recommendation of the home care provider being removed from the review after they achieve a 90% approval rate. After this targeted rate is achieved, I recommend the established frequency of spot checks to be conducted annually at no more than 5% of a providers claims. Thank you for considering my comments.
First Name: Anonymous

Last Name: Anonymous
City:
Country: United States
State or Province: Wisconsin
ZIP/Postal Code: 53089
Email Address:
Organization Name:
Category:
Cover Page:

July 17, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services

950 F STREET NW | WASHINGTON, DC 20004 | WWW.HOMEHEALTH4AMERICA.ORG

7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted via regulations.gov

Re: Issues for Consideration in the Review Choice Demonstration

Dear Administrator Verma:

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 May 31, 2018, regarding the Pre-Claim Review Demonstration ("PCRD") For Home Health Services (Form Number: CMS-10599). As part of the proposed revisions to this demonstration, CMS has renamed the demonstration the Home Health Review Choice Demonstration ("RCD").

We appreciate CMS listening to the feedback we provided during PCRD and incorporating some of this feedback into RCD. Overall, the Partnership supports home health policy reforms that balance the goals of improving the quality of patient care, access to care, the efficiency of care delivery, and the integrity of the Medicare program. Home health policy reforms with such goals should be implemented in a least burdensome manner for providers and patients alike. Bearing these principles in mind, we are particularly appreciative of the RCD's provision for an exemption, or "Gold Standard," for providers who achieve a 90% or greater affirmation rate during initial review. While we believe that RCD is a step in the right direction, we request that CMS work with us to help ensure that RCD is not implemented before policies, guidance, and training have been fully developed and implemented. We appreciate the Administration's dedication to placing patients over paperwork—RCD should be implemented in a manner consistent with this goal.

We are providing our comments on the RCD with the hope that CMS will take proactive steps to work with us to ensure the RCD is successful for home healthcare beneficiaries, providers, and CMS.

I. Issues of Concern with Review Choice Demonstration

a. Timeline

It is imperative that CMS provide all stakeholders with sufficient advance notice setting forth the implementation dates in order to make sure RCD is successfully implemented. CMS has released a FAQ which provides that the rollout will be staggered with Illinois going first, followed by Ohio and North Carolina, and later Texas and Florida. We request information on what CMS's expected timeline is for the rollout of RCD to each state.

In order to ensure the highest quality patient care and efficient business operations, we request that CMS engage in a transparent discussion with us as plans are made for rolling out RCD to additional states. We would like to know how much advance notice will be provided between rollouts and how much advance notice will each state receive prior to RCD being implemented? In addition, the FAQ references RCD being potentially implemented in additional Palmetto/JM jurisdiction states in later years. What is the expected timeline for each of these states?

We note that RCD falls under CMS's demonstration authority, as such, will CMS be providing guidance letters on additional parameters of the demonstration prior to October 1, 2018?

b. Gold Standard

We deeply appreciate CMS incorporating our request for a Gold Standard Exemption in the RCD. We believe that the Gold Standard is consistent with CMS's "Patients Over Paperwork" mission and will help alleviate administrative burdens for all stakeholders without compromising program integrity.

We request CMS provide additional information regarding the Gold Standard, specifically:

1. Does the 90% affirmation rate apply to cases after the first level of review or after the review has been completed?

2. In cases where a provider is not afforded the Gold Standard Exemption, what appeals process will be provided to providers who believe their claims successfully achieve a 90% affirmation rate?

3. Once an HHA achieves a 90% affirmation rate from a minimum of 10 claims, how will providers be notified of their qualification for the Gold Standard Exemption?

4. Will providers achieving a 90% affirmation rate continue to submit pre or post-claim review until they are formally notified of qualifying for Gold Standard Exemption? What is the time period to be between the time a provider achieves a 90% affirmation rate and notification by CMS to the provider of the qualification for exemption?

5. For what time period does an HHA achieving Gold Standard Exemption qualify for such exemption? We believe that HHAs achieving the Gold Standard Exemption should qualify for such exemption for the entire five-year duration of the demonstration.

6. Once a provider qualifies for and opts for Gold Standard Exemption, what standard will be applied to a provider during the spot checks? Will a provider be required to maintain an affirmation rate of at least 90% under the spot checks?

7. What review and appeals process will apply to the Gold Standard Exemption providers who fall below the prescribed affirmation rate requirement during the spot checks?

c. Data Questions

We request CMS explain the basis for its Changes in Burden estimate provided in the Supporting Statement Part A (CMS-10599/0938-1311) that beneficiaries in the Palmetto/JM jurisdiction will receive an average of 1.12 episodes of care per year, down from 3 episodes per year under the earlier version of this demonstration. We also request clarification whether this calculation is based solely on admissions or whether this includes re-certifications as well. If this data includes re-certifications, CMS should align its calculations to account for this.

As shown in the chart below, in reviewing the FY 2015 and FY 2016 claims in the CMS PUF files,[1] the average total episodes per beneficiary per year in the 16 states under Palmetto/JM's jurisdiction was 2.19 in FY 2015 and 2.15 in FY 2016. Further, the national average was 1.92 episodes per beneficiary per year. Based on this information, we request CMS clarify the basis for its Changes in Burden of 1.12 episodes per beneficiary.

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html.

AL	2.05
AR	1.93
FL	1.88
GA	1.76
IL	2.00
IN	1.75
KY	1.94
LA	2.75
MS	2.38
NC	1.64
NM	1.97
OH	1.81
OK	2.85
SC	1.58
TN	2.09
TX	2.90
Total	**2.15**

-11J,.

~~ OhioHealth · I ˜u–

July 30, 2018

Centers for Medicare & Medicaid Services

A TfN: CMS-1 0599

7500 Security Boulevard

Baltimore, Maryland 21244

Re: CMS-10599 Pre-Claim Review Demonstration for Home Health Services

Dear Sir or Madam:

180 East Broad Street
Colu mbus, Ohio 43215
ohiohealth.com

I am writing on behalf of OhioHealth, a large hospital system serving the community since 1891. OhioHealth is a family of28,000 associates, physicians and volunteers, and a network of 11 hospitals, over 50 ambulatory sites, hospice, home-health, medical equipment and other health services spanning a 47-county area throughout Ohio. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Pre-Claim Review Demonstration for Home Health Services, CMS-10599.

OhioHealth Home Health is a skilled home care service. We treat patients throughout central Ohio and offer an array of services designed to help our patients recover and rehabilitate in the comfort and safety of their residences. Some of our services include physical, speech and occupational therapy, specially trained IV nursing team for in-home infusion˜ telehealth in-home monitoring of vital signs and chronic disease management.

First, we agree with CMS that home health agencies (HHAs) must submit proper documentation and comply with existing regulations. We further agree that Medicare fraud amongst bad actors in the home health industry must be held to account.

However, as a system with a bona fide compliance department and a commitment to providing quality care in a value-based environment, OhioHealth Home Health believes the proposed preclaim demonstration may have unintended and negative consequences, as outlined below:

) A prior attempt to implement pre-claim review in lllinois resulted in additional administrative burdens, inconsistency in CMS audits and pushing some responsible HHAs out ofbusiness. The proposed pre-claim demonstration project may likely present those same problems for HHAs that are already operating in compliance with CMS' regulations.

);> The proposed demonstration represents the unfortunate continuation of a pattern in home health services of decreasing Medicare reimbursements while increasing regulations that increase costs.

);> The current climate in healthcare, generally, is value-based and promotes reduced costs and increased efficiency; this demonstration has the potential to do the opposite on both counts.

In short, this demonstration project will adversely impact compliant HHAs. An audit mechanism to bold HHAs to account is already in place and at CMS' disposal. Yet we do understand what CMS is attempting to accomplish with this demonstration and offer the following recommendations for improvement:

);> Delay implementation of the pre-claim demonstration project in Ohio for 12

months. This will allow for CMS to learn and possibly improve the project during its initial implementation in lllinois.

)> Place a one year moratorium on implementation of the pre-claim review demonstration, applicable to HHAs that are accredited by the Joint Commission or have a verifiable compliance department.

)> Examine non-punitive measures to strengthen and incent the home health care industry, as home health care is less costly than equivalent care delivered in hospitals and skilled nursing facilities.

)> Maintain the provision that allows HHAs that reach a target pre-claim review to opt out of future claim reviews.

We appreciate your consideration of these comments.

Sincerely,

Connie Gallaher
President, Home Care

1800 Diagonal Road, Suite 600 Alexandria, VA 22314

July 30, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Submitted via regulations.gov

Re: CMS-10599 Pre-Claim Review Demonstration for Home Health Services

Dear Administrator Verma:

ElevatingHOME and Visiting Nurse Associations of America (VNAA) appreciate 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 May 31, 2018, regarding the Pre-Claim Review Demonstration (PCRD) For Home Health Services (Form Number: CMS-10599). As part of the proposed revisions to this demonstration, CMS has renamed the demonstration the Home Health Review Choice Demonstration (RCD). ElevatingHOME and VNAA advance quality, value and innovation in home-based care and represents mission-driven providers of home and community-based health care, including hospice, across the United States. Our members provide high-quality, patient-centered care at home, as well as offer support for family caregivers. ElevatingHOME is an industry organization launched to unify America's for-profit and not-for-profit home-based health (home health and hospice) care providers and to advocate for high-quality, affordable care. ElevatingHOME was formed by the leadership of the Visiting Nurse Associations of America (VNAA) with leaders and stakeholders from across the country. ElevatingHOME's mission is to align, unify, and strengthen the home-based care industry.

They primarily serve the most clinically complex and vulnerable patients, who are by definition homebound and who will benefit from having closely integrated health exchange between all members of the care team—regardless of the severity of their illness—and serve a mixture of Medicare, Medicaid, privately-insured and uninsured patients. Home health providers continue to provide value and innovation in home-based care and care coordination. Home-based care providers work to improve the management of patients with chronic conditions, thus addressing some of the greatest challenges in health care today, including medication management, uncoordinated transitions of care and high rates of unnecessary hospital and emergency department utilization. In addition, home health provides medically

necessary, skilled services in an incredibly efficient manner, providing care at a fraction of the cost of institutional care.

We appreciate CMS listening to the feedback we provided during PCRD and incorporating some of this feedback into RCD. ElevatingHOME and VNAA support home-based care reforms and innovations that 2

balance the goals of improving the quality of patient care, access to care, the efficiency of care delivery, and the integrity of the Medicare program. Additionally, efficiency of care should include implementations that do not add burden and potentially shift focus from patients and quality to administrative burden.

Within the RCD demonstration there are the provisions for a "Gold Standard," for providers who achieve a 90% or greater affirmation rate during initial review. While we believe that RCD is a step in the right direction, we request that CMS work with us to help ensure that RCD is not implemented before policies, guidance, and training have been fully developed and implemented. We appreciate the Administration's dedication to placing patients over paperwork—RCD should be implemented in a manner consistent with this goal.

Our hope is that CMS will take proactive steps to work with us to ensure the RCD is successful for home healthcare patients, their families, providers, and CMS.

l **I. Issues of Concern with Review Choice Demonstration**

Regardless of the lack of success in curbing waste, fraud and abuse in the Pre-Claim Review Demonstration, CMS seems to be determined to move forward with minor modifications in the Review Choice Demonstration. ElevatingHOME and VNAA continue to stand ready to assist in this manner *and* have volunteered guardrails to both CMS and the HHS Office of Inspector General. We believe that there are many avenues that can be pursued to reduce waste, fraud and abuse and RCD and PCRD are just focused on documentation processing. With regulations that continue to minimize the role of home health records (regardless of recent passage of legislation), home health agencies are continually in the crosshairs for documentation. However, despite the slow progress in improving the reporting process, the improper payment rate continues to drop.

This demonstration sadly seems to be in complete opposition to the Administration's claim of wanting to place patients over paperwork. This sadly requires highly qualified and trained clinicians to focus on paperwork over patients. The following comments are provided in the hopes of improving the RCD. However, it is our fervent belief that CMS and HHS could achieve much more with a collaborative effort amongst the home health industry and their representatives. No one wants there to be waste, fraud and abuse in the industry; it lowers the standing of the vital services provided to the current and future patients and their families.

l **II. Comments for Improvement**

a. Timeline

With such a tight timeline, it is imperative that CMS

provide all stakeholders with sufficient advance notice setting forth the implementation dates in order to make sure RCD is implemented with the least complications. CMS has released a FAQ which provides that the rollout will be staggered with Illinois going first, followed by Ohio and North Carolina, and later Texas and Florida. We request information on what CMS's expected timeline is for the rollout of RCD to each state.

In order to ensure the highest quality patient care and efficient business operations, we request that CMS engage in a transparent discussion with providers and their representatives as plans are made for rolling out RCD to additional states. We would like to know how much advance notice will be provided between rollouts and how much advance notice will each state receive prior to RCD being 3

implemented? In addition, the FAQ references RCD being potentially implemented in additional Palmetto/JM jurisdiction states in later years. What is the expected timeline for each of these states?

We note that RCD falls under CMS's demonstration authority, as such, will CMS be providing guidance letters on additional parameters of the demonstration prior to October 1, 2018?

When will providers be able to view the forms for pre-claim versus post-claim so that they can make appropriate decisions regarding the model they will participate in?

There has been some confusion about being locked-in once a decision is made about the version of review is selected – pre-claim, post, or reduction of rate. Is a provider locked into a version of anytime period and if so, how long and importantly – why?

b. Gold Standard

We deeply appreciate CMS incorporating our request for a Gold Standard Exemption in the RCD. We believe that the Gold Standard is consistent with CMS's "Patients Over Paperwork" mission and will help alleviate administrative burdens for all stakeholders without compromising program integrity.

We concur with the thoughts of the Partnership for Quality Home Healthcare (PQHH) and request CMS provide additional information regarding the Gold Standard, specifically:

1. Does the 90% affirmation rate apply to cases after the first level of review or after the review has been completed?
2. In cases where a provider is not afforded the Gold Standard Exemption, what appeals process will be provided to providers who believe their claims successfully achieve a 90% affirmation rate?
3. Once an HHA achieves a 90% affirmation rate from a minimum of 10 claims, how will providers be notified of their qualification for the Gold Standard Exemption?
4. Will providers achieving a 90% affirmation rate continue to submit pre or post-claim review until they are formally notified of qualifying for Gold Standard Exemption? What is the time period to be between the time a provider achieves a 90% affirmation rate and notification by CMS to the provider of the qualification for exemption?
5. For what time period does an HHA achieving Gold Standard Exemption qualify for such exemption? We believe that HHAs achieving the Gold Standard Exemption should qualify for such exemption for the entire five-year duration of the demonstration.
6. Once a provider qualifies for and opts for Gold Standard Exemption, what standard will be applied to a provider during the spot checks? Will a provider be required to maintain an affirmation rate of at least 90% under the

spot checks?
7. What review and appeals process will apply to the Gold Standard Exemption providers who fall below the prescribed affirmation rate requirement during the spot checks?

c. Parity

Not all providers in planned PRD states have the same Medicare Administrative Contractor. How will CMS ensure that physicians - who will have a greater administrative burden with providers in the RCD - 4

don't cease referrals to those providers in the demo and shift to providers in the same state who are not required to participate? This is of significant concern and seems to provide an unintended preference to the providers who are not participating. We are happy to discuss this in greater detail and provide examples.

I **III. Closing**

We appreciate you taking the time and consideration to review these comments. We again offer to come to the table and collaborate on a better answer that truly places the needs of patients over paperwork. If you have any questions or concerns, please contact Joy Cameron, VP of Policy and Innovation at 571-527-1536 or jcameron@vnaa.org.

Best regards,
Joy Cameron
VP of Policy and Innovation 5

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0426
Current Document ID: CMS-2018-0071-DRAFT-0426
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: Pre-claim review was tried and it created so much havoc it was cancelled. This process will create an excessive cost and administrative burden for all home health agencies. Instead of placing this burden on ALL HH agencies, why not take a different route, and place the burden on the agencies that are suspect of fraud? Why not let the medicare financial intermediaries do their job and pull out suspect transactions? Why not start with the Physicians that are initiating the HH Orders and have some type of system that they can log in and upload the services that they are ordering and then validate the HH claims against the Physician Orders for HH services? My perception is that the government is attempting to eliminate all the small HH agencies and only work with the very large corporate conglomerates.
First Name: Randy
Last Name: Paramore
City: Houston
Country: United States
State or Province: Texas
ZIP/Postal Code: 77084

Email Address: rparamore@ahcglobal.com
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-fcpw
Page Count: 1
Total Page Count
Including Attachments:
1

Submitter Info

Comment: Pre-claim review was tried and it created so much havoc it was cancelled. This process will create an excessive cost and administrative burden for all home health agencies. Instead of placing this burden on ALL HH agencies, why not take a different route, and place the burden on the agencies that are suspect of fraud? Why not let the medicare financial intermediaries do their job and pull out suspect transactions? Why not start with the Physicians that are initiating the HH Orders and have some type of system that they can log in and upload the services that they are ordering and then validate the HH claims against the Physician Orders for HH services? My perception is that the government is attempting to eliminate all the small HH agencies and only work with the very large corporate conglomerates.
First Name: Randy
Last Name: Paramore
City: Houston
Country: United States
State or Province: Texas
ZIP/Postal Code: 77084
Email Address: rparamore@ahcglobal.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0427
Current Document ID: CMS-2018-0071-DRAFT-0427
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Priscilla
Last Name: Reynolds
City: Coconut Creek
Country: United States
State or Province: Florida
ZIP/Postal Code: 33066
Email Address: RevaJoshua@aol.com
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)

Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-q3of
Page Count: 1
Total Page Count
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1

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Priscilla
Last Name: Reynolds
City: Coconut Creek
Country: United States
State or Province: Florida
ZIP/Postal Code: 33066
Email Address: RevaJoshua@aol.com
Organization Name:
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Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
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Number of Attachments: 0
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33467
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)

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Component:
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Submitter Info

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First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33467
Email Address:
Organization Name:
Category:
Cover Page:

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Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0429
Current Document ID: CMS-2018-0071-DRAFT-0429
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Number of Submissions: 1

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Submitter Info

Comment: CMS continues to subject home health agencies to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program will further increase the administrative and financial burdens on agencies without addressing the home health systems vulnerabilities. This Demonstration is unreasonable because these states already have Targeted Probe and Educate occurring on multiple agencies and some of these states are already under Value-Based Purchasing. The return of a pre-claim review demonstration is premature in that CMS has not implemented what was learned from the previous pre-claim review demonstration in Illinois. Nor has CMS considered alternatives suggested by the home care industry. This Demonstration inhibits patient choice and access to care, especially in the rural areas we serve. While home care agencies strive to achieve higher quality care with increased efficiencies and less reimbursement, the added administrative costs of this Demonstration pose an additional financial burden on agencies.
First Name: Anonymous
Last Name: Anonymous

City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 79124
Email Address:
Organization Name:
Category:
Cover Page:

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Component:
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Submitter Info

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First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 79124
Email Address:
Organization Name:

Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0430
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/28/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Submitter Info

Comment: Referrence number 2018-11492. We did Pre-claim review in Illinois the last time it was implemented and It was a lot of work, from organizing, printing/copying the chart, scanning, uploading, submitting. It takes time and me and my staff has to work overtime just to be able to submit Pre claim review on time. Since we have a high affirmation rate, I would like to propose for Illinois agencies who complied with PCR before with high percentage of affirmation to be EXEMPTED since we have already demonstrated compliance.
First Name: Vilma
Last Name: Tolentino
City: Skokie
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60076
Email Address: Heritagehomehealthcare@gmail.com
Organization Name:
Category:
Cover Page:

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City: Skokie
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60076
Email Address: Heritagehomehealthcare@gmail.com
Organization Name:
Category:
Cover Page:

July 26, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services Office of Strategic Operations and Regulatory Affairs Division of Regulations Development Attention: 2018-11492/CMS-2018-0071-0001 Room C4-26-05 7500 Security Boulevard Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

RE: Agency Information Collection Activities; Proposals, Submissions, and Approvals – Pre-Claim Review Demonstration for Home Health Services (2018-11492/CMS-2018-0071-0001)

Dear Administrator Verma:

The Illinois HomeCare and Hospice Council (IHHC) writes to offer comments on document 2018-11492/CMS-2018-0071-0001, "Agency Information Collection Activities; Proposals, Submissions, and Approvals – Pre-Claim Review Demonstration for Home Health Services." IHHC is a trade association representing home health and hospice providers in Illinois.

Illinois is uniquely situated to provide meaningful feedback to CMS regarding the proposed Review Choice Demonstration for Home Health Services (RCD). Illinois was the only state to participate in the Pre-Claim Review Demonstration (PCR) from August 2016 through March 2017 and according to the latest data supplied by CMS, as of January 14, 2017, Illinois agencies attained a 91.7 percent affirmation rate after 24 weeks of participation in PCR. While we have many outstanding questions and suggestions for CMS regarding PCR and RCD, IHHC sincerely appreciates CMS engaging in a more traditional public notice and comment process for RCD; thank you for the opportunity to provide feedback.

Request for Data

Affirmation Rates

As previously mentioned, the most recent data Illinois agencies have from CMS regarding performance under PCR is from January 14, 2017. Like CMS, home health agencies rely heavily on data to make informed decisions about how to best serve patients. Especially now that CMS plans to implement RCD, it is vital that Illinois home health agencies have access to the performance data captured by CMS during the final 11 weeks of PCR**. IHHC requests CMS immediately publicly share PCR affirmation rates for January 15, 2017, through March 31, 2017.**

Goals of PCR

CMS stated its goals in implementing PCR were to improve "methods for the identification, investigation, and prosecution of Medicare fraud occurring among Home Health Agencies (HHAs) providing services to people with Medicare benefits," and to help "reduce expenditures while maintaining or improving quality of care." What metrics did CMS use to determine whether PCR met its stated goals? Did CMS collect any data during PCR relative to the number of cases of fraud identified, investigated and prosecuted? Was PCR successful in its stated goal of improving methods for the identification, investigation and prosecution of fraud? How did CMS measure this success? **IHHC requests CMS publicly share all available data related to fraud exposed by PCR.**

Despite the fact that PCR is not considered a traditional pre-authorization program as home health agencies provide services to Medicare beneficiaries and later submit a provisional claim for affirmation or non-affirmation of coverage prior to submission of the final claim for payment, a recent U.S. Government Accountability Office (GAO) report[1] to the U.S. Senate Finance Committee examining CMS prior-authorization demonstrations included analysis on PCR. In this report, the GAO estimates potential savings from PCR at $104.2 million and the GAO recommended that CMS take action to continue prior authorization efforts to reduce spending.

[1] United States Government Accountability Office, *Report to the Committee on Finance, U.S. Senate: Medicare – CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending,* GAO-18-341 (Washington, D.C.: April 2018).

In written comments to the GAO report, the Department of Health and Human Services (HHS) indicated it "has been closely monitoring the impact of the prior authorization and pre-claim review programs on beneficiaries, suppliers, providers, and Medicare expenditures to evaluate the results of each program and help inform next steps." In addition, footnote 24 of the GAO report states, "CMS has also estimated savings for the demonstrations. However, these estimated savings are not comparable to GAO's estimates because they do not cover the same period of time." Unfortunately, the GAO report only includes data through March 2017; there is no indication whether home health expenditures remained steady, declined further or

increased following the pause of PCR on April 1, 2017. To fully evaluate PCR's effect on expenditures, we need a more complete picture of spending in the months following PCR. How did CMS estimate savings under PCR? Was PCR successful in its stated goal of reducing expenditures? How did CMS measure this success? Over what period of time did CMS estimate savings? How does CMS' estimates differ from GAO's estimates? **IHHC requests CMS publicly share its estimates of Medicare savings under PCR.**

Further, it is important we have a full understanding of *how* PCR may have changed agency behavior, if there were positive or negative impacts on patient access to care and if there were other factors, apart from PCR, that may have contributed to a decline in expenditures. Has CMS analyzed breakdowns of spending on different types of episodes pre-PCR, during PCR and post-PCR? Were there any changes to the nature or length of the episodes? Were there any changes to the percentage of patients with certain diagnoses utilizing home health services? Were there any changes to the number of recertifications? Were there changes in admission patterns to acute care and post-acute care settings? Were there any agencies that did not participate in PCR? **IHHC requests CMS publicly share all available data on changes in patient, episode and agency characteristics during PCR.**

Additionally, under PCR, CMS placed importance not just on reducing expenditures but on maintaining or improving quality of patient care. What metrics did CMS use to monitor quality of care under PCR? Has CMS performed an analysis of data submitted under the Home Health Quality Reporting Program (HHQRP) during PCR? Did care quality remain stable or improve during this time period? **IHHC requests CMS publicly share all available data and any analysis performed on the relationship between expenditures and care quality during PCR.**

Goals of RCD

Without a clear picture of the success or failure of PCR, IHHC questions CMS' decision to move forward with RCD in Illinois, Ohio, North Carolina, Florida and Texas. The GAO report indicates Medicare home health expenditures in Illinois declined during the time PCR was in effect, however we do not know for certain how or why, if CMS agrees with the GAO's estimates, and whether PCR met its other stated goals of targeting fraud and maintaining or improving care quality.

CMS states the goals of RCD are to "make sure that payments for home health services are appropriate through either pre-claim or post payment review, thereby working towards the prevention and identification of potential fraud, waste, and abuse; the protection of Medicare Trust Fund from improper payments; and the reduction of Medicare appeals." IHHC is concerned that CMS makes no mention of care quality as a stated goal of RCD. While we certainly agree with CMS and share its goal of ensuring payments for home health services are appropriate, **IHHC encourages CMS to incorporate care quality as a goal of RCD and any future effort designed to reduce Medicare home health expenditures.**

Additionally, what factors did CMS consider when deciding to launch RCD in Illinois and the four other states? How were these states selected and why was Illinois chosen to go first? **IHHC**

requests CMS publicly share the data it considered when determining the states in which to implement RCD including but not limited to how Illinois agencies performed on Targeted Probe and Educate (TPE) efforts, PCR affirmation rates for the final 11 weeks of the program, any changes to the rate of Medicare appeals during PCR and any evidence of fraud.

Exemption for High Performing Agencies

As previously mentioned, according to the latest data supplied by CMS, as of January 14, 2017, Illinois agencies attained a 91.7 percent affirmation rate after 24 weeks of participating in PCR. Presumably, that affirmation rate was even higher by the time PCR was paused on March 31, 2017, as agencies gained more experience with program. Because many Illinois agencies achieved high affirmation rates under PCR, **IHHC strongly urges CMS to implement an exemption under RCD for high-performing agencies**, especially since CMS has not indicated that Medicare home health expenditures in Illinois significantly increased after PCR was paused.

On page 2 of RCD *Supporting Statement Part A*,[2] CMS indicates that agencies meeting a target affirmation or claim approval rate, "90 percent, based on a minimum of 10 pre-claim requests or claims submitted," "may choose to be relieved from claim reviews, except for a spot check of 5 percent of their claims to ensure continued compliance." It is not clear whether meeting the target rate on 10 pre-claim requests or claims submitted applies to all agencies regardless of size or whether the word "minimum" implies that CMS plans to implement a tiered system based on agency size or some other criteria. **IHHC requests clarification of this process as well as the spot-check process** (e.g. how the 5 percent of claims will be identified and selected for spot check). **IHHC also requests CMS apply performance credit to Illinois agencies that achieved at least 90 percent affirmation rates on 10 pre-claim requests under PCR, thereby exempting high performing Illinois agencies from the requirements of RCD.**

[2] Centers for Medicare and Medicaid Services, *Supporting Statement Part A: Pre-Claim Review Demonstration for Home Health Services,* CMS-10599/0938-1311 (Baltimore, MD: May 2018).
https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending

Implementation Logistics and Suggested Program Efficiencies

If CMS moves forward with implementation of RCD in Illinois, Ohio, North Carolina, Florida and Texas, IHHC recommends the following based on our experience with PCR:

Consistency

One main pain point for Illinois agencies during PCR was inconsistency in the pre-claim review process. While much of this inconsistency will be resolved simply by the fact that there is only one MAC administering RCD instead of the two MACs that administered PCR, **IHHC recommends that CMS give clear instructions to Palmetto regarding exactly which data**

elements, forms and documentation agencies must submit so providers know up front what is required, the format for submission and that those requirements will not change from claim-to-claim, reviewer-to-reviewer.

Similarly, we recognize that Palmetto will likely need to hire new reviewers to implement RCD. We understand that there will be a learning curve for agencies and reviewers alike during the first few months of implementation, however, it is vital that reviewers are given appropriate training and there is a level of consistency in the reviewer pool. For program integrity purposes, it does not make sense to assign one reviewer to one agency, however, **IHHC recommends assigning a pool of approximately five reviewers to an agency to improve consistency and efficiency of reviews.**

Flexibility

IHHC encourages CMS to implement some flexibility into RCD, especially during the first few months of implementation when reviewers and agencies will be working through the kinks in the system. We appreciate the fact that Palmetto will be making some updates to the submission portal to improve user efficiency and similar to PCR, **we ask CMS to implement a grace period** at the beginning of the program so that agencies are not penalized while trying to get up to speed on the format of the new portal.

Transparency

Agencies need timely access to performance data under RCD in order to evaluate how they are performing under the program and update their procedures/processes accordingly. While we still do not know how Illinois agencies performed during the last eleven weeks of PCR, information sharing under RCD should be a two-way street. **IHHC recommends that CMS require Palmetto share monthly progress reports with both agencies and the public** containing information such as the number of claims submitted, affirmation rates/non-affirmation rates, the reason for non-affirmation, the number of resubmissions and the breakdown of agencies that chose pre-claim review, post payment review or across-the-board payment reduction.

Further, if CMS intends to expand RCD to other states in the Palmetto jurisdiction and potentially to states under the jurisdiction of other MACs, **IHHC recommends CMS formalize a system for evaluating the success or failure of RCD in meeting its stated goals**. Additionally, **IHHC recommends CMS issue quarterly public reports during the five-year demonstration** containing information on the metrics, measures and data it uses to determine whether RCD is meeting its stated goals.

Conclusion and Alternatives

IHHC shares CMS' goals of ensuring that home health services are medically necessary and appropriate, however, it is clear that there are many unanswered questions regarding PCR and RCD. First and foremost, IHHC is concerned by the fact that CMS intends to move forward with

RCD without a full understanding of whether PCR met its stated goals. Given these uncertainties, **we strongly encourage CMS to perform a full analysis of PCR before moving forward with RCD**. Additionally, instead of spending $400 million over 5 years on RCD and because most first time non-affirmations under PCR were a result of incomplete documentation rather than provision of medically unnecessary services, **IHHC believes CMS could alternatively meet its goal by moving forward with a more targeted approach aimed at improving documentation.** Ideas include:

1. Implementation of a documentation certification by the home health agency that would employ a checklist of the required documentation needed to support a claim
2. Clarified guidance on specific documentation requirements such as when, where, and how a physician must sign required documentation
3. Development of model documentation forms. The CMS 485 form can be easily modified to accommodate all of the needed elements.
4. Revised regulatory standards on physician certification and face-to-face encounter documentation that integrates the physician record with the home health agency and other provider records into a single review for a complete rather than partial record review to establish eligibility
5. Targeted education directed to both home health agencies and physicians using the tools referenced in 1-4 above
6. Detailed and specific explanations provided with adverse claim determinations
7. MAC education and oversight by CMS specific to documentation standards

We sincerely appreciate CMS engaging stakeholders through a public comment process; thank you for the opportunity to provide comments. We hope you incorporate the suggestions of IHHC and home health agencies in Illinois before finalizing the Demonstration.

Sincerely,
Cheryl Adams RN, BSN, MBA
IHHC President

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0405
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Submitter Info

Comment: The Illinois HomeCare & Hospice Council (IHHC) writes to offer the attached comments on document 201811492/CMS-2018-0071-0001, Agency Information Collection Activities; Proposals, Submissions, and Approvals Pre-Claim Review Demonstration for Home Health Services. IHHC is a trade association representing home health and hospice providers in Illinois. Thank you for the opportunity to provide feedback.
First Name: Liz
Last Name: Vogt
City: Springfield
Country: United States
State or Province: Illinois
ZIP/Postal Code: 62701
Email Address: lizvogt@ilhomecare.org
Organization Name: Illinois HomeCare & Hospice Council
Category:
Cover Page:

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First Name: Liz
Last Name: Vogt
City: Springfield
Country: United States
State or Province: Illinois
ZIP/Postal Code: 62701
Email Address: lizvogt@ilhomecare.org
Organization Name: Illinois HomeCare & Hospice Council
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Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0406
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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Comment: Thank you for asking for comments. We are all concerned about the integrity of Medicare and utilization of the home care benefit for folks who need care provided in the comfort and privacy of their home and at a much lower cost than at a hospital or other in-patient facility. Adding additional regulation that does not assist in targeting the bad players in home care reduces an agencies ability to remain ready and able to provide services.. The burden of additional regulation does not produce a safer or better home care product. It increases costs and in some cases drives good providers out of business. Here is a suggestion: Utilize the PEPPER report to take a closer look at agencies that exceed the 80% threshold in areas of concern. Provide education and if issues continue to appear, create a better methodology to monitor those agencies. By doing this, you will in essence be utilizing the tools available at a targeted approach. Please consider this option as it would also reduce the cost to the federal government as taking a targeted approach would reduce the number of auditors taking the "hit or miss" approach.
First Name: Kathy

Last Name: Cody-Guastella
City: Tallahassee
Country: United States
State or Province: Florida
ZIP/Postal Code: 32309
Email Address: hcnetwork@nettally.com
Organization Name:
Category:
Cover Page:

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City: Tallahassee
Country: United States
State or Province: Florida
ZIP/Postal Code: 32309

Email Address: hcnetwork@nettally.com
Organization Name:
Category:
Cover Page:

Trinity Health
At Home

July 30, 2018

Administrator Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2016-0012-0001
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–10599 Medicare Review Choice Demonstration; Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Review Choice Demonstration for Home Health Services.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 90 hospitals, 120 continuing care programs—including PACE, senior living facilities and home care and hospice services that provide nearly 2.5 million visits annually. Our delivery of home health includes services in Florida, Ohio, and Illinois, all of which are states included in the proposed pre claim review demonstration.

CMS has proposed a Review Choice Demonstration which is similar to the prior Pre Claim Review Demonstration Project, which is intended to assure that payments for Home Health services are appropriate before the claims are paid, with the aim of preventing fraud, waste and abuse in a more consistent and standardized manner. The information CMS seeks will be obtained through Medicare contractors for two specific purposes; to determine proper payments are approved for qualified value-based programs, and to determine if there is suspicion of fraud. These CMS contractors will require information from home health providers in advance to determine appropriate payment and qualification for the proposed program and this would become standard operating procedure necessary to submit billing claims.

Trinity Health has several concerns with this new iteration of the demonstration. We know from our experience with this demonstration in 2016 that this policy could impair our ability to serve patients and add layers of administrative and management burden, while having little ability to detect and combat additional fraud. In fact, there was never an announcement that delineated any fraudulent activity being intercepted or any charges brought as a result of pre claim review findings following the prior program in 2016. In fact, it is not clear what if any effect that demonstration had on fraudulent activity. On the contrary most errors that were found during that time were simply human errors or clerical errors that were corrected during the process. The targeted probe and educate and other ADRs already find those kinds of errors and result in paybacks or appeals. The Pre-Claim Review Demonstration was a costly program, approximately a $400 million expense that resulted in no demonstrated fraudulent findings.

Illinois agencies generally reached levels of affirmation around 90% by the end of the program, so it is counter-intuitive that the program would start with Illinois again when they have already demonstrated such a high level of compliance. Calling this a Review Choice Program is really a misnomer because agencies effectively have no choice but to participate or have 25% of their revenue taken away. We urge CMS, instead of moving forward with this demonstration, to continue working with industry leaders to develop appropriate and targeted approaches to identify and eliminate fraud and abuse.

Adverse Implications for Improved Patient Outcomes and Costs of Care Without Intended Benefit
We learned from this program in Illinois that it took the skill of the current clinical full time resources in the office and an additional full time employee that we had to hire in order to manage the submission process because there are some clinical questions in the submission workflow in Palmetto's website. This is additional cost to recruit, hire and train, and also takes that critical nursing resource out of patient care which is where it belongs.

Uncertain Target Claim Affirmation or Approval Rate
The announcement of the possibility of reaching a target rate thus stopping the pre claim review for an agency is a welcome change to the prior program. However, since there is no explanation of what that rate may be or how long that rate would have to be sustained it is also worrisome and continues to foster uncertainty for the industry. Would that rate be calculated on only initial submissions, subsequent submissions? Would it be a rolling time frame or calculated one month at a time? For instance if calculated on a rolling year it could take years to be relieved of this program, if calculated month to month, it may only take several weeks to be relieved. This makes it very difficult to anticipate the staffing needs of this program.

Adverse Impact on Revenue Cycle
In the prior program, the pre-claim review submission process took approximately one hour per claim. So considering that one person could only complete 8-10 of these submissions per day, if the agency has more than 10 admissions per day as our agency did, the agency is starting out behind in revenue cycle. Within a month or so of this program beginning, we were behind in billing by tens of thousands of dollars. From a cash flow perspective, this is not possible to sustain business operations.

Uncertainty Around Submission Process
During the last demonstration it took months for Palmetto to implement an efficient web based submission process. With the new program, it is uncertain whether Palmetto will start out using the same process, or implement something new that then needs to be refined over time. Also previously, at times documentation would be submitted and non-affirmed then resubmitted with no changes and be affirmed. This seems to reflect a lack of inter-rater reliability among the staff reviewing these records and it created uncertainty and a lack of predictability among providers as to how to comply.

Conclusion
CMS has already implemented extensive regulatory requirements, safeguards, criteria, and accountability mechanisms in the home health care industry, including the face-to-face requirements, episode payments, value-based purchasing, the Program for Evaluating Payment Patterns Electronic Report (PEPPER), and mandatory performance reporting. Through additional documentation requests, review and auditing, CMS already has in place the capability to deny inappropriate admissions to home health. These current programs include sufficient oversight of home health to identify patterns of inappropriate admissions.

Any proposal would be better suited to target specific agencies suspected of fraud, rather than implement an across-the-board, sweeping approach for every agency to get prior-authorization before submitting a claim. CMS has the data to target suspected fraud and abuse, therefore efforts such as this would be better focused to further identify and address these bad actors, not create all of the above unintended consequences for patients, providers, and CMS.

In our Trinity Health home health ministries, we are committed to program integrity and work diligently to ensure quality and integrity in our service delivery. Our ministries have done very well in CMS' retrospective review to meet current criteria and standards.

An across-the-board pre claim review is a redundant procedural step that will impact access to care and raise administrative costs with little or no return in quality of care. Providers already submit information to CMS on the proposed scope and duration of care, and CMS can already recover payments for care that is later deemed unsubstantiated. We stand ready to work with policymakers to advance appropriate and targeted program integrity measures, rather than risk access to necessary care for vulnerable patients.

We thank CMS for the opportunity to provide input on this issue. If you have any questions on our comments, please feel free to contact me directly.

Sincerely,

Elizabeth Buckley, RN, BSN, JD, CPHRM
Integrity & Compliance Officer
Trinity Health At Home

734-343-6535

Elizabeth.buckley@trinity-health.org

Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

Centers for Medicare & Medicaid Services

Office of Strategic Operations and Regulatory Affair

Division of Regulations Development

Attention: Document Identifier/OMB Control Number ll

Room C4–26–05

7500 Security Boulevard

Baltimore, Maryland 21244–1850.

Re: CMS-10599

To whom it may concern,

The Texas Association for Home Care & Hospice (TAHC&H) represents over 1,200 licensed home care and hospice agencies in Texas and strongly urges the Centers for Medicare & Medicaid Services (CMS) to reconsider the implementation of the revised Pre-claim Review Demonstration (PCRD) known as Review Choice Demonstration for Home Health (RCD). Texas is one of the states identified in in this demonstration, and we oppose burdensome new regulations and demonstration programs that fail to combat Medicare fraud. We believe the decision to restart this demonstration is premature and unnecessary. The 2016 PCRD demonstration created havoc for home health agencies and patients while providing no evidence that this very expensive and administratively burdensome program decreased fraudulent claims.

RCD will cost CMS $400 million over 5 years to administer. In addition, the PCRD experience indicates that HHAs will incur significant costs as well to submit and manage the exponentially increased paperwork that PCRD/RCD requires. While HHAs strongly support sensible program integrity measures, better alternatives to RCD readily exist. Further, CMS appears to have taken few if any steps to study the operation, focus, and outcome of PCRD before launching this nearly identical proposal. PCRD was a demonstration program that provides the opportunity for gaining insights that would be helpful in crafting program integrity measures such as the suggestions proposed later in this document and for doing so in ways that bring efficiency and success. Accordingly, TAHC&H recommends that CMS undertake a full review of PCRD and work with stakeholders on data based alternatives before proceeding with RCD.

CMS should suspend RCD until its need and value are fully evaluated, using PCRD as the basis for the evaluation, and viable alternatives are utilized first.

The purpose of any Medicare demonstration program is to learn what works and what does not work. For many years, Medicare has relied on demonstration programs to determine the best course of action that should be applied on a program-wide basis. PCRD was a valuable learning experience for CMS. However, CMS has not taken advantage of that learning opportunity in crafting the proposed RCD. Essentially, RCD simply repeats PCRD and adds some other claim review options for HHAs without consideration of what happened in PCRD. The

proposed options—100% post-payment review or a 25% payment rate reduction plus claim reviews by a RAC—are in no way related to anything that could be learned from PCRD. What has been learned from PCRD indicates that further analysis could provide exceptionally important information that might avoid a $400 million expenditure by CMS along with the costly administrative burden by the HHAs in the five targeted states. We know the following from PCRD:

1. CMS did not identify any fraud through PCRD, the virtual twin predecessor to RCD. However, the CMS proposal continues to advance that the program will be used to "develop or demonstrate improved methods for the investigation and detection of fraud" under the authority of Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 USC 1395b-1(a)(1)(J)). Given that result, there are important questions as to whether CMS has the authority for the proposed program.

2. PCRD showed that there are common characteristics of HHAs at risk of improper claims that would permit efficient targeting of claim reviews. Over the term of PCRD and the months that followed PCRD, it is clear that claims review does not affect all HHAs uniformly. Instead, the data shows that HHAs are broken up into three classes: HHAs with significant claims volume reduction; HHAs with an increase in claims volume; and HHAs with claims volume equivalent to pre-PCRD periods. The HHAs with claim volume decline are generally newer and smaller HHAs.

   Further study can be useful to determine if predictive modeling is possible, allowing for an efficient targeting of RCD at the outset.

3. According to data analyzed by the National Association for Home Care and Hospice, thousands of Medicare beneficiaries in Illinois lost home health care during PCRD and CMS has not evaluated what harm that may have caused them or what increase in Medicare expenditures occurred in other Medicare service sectors. These patients presumably do not just simply disappear. However, if these individuals truly did not need home health services or any other health care services as alternatives to home care, CMS can determine if there are any common characteristics for purposes of looking any one of a wide range of program integrity options rather than proceed with the most expensive one available, PCRD/RCD. For example, if the reduced patient population comes primarily from certain Home Health Resource Groupings (HHRG), CMS could easily target those patient categories rather than use the shotgun approach of PCRD and planned in RCD—100% of claims.

PREVENTATIVE ACTION STEPS

1. The single, most important reform would be to revise regulatory standards on physician certification and face-to-face encounter documentation to integrate the physician record with the HHA and other provider records into a single review for a complete, rather than partial record review to establish eligibility. The PCRD demonstrated that physician certification and F2F compliance determinations should be based upon a full record review if an accurate eligibility decision is to be reached. Currently, CMS medical reviews require that the physician's record must be sufficient, on its own, to establish eligibility. Physicians can effectively document the clinical status and needs of a patient, but a full record is needed to determine whether the practical limitations triggered by the patient's condition render the patient homebound under Medicare coverage standards. This would be done with existing documentation and would not require any new paperwork from physicians or HHAs thereby limiting burdens. The CMS proposal for combined review of the certifying physician record and the HHA record falls somewhat short of a simple combination review as it

requires HHAs to incorporate the HHA record into the physician record. Such is unnecessary if CMS instead checks the HHA record for consistency with the physician record.

2. Development of model documentation forms. The CMS 485 form can be easily modified to accommodate all of the needed elements. This modification should, at a minimum, include the needed elements to demonstrate compliance with the F2F and physician certification requirements. The electronic templates for documentation are nothing more than the equivalent of blank forms in an electronic format.

3. Implementation of a documentation certification by the HHA that would employ a checklist of the required documentation needed to support a claim. For example, this approach would require that an HHA specifically confirm/certify that it has checked compliance with the various documentation requirements such as physician signed and dated certifications. The confirmation could be an internal process or can be considered as a formal element to the claim submission.

4. Clarified guidance on existing documentation requirements for such as when, where, and how a physician must sign required documentation. The home health community can work collaboratively with CMS to construct the guidance. Areas of need under current rules include: physician F2F documentation; eligibility documentation; patient goals; and homebound status.

5. Targeted education directed to both HHAs and physicians using the tools referenced in 1-4 above. Physician education has been extremely limited. HHA education has fallen short of effectiveness. An educational partnership with the Home health care community and physician groups would be more effective.

6. Detailed and specific explanations provided with adverse claim determinations. Current determinations use boilerplate explanations that are merely conclusory, e.g. the physician's record is insufficient to establish eligibility.

7. MAC education and oversight by CMS specific to documentation standards. The PCRD-IL established that MAC errors exist and are correctible with proper attention.

CLAIM REVIEW ALTERNATIVES

100% pre-claim review or post-payment review can help bring about corrections of HHA errors, but it will work best in a modified, scaled-back form. However, claims review should be employed only after the remedies referenced above have been utilized and demonstrated as not fully effective. The options in that regard are:

1. An optional pre-claim review—- CMS has already indicated that an optional PCR is a better way to go. TAHC&H agrees. However, 100% post-payment review is not a first line alternative option as the appeals process is backlogged and use of post-payment review will only serve to exacerbate the problem. A 25% rate reduction option is also not a valid option as it is counter to the CMS stated intent of PCR to reduce fraud and abuse. In fact, TAHC&H believes that any HHA that accepts a 25% rate reduction is suspect.

2. Automated review of claims on a prepayment basis using edits related to the billing form and OASIS. The billing form can be modified to incorporate essential eligibility data fields, which in conjunction with an interoperable OASIS review, can demonstrate eligibility.

3. Random, ongoing application of preclaim review where a small percentage of RAP submissions trigger the potential for a preclaim review. With this approach, an HHA prepares every patient record with the potential of its selection for review. However, the reviews occur randomly so as to reduce the overall volume.

4. Targeted reviews based on performance, statistical aberrancies, or nature of the claim, e.g., outliers. Performance-based exemptions should occur through a defined process that sets out the testing period and

the performance standard required to qualify for the exemption. The CMS proposal for performance-based exemptions is discussed below. TAHC&H is grateful for the CMS consideration of this recommendation.

5. Reduced percentage of claims subject to PCR. This approach would bring about efficiencies for all stakeholders while likely achieving comparable effectives with HHAs and MACs learning from the claims subject to review and applying the learning to all claims.

6. Use of a process similar to an Independent Review Organization where the HHA selects a compliance organization that does a claims audit and certifies, consistent with CMS-approved standards, that the HHA reached an acceptable level of claim accuracy. Such providers would be exempt from any MAC process, prepayment review, or post-payment review outside of allegations of fraud for a period of time. Periodic follow-up audits would be performed to determine whether the exemption continues. CMS/OIG uses this type of process for corporate integrity agreements. Further, CMS utilizes private accrediting entities with "deemed status" for purposes of determining compliance with the Conditions of Participation. This process would be the claim compliance equivalent to "deemed status." The process would be integrated with an OIG-consistent corporate compliance plan. However, this process should be viewed, at most, as an optional process for HHAs as it is very costly. It would be expected that only a few entities would utilize such an approach.

The home health community can be an effective partner with CMS in developing and implementing corrective actions. A high improper payment rate as a result of documentation errors or otherwise is detrimental to all Medicare stakeholders. TAHC&H is ready, willing and able to be such a partner with CMS as we believe the above demonstrates that we can provide constructive contributions to the development of solutions. The alternatives to RCD set out above warrant CMS's serious consideration as they can be both effective and efficient.

If CMS moves forward with its plans for RCD, TAHC&H offers the following recommendations.

Implementation Timing

CMS should publish a timetable for implementation of RCD that includes the following:

1. A phased-in approach. CMS should pause expansion until a period of time following each state's RCD experience of 3 to 6 months to permit modification based on what is learned in each state.

2. The phase-in should involve at least 3 months between each state.

3. No state should be provided less than a 3 month prior notice.

Streamlined Documentation

CMS should consider a streamlined documentation requirement. For example, CMS could make determinations based on the Plan of Care and the OASIS documentation. In the event that the reviewers conclude more is needed to make a decision in an individual review, the added documentation can be requested by the MAC.

With respect to the post-payment review option, CMS should develop a documentation checklist that focuses on the needed documents rather than seeking everything the HHA has in its patient records.

Exemption Standards

The proposal includes a reference to an exemption based on performance of the HHA. However, the detail is very much lacking. RCD should not move forward until there is a full public display of the exemption standards. These standards should include:

1. The minimum number or percentage of claims processed before an HHA becomes eligible for an exemption
2. The minimum time that must occur before an exemption can be established
3. The duration of an exemption
4. The standards for spot checking of claims (not just the 5% sample referenced)
5. Notice and opportunity to comment on proposed standards
6. Permitting Illinois HHAs to be credited with performances in the PCRD demonstration project

Coverage Policy

As previously referenced, CMS should revise its policy that requires that the physician record, on its own, support Medicare coverage eligibility. It is very evident that physician records are generally insufficient to support homebound status and skilled need in the home. That occurs because physicians are documenting their visit and not crafting their documentation to also meet Medicare Home Health documentation requirements. Further, CMS and its MACs have done little to educate physicians on Medicare home health documentation requirements.

Instead, CMS should learn from the PCRD experience and automatically evaluate the physician and HHA records in combination. The dramatic increase in review affirmations is a telling sign that the limited record review is the root cause of much of the improper payment rate.

Beneficiary Information Regarding the RCD Process

Illinois HHAs reported numerous concerns with the information provided to Medicare beneficiaries during PCRD. TAHC&H recommends that CMS engage representatives from the beneficiary community in Texas to develop a beneficiary notice that clearly explains rights under RCD. TAHC&H is available to work with CMS on this element.

Improve the Reliability of the Record Submission Process

PCRD was plagued with ongoing problems with electronic documentation submissions. CMS must fully test MAC capabilities in this regard before proceeding. Further, CMS must require the MAC to maintain an inventory record of all HHA submissions as too frequently in PCRD the MAC alleged that records had not been sent on particular claims while the HHA assured that such had been sent.

MAC Reviewer Capability and Competence

Early claims reviews during PCRD demonstrated that the MAC was insufficiently prepared to handle the workload or to bring necessary competence to claims reviews. At one point, CMS deemed it necessary to audit the MAC performance and to correct review errors. CMS should take all necessary steps to ensure that the MAC is ready for RCD. Quality not volume should be the performance measure.

HHA Training

The PCRD experience demonstrated that HHA training by MACs fell short of adequacy. MACs should rely upon CMS direction to devise and present detailed HHA training prior to the start of RCD reviews. CMS should audit the MAC presentation off HHA training to determine whether quality standards are achieved. The HHA training should precede RCD reviews by at least one month.

Protection against Further Claim Review

The main benefit of 100% review for HHAs should be the assurance that approved claims will not ever be subject to any later review by a Medicare integrity contractor, CMS, OIG, or others with the exception of fraud

investigations that are focused on fraudulent documentation. CMS should issue a formal regulation to that effect for RCD reviews. An FAQ alone does not create binding policy.

Reimbursement for Increased HHA Costs

RCD is an extraordinary action for HHAs that comes at extraordinary cost. CMS will be providing additional reimbursement to the MAC to cover its extraordinary costs. CMS will cover its own added costs as well. However, there is no indication that any HHA will be entitled to increased reimbursement, directly or indirectly, for the added costs that the HHAs will experience.

The cost of RCD is not within the current episode or per visit rates applied to home health services. Further, the annual inflation update, Market Basket Index, will not account for the added costs. Unless CMS provides an add-on in reimbursement with each claim or provides a mechanism for direct cost reimbursement, HHAs in the targeted states will be relegated to a national payment rate that is not adjusted for the unique and costly experience of participating in the RCD demonstration program.

CMS may be correct that RCD HHAs will only be providing the same record that all HHAs must compile. However, the costs of concern go far beyond customary record processing. Typical claims reviews for HHAs is a small percentage of their annual claim volume with many HHAs subject to little or no claims reviews for years. It is the expanded claim review process, not the original record composition that brings the new costs of concern.

The additional actions required of HHAs in PCRD/RCD include:

1. Record assembly for transmission to the MAC
2. Record review by licensed health professionals prior to transmission (RNs)
3. Development of a record summary, written by an RN, to highlight eligibility (a very necessary action to protect the HHA from a wrongful rejection)
4. Actual transmission of record to the MAC
5. Tracking of the status of claim reviews
6. Responding to MAC inquiries on submitted claims by professional staff
7. Resubmission upon erroneous rejection

HHAs should not suffer unnecessary costs for a CMS demonstration program. CMS should use its demonstration project authority to account for and reimburse HHAs for added costs the same way it provides added payment to MACs handling their part of the project. To do otherwise raises serious questions about the validity of the project.

Thank you for the opportunity to submit these comments. TAHC&H is available at your convenience to discuss any aspect of these comments or the RCD proposal at 512-338-9293.

Respectfully Submitted by Sarah Mills, Director of Government Relations and Regulatory Affairs

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Submitter Info

Comment: We are a home health agency in the Treasure coast area of Florida. I am writing to address the Pre-Claim Review process. While I understand the rational for the demonstration project, I find the additional regulatory burden on a small provider very taxing and potentially catastrophic. The complex and burdensome project applied across all providers is unfair, when the data is available and unused by CMS. The Medicare Administrative contractors are already engaging in targeted probe and educate programs, along with the ZPIC, RAC audits. Also the PEPPER Reports that flag potential behaviors. Why do

we continually punish all providers when the data is there to mine? With the potential PDGM changes, 30 day episodic changes, LUPA adjustments, and OASIS changes how is a small provider to provide staff to accommodate all the regulatory burden? Also, and added issue in the state of Florida is the HHVBP. The regulatory considerations being made in Physician Practices to give more time to patients should be considered in home health as well. I have been in this business for 30 years and the burden on home health has never been greater. While we understand the drive to quality outcomes and care, the more regulatory burden the less quality patient time will exist. We ask CMS to take into consideration the delay of PCR due to the immense change occurring in our present environment.

First Name: Wendy
Last Name: McElroy
City: Lake Worth
Country: United States
State or Province: Florida
ZIP/Postal Code: 33461
Email Address: Wmcelroy@redi-nurse.com
Organization Name:
Category:
Cover Page:

Document Details

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Phase Sequence: 1
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Comment on Document ID: CMS-2018-0071-0001
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Submitter Info

Comment: Dear Administrator Verma, Thank you for the opportunity to comment on CMS-10599 Pre-Claim Review Demonstration for Home Health Services. As one who has nearly 42 years experience in the health care industry, ranging from a Medicare auditor with a former Fiscal Intermediary, a former hospital controller, a financial and reimbursement consultant to the home health care industry and a current owner / administrator of three (3) home health care providers, I feel compelled to comment on this proposal. This is by far the most restrictive change to providers' payments that CMS has ever proposed. Why is home

health care as an industry constantly being scrutinized? This type of Pre-Claim or post-payment review will only hurt the many providers who are providing quality medically necessary home health care services to the many sick, feeble and frail elderly patients in the communities that we serve. Yes, there is Medicare fraud in the home health care industry, as well as many other service areas under the CMS administered oversight. Singling out the home health care industry for this type pre-claim or post-payment review is very unfair. The suggestion that providers who do not wish to participate can choose to accept 25% less for the services they provide, is not a realistic alternative. The Medicare Administrative Contractors (MAC) cannot handle the volume of 100% pre-claim or post-payment reviews, thereby severally slowing down cash flow to those very providers who have had their reimbursements reduced for the past 10 years. Also, this approach identifies all providers as guilty fraudulent operators, until they prove themselves innocent. Several home health companies have gone through several rounds of the MAC's Additional Development Requests (ADRs) and the results have supported that their claims were for legitimate medically necessary services. So, why should they now be subject to the proposed 100% pre-claim or post-payment reviews? There are processes in place currently to determine if Medicare payments are appropriate to home health care providers. There can be other more realistic means of Medicare fraud detection than to do a blanket policy that negatively impacts all home health care providers by requiring a 100% pre-claim or post-payment review. Please don't put another burden on the home health care industry that threatens our financial viability as a business and causes further hardship on those of us who do it right. As one who has experience in this industry from both the enforcement and provider sides, I will gladly offer suggestions for more practical and effective ways to detect Medicare fraud in the home health care industry and other programs administered by CMS. Again, thank you for the opportunity to comment.

First Name: Carl
Last Name: Clark
City: Metairie
Country: United States
State or Province: Louisiana
ZIP/Postal Code: 70002
Email Address: cclark@vitalhcgroup.com
Organization Name:
Category:
Cover Page:

BayCare

HomeCare

July 20, 2018
The Honorable Seema Verma
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 2020 I
RE: Document Number: 2018-11492
Submitted via regulations.gov.
Dear Administrator Verma:

8452 118th Ave North
Largo, FL 33773
(727) 394-6452Telephone
(727) 394-6540 Fax
www.baycarehomecare.com

BayCare Health System appreciates the opportunity to provide comments on the information request *Title of Information Collection:* Pre-Claim Review Demonstration for Home Health Services; *Use.*

BayCare is the largest not-for-profit health care system in West Central Florida, delivering highquality
health care services through 15 hospitals and more than 400 service locations across the Tampa Bay region. Our mission is to improve the health of all we serve through communityowned, health care services that set the standard for high-quality, compassionate care. Inpatient and outpatient services include acute care, primary care, imaging, laboratory, behavioral health, home care, and wellness. In 2017, BayCare conducted more than 850,000 home visits for patients in 13 counties in the State of Florida, and in the same year provided $391 million in Community Benefit to include traditional charity care, un-reimbursed Medicaid costs, meanstested programs and community services. Together with our community partners, BayCare is committed to ensuring health equity and striving to achieve the best possible health outcomes for all.

We are writing to express our strong opposition to the CMS proposal to reinstate a controversial claim review demonstration project whereby CMS would review I 00 percent of home health agency (HHA) claims.

Under the proposed revamped HHA claim review demonstration project, CMS is proposing to give HHAs two options related to their claim review: a) I 00 percent pre-payment claim review or b) I 00 percent post-payment claim review. If an HHA does not wish to submit to either postor pre-payment review, CMS is proposing that the HHA will receive a 25 percent payment reduction on all submitted claims and may be eligible for review by Recovery Audit Contractors (RACs).

While we appreciate and support appropriate efforts to identifY and take action against Medicare fraud occurring among Home Health Agencies (HHAs) providing services to Medicare patients in Florida and across the country, we do not believe the proposed pre-claim review process is an effective means to achieve that end.

Rather, as evidenced by implementation of pre-claim review for home health services in the State of Illinois in 2016, such a process results in decreased access to care for some of our country's most vulnerable individuals without addressing fraud and enhancing program integrity.

The Illinois experience brought enhanced administrative costs and burden for clinicians and staff, without a corresponding benefit to patients. It resulted in confusion across the continuum of stakeholders - including patients, providers and the fiscal intermediary- as standards for denials were unclear. It did not combat fraud but rather resulted in fewer options for vulnerable seniors and disabled individuals who rely on Medicare home health services to receive vital care. An estimated 60 home health agencies exited the Medicare home health business in Illinois following implementation of the demonstration in the state.

Notably, CMS had previously postponed the demonstration, in part, after 116 members of Congress signed a letter in May 2016 addressed to the Secretary of Health and Human Services and the Administrator of CMS asking them to withdraw the proposed demonstration. These members of Congress felt the project would restrict access to necessary care, be too costly to taxpayers, and that CMS lacked the authority to implement the project in the manner they chose. The Congressional letter identified the over a quarter of a billion dollar price tag as adding an incredible administrative cost to physicians and home health agencies while doing very little to prevent fraud.

Based on the Illinois model, we remain very concerned with the potential negative impact for seniors and disabled individuals in the State of Florida should implementation of the revised preclaim review program move forward in our state. A I 00 percent claim review poses a significant administrative burden and increased costs for our health system- including an estimated 13 employees and a cost of roughly $600,000 annually. This would involve not only administrative staff but also require us to redeploy nurses- whose focus would be solely on submitting paperwork rather than delivering care that is urgently needed in the communities we serve. Given a significant nursing shortage in Florida and across the country, we believe strongly our nurses should be utilized for patient care rather than clerical purposes. Further, it is unclear how the additional review responsibilities potentially imposed on Medicare Administrative Contractors will affect the timeliness of Medicare reimbursement for providers.

Finally, BayCare and other providers are preparing for significant reimbursement changes for home health services mandated by the Bipartisan Budget Act of2018, which are scheduled to go into effect on January I, 2020. As considerable resources are required to ensure effective implementation of those changes, our concerns with the added administrative burden and resources that would be required of our health system should I 00 percent claim review be required in the State of Florida are further deepened.

Accordingly, we urge CMS to consider alternative means to address concerns with those suspected of improper billing within the Medicare home health system. For example, easing face-to- face physician requirements for home health services by allowing an exemption from this requirement for patients being admitted to home care directly from an acute inpatient hospitalization. The existing post claim review audits show that a major contributor to high claim denial rates is due to incomplete physician face-to-face and other certification documentation. Regulatory solutions and appropriate enforcement that truly address improper billing should be explored rather than implementing a demonstration program that will only serve to increase administrative burdens across the continuum of care and decrease access to critical health care services for many of the most vulnerable in our state and across the country.

We appreciate your consideration of our comments. Should additional information be helpful as you evaluate next steps, please contact Joni Higgins at joni.higgins@baycare.org or 727-519-1220.

Sincerely,

Daniel Sweeney
Vice President of Home Health
BayCare HomeCare

Document Details

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Submitter Info

Comment: I completely understand CMS's desire to ensure compliance with all regulatory requirements. That is not at issue. At the same time, I believe that this pilot project will decrease quality care for Medicare beneficiaries. It will do so by 1) disallowing/disapproving care that is medically necessary for the beneficiary's well-being and 2) adding administrative burden to the home health agencies which will result in resources being diverted from care. I believe that the program as it was initially attempted in Illinois last time had several fatal flaws. The reviewers did not have enough knowledge/training in home healthwhat is appropriate, what is necessary or beneficial for the Medicare beneficiaries. As a result, far too many beneficiaries were denied the care that was rightfully due them. You have only to examine the denials versus ultimate affirmations to see that a grave injustice was perpetrated on the beneficiaries and the home health agencies that served them. If you don't think that denials, even if they were eventually affirmed, had an influence on practice patterns, I would strongly ask you to look to the real world and not the hypothetical one where everything is easy and

there are no unintended consequences. I also believe that the administrative burden you're placing on home health agencies will detract from patient care. Again, I remember from the initial call that CMS representatives were saying there would be little to no administrative burden because this is information/documentation that we should be gathering to begin with. The fact that we are gathering the information is true, but the handling and submission of all documentation to CMS (as opposed to a small sample we may submit in response to an ADR) is a huge burden. Again, look at what actually happened in Illinois, not what you thought might happen in a land where there are no unintended consequences. As you know, CMS's infrastructure failed to accommodate the submissions from Illinois. The electronic submission failed, people were resorting to sending faxes which were often either lost or incomplete. From talking with people who lived through PCR in Illinois, it was a disaster. While you might have learned some lessons from the previous attempt at PCR, I believe that this pilot program will again result in worse care to your Medicare beneficiaries, not better care. There has to be a better ways to care for your beneficiaries than wrongly depriving them of the care they deserve while simultaneously diverting home health resources from patient care into administrative burden. By the way, I understand that two of the CEO's of the largest home health agencies recently said they weren't bothered by PCR. I know one of their company's representatives in my area said they were excited about PCR because it will result in many smaller home health agencies going out of business (due to the increased administrative burden), which would result in the larger agencies absorbing patients that would have chosen smaller agencies if they were given a choice. As the owner of a small home health agency, I can assure you that we put as much money as possible back into care and don't have a large infrastructure to accommodate increased administrative burdens. Again, Medicare beneficiaries and agencies that spend a higher percentage of their reimbursement providing care will lose. I strongly urge you to consider alternative ways to provide the care that your beneficiaries need while ensuring regulatory compliance. Hurting beneficiaries and smaller home health agencies is not the right way to do this.
First Name: Ron
Last Name: Tester
City: Denton
Country: United States
State or Province: Texas
ZIP/Postal Code: 76205

Email Address: ron.tester@gmail.com
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/19/2018
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Component:
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1

Submitter Info

Comment: I completely understand CMS's desire to ensure compliance with all regulatory requirements. That is not at issue. At the same time, I believe that this pilot project will decrease quality care for Medicare beneficiaries. It will do so by 1) disallowing/disapproving care that is medically necessary for the beneficiary's well-being and 2) adding administrative burden to the home health agencies which will result in resources being diverted from care. I believe that the program as it was initially attempted in Illinois last time had several fatal flaws. The reviewers did not have enough knowledge/training in home healthwhat is appropriate, what is necessary or beneficial for the Medicare beneficiaries. As a result, far too many beneficiaries were denied the care that was rightfully due them. You have only to examine the denials versus ultimate affirmations to see that a grave injustice was perpetrated on the beneficiaries and the home health agencies that served them. If you don't think that denials, even if they were eventually affirmed, had an influence on practice patterns, I would strongly ask you to look to the real world and not the hypothetical one where everything is easy and there are no unintended consequences. I also believe that the administrative burden you're placing on home health agencies will detract from patient care. Again, I remember from the initial call that CMS representatives were saying there would be little to no administrative burden because this is information/documentation that we should be gathering to begin with. The fact that we are gathering the information is true, but the handling and submission of all documentation to CMS (as opposed to a small sample we may submit in response to an ADR) is a huge burden. Again, look at what actually happened

in Illinois, not what you thought might happen in a land where there are no unintended consequences. As you know, CMS's infrastructure failed to accommodate the submissions from Illinois. The electronic submission failed, people were resorting to sending faxes which were often either lost or incomplete. From talking with people who lived through PCR in Illinois, it was a disaster. While you might have learned some lessons from the previous attempt at PCR, I believe that this pilot program will again result in worse care to your Medicare beneficiaries, not better care. There has to be a better ways to care for your beneficiaries than wrongly depriving them of the care they deserve while simultaneously diverting home health resources from patient care into administrative burden. By the way, I understand that two of the CEO's of the largest home health agencies recently said they weren't bothered by PCR. I know one of their company's representatives in my area said they were excited about PCR because it will result in many smaller home health agencies going out of business (due to the increased administrative burden), which would result in the larger agencies absorbing patients that would have chosen smaller agencies if they were given a choice. As the owner of a small home health agency, I can assure you that we put as much money as possible back into care and don't have a large infrastructure to accommodate increased administrative burdens. Again, Medicare beneficiaries and agencies that spend a higher percentage of their reimbursement providing care will lose. I strongly urge you to consider alternative ways to provide the care that your beneficiaries need while ensuring regulatory compliance. Hurting beneficiaries and smaller home health agencies is not the right way to do this.

First Name: Ron
Last Name: Tester
City: Denton
Country: United States
State or Province: Texas
ZIP/Postal Code: 76205
Email Address: ron.tester@gmail.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0457
Current Document ID: CMS-2018-0071-DRAFT-0457
Title: FL
Number of Attachments: 0
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Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Component:
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Submitter Info

Comment: Thank you for the opportunity to comment. We oppose the former pre-claim initiative now renamed to the Home Health Review Choice Demonstration being reactivated as proposed by this rule effective 10/1/2018. The home health industry seems to be subject to the most stringent and ever-changing requirements and guidelines. We are constantly having to change processes and monitor the industry to ensure compliance with regulations. To place every agency in 5 different states on 100% review will likely not solve the problem of fraud in the industry and will likely result in overspending at the

government level on resources to run a program that may according the CMS website potentially reduce the rate of improper payments. This same article states and this demonstration will improve provider compliance with Medicare rules and requirements. Medicare agencies are already subject to surveys that ensure compliance with rules and requirements so to add this as reason for the review choice demonstration seems like a double burden to agencies. A pre-claim type initiative will affect Medicare recipients ability to receive and timely and proper care. It will overload physicians as well as their offices will be inundated with agencies calling to get orders signed so that they can comply with pre-claim submission timelines and requirements. Please consider the last time this time of initiative was proposed and the affect it had on so many agencies in Illinois and the end result of it being stopped due to the amount of confusion and turmoil it caused in that one state alone. Thank you again for your consideration of all providers comments. CMS 10599.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33330
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0454
Current Document ID: CMS-2018-0071-DRAFT-0454
Title: PA
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
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1

Submitter Info

Comment: July 26, 2018 CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development Attention: OMB: 09381311 CMS10599 7500 Security Boulevard Baltimore, Maryland 212441850 Re: Pre-Claim Review Demonstration for Home Health Services University of Pittsburgh Medical Center (UPMC) Community Provider Services provides a continuum of post-acute services including home health care, hospice, community-based services, adult day service, PACE, skilled, assisted and independent living residences, continuing care communities, as well as technology

solutions and person-centered practices that support the overall health and well-being of seniors, children, and those with special needs. UPMC Home Healthcare is a conglomerate of several Medicare Certified Home Health Agencies and Hospices that provides homebased health care services across many counties and communities in Pennsylvania through an expansive network of providers. On behalf of UPMC Home Healthcare, we wish to bring to your attention profound concerns with the Pre-Claim Review Demonstration (PCRD) for Home Health. UPMC concurs with CMS stated goal of findings ways to identify and combat fraud and abuse. However, instituting a choice demonstration that will likely harm beneficiaries and impede access to care is not the solution. Further, it is not clear that this demonstration will help CMS develop improved procedures to identify, investigate and prosecute Medicare fraud. Most providers, including diligent not-for-profit Home Health providers like UPMC Home Healthcare, should not endure the process of identifying those engaged in fraudulent behavior and taking steps to correct the problem. We believe a choice to not participate in the demonstration accompanied by a 25 percent payment reduction in all claims is not a meaningful choice. The increase in auditing should be providing CMS the information needed to pinpoint agencies that are providing care in a questionable manner and should allow Medicare to focus on those providers rather than implementing a broad demonstration on all home health providers in select states which has been riddled with inconsistencies and confusion. Foremost, what assurance can be provided that this Pre-Claim demonstration will not prevent high quality, innovative, mission-driven not-for-profit providers from delivering home health services in their communities? Moreover, how can providers be assured that PCRD does not conflict with achieving CMS two new Meaningful Measure Areas: Care is Personalized and Aligned with Patients Goals and Patients Experience of Care? Ultimately, we recommend that CMS conduct a thorough review of data gathered from the PCRD Pilot in 2017 to determine the issues revealed during that project. Comments/Questions: We request further detail on PCRD. We have cited below the frequently asked questions among home health staff regarding PCRD. What is the target affirmation rate? How long does the provider need to maintain the affirmation rate until CMS removes the provider from the PCRD process? What documentation (both pre-and-post) will need to be submitted? What is the time frame for submitting the documentation in the post-review process? Will CMS continue to pay providers the RAP in the post-review process? With respect to eligibility

criteria, will the PCRD rely on the physicians medical record rather than the HHA record to establish the skilled need and homebound status? If so, this creates several logistical issues for the Home Health provider for several reasons: 1. HHAs have no control over the physicians incorporation of this documentation into his/her records; 2. An additional burden is created for the physician to sign, date and return the documents to HHAs to prove this incorporation; 3. If the Home Health documentation is not incorporated, HHAs are left with incomplete documentation required to establish Medicare benefit eligibility. The combination of the physician and home health record provides a much clearer picture on a patients medical needs and homebound status. However, that full review only occurs if the physician signs all the records from the HHA and incorporates into his/her record. We seek further clarification since a provision in the Bipartisan Budget Act passed in February 2018 permits, but does not require, CMS to evaluate both the physician and the home health medical record as supporting material for eligibility. UPMC Home Healthcare and our industry associations including Leading Age and the National Home Care and Hospice Association appreciate the opportunity to work with CMS to improve the home health care benefit. Please contact us for further discussion. Sincerely,
Paula Thomas, RN, MSN, DNP President, UPMC Home Healthcare Northpointe Center III 300 Northpointe Circle, Suite 201 Seven Fields, PA 16046 Phone: 724-778-4663
First Name: Paula
Last Name: Thomas
City: Seven Fields
Country: United States
State or Province: Pennsylvania
ZIP/Postal Code: 16046
Email Address: fedeliturianon@upmc.edu
Organization Name:
Category:
Cover Page:

Document Details

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Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
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Title: OH
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). I do not want pre-claim review. As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the

"Pre-Claim Demonstration for Home Health Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Desera
Last Name: Rhule
City: Centerville
Country: United States
State or Province: Ohio
ZIP/Postal Code: 45459
Email Address: iking@graceworks.org
Organization Name:

Category:
Cover Page:

RCDcomments1

RCDcomments1

Dawn Futris
1065 W North Shore Ave Unit 1
Chicago, IL 60626
July 30, 2018
The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services Office of Strategic Operations and Regulatory Affairs Division of Regulations Development Attention: 2018-11492/CMS-2018-0071-0001 Room C4-26-05 7500 Security Boulevard Baltimore, MD 21244-1850
Submitted electronically via regulations.gov
RE: Agency Information Collection Activities; Proposals, Submissions, and Approvals – Pre-Claim Review Demonstration for Home Health Services (2018-11492/CMS-2018-0071-0001)
Dear Administrator Verma:
Thank you for allowing comment on document 2018-11492/CMS-2018-0071-0001, "Agency Information Collection Activities; Proposals, Submissions, and Approvals – Pre-Claim Review Demonstration for Home Health Services." I've been in home health for 26 years in Illinois and helped lead our agency through Pre-Claim Review (PCR) and will be leading with Review Choice Demonstration (RCD).
Goals, Exemptions & Transparency for PCR & RCD
At this point, the goals of RCD remain unclear, specifically for Illinois as well as other states to follow. Was PCR and is RCD meant to decrease fraud, decrease CMS expenditures, or verify agency compliance with certain documentation requirements? Specifically, in Illinois, did PCR achieve the goals? If so, why is Illinois repeating the process? The current information from CMS/Palmetto states that after a review of at least 10 charts, with a passing rate of 90%, that agency will be able to stop RCD. For those agencies that met that 90% PCR affirmation, why are they participating in RCD?

Some transparency for CMS' plans for Illinois, and specifically those agencies that beat the 90% threshold, would be appreciated. Are we being reviewed again or are our submissions meant to train the new reviewers? If an agency has already surpassed the CMS goals, what is the purpose of participating in RCD? Why are they not allowed an exemption to RCD?

More transparency related to the future states that will be participating in RCD is also requested. While Illinois has already participated in PCR, if required to participate in RCD, the ten charts is not a burden. However, will those same guidelines move to other states? Ten charts for future states may not produce the same results as ten charts in Illinois. It seems PCR was a learning experience for both agencies and reviewers. As someone who experienced PCR, those states deserve advance warning about how RCD will affect them.

It would also be helpful for CMS to be transparent in differentiating PCR data from Palmetto and CGS. The two MACs managed PCR quite differently and understanding the different impact of the two would help point to best practices.

CMS has published the decreased home health payments made to Illinois agencies during PCR. It would also help us understand the cost CMS experienced related to PCR. What steps will be taken with RCD to control those costs? Specifically, what were the cost related to reviewers, technology updates, and submission processing?

Pre-Claim Review Impact on Agencies

With only six weeks to prepare for PCR, agencies were in a mad dash to re-allocate staffing, work with their technology vendors, train staff, organize for submissions.

Allocating staffing & PCR inconsistencies

With little advance warning, staffing to plan, implement, and complete PCR had a huge impact on the agency I work for.

Prior to PCR starting, we participated in a probe and educate audit of five charts with Palmetto. This process was quite helpful and prepared us for PCR. It seems that if all MACs completed a similar process, agencies would understand and have time to make any changes in their processes.

We were fortunate to be able to attend Palmetto training sessions. Our E.H.R. vendor attended as well. However, with both CGS and Palmetto, PCR submission problems and review inconsistencies were problematic.

We worked with our E.H.R vendor to create reports to process and track PCR. However, with Illinois being the only state initially participating, unclear expectations, and changing expectations, our vendor was not able to move a more defined process out. We had to manually track the process in order to understand where we were with PCR. We needed to create internal processes for submissions, tracking of submissions, correcting any non-affirmations, and submitting claims once affirmed.
The documents were well defined by Palmetto, but the submission process itself proved to have many inconsistencies.

- • The ability to access Palmetto was not consistent, impacting our ability to staff.
- • There were multiple examples of submissions that got lost in Palmetto. Even with a Document Control Number, submissions may/may not have actually been processed. This impacted our ability to track and wasted time in attempting to resolve the issue or resubmitting the documents.
- • Palmetto set up PCR with multiple tasks. Many of the documents were the same for the various tasks, but each task required a separate document, resulting in wasted time and duplications.
- • Palmetto merged all documents together for reviewers which left agencies asking why the multiple tasks existed in the first place.
- • Reviewers were inconsistent. There were times when we received a non-affirmation. We knew the documents were in place and re-submitted. Some re-submissions were made with no changes while others were submitted with highlights to the data previously overlooked by reviewers. Those resubmissions were then affirmed.

• PCR was not meant to be a full chart audit. Elements were defined, but then changed as PCR progressed. It appeared that Palmetto had meetings with reviewers, explaining home health regulations and then agencies were suddenly non-affirmed if they did not submit documentation not previously defined as required. For example: o Therapy short and long term goals were not required as part of PCR. At some point, Palmetto reviewers required those goals. We wasted time by re-submitting documentation with those goals.

o Palmetto reviewers started non-affirming submissions if we did not provide proof that the certifying physician and the community physician had not communicated with each other. Once again, this was not defined as a requirement of PCR. This also provided a hardship to agencies as that documentation sits with the physicians, not the agencies.

This table shows the staffing impact PCR had on my agency.

I respectfully request that the documentation required is clearly defined and does not change in scope with this round of RCD.

Another inconsistency was related to the MAC reviewing PCR. Palmetto and CGS had different submission processes, required elements, and affirmation criteria. While RCD will only fall under Palmetto's jurisdiction initially, what are the plans for all MACs to follow similar guidelines and move this process out to the agencies they oversee?

Defining RCD

With RCD starting in potentially two months, we still have no specific information related to new/revised documentation requirements, submission process, or charts selection or quantity. Once again this puts us at a disadvantage. We are not able to work with our E.H.R vendor, update internal software, or plan staffing. A minimum of "ten" charts does not allow for agency planning. Currently, there are no Palmetto training sessions scheduled, so once again, we will only have weeks to prepare, putting us at a disadvantage.

Conclusion

PCR helped our agency clearly define the elements CMS required:

- • The actual face-to-face encounter with the patient/physician
- • Signed and dated plan of care
- • Physician's certification statement
- • Documentation supporting homebound status and skilled need

We ask that CMS and the MACs clearly define required elements for each document. All MACs should include these very specific elements in any ADRs and complete probe and educate sessions, focusing on the education for agencies. This would allow agencies, medical staff, and E.H.R. vendors the opportunity for standardization.

If RCD is moving forward, please consider exempting agencies who had an affirmation rate during PCR greater than 90%. Required elements should be identified and shared immediately allowing agencies the time to plan. Palmetto's technology and submission process needs to be streamlined and seamless. Reviewers should be trained with consistency in responses a priority. Data post RCD go-live should be transparent and shared in a timely fashion.

Sincerely,

Dawn Futris RN, BSN, MSHI

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Phase Sequence: 1
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Submitter Info

Comment: Thank you for the opportunity to comment on this proposed intended action. This process is entirely unneeded now that every home health agency is required to participate in the Targeted Probe and Educate program. The rollout of TP&E in October 2017 implies you already have the required technology and infrastructure to locate potentially fraudulent activities and billing practices of individual home health agencies. Based on the previous Pre-Claim Review process that was required of Illinois between Aug 2017-March 2017, it is VERY evident that Palmetto is unable to train Review stag

sufficiently to carry out a project of this magnitude. Agencies submitted documentation under PCR to have something rejected only to have a different reviewer locate something else to delay the payment process. After a series of back and forth documentation exchanges, the claim was paid in full. This full payment clearly indicates that the majority of agencies understand and are following the CoPs correctly and admitting only Medicare beneficiaries that qualify for re-imbursement. Thus focusing on the fraudulent agencies is the correct course of action. Enacting the proposed process will waste millions in payroll, training and infrastructure for the staff that Palmetto will be utilizing for this proposed process. Without targeting fraudulent agencies with the current infrastructure being utilized for TP&E for all licensed Medicare agencies, would itself be a fraudulent waste of money by Medicare and Palmetto. Medicate funds would be put to much better use in continuing to improve the process of data analysis to identify fraudulent agencies as opposed to implementing a process as proposed simply due to the manual process of reviewing 100% of documentation from any state.

First Name: Michael
Last Name: Tidd
City: Idaho Falls
Country: United States
State or Province: Idaho
ZIP/Postal Code: 83404
Email Address: Michael.tidd@goldcoastcoding.com
Organization Name:
Category:
Cover Page:

Document Details

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Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0444
Current Document ID: CMS-2018-0071-DRAFT-0444
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Number of Attachments: 0
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Date Posted:
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

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Component:
File Code:
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1

Submitter Info

Comment: I appreciate the opportunity to provide feedback on this initiative. The intent to reduce waste and abuse specific to Medicare spending is critical to long term viability of the program. Home health has been seen as an area in which both are occurring and attempts to address concerns have achieved inconsistent results. Although the messaging around this revamped Pre Claim Review Demonstration Project indicates this will not impede beneficiary access to services, will not change the current benefit and will not add new requirements, it does not account for the increased administrative burden

and costs as were reported in Illinois - the only state where the original program was implemented. As a resident of Illinois, the process was not as smooth across the board as some have reported. When small and medium sized providers do not have the manpower to gather all required elements quickly, especially those that are controlled by physician participation, the ability to effectively serve patents is impacted. The success rates reported do not include the number of claims agencies had to hold on to for extended periods waiting for documentation before submitting - sometimes weeks beyond the start of services - which delayed payments for care. Proposed changes in 2019 regarding the detail level of information from the physician specific to certification/recertification are going in the right direction, making a program that in any way holds one setting accountable for aspects they cannot directly control is a less than ideal mechanism for assessing compliance. If the content of physician documentation is inadequate, there is no penalty impacting him or her directly - the home health agency carries that burden alone. For programs that are monitoring compliance and enacting repercussions, all entities should be held accountable. As the first implementation was a demonstration, it would be important for the industry to see the data gathered from Illinois, the analysis of trends and the refinements made based on those trends to better understand the rationale for bringing the program back and expanding it. At a minimum, the reintroduction should be delayed until further analysis is conducted and the industry can participate in refinements that will achieve the desired results.

First Name: Cindy
Last Name: Krafft
City: Peoria
Country: United States
State or Province: Illinois
ZIP/Postal Code: 61604
Email Address: ckhomerehab@yahoo.com
Organization Name: Kornetti & Krafft Health Care Solutions
Category:
Cover Page:

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Document File:
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Phase Sequence: 1
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Current Document ID: CMS-2018-0071-DRAFT-0443
Title: FL
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Submitter Info

Comment: Thanks very much for the opportunity to comment on the Review Choice Demo. I have several issues with this reboot to the Pre-Claim demo: Issues: 1. Significant increase in administrative burden for Home Health Agencies. Agencies have had to reduce admin staff due to increased difficulty processing claims and decreased payment every year. 2. Agencies can choose one of three options. Yet there is no indication of any timeframes each of these items will take not whether the requirements of documentation will be different with each choice. 3. The Home Health Agency benchmark is not

clearly defined. The agency does not know what the goal is to be subjected to occasional spot checks. How often is occasional? 4. These types of anti-fraud processes are unduly burdensome on innocent agencies and they are de facto guilty until proven innocent." CMS has access to claims data that can be studied and extrapolated to show areas of duplicate or abnormal billing trends. This would seem to be a more specific and efficient way to find potential fraud. 5. Agencies and stakeholders have not been given the opportunity to review the details of the pre-claim demo that occurred in Illinois. This knowledge would allow agencies to avoid pitfalls and increase their chance of success in a efficient more cost effective manner. Please take the time to review my as well as all of the other thoughtful comments before burdening agencies unnecessarily. Respectfully Sherry Teague, MESS, ATC, PTA, HCS-D, HCS-O Kornetti & Krafft Health Care Solutions

First Name: Sherry
Last Name: Teague
City: Citrus Springs
Country: United States
State or Province: Florida
ZIP/Postal Code: 34434
Email Address: teague@valuebeyondthevisit.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Submitter Info

Comment: RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. My name is Jonathan Weber and I am a board certified clinical specialist in geriatric physical therapy. I work as a physical therapist for a home health agency with four locations in Colorado. I am also our agency's therapy clinical manager for the two offices

in our northern region. I am extremely passionate about serving our patients in the home health setting and the goal of keeping patients in their own homes safely for as long as possible. I am very grateful that CMS has recognized some significant problems that exist in the setting and appreciative of the effort to address and correct these problems. However, I am worried the recently proposed Review Choice Demonstration will exacerbate instead of remedy those problems. The Review Choice Demonstration and the process it entails if adopted on a larger scale will not only fail to reduce Medicare appeals, it will drastically increase them. My concern with this stems from my agency's own recent experience with the Targeted Probe and Educate audits. We had several claims denied during this process in which the auditors drew very clinically inappropriate conclusions from our documentation which they used as grounds for a denial. In one case specifically the auditor reviewed our admitting clinician's SOC documentation of the Braden Scale and referenced the language in that tool that the patient was walking frequently outside the room at least twice a day and inside the room at least every two hours in the home as evidence that the patient was not homebound. This tool is specifically a measure of a patient's risk for skin breakdown and not in anyway correlated to homebound status nor is it intended for use in determining the safety of a patient's mobility. She also reviewed our therapist's evaluation of the patient's mobility which included 3 objective measures that classified the patient as a significant fall risk and supported her homebound status. The measures used are all very well supported in the literature as fall risk indicators. However, the physician's visit notes included phrases that said the patient's gait was, good and coordination was, good. The auditor made the argument that the documentation in the physician's notes did not corroborate our agency's documentation despite the fact that the physician also signed our PT's documentation which included a much more thorough and evidenced based assessment. My point in bringing this up is not to discuss the specifics of our recent denials but point out that there is far too much room for interpretation with respect to some of the issues that determine eligibility for home health services and whether documentation supports the need. The Review Choice Demonstration may ultimately cut down on improper payments and appeals for cases where agencies are not meeting basic requirements. But from what I have seen previously, auditors are reviewing cases with the intent to deny and searching for any possible grounds to make the

argument that a claim does not meet the requirements. On top of that, I am concerned that auditors will have major incentives to deny with the Review Choice Demonstration. If CMS is going to have contractors reviewing every single claim, this will have to be a major cost which the agency I am sure is hoping to be offset by a reduction in improper payments. This creates an incentive whether direct or indirect for contractors to deny given the need to meet CMS' expectation. That is very alarming considering the fact that there is such wide room for these contractors to make the assertion that a claim should be denied. It is difficult for me to see how a situation in which contractors are incentivized to deny claims while given substantial leeway in their ability to make a determination that a claim should be denied will lead to anything other than a sharp rise in appeals. Ultimately I fear that the end result of this will be that agencies begin to look at referrals from the standpoint of the likelihood a potential claim will get denied or affirmed instead of focusing on what the patients need. I am concerned this will cause a considerable barrier to access in care for beneficiaries as agencies will have to err on the side of not admitting patients if there is any possible room that the claim could be denied. In conclusion, I support CMS' efforts to address fraud and abuse in home health care, but I believe the Review Choice Demonstration will ultimately only create significant barriers to patient care. Thank you for your consideration. Sincerely, Jonathan Weber PT, DPT

First Name: Jonathan
Last Name: Weber
City: Thornton
Country: United States
State or Province: Colorado
ZIP/Postal Code: 80602
Email Address: jrweber50@hotmail.com
Organization Name:
Category:
Cover Page:

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CARLE FOUNDATION HOSPITAL

July 27, 2018

Seema Verma, Administrator
Centers for Medicare 84 Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10599
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-10599 Pre-Claim Review Demonstration for Home Health Services

Dear Ms. Verma:

On behalf of Carle Home Care, a division of Carle Foundation Hospital, located in Urbana, Illinois, we appreciate the opportunity to provide comments on the recent Notice regarding the collection of information under the Pre-Claim Review Demonstration for Home Health Services, CMS-10599. Carle is a vital regional healthcare provider in east-central Illinois, serving nearly 250,000 unique patients system-wide in 2017. Our system is comprised of a tertiary hospital, multiple ambulatory clinics, a surgery center, and other types of healthcare. Carle Home Care serves as one of the largest home health providers in the region, with an average daily census of over 300 patients in 2017 in our 19-county service area. We have reviewed the Notice with trepidation and outline the basis of our concerns below.

Carle Home Care works to be a leader in the delivery of healthcare with efficiency and value and we have been serving our communities since 1983. Carle Home Care employs 57 FTEs. As a Home Health provider in the state of Illinois, Carle Home Care was on the "front lines" of the previous demonstration and saw first-hand the issues that the claim affirmation process created. Under the previous implementation of the Pre-Claim Review Demonstration for Home Health, Carle Home Care worked tirelessly to achieve a high affirmation rate, 98.1%, by the time of the demonstration was suspended. The affirmation rate was one of the highest in the state and came only at the cost of several FTEs which were redirected from patient care to achieve compliance.

Upon the suspension of the previous Pre-Claim Review Demonstration for Home Health, Carle Home Care redirected the FTEs back to patient care. The suspension of the previous demonstration was appropriate, as the policy was fraught with concerns. At the time, the entire Illinois Congressional delegation expressed their concern about the "broad scope of the demonstration, its impact on beneficiary access to services, and the potential impact on Medicare costs due to delays in medically necessary services and readmissions," in their letter to former CMS Acting Administrator Andy Slavitt dated October 4, 2016. In direct response to the notice of additional information collection and restarting the demonstration in CMS— 10599, Carle Home Care is again concerned about a myriad of unknowns and high probability of increased paperwork burden associated with the notice.

The new choices CMS proposed to offer, which include a 100% pre-claim review, a 100% post-payment review, or a 25% payment reduction, present three very difficult options for home health providers large and small. A 25% payment reduction is not a viable choice for reputable organizations operating on thin margins. The

pre-claim and post-payment reviews both represent increased paperwork burdens which will not improve access for Medicare recipients.

Further, the proposal is the antithesis to the CMS *"Patients Over Paperwork"* initiative which calls for streamlining regulations to reduce unnecessary burdens, increase efficiencies, and improve the beneficiary experience. While Carle Home Care appreciates the effort of CMS regulators to weed out home health fraudsters in Illinois and other high population states, the implementation of the three choices without recognition of the reputation and high ethical standards of organizations such as Carle, increases the paperwork burden and decreases efficiencies for providers. Any proposal in this space must balance the need to combat fraud with the need for patients to access quality providers.

We recognize that CMS proposes a vague description of a target pre-claim review affirmation or postpayment review claim approval rate in the notice, however without additional clarity on how and when this target/rate could be reached by a reputable provider, the problem remains. If CMS moves forward with implementation of the burdensome regulation, we recommend, at a minimum, that CMS clearly outlines the target/rate goalposts for both home health providers and the Medicare Administrative Contractors (MACs). This new Pre-Claim Review Demonstration for Home Health proposal comes at a time when the industry is dealing with many new arduous regulations and by CMS own estimation will increase the paperwork burden by 670,375 hours each year. This is equivalent to over 300 new (or redirected) FTEs annually, which would produce no appreciable improvement in patient outcomes, and is likely to negatively impact the beneficiary experience. This proposal and other inefficient regulations on the industry take a clinician's valuable time away from their patients in favor of excessive paperwork.

In conclusion, Carle Home Care encourages CMS to move forward cautiously and work to ensure the delicate balance between access to quality care and reduction of fraudulent practices. Further, before the implementation of a Pre-Claim Review Demonstration in Illinois or any other state, we encourage CMS to provide robust education and training for the MACs as well as Home Health Agencies to ensure maximum communication. Finally, we respectfully request that CMS collaborate with industry stakeholders such as the Illinois Home Care and Hospice Council (IHHC) and the National Association for Home Care and Hospice (NAHC) toward a resolution that will work for reputable home health providers, Medicare beneficiaries, and CMS.

Respectfully submitted,

nifer WI en MSN, RN
Director
Carle Home Health Services
The Carle Foundation

Document Details

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Comment: July 30, 2018 The Honorable Seema Verma Administrator Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, Maryland 21244-1850 Submitted via regulations.gov Re: Issues for Consideration in the Review Choice Demonstration Dear Administrator Verma: The Alabama Association for Home Care (the AAHC), the sole Alabama Association exclusively representing Medicare certified Home Health Agencies in the State of Alabama dedicated to ensuring the quality, efficiency, and integrity of the Medicare home healthcare benefit for homebound seniors and disabled in Alabama, 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 May 31, 2018, regarding the Pre-Claim Review Demonstration (PCRD) For Home Health Services (Form Number: CMS-10599). As part of the proposed revisions to this demonstration, CMS has renamed the demonstration the Home Health Review Choice Demonstration (RCD). Since Palmetto GBA is the Medicare Administrative Contractor (MAC) for Alabama,

Alabama HHAs would eventual be subject to reimbursement burdens under RCD when it is expanded, AAHC appreciates CMS consideration to the AAHCs comments on RCD. Like all HHAs associations and their members, the AAHC supports home health policy reforms that promote the integrity of the Medicare Program and balance the goals of improving the quality of patient care, access to care, the efficiency of care delivery, and do not impose new, unproven and costly regulatory costs when current law and regulations, and program instructions are in-place that can achieved the above three goals. AAHC agree with the Administration that prior Home Health policy reforms, like the Pre-Claim Review Demonstration (PCRD), that were determine to be ill-conceived should be looked upon with a fresh eye to achieve everyones mutually desired goals and must not be implemented in the almost identically burdensome manner for providers and patients alike by simply making a few modification and renaming the earlier proposed demonstration the Review Choice Demonstration (RCD). Therefore, the AHHC urges that the RCD also be tabled and that CMS focus it resource and attention on the numerous regulatory processes HHAs must now comply with so that Fraud and Abuse is detected and stopped. These would include but not be limited to routine reviews by MACs, targeted reviews by UPICs and RACs. AAHC would concur with the American Hospital Associations comments that (1) we cannot support any reduction in access to care for beneficiaries seeking services from HHAs with no indication of fraud under the current reviews by MACs; RACs and ZPICs now UPICs. (2) CMS continued all-encompassing design needlessly imposes significant and unwarranted burdens on HHA, hospital, Skilled Nursing Facility and Physicians providers with no history of fraud. (3) Despite the far-reaching impact of the proposed RCD demonstration, CMS notice still does not provide a commensurate level of detail regarding either the rationale for this 100 percent review or the proposed implementation plan. (4) Like the AHA, AAHC is also concerned that the demonstration runs counter to CMS-led efforts to improve the HH prospective payment system (PPS) and episodes of care involving home health services. Failing a decision to suspend the RCD, AAHC appreciates the RCDs provision for an exemption, or Gold Standard, for providers who achieve a 90% or greater affirmation rate during initial review. While we believe that RCD is a step in the right direction, we request that CMS continue its productive discussions and work with HHA National representatives such as the National Association for Home Care (NAHC), the Partnership for Quality Home Health (PQHH), the ElevatingHome/Visiting Nurses Association of America (EH/VNAA)

and the American Hospital Association (AHA) to ensure that RCD is not implemented before policies, guidance, and training are fully developed and implemented. We appreciate the Administrations dedication to placing patients over paperworkRCD should be implemented in a manner consistent with this goal. AAHC agrees with and Incorporates by Reference the comments of these national organizations on the RCD with the hope that CMS will take proactive steps to work with them to ensure the RCD is successful for home healthcare beneficiaries, providers, and CMS. Respectfully, John G. Beard, MBA/JD President Alabama Association for Home Care c/o Alacare Home Health and Hospice 2400 John Hawkins Parkway Suite 104 Birmingham, AL 35244 205-981-8581 john.beard@alacare.com

First Name: JOHN
Last Name: BEARD
City: BIRMINGHAM
Country: United States
State or Province: Alabama
ZIP/Postal Code: 35244
Email Address: john.beard@alacare.com
Organization Name: Alabama Association for Home Care
Category:
Cover Page:

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Submitter Info

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HH prospective payment system (PPS) and episodes of care involving home health services. Failing a decision to suspend the RCD, AAHC appreciates the RCDs provision for an exemption, or Gold Standard, for providers who achieve a 90% or greater affirmation rate during initial review. While we believe that RCD is a step in the right direction, we request that CMS continue its productive discussions and work with HHA National representatives such as the National Association for Home Care (NAHC), the Partnership for Quality Home Health (PQHH), the ElevatingHome/Visiting Nurses Association of America (EH/VNAA) and the American Hospital Association (AHA) to ensure that RCD is not implemented before policies, guidance, and training are fully developed and implemented. We appreciate the Administrations dedication to placing patients over paperworkRCD should be implemented in a manner consistent with this goal. AAHC agrees with and Incorporates by Reference the comments of these national organizations on the RCD with the hope that CMS will take proactive steps to work with them to ensure the RCD is successful for home healthcare beneficiaries, providers, and CMS. Respectfully, John G. Beard, MBA/JD President Alabama Association for Home Care c/o Alacare Home Health and Hospice 2400 John Hawkins Parkway Suite 104 Birmingham, AL 35244 205-981-8581 john.beard@alacare.com

First Name: JOHN
Last Name: BEARD
City: BIRMINGHAM
Country: United States
State or Province: Alabama
ZIP/Postal Code: 35244
Email Address: john.beard@alacare.com
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Comment: RE: Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. My name is Jonathan Weber and I am a board certified clinical specialist in geriatric physical therapy. I work as a physical therapist for a home health agency with four locations in Colorado. I am also our agency's therapy clinical manager for the two offices in our northern region. I am extremely passionate about serving our patients in the home health setting and the goal of keeping patients in their own homes safely for as long as possible. I am very grateful that CMS has recognized some significant problems that exist in the setting and appreciative of the effort to address and correct these problems. However, I am worried the recently proposed Review Choice Demonstration will exacerbate instead of remedy those problems. The Review Choice Demonstration and the process it entails if adopted on a larger scale will not only fail to reduce Medicare appeals, it will drastically increase them. My

July 26, 2018
Seema Verma
Administrator
Centers for Medicare & Medicaid Services Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; CMS—10599.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,100 hospital-based home health (HH) agencies, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) agency information collection notice on the home health "Review Choice" demonstration. Specifically, the agency would revise the original demonstration, initially implemented in Illinois from August 2016 through April 2017, and implement it on or after Oct. 1, 2018. CMS states that the purpose of this demonstration is to improve procedures for the identification, investigation, and prosecution of potential Medicare fraud in the home health field.

In summary, the AHA urges CMS to not re-implement this demonstration as proposed. First, we cannot support any reduction in access to care for beneficiaries seeking services from HH agencies with no indication of fraud. Second, the across-the-board design would needlessly impose significant and unwarranted burden on providers with no history of fraud. Third, despite the far-reaching impact of the proposed demonstration, the agency's notice does not provide a commensurate level of detail regarding either the rationale for 100 percent review or the proposed implementation plan. Finally, we also are concerned that the demonstration runs counter to CMS-led efforts to improve the HH prospective payment system (PPS) and episodes of care involving home health services.

Instead, the AHA urges CMS to share its findings from the first iteration of the demonstration. Doing so would help fulfill the purpose of a demonstration, which is to study and, if possible, refine a potential future policy. In particular, the field has found that the initial demonstration did result in improved documentation practices, which raised the acceptance rate for pre-claim review submissions from 40 percent to more than 90 percent. However, we have no indication from the agency regarding any corresponding reduction in fraudulent behavior. The types of correctable documentation changes that occurred should be studied by CMS and shared with the national provider community. Doing so would be more fruitful than furthering the proposed, and likely ineffective, fraud reduction demonstration.

Background. The initial version of this demonstration, launched in Illinois in August 2016, required Medicare's pre-claim review for all HH services provided in five states: Florida, Illinois, Massachusetts, Michigan, and Texas. When it was paused in April 2017, it was active in Illinois and about to launch in Florida. The original demonstration was the subject of extensive concern from Congress, the AHA and the HH field based on its overly broad focus, targeting almost 1 million claims per year when fully implemented. Instead, we advocated that the agency should rely on available data analysis tools to specifically target the subset of providers with a high risk of fraud.

The proposed new version of the demonstration would present three options to HH agencies in Florida, Illinois, Ohio, North Carolina, and Texas:

- Participate in 100 percent pre-claim review until a certain "target affirmation" or "claim approval" rate is reached;
- Participate in 100 percent post-payment review until a certain "target affirmation" or "claim approval" rate is reached; or
- Submit claims without undergoing such reviews, but receive a 25 percent payment reduction on all claims and remain eligible for review by a recovery audit contractor (RAC).

We note that in the target states, of the 4,986 HH agencies, 179 are hospital-based providers. CMS states that the demonstration would run for five years and begin on or after Oct. 1, 2018 in Illinois, and would next expand to Ohio and North Carolina.

The Demonstration Would Reduce Beneficiary Access to Care

This demonstration would reduce access to care, especially for beneficiaries seeking care from smaller or mid-size home care providers. As we saw in Illinois during the initial demonstration, smaller providers are often unwilling to begin providing services until pre-claim review is completed. Specifically, they determined that beginning care prior to the completion of a pre-claim review was too financially risky.

In other words, they lacked the capacity to bear the risk associated with commencing care without reasonable assurance that Medicare payment would be provided. As a result, beneficiaries either were not able to use their HH agency of choice, or experienced delays in receiving care. In fact, more than 40 smaller HH agencies in the Illinois demonstration closed, in large part due to this problem. **These access challenges could be greatly mitigated by only implementing this demonstration for HH agencies with history of fraud or evidence of fraud risk.**

100 Percent Claims Review Is Excessive and Would Penalize Providers with No History of Fraud

The AHA strongly supports efforts to reduce fraud and abuse in the Medicare program. However, this demonstration would not focus on likely sources of HH fraud and abuse identified through data analytics. As such, rather than the proposed 100 percent audit approach, we encourage CMS to focus on interventions that target specific HH agencies, specific forms of fraudulent activities, or specific areas with likely fraudulent practices, as identified by the agency's analysis of Medicare claims. Such an approach would avoid burdening the entire HH field and all HH beneficiaries in the demonstration states, as well as already-overloaded Medicare contractors.

While we do not support the proposed version of the demonstration, should the agency proceed, we urge alignment between the chosen fraud-reduction intervention and known forms of fraud. Unfortunately, for either the initial or the proposed version of the demonstration, CMS did not discuss the prevalence of particular types of fraud in the demonstration states or how 100 percent claims audits would curtail such fraud in a manner more effective than other approaches. However, as reported by U.S. Assistant Attorney Stephen Chahn Lee in his *Law-Enforcement Observations About Home-Health Fraud*[1] presentation to stakeholders during a CMS open door forum, common forms of home health fraud include the following:

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Downloads/Special-Open-Door-Forum-on-Home-Health-Fraud.pdf.

- HH agencies paying kickback fees to primary-care physicians for referrals;
- Marketers shopping for physicians with no relationship to the patient who will certify a patient as being medically necessary for HH services;
- Nurses lying about patients' conditions during assessments to make patients seem sicker than they actually are;
- HH agencies creating false documentation to indicate that doctors and nurses are discussing patients' conditions and care, such as fake telephone orders;
- Nurses falsifying documentation to indicate that routine checkups are necessary; and

• Agencies discharging and then re-admitting patients at the same or related agency when there is no intervening change in the patient's medical condition;

As such, before advancing any new HH fraud intervention, we encourage CMS to detail which particular forms of fraud are being pursued and the evidence for the particular approach/es relative to the goals of identifying, investigating, and prosecuting HH fraud.
In addition, CMS states that the audits are partially designed to determine "if there is a suspicion of fraud." **However, imposing a 100 percent audit rate when the agency admittedly is still seeking evidence of fraud would be premature, excessive, and an irresponsible imposition of burden on beneficiaries as well as agencies with no history or evidence of fraud.**
Fortunately, there is a plethora of alternative interventions already underway by multiple fraud-fighting agencies. For example, since its inception in March 2007, the Medicare Fraud Strike Force charged more than 3,500 defendants who falsely billed the Medicare program for over $12.5 billion, as reported by the Department of Justice (DOJ) in May 2018. This laudable outcome reflects the joint initiative between the DOJ Criminal Division Fraud Section and the Department of Health and Human Services (HHS) to prevent and deter fraud and enforce current anti-fraud laws around the country. Another example of a multi-agency fraud initiative is the Health Care Fraud Prevention Partnership (HFPP). This involves CMS, DOJ, HHS Office of Inspector General (OIG), the Federal Bureau of Investigation, private insurers, states, and associations in the HFPP to prevent health care fraud on a national scale. To detect and prevent payment of fraudulent billings, the HFPP exchanges information and best practices across the public and private sectors, and, since 2013, has conducted eight studies that enabled substantive actions, such as payment system edits, revocations, and payment suspensions to stop fraudulent payments and improve the government's collective forces against fraud, waste, and abuse. The amount of data collected in support of HFPP studies increased by 300 percent in fiscal year (FY) 2016, leading to the performance of new studies, the replication of prior studies with new data and the attainment of actionable leads.
Under another tool, CMS targets particular providers through the agency's use of the Affordable Care Act authority to suspend Medicare payments to providers during an investigation of a credible allegation of fraud. CMS also has authority to suspend Medicare payment if reliable information of an overpayment exists. For example, CMS reports that during FY 2016, there were 508 payment suspensions that were active at some point during the fiscal year. These evidence-based interventions are clearly reducing Medicare crime, including HH fraud. **Given their success, the use of measures such as these, which stem from the detailed study of specific HH Medicare fee-for-service (FFS) claims patterns, should be expanded in lieu of across-the-board approaches.** We also continue to support proven tactics to

change HH payment policy, such as reducing the occurrence of HH high-cost outlier claims, and continuing the current moratorium on new HH Medicare provider licenses in high-fraud areas.
In addition, we urge CMS to look to the common-sense, intermediate measures already suggested by the field, including the following that the AHA supports:
• Targeting the subset of providers across the country, conditions, or specific areas for which CMS has evidence of fraud risk; or
• If CMS is determined to continue with implementing the proposed demonstration: o Mitigating administrative burden for non-fraudulent providers by lowering the targeted rate of claims review to a level far below 100 percent;
o Shifting the focus of the demonstration to identifying and disseminating opportunities to improve documentation; or
o Implementing optional pre-claim review, which would both reduce burden while still generating process and documentation improvement insights to share with the overall field.

Proposed Demonstration Misaligned with Other Reform Efforts

HH PPS Reform. **We also are concerned that the timing of the demonstration would result in unprecedented upheaval for the HH field given the pending overhaul of the HH PPS and other marketplace reforms.** Specifically, CMS has proposed a major re-engineering of the HH PPS for calendar year (CY) 2020. This follows extensive research that yielded a payment model shared with the field in 2016, proposed for implementation July 2017, and then withdrawn in November 2017. The scope of CMS's proposed reforms for CY 2020 cannot be overstated – they would be a complete departure from the payment model in effect since 2000. The proposed new HH PPS case-mix system would replace the reliance on a single payment driver – a patient's utilization of therapy – with a more comprehensive clinical profile. This new system design, which relies on a multitude of distinct factors to set payment, may reduce the prevalence of certain types of fraud. Regardless, transitioning to this new payment model would require comprehensive education and training. **As such, asking every HH agency in the demonstration states also to undergo 100 percent claims review would be excessive, especially for smaller providers.**
Alternative Payment Models. Many HH agencies are partnering with other providers, including hospitals, in new ways to improve clinical outcomes and lower overall spending. The resulting new protocols and clinical care pathways, as encouraged by CMS, often focus on more strategic use of the HH setting and are garnering the attention and resources of many of the top HH agencies in the nation. Unfortunately, the proposed demonstration, which targets a problem perpetrated by only a subset of HH agencies, would reduce the time and funds available to the agencies working

to improve episodes of care that involve HH services. **In other words, the proposed demonstration runs counter to CMS-sponsored efforts to improve episodes of care by streamlining transitions to home care, improving care protocols and reducing avoidable readmissions to hospitals.**

Information Collection Request Does Not Contain Adequate Level of Detail

The information collection request provides an inadequate level of detail given the complex scope of the proposal that would affect every HH agency in the targeted states.

Insufficient Detail Included in Notice. In CMS's one-and-a-half page notice describing the demonstration, the agency fails to describe lessons learned from the initial demonstration. It also fails to include an explanation of why the agency moved away from a sole focus on pre-claim review to also include a second option of post-payment audits. Further, CMS had indicated to the field that it was considering additional alternatives, such as not requiring 100 percent audits, but these options were not shared. This lack of information is insufficient to support such a broad demonstration.

In addition, CMS also failed to share information on:

- The amount and types of HH fraud in the targeted states compared to that of other states, in terms of number of claims and dollar impact;
- The amount of HH fraud within the targeted states, county, or local area, in terms of number of claims and dollar impact;
- The amount of HH fraud for particular conditions in the targeted states, county, or local area, in terms of number of claims and dollar impact; and
- The estimated cost-benefit ratio for a typical targeted fraud-fighting program, such as the DOJ and OIG examples noted above, versus across-the-board programs, such as this demonstration.

Notice Lacks Burden Estimate. As discussed, we expect that the proposed demonstration would cause excessive burden for both beneficiaries and providers, as well as CMS and its contractors engaged in both administering claims and appeals. Yet, the information collection notice provides no estimate of burden or, alternatively, alignment with the agency's paperwork reduction goals. The notice also lacks an estimate of claims that would be affected, although the agency estimated that the initial demonstration would affect 900,000 per year, when fully implemented. In addition, for any provider that opts out of 100 percent review to pursue the 25 percent penalty in combination with RAC review, we are concerned that an uptick in audits, denials, and appeals would tax the current Medicare appeals process for HH claims, which could contribute to an appeals backlog that threatens the financial wherewithal of smaller providers.

Lack of Detail on Transitioning from 100 Percent Review to Targeted Checks. Further, the notice's one sentence explanation of the mechanism proposed to allow HH agencies to reach a certain "target affirmation" or "claim approval" falls far short of the detail needed by stakeholders to understand the impact of the proposed demonstration. For example, it is unclear whether CMS or the contractor would set the target rates, what they would be, and whether all agencies across the demonstration states would be subject to the same or different rates.

Given our concerns with the proposed demonstration described above, if the agency wishes to proceed, the AHA urges CMS to re-issue another iteration of the proposal that takes into account the field's concern with the program and operational details.

We appreciate your consideration of these issues. Please contact me if you have questions, or feel free to have a member of your team contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels

Executive Vice President

Government Relations & Public Policy

concern with this stems from my agency's own recent experience with the Targeted Probe and Educate audits. We had several claims denied during this process in which the auditors drew very clinically inappropriate conclusions from our documentation which they used as grounds for a denial. In one case specifically the auditor reviewed our admitting clinician's SOC documentation of the Braden Scale and referenced the language in that tool that the patient was walking frequently outside the room at least twice a day and inside the room at least every two hours in the home as evidence that the patient was not homebound. This tool is specifically a measure of a patient's risk for skin breakdown and not in anyway correlated to homebound status nor is it intended for use in determining the safety of a patient's mobility. She also reviewed our therapist's evaluation of the patient's mobility which included 3 objective measures that classified the patient as a significant fall risk and supported her homebound status. The measures used are all very well supported in the literature as fall risk indicators. However, the physician's visit notes included phrases that said the patient's gait was, good and coordination was, good. The auditor made the argument that the documentation in the physician's notes did not corroborate our agency's documentation despite the fact that the physician also signed our PT's documentation which included a much more thorough and evidenced based assessment. My point in bringing this up is not to discuss the specifics of our recent denials but point out that there is far too much room for interpretation with respect to some of the issues that determine eligibility for home health services and whether documentation supports the need. The Review Choice Demonstration may ultimately cut down on improper payments and appeals for cases where agencies are not meeting basic requirements. But from what I have seen previously, auditors are reviewing cases with the intent to deny and searching for any possible grounds to make the argument that a claim does not meet the requirements. On top of that, I am concerned that auditors will have major incentives to deny with the Review Choice Demonstration. If CMS is going to have contractors reviewing every single claim, this will have to be a major cost which the agency I am sure is hoping to be offset by a reduction in improper payments. This creates an incentive whether direct or indirect for contractors to deny given the need to meet CMS' expectation. That is very alarming considering the fact that there is such wide room for these contractors to make the assertion that a claim should be denied. It is difficult for me to see how a

situation in which contractors are incentivized to deny claims while given substantial leeway in their ability to make a determination that a claim should be denied will lead to anything other than a sharp rise in appeals. Ultimately I fear that the end result of this will be that agencies begin to look at referrals from the standpoint of the likelihood a potential claim will get denied or affirmed instead of focusing on what the patients need. I am concerned this will cause a considerable barrier to access in care for beneficiaries as agencies will have to err on the side of not admitting patients if there is any possible room that the claim could be denied. In conclusion, I support CMS' efforts to address fraud and abuse in home health care, but I believe the Review Choice Demonstration will ultimately only create significant barriers to patient care. Thank you for your consideration. Sincerely, Jonathan Weber PT, DPT

First Name: Jonathan
Last Name: Weber
City: Thornton
Country: United States
State or Province: Colorado
ZIP/Postal Code: 80602
Email Address: jrweber50@hotmail.com
Organization Name:
Category:
Cover Page:

Document Optional Details

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Submitter Info

Comment: RE: Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services Dear Administrator Verma: I am writing in response to the request for comments on the Centers for Medicare and Medicaid Services (CMS) Review Choice Demonstration for Home Health Services. My name is Jonathan Weber and I am a board certified clinical specialist in geriatric physical therapy. I work as a physical therapist for a home health agency with four locations in Colorado. I am

also our agency's therapy clinical manager for the two offices in our northern region. I am extremely passionate about serving our patients in the home health setting and the goal of keeping patients in their own homes safely for as long as possible. I am very grateful that CMS has recognized some significant problems that exist in the setting and appreciative of the effort to address and correct these problems. However, I am worried the recently proposed Review Choice Demonstration will exacerbate instead of remedy those problems. The Review Choice Demonstration and the process it entails if adopted on a larger scale will not only fail to reduce Medicare appeals, it will drastically increase them. My concern with this stems from my agency's own recent experience with the Targeted Probe and Educate audits. We had several claims denied during this process in which the auditors drew very clinically inappropriate conclusions from our documentation which they used as grounds for a denial. In one case specifically the auditor reviewed our admitting clinician's SOC documentation of the Braden Scale and referenced the language in that tool that the patient was walking frequently outside the room at least twice a day and inside the room at least every two hours in the home as evidence that the patient was not homebound. This tool is specifically a measure of a patient's risk for skin breakdown and not in anyway correlated to homebound status nor is it intended for use in determining the safety of a patient's mobility. She also reviewed our therapist's evaluation of the patient's mobility which included 3 objective measures that classified the patient as a significant fall risk and supported her homebound status. The measures used are all very well supported in the literature as fall risk indicators. However, the physician's visit notes included phrases that said the patient's gait was, good and coordination was, good. The auditor made the argument that the documentation in the physician's notes did not corroborate our agency's documentation despite the fact that the physician also signed our PT's documentation which included a much more thorough and evidenced based assessment. My point in bringing this up is not to discuss the specifics of our recent denials but point out that there is far too much room for interpretation with respect to some of the issues that determine eligibility for home health services and whether documentation supports the need. The Review Choice Demonstration may ultimately cut down on improper payments and appeals for cases where agencies are not meeting basic requirements. But from what I have seen previously, auditors are reviewing cases with the intent to

deny and searching for any possible grounds to make the argument that a claim does not meet the requirements. On top of that, I am concerned that auditors will have major incentives to deny with the Review Choice Demonstration. If CMS is going to have contractors reviewing every single claim, this will have to be a major cost which the agency I am sure is hoping to be offset by a reduction in improper payments. This creates an incentive whether direct or indirect for contractors to deny given the need to meet CMS' expectation. That is very alarming considering the fact that there is such wide room for these contractors to make the assertion that a claim should be denied. It is difficult for me to see how a situation in which contractors are incentivized to deny claims while given substantial leeway in their ability to make a determination that a claim should be denied will lead to anything other than a sharp rise in appeals. Ultimately I fear that the end result of this will be that agencies begin to look at referrals from the standpoint of the likelihood a potential claim will get denied or affirmed instead of focusing on what the patients need. I am concerned this will cause a considerable barrier to access in care for beneficiaries as agencies will have to err on the side of not admitting patients if there is any possible room that the claim could be denied. In conclusion, I support CMS' efforts to address fraud and abuse in home health care, but I believe the Review Choice Demonstration will ultimately only create significant barriers to patient care. Thank you for your consideration. Sincerely, Jonathan Weber PT, DPT

First Name: Jonathan
Last Name: Weber
City: Thornton
Country: United States
State or Province: Colorado
ZIP/Postal Code: 80602
Email Address: jrweber50@hotmail.com
Organization Name:
Category:
Cover Page:

30 Association Drive, P.O. Box 227, Manchester, Maine 04351-0227
July 27, 2018
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Ph: 207-213-6125 | Fax: 207-213-6127
www.HomeCareAlliance.org
Division of Regulations Development
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Subject: CMS 10599 Pre-Claim Review Demonstration for Home Health Services
To Whom it May Concern,
On behalf the Home Care & Hospice Alliance of Maine and our member organizations we offer the following comment regarding the proposal to establish a revised pre-claim review demonstration project for Medicare home health services.
The return of pre-claim review, even with revisions, is premature and fails to address the design flaws of the original pre-claim review project. The initial pre-claim review demonstration project had a significant negative impact on patients and providers in the state of Illinois, damaging cash flow and causing delay in treatment in some cases. Altering the demonstration project to allow for pre-claim or post payment review confirms that CMS has not taken advantage of what it learned during demonstration project in Illinois in 2016-2017 where claims errors that related to documentation were ultimately limited to correctable paperwork errors.
Rather than replicate a flawed demonstration project, CMS should publically release all of the data from the original project to allow for an independent and thorough evaluation of the project, including an evaluation of the best alternatives to pre-claim review that can address any deficiencies uncovered through the analysis. With this information CMS and home care providers can institute appropriate corrective measures that do not needlessly increase administrative burdens and costs of care.
The home care community has presented multiple and less burdensome alternatives to CMS that we believe will be equally or more effective than pre-claim review. It would be prudent for CMS to look to these alternatives before requiring home health agencies to take staff away from patient care to chase after endless paperwork.
Thank you for the opportunity to provide comment on the pre-claim review demonstration proposal.
Sincerely,
Lisa Harvey-McPherson Laurie J. Belden Chair, Government Affairs Committee Associate Director

Alliance for Home Health Quality & Innovation
80 M St. SE, Washington, DC 20003 | 202-750-4428
www.ahhqi.org
July 26, 2018
CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development,
Attention: Document Identifier/OMB
Control Number CMS–10599, Room C4–26–05,
7500 Security Boulevard, Baltimore,
Maryland 21244–1850

SUBMITTED ELECTRONICALLY VIA REGULATIONS.GOV

RE: CMS–10599 Pre-Claim Review Demonstration for Home Health Services

To whom it may concern:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the Centers for Medicare and Medicaid Services' request for comments on the Paperwork Reduction Act (PRA) notice in the *Federal Register* proposing a new Pre-Claim Review Demonstration for home health services, in 83 Fed. Reg. 105 (May 31, 2018). The Alliance appreciates the opportunity to provide comments.

About the Alliance for Home Health Quality and Innovation

The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. For more information about our organization, please visit: http://ahhqi.org/.

The Alliance is supportive of comments submitted by our colleagues at the Visiting Nurse Associations of America and ElevatingHOME, the Partnership for Quality Home Healthcare, and the National Association for Home Care and Hospice. In addition to supporting these organizations' comments, the Alliance appreciates the opportunity to provide comments in the following topic areas: (I) burden on providers; and (II) using targeted means of addressing fraud, waste and abuse.

I. Burden on Providers

As addressed in our comments on the previous iteration of the Pre-Claim Review Demonstration, the Alliance remains concerned about the potentially excessive burden placed on providers through the demonstration. These concerns were belied by provider experiences in the first demonstration, which ultimately forced the pause and delay of the rest of the demonstration.

While the Alliance does appreciate the increased flexibility with the addition of post-payment review, concerns regarding potentially unnecessary administrative burden and infeasibility remain.

Firstly, home health providers will be locked in to the option they choose: pre-claim, postpayment, or waiver. However, whichever option is chosen may not be the best arrangement for every patient and situation, hindering the ability to provide optimal care to each patient individually. For those who choose the pre-claim review option, the issue of delays as a result of administrative capabilities remains. The pre-claim process makes prompt care difficult as there has been and will continue to be a lag in administrative review given the individualistic nature of the home health plan of care and the services provided by home health care. This will place undue burden on both providers and Medicare contractors to speed up the process in order to facilitate appropriate care.

Additionally, post-payment review has the potential to punish providers who administered care that was clinically necessary at the time the plan of care was written, but which may be deemed unnecessary later if a patient fails to progress as expected. Furthermore, concerns regarding lack of consistency with the previous demonstration, as well as continued concerns regarding documentation, may lead to providers choosing to implement pre-claim as they may fear the lack of clear understanding about what is expected with regard to paperwork will lead to payment denials for appropriate care already provided.

Overall, while the Alliance appreciates CMS's effort to address one of the concerns with the original PCRD demonstration and provide further documentation, questions remain and

concerns
regarding burden and access for providers and patients.

II. Importance of Pursuing Targeted Means of Addressing Fraud, Waste and Abuse

Targeting and eliminating fraud, waste, and abuse is a critical and important goal for CMS.
However, a blanket screening program for all home health services, rather than a targeted
approached, will cause the aforementioned undue burden on providers, with potential consequences for patients. Instead, the Alliance would appreciate the chance to work with CMS
on a more targeted approach to identifying fraud, waste, and abuse in home health care. As noted
in the Alliance's previous comments, using claims data to identify atypical billing practices is
one way to find providers who may be engaging in the bad behavior. CMS can then utilize that
information to continue investigations and see if there is suspected fraud without placing undue
burden on home health providers as a whole. Though there may be legitimate explanations for
aberrations in billing, this is one means of targeting agencies that may be committing fraud.

The Alliance and its members remain committed to helping CMS and the Office of the Inspector
General (OIG) to develop appropriate methods to investigate and prosecute fraud in home health
care. The Alliance recommends development of a public-private partnership or working group
that would support CMS and OIG's efforts in this area and would welcome the opportunity to
engage in such an endeavor.

* * *

Thank you for the opportunity to comment on this notice. Should you have any questions, please
contact me at jschiller@ahhqi.org.

Sincerely,

Jennifer Schiller
Director, Policy Communications & Research

July 25, 2018

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number 0938-1311
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-10599, Pre-Claim Review Demonstration for Home Health Services

Dear Administrator Verma:

AARP appreciates the opportunity to comment on this important information collection request regarding the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Pre-Claim Review Demonstration for Home Health Services. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

CMS proposes a five-year demonstration in Illinois, Ohio, North Carolina, Florida, and Texas in which all home health agencies would choose between 100 percent pre-claim review, 100 percent postpayment review, or not undergoing such reviews but receiving a 25 percent payment reduction for all claims submitted for home health services. Providers selecting this third option may be eligible for review by Recovery Audit Contractors (RACs). While AARP supports CMS' goals of developing improved procedures to identify, investigate, and prosecute fraud and protecting Medicare from improper payments, AARP is very concerned about the impact of this proposed demonstration on Medicare beneficiaries and their families and urges CMS to reconsider the parameters of this demonstration. 2

AARP is concerned that the proposed Pre-Claim Review Demonstration, renamed the Home Health Review Choice Demonstration, would reduce or delay necessary home health services for Medicare beneficiaries, which could result in increasing hospital lengths of stay and readmissions. Medicare beneficiaries receiving home health care must have it ordered by a physician, be homebound, need part-time or intermittent skilled nursing care or therapy services, and meet other criteria. Beneficiaries commonly receive home health care after an inpatient hospitalization and they need timely access to care. However, prior hospitalization is not a requirement for Medicare home health services. In fact, many beneficiaries may find these services allow them to stay in their homes while avoiding hospitalization.

Medicare beneficiaries who need home health are most often not in a position where they can wait for pre-claim review. Without timely access to necessary care, they may risk adverse consequences that reduce their quality of care and cost Medicare more money. Medicare home health beneficiaries tend to be older and sicker and are often at critical points in their care when they need home health services. Under the revised demonstration, a Medicare Administrative Contractor (MAC) has ten days to inform the home health agency (HHA) that their pre-claim review has been given an affirmative or non-affirmative decision. CMS notes that a HHA *may* begin providing home health services prior to submitting the pre-claim review request and may continue to do so while waiting for a decision. According to CMS, in that way, beneficiary access to treatment will not be delayed, and an agency may make an unlimited number of resubmissions for the pre-claim review request in order to make any needed changes to receive a provisional affirmed decision. However, an agency does not have to begin providing home health services prior to submitting the pre-claim review request, and this means an agency has to be willing to provide care upfront before knowing they will be paid for the care. This could present a serious deterrent to an agency's willingness to provide home health to a large number of beneficiaries, especially those who are not expected to improve, but rather rely on home health to maintain their function or prevent or slow decline. Even postpayment review makes many agencies extremely hesitant to serve such beneficiaries, despite their eligibility for Medicare home health if they meet all the necessary criteria. While Medicare may recoup some payments for claims, post-payment review also does not necessarily prevent fraud if the payment is made first and then the review is done. In fact, the option to accept a 25 percent cut in claims payment may essentially be no choice at all.

While beneficiary notifications are important, the pre-claim review could create additional paperwork and administrative burden for Medicare beneficiaries and their family caregivers, often at a vulnerable and stressful time when the focus should be on receiving necessary care, ensuring smooth care transitions, and enabling the beneficiary to live in their own home. CMS observes, "HHAs or beneficiaries participating in this option must submit a pre-claim review request before the claim is submitted for payment." Medicare beneficiaries or their family caregivers should not have to submit a pre-claim review request. Having them do so is counter to patients over paperwork. Patients should not have to submit this paperwork to get the care they need in demonstration states. 3

AARP also notes that CMS attempted an earlier version of this demonstration in multiple states, that it was only implemented in one state and paused after a year, and even in that one state, there were issues with the demonstration.[i] The demonstration also relies on MACs appropriately administering Medicare coverage of home health under the law. Given the challenges for beneficiaries who need and rely on home health to maintain their function or prevent or slow decline, it is critical that MACs and reviewers correctly understand and accurately implement the law. We are concerned that MACs will not be prepared to review all the claims that would require review under the demonstration.

[i] https://homehealthcarenews.com/2018/05/home-health-ready-to-fight-pre-claim-reviews-dreaded-return/, https://homehealthcarenews.com/2016/10/lawmakers-urge-cms-to-halt-pre-claim-in-illinois/, http://www.medicareadvocacy.org/home-health-pre-claim-review-demonstration-model-take-two/

We suggest CMS consider a more targeted approach, such as focusing more on certain providers using predictive analytics or other tools to target fraud, waste, and abuse, or engaging stakeholders to help develop appropriate tactics to combating fraud and abuse, rather than this overly broad and arbitrary demonstration for all Medicare beneficiaries in these five states. We urge CMS to not move forward with this demonstration and instead consider other ways to achieve its objectives. In addition, the private sector often follows Medicare's lead, so any problems beneficiaries have with this approach in Medicare could be exacerbated if private insurers also use the demonstration's approach and it leads to individuals not receiving necessary home health services.

Thank you for the opportunity to comment on this information collection notice and for your consideration of our comments that the proposed demonstration could have adverse consequences for Medicare beneficiaries and their family caregivers in Illinois, Ohio, North Carolina, Florida, and Texas. If you have any questions, please contact me or Rhonda Richards on our Government Affairs staff at rrichards@aarp.org or (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs

July 30, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma Administrator Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, Maryland 21244-1850

Re: CMS -10599/0938-1311 Review Choice Demonstration for Home Health Services

Dear Administrator Verma:

Amedisys, Inc. ("Amedisys") is a national home health and hospice provider with over 16,000 employee serving patients in 36 states through more than 400 Medicare-certified home health and hospice agencies, as well as personal care services. We appreciate the opportunity to respond to the Paperwork Reduction Act (PRA) notice published in the Federal Register on May 31, 2018 seeking public comment on the revised demonstration, previously known as Pre-Claim Review Demonstration for Home Health Services (PCR).

It is our understanding that 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 providing services for Medicare beneficiaries.

Amedisys joined its industry colleagues in opposition to the original PCR during the comment period in spring of 2016. Thereafter, we continued to communicate with the industry and others in demonstrating how burdensome PCR was on our clinicians and operators. CMS' willingness to suspend the demonstration in March 2017, before the scheduled implementation in Florida, was welcome news. While we were surprised to hear of the release of a revised PCR, now called the Review Claim Demonstration for Home Health Services, we are cautiously optimistic because the proposed revisions address some of the concerns we had with the original demonstration. However, we still do harbor some concerns due to the lack of involvement of the industry in the development of the revised demonstration, the failure to disclose any data and/or lessons learned from PCR in Illinois and unanswered questions that remain as comments are due. Accordingly, we offer the following comments and questions in response to the PRA notice:

Ninety Percent Targeted Affirmation Rate

One of the biggest perceived improvements in the revised demonstration and one advocated for by providers during the initial demonstration was for providers who showed a sufficiently high affirmation rate to be relieved of the burden of pre-claim review. In the Revised Supporting Statement, CMS proposes to create a threshold for agencies, after which they would no longer be required to participate in pre- or post-claim review. Once a HHA reaches the target pre-claim review affirmation or post-payment review claim approval rate, it may choose to be relieved from claim reviews, except for a spot check of 5 percent of their claims to ensure continued compliance."[1] While we applaud CMS for allowing providers who have achieved the targeted affirmation rate to be removed from the demonstration; however, we do have the following questions:

[1] Paperwork Reduction Act Supporting Statement Part A, page 2, paragraph 3.

1. Upon what is the 90 % approval based?

2. If a provider has ten claims/pre-claims submitted and passes a minimum of nine during the first week of the demonstration, is that provider exempt from further review (except for the referenced 5% spot check)?

3. Please provide concrete examples and scenarios about both the 90% targeted affirmation rate and the subsequent 5% spot check.

4. For those providers in Illinois that achieved 90% affirmation rates prior to the March 31, 2017 suspension of PCR, will they be required to participate in the revised demonstration or will they be deemed to have already reached the target affirmation rate?

5. Will there be a formal notice of an HHA reaching the targeted affirmation rate? If so, will that come from the CMS or the MAC?

6. What is the frequency of the "spot checks", and would there be consideration of eliminating or decreasing the spot check altogether if the HHA continues to show a sustained rate of 90% or better over time?

7. What happens if an agency fails a spot check?

8. Will there be an appeal mechanism prior to reinstituting the review?

9. Will CMS consider aggregating multiple providers that share common ownership once a specific % of the overall commonly owned providers reach the targeted 90% compliance?

Required Documentation Questions/Comments

1. Will providers be able to estimate how many episodes may be required for a patient to reach their goals and request a review for the entire admission up front?

2. Could CMS please explain the benefit of requesting multiple episodes if subsequent plans of care must be submitted for an affirmed episode to obtain additional affirmation? Would the physician orders and Plan of Care (POC) require physicians' signatures prior to release?

3. The requirement to wait to receive the physician's signature places an undue burden on agencies and increases the burden to achieve timely submission of pre-claim review. Currently, the RAP is paid prior to signature on the POC. While we agree that HHA's may have influence over this process, providers are not able to control the timeliness of physicians' responses.

4. Do ***all*** of the previous guidance and FAQs from the PCR demonstration apply?

Other Questions/Concerns/Clarity Needed

1. In Question 4 of the FAQs, CMS states that "increased evidence of fraud, waste or abuse" will dictate whether the demonstration expands outside of the announced five states. Will CMS provide substantive findings of evidence of fraud, waste or abuse, clearly distinguishing between these finding and "improper documentation"?

2. Are effective dates for each state yet available? What notification will be provided related to expansion of the demonstration?

3. We would again recommend that CMS consider a more targeted approach in each State, focusing in on specific counties where fraud has been suspected?

4. Has CMS considered the trending decline in the improper payment rate for home health and the role documentation requirements have played?

5. What does this mean for areas where there is ongoing Targeted Probe and Educate (TPE) activity?

6. Will TPE activity continue in addition to the demonstration?

7. How will the demonstration impact other audits performed by ZPIC/UPIC, RAC, P&E? Will these activities continue in demonstration states?

8. We would request that CMS instruct the MACs to utilize the same reviewer to review subsequent episodes to decrease inconsistencies between reviewers.

9. Will the face-to-face documentation be required on subsequent episodes of care if the first episode of care is affirmed with the initial face to face documentation?

10.Does an affirmative pre-claim review remain valid when the patient experiences a significant change in condition necessitating a change to the Plan of Care?

Amedisys appreciates the opportunity to comment on this demonstration and seeks to partner with CMS on policy impacting seniors in their homes. This includes all public policy impacting home health, hospice, chronic-care, care delivered at home, and end-of-life care, as well as the impact of post-acute care policy has on the broader healthcare population. If you have any questions, feel free to contact me at 615-928-5494.

Sincerely,

Susan Sender, RN, BSN, CHCE
SVP & Chief Clinical Officer
Amedisys, Inc.

Document Details

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Document Optional Details

Submitter Info

Comment: Thank you for the opportunity to comment on the proposal for Doc#2018-11492, CMS-10599 Pre-Claim Review Demonstration. As a veteran home health provider and individual Medicare recipient, I am requesting that you cancel or at least postpone this proposed demonstration until there is time for CMS to work with veteran home health leaders to identify a better way to crack down on fraud and address any waste and abuse within the home health community. Clearly, the vast majority of individuals and agencies within the home health industry are opposed to fraud, abuse and waste within the home health program. In fact, the home health industry persisted in raising awareness of issues of fraud and abuse in Florida to local, regional and federal entities for several years prior to the eventual investigation and crackdown in Florida several years ago. CMS implemented a home health pre-Claim Review Demonstration project previously in Illinois, that had to be cancelled prior to expanding it to other states because of unresolved issues with the efficacy of the program. While this new demonstration project offers home health agencies a choice of review options, many of the original problems with the

first demonstration continue to exits. The most significant issue related to Home Health pre-claim reviews is the expectation that physicians can adequately document the specifics to demonstrate patients meet the home health eligibility requirements. This requirement is unrealistic since failure to completely or properly document patient's needs has no financial or programmatic impact on the physicians and is seen as extra unnecessary work in their already busy schedule. The issues related to inadequate physician documentation of the FACE TO FACE requirement and other eligibility requirements is widely acknowledged by home health agencies, Medicare Administrative Contractors, in OIG reviews and by many within CMS as well. As long as there is no way to hold the physician responsible for inadequate documentation and not allowing home health documentation to support the eligibility requirements, there will continue to be major issues with the pre-claim review process. Denials under this program have consistently resulted in major financial losses to home health agencies and also lost opportunities for care for patients since agencies were forced to hold services waiting for adequate physician documentation that often was never submitted. While CMS has indicated actions to directly address this major issue, they have still not been implemented and until they are resolved, home health agencies will continue to be at risk for major financial losses that are not sustainable over time. ========= As a registered nurse, I have worked in and with multiple types of home health providers throughout the country for the last 20 years in a multitude of roles including 10 years focusing on evaluating Medicare regulatory and Coverage compliance. In this role, it has been clear that home health agencies are continually striving to ensure they are in compliance with all regulations. Dollars and manpower needs to focus on identifying the few agencies that are involved in fraud, abuse and waste of Medicare funds rather than focusing on the total number of agencies. It is clear that there is considerable data available to aid CMS and its contractors to focus on those agencies at high risk of inappropriate actions and abuses of the Medicare system and poor quality outcomes rather than subjecting the entire industry and CMS to unnecessary time and costs. Thank you for your consideration of these comments
First Name: Judy
Last Name: Adams
City: Durham
Country: United States

State or Province: North Carolina
ZIP/Postal Code: 27713
Email Address: jradams31@gmail.com
Organization Name: Adams Home Care Consulting
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/29/2018
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Status Set By: Public
Component:
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1

Submitter Info

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Country: United States
State or Province: North Carolina
ZIP/Postal Code: 27713
Email Address: jradams31@gmail.com
Organization Name: Adams Home Care Consulting
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0433
Current Document ID: CMS-2018-0071-DRAFT-0433
Title: FL
Number of Attachments: 0
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Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/29/2018
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Submitter Info

Comment: Re: Agency Information Collection Activities; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services. On behalf of home health providers in the state of Florida, I would like to comment on the proposed Pre-Claim Review (PCR) Demonstration Request by CMS. We at one of the home health providers located at the Treasure Coast of Florida are concerned about the implications and unintended consequences of this proposed PCR demonstration. CMS is unfairly subjecting HHAs to a very complex and burdensome pilot program and demonstration that is not guaranteed to combat the fraud and abuse it purported to identify and prosecute. This demonstration unfairly and arbitrarily scrutinizes all HHAs in the selected states, regardless of those who have already established a history of compliance with the existing rules and regulations. There is already existing mechanism and audit tools that the Medicare Administrative Contractor (MAC) like Palmetto GBA are already engaging such as Targeted & Probe & Educate (TPE), PEPPER Reports. Pursuing to implement this demonstration will increase the administrative and financial costs associated

with complying with the demonstrations requirements which will force the HHAs to reduce wages or eliminate positions and redirect their staff away from clinical care and toward compliance with duplicative and onerous documentation and clinical records requests. This will limit the HHAs capability to provide care and services to medically complex and functionally impaired patients. The providers are expected to appropriately develop and execute a discharge plan for their patients but how can you do it if they are in fear that the services will not be covered. It goes also without saying that it will also negatively impact the beneficiaries access to home health care services. The risk to the beneficiaries cannot be understated. This PCR demonstration is also coming in the heels of other regulatory challenges like HH Value Based Purchasing (HHVBP), COP, TPE, ZPIC, RAC, to name a few. This burdensome demonstration will stretch the meager resources of HHAs while reimbursement rate is being consistently cut, thereby resulting to possible unintended consequences of: (a) closing majority of the doors of HHAs; (b) changing the process of providing HH services to beneficiaries whereby the care decisions of clinicians are override by the projects auditors who will deny claims without consideration of the beneficiaries individual need for care and total condition. Giving this significant clinical decision making authority to the third party contractor for this project is not appropriate and justifiable in accordance with Medicare coverage guidelines; (c) Runs counter to the CMS recent pronouncements of modernizing Medicare Program by giving clinicians more face-to-face time encounter with their patients rather than spending more time with the computer documenting to justify to insurance for reimbursement. We hope CMS will take into consideration the above stated concerns as the benefits does not outweighs the negative outcomes of this PCR demonstration.

First Name: Susan
Last Name: Perry
City: Port Saint Lucie
Country: United States
State or Province: Florida
ZIP/Postal Code: 34952
Email Address: sperry@mihom.com
Organization Name:
Category:
Cover Page:

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City: Port Saint Lucie
Country: United States
State or Province: Florida
ZIP/Postal Code: 34952
Email Address: sperry@mihom.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0205
Current Document ID: CMS-2018-0071-0220
Title: IL
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Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Posted
Received Date: 07/13/2018
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Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Tracking Number: 1k2-9493-vcmx
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Submitter Info

Comment: Sir/Ma'am: Alphonsa Home Health Agency, if given the chance, prefers pre-claim review on 100% of claims. This way, we know that we are on the right path every time, and with lesser worries of risk of losing payment for skilled services rendered. Being a small home health agency, all financial resource matters in order to provide high quality expected care. Thank you very much. Sincerely, Rosamma Philip RN Agency Supervisor
First Name: Rosamma
Last Name: Philip

City: Elmhurst
Country: United States
State or Province: Illinois
ZIP/Postal Code: 60126
Email Address: alphonsahhc@gmail.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0183
Current Document ID: CMS-2018-0071-0211
Title: KY
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Submission Type: Web
Number of Submissions: 1

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Page Count: 1
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Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health

Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Gaylene
Last Name: Carl
City: Wurtland
Country: United States
State or Province: Kentucky
ZIP/Postal Code: 41144
Email Address: gaylene_carl@bshsi.org
Organization Name:
Category:

Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0205
Current Document ID: CMS-2018-0071-0220
Title: IL
Number of Attachments: 0
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Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
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Received Date: 07/13/2018
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City: Elmhurst
Country: United States
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ZIP/Postal Code: 60126
Email Address: alphonsahhc@gmail.com
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Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0231
Current Document ID: CMS-2018-0071-0222
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
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Submission Type: API
Number of Submissions: 1

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File Code:
Tracking Number: 1k2-94b7-2a6t
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Submitter Info

Comment: As a leader in my home health agency and a true advocate for quality home health care, I am writing to request that you contact the Centers for Medicare and Medicaid Services (CMS) and urge the agency not to finalize the Review Choice Demonstration for Home Health Services. My specific concerns include the following: The Review Choice Demonstration Will Hinder Patient Access. Instituting 100% pre-claim or post-payment review, or minimal review with a 25% payment reduction, will force home health agencies (HHAs) to reduce wages or eliminate positions altogether to compensate for the

increase in administrative and financial costs associated with complying with the demonstrations requirements. HHAs, referring physicians, and other clinicians on the beneficiarys care team will be forced to redirect staff time away from the beneficiarys clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. I have concerns that the demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired beneficiaries. The Review Choice Demonstration will impose undue administrative and financial burden on providers. CMS is disproportionately subjecting HHAs to complex and burdensome Medicare pilot programs and demonstrations. This demonstration is a duplicative process of oversight that will only add to the administrative burdens that already plague HHAs. The demonstration unfairly and arbitrarily scrutinizes all HHAs in the selected states, even those with long-established records of compliance with existing rules and regulations. The Review Choice Demonstration will take care planning decisions away from HHA clinicians. The beneficiarys care team strives to ensure the beneficiary receives appropriate care, at the appropriate time, in the right setting, based on clinical considerations. It is the responsibility of the provider, such as the physical therapist or registered nurse, to make judgments that are in the best clinical interests of the beneficiary. However, the demonstration, in effect, overrides the judgment of the provider, redirecting the care decision-making process to Palmettos medical review staff, individuals who frequently make medical denial decisions without consideration of the beneficiarys total condition and individual need for care. In essence, this demonstration is contradictory to CMSs top priorityto put patients first. I believe the demonstration falls short of being sufficient as a program integrity tool to offset the downside risks to Medicare beneficiaries and HHAs. As your constituent, I request that you contact CMS on my behalf and strongly urge them not to move forward with the Review Choice Demonstration for Home Health Services unless and until CMS can ensure that beneficiaries access to home health care services will not be threatened. Please do not hesitate to reach out to me if you have any questions or need any additional information. Thank you for your consideration.
First Name: Carlos
Last Name: Morales
City: Lubbock

Country: United States
State or Province: Texas
ZIP/Postal Code: 79424
Email Address: cmorales@chhsi.com
Organization Name: Caprock Home Health Services, Inc.
Category:
Cover Page:

17410 College Parkway, Suite 150 • Livonia, MI 48152 • 877-827-0788 • TrinityHealthAtHome.org

July 30, 2018

Administrator Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2016-0012-0001
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–10599 Medicare Review Choice Demonstration; Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Review Choice Demonstration for Home Health Services.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 90 hospitals, 120 continuing care programs—including PACE, senior living facilities and home care and hospice services that provide nearly 2.5 million visits annually. Our delivery of home health includes services in Florida, Ohio, and Illinois, all of which are states included in the proposed pre claim review demonstration.

CMS has proposed a Review Choice Demonstration which is similar to the prior Pre Claim Review Demonstration Project, which is intended to assure that payments for Home Health services are appropriate before the claims are paid, with the aim of preventing fraud, waste and abuse in a more consistent and standardized manner. The information CMS seeks will be obtained through Medicare contractors for two specific purposes; to determine proper payments are approved for qualified value-based programs, and to determine if there is suspicion of fraud. These CMS contractors will require information from home health providers in advance to determine appropriate payment and qualification for the proposed program and this would become standard operating procedure necessary to submit billing claims.

Trinity Health has several concerns with this new iteration of the demonstration. We know from our experience with this demonstration in 2016 that this policy could impair our ability to serve patients and add layers of administrative and management burden, while having little ability to detect and combat additional fraud. In fact, there was never an announcement that delineated any fraudulent activity being intercepted or any charges brought as a result of pre claim review findings following the prior program in 2016. In fact, it is not clear what if any effect that demonstration had on fraudulent activity. On the contrary most errors that were found during that time were simply human errors or clerical errors that were corrected during the process. The targeted probe and educate and other ADRs already find those kinds of errors and result in paybacks or appeals. The Pre-Claim Review Demonstration was a costly program, approximately a $400 million expense that resulted in no demonstrated fraudulent findings.

17410 College Parkway, Suite 150 • Livonia, MI 48152 • 877-827-0788 • TrinityHealthAtHome.org

Illinois agencies generally reached levels of affirmation around 90% by the end of the program, so it is counter-intuitive that the program would start with Illinois again when they have already demonstrated such a high level of compliance. Calling this a Review Choice Program is really a misnomer because agencies effectively have no choice but to participate or have 25% of their revenue taken away. We urge CMS, instead of moving forward with this demonstration, to continue working with industry leaders to develop appropriate and targeted approaches to identify and eliminate fraud and abuse.

Adverse Implications for Improved Patient Outcomes and Costs of Care Without Intended Benefit

We learned from this program in Illinois that it took the skill of the current clinical full time resources in the office and an additional full time employee that we had to hire in order to manage the submission process because there are some clinical questions in the submission workflow in Palmetto's website. This is additional cost to recruit, hire and train, and also takes that critical nursing resource out of patient care which is where it belongs.

Uncertain Target Claim Affirmation or Approval Rate

The announcement of the possibility of reaching a target rate thus stopping the pre claim review for an agency is a welcome change to the prior program. However, since there is no explanation of what that rate may be or how long that rate would have to be sustained it is also worrisome and continues to foster uncertainty for the industry. Would that rate be calculated on only initial submissions, subsequent submissions? Would it be a rolling time frame or calculated one month at a time? For instance if calculated on a rolling year it could take years to be relieved of this program, if calculated month to month, it may only take several weeks to be relieved. This makes it very difficult to anticipate the staffing needs of this program.

Adverse Impact on Revenue Cycle

In the prior program, the pre-claim review submission process took approximately one hour per claim. So considering that one person could only complete 8-10 of these submissions per day, if the agency has more than 10 admissions per day as our agency did, the agency is starting out behind in revenue cycle. Within a month or so of this program beginning, we were behind in billing by tens of thousands of dollars. From a cash flow perspective, this is not possible to sustain business operations.

Uncertainty Around Submission Process

During the last demonstration it took months for Palmetto to implement an efficient web based submission process. With the new program, it is uncertain whether Palmetto will start out using the same process, or implement something new that then needs to be refined over time. Also previously, at times documentation would be submitted and non-affirmed then resubmitted with no changes and be affirmed. This seems to reflect a lack of inter-rater reliability among the staff reviewing these records and it created uncertainty and a lack of predictability among providers as to how to comply.

Conclusion

CMS has already implemented extensive regulatory requirements, safeguards, criteria, and accountability mechanisms in the home health care industry, including the face-to-face requirements, episode payments, value-based purchasing, the Program for Evaluating Payment Patterns Electronic Report (PEPPER), and mandatory performance reporting. Through additional documentation requests, review and auditing, CMS already has in place the capability to deny inappropriate admissions to home health. These current programs include sufficient oversight of home health to identify patterns of inappropriate admissions.

Any proposal would be better suited to target specific agencies suspected of fraud, rather than implement an across-the-board, sweeping approach for every agency to get prior-authorization before submitting a claim. CMS has the data to target suspected fraud and abuse, therefore efforts such as this would be better focused to further identify and address these bad actors, not create all of the above unintended consequences for patients, providers, and CMS.

In our Trinity Health home health ministries, we are committed to program integrity and work diligently to ensure quality and integrity in our service delivery. Our ministries have done very well in CMS' retrospective review to meet current criteria and standards.

An across-the-board pre claim review is a redundant procedural step that will impact access to care and raise administrative costs with little or no return in quality of care. Providers already submit information to CMS on the proposed scope and duration of care, and CMS can already recover payments for care that is later deemed unsubstantiated. We stand ready to work with policymakers to advance appropriate and targeted program integrity measures, rather than risk access to necessary care for vulnerable patients.

We thank CMS for the opportunity to provide input on this issue. If you have any questions on our comments, please feel free to contact me directly.

Sincerely,

Elizabeth Buckley, RN, BSN, JD, CPHRM Integrity & Compliance Officer Trinity Health At Home
734-343-6535
Elizabeth.buckley@trinity-health.org

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
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Phase Sequence: 1
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Title: TX
Number of Attachments: 0
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Posting Restriction: No restrictions
Submission Type: API
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Document Optional Details

Submitter Info

Comment: Dear Administrator Verma, I appreciate the opportunity to submit comments regarding the proposed Medicare Pre-Claim Demonstration. As a long-time home health nurse who now works for a management company who manages home health care, I am very concerned about the negative impact the Review Choice Demonstration on our patients and home health agencies. I do understand that there are some agencies who are fraudulent; however, I feel most agencies desire to do a good job and serve our patients well. This Demonstration is unreasonable because the states involved have already been through the Probe and Educate. This method was much more reasonable than a 100% review of an agency's charts. Whiles I appreciate there will be no delay in the provision of medically necessary care for Medicare beneficiaries, this process will pose an undue financial burden on agencies who will not receive reimbursement for a non-affirmed pre-claim review. In Illinois, we saw the hardship of uploading the required information to a government-contracted system that was not prepared for the volume of received reviews. It was both a financial and administrative hardship for the Illinois home

health agencies. The cost to the federal government to reimburse MACs for this Demonstration is excessive and don't approach the theoretical cost savings expected from this program. Surely there is a more reasonable solution. I do not believe CMS' efforts to identify, investigate and prosecute Medicare fraud is supported by this proposed Demonstration. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. Perhaps a trial process with a few home care providers with high billing error rates could be implemented before a statewide process is enacted. Please do not go forward with this Demonstration. It simply does not make financial sense and will cause undue burden on the many home health agencies who are honest. Sincerely, DeAnn Briscoe, RN

First Name: DeAnn
Last Name: Briscoe
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 76210
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ih-egk4
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Dear Administrator Verma, I appreciate the opportunity to submit comments regarding the proposed Medicare Pre-Claim Demonstration. As a long-time home health nurse who now works for a management company who manages home health care, I am very concerned about the negative impact the Review Choice Demonstration on our patients and home health agencies. I do understand that there are some agencies who are fraudulent; however, I feel most agencies desire to do a good job and serve our patients well. This Demonstration is unreasonable

because the states involved have already been through the Probe and Educate. This method was much more reasonable than a 100% review of an agency's charts. Whiles I appreciate there will be no delay in the provision of medically necessary care for Medicare beneficiaries, this process will pose an undue financial burden on agencies who will not receive reimbursement for a non-affirmed pre-claim review. In Illinois, we saw the hardship of uploading the required information to a government-contracted system that was not prepared for the volume of received reviews. It was both a financial and administrative hardship for the Illinois home health agencies. The cost to the federal government to reimburse MACs for this Demonstration is excessive and don't approach the theoretical cost savings expected from this program. Surely there is a more reasonable solution. I do not believe CMS' efforts to identify, investigate and prosecute Medicare fraud is supported by this proposed Demonstration. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. Perhaps a trial process with a few home care providers with high billing error rates could be implemented before a statewide process is enacted. Please do not go forward with this Demonstration. It simply does not make financial sense and will cause undue burden on the many home health agencies who are honest. Sincerely, DeAnn Briscoe, RN

First Name: DeAnn
Last Name: Briscoe
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 76210
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0422
Current Document ID: CMS-2018-0071-DRAFT-0422
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: Our organization successfully completed the probe and educate with 100% compliance; therefore it is unnecessary to subject organizations that are complying with all the state and national regulations to unwarranted scrutiny in an effort to flush out the offenders. I firmly believe that agencies who have demonstrated compliance should not have to endure further scrutiny. Why not consider sampling (i.e. probe and educate) as this method can accomplish the same thing (i.e. identify the agencies who are not complying with rules and regulations) as opposed to an extensive pre or post claim review. Consequently, agencies in small cohorts who are dedicated to putting patients first are being forced to incur additional unwarranted expenses to keep up with the unpredictable demands from individuals who has no concept of home health and the many demands.
First Name: S
Last Name: G
City:
Country: United States
State or Province: Florida

ZIP/Postal Code: 33431
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-76yg
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Our organization successfully completed the probe and educate with 100% compliance; therefore it is unnecessary to subject organizations that are complying with all the state and national regulations to unwarranted scrutiny in an effort to flush out the offenders. I firmly believe that agencies who have demonstrated compliance should not have to endure further scrutiny. Why not consider sampling (i.e. probe and educate) as this method can accomplish the same thing (i.e. identify the agencies who are not complying with rules and regulations) as opposed to an extensive pre or post claim review. Consequently, agencies in small cohorts who are dedicated to putting patients first are being forced to incur additional unwarranted expenses to keep up with the unpredictable demands from individuals who has no concept of home health and the many demands.
First Name: S
Last Name: G
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33431
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0421
Current Document ID: CMS-2018-0071-DRAFT-0421
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Teresa
Last Name: Perez
City: Boca Raton
Country: United States
State or Province: Florida
ZIP/Postal Code: 33431
Email Address: teresa.perez@fivestarhomecare.com
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)

Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-y7nk
Page Count: 1
Total Page Count
Including Attachments:
1

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Teresa
Last Name: Perez
City: Boca Raton
Country: United States
State or Province: Florida
ZIP/Postal Code: 33431
Email Address: teresa.perez@fivestarhomecare.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0420
Current Document ID: CMS-2018-0071-DRAFT-0420
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 34952
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)

Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-sp8a
Page Count: 1
Total Page Count
Including Attachments:
1

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 34952
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0419
Current Document ID: CMS-2018-0071-DRAFT-0419
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: While I agree with the initiatives to be fiscally responsible with the Medicare Trust Fund, I believe that the Review Choice Demonstration Project is not an effective or efficient means of doing so. The original Pre-Claim review demonstration project in 2017 showed the level of burden to Home Health Agencies and Fiscal Intermediaries to be excessive, resulting in confusion, delays, and inconsistent outcomes. Per the document Percentage of Affirmed/Partially Affirmed Pre-Claim Review Requests in Illinois (Week 24), the fully affirmed approval rate was 88.5% and the partially affirmed rate was 3.2%, leaving a non-affirmation rate of just 8.3%. To place a burden on 100% of agencies in a state to identify 8.3% of submitted claims to be non-reimbursable is an excessive waste of resources, both for the home health agency as will as CMS/Fiscal Intermediaries. Instead, I believe the Probe & Educate program, which is already in effect, should be modified to identify agencies with billing discrepancies, and energy and resources should be focused where the return on effort will be maximized. It is my belief that Medicare possess enough billing data to identify trends that would

allow for more focused efforts, resulting in more beneficial results. A second concern is the focus of the Project in a limited number of states. I believe this can lead agencies in non-Project states to be encouraged to continue with their current practices, whether compliant or not, because they are in a state that is "not on the radar". However, a more widespread Probe & Educate project would identify home health agencies with billing deficiencies regardless of geographic location.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33431
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-yfl9
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: While I agree with the initiatives to be fiscally responsible with the Medicare Trust Fund, I believe that the Review Choice Demonstration Project is not an effective or efficient means of doing so. The original Pre-Claim review demonstration project in 2017 showed the level of burden to Home Health Agencies and Fiscal Intermediaries to be excessive, resulting in confusion, delays, and inconsistent outcomes. Per the document Percentage of Affirmed/Partially Affirmed Pre-Claim Review Requests in Illinois (Week 24), the fully affirmed approval rate was 88.5% and the partially affirmed rate was 3.2%, leaving a non-affirmation rate of just 8.3%. To place a burden on 100% of agencies in a state to identify 8.3% of submitted claims to be non-reimbursable is an excessive waste of resources, both for the home health agency as will as CMS/Fiscal Intermediaries. Instead, I believe the Probe &

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First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33431
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0418
Current Document ID: CMS-2018-0071-DRAFT-0418
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Nicole
Last Name: Doolittle
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33073
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)

Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ik-mbqs
Page Count: 1
Total Page Count
Including Attachments:
1

Submitter Info

Comment: We suggest considering a continued sampling from a probe and educate as opposed to 100% review of all charts. Agencies who are compliant with adhering to Medicare rules and regulations should not be scrutinized for the ones who arent. Furthermore, this measure was met with numerous flaws during its initial implementation and agency has no guarantee that these wrongful denials would not be repeated.
First Name: Nicole
Last Name: Doolittle
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33073
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0416
Current Document ID: CMS-2018-0071-DRAFT-0416
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: The previous rollout of the pre-claim demonstration in Illinois was unsuccessful and CMS even admitted that by pausing the efforts and stopping the rollout to other states. They indicated further education would be need to providers but have never provided any further education and are now looking to start back up the same initiative but calling it something slightly different and changing some of its requirements. It overburdens agencies with additional administrative staff and requirements. Any additional resources an agency hires should be directed at improving patient care and service to the community. We thank you for the opportunity to comment on CMS 10599 "Home Health Review Choice Demonstration"
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33330
Email Address:

Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ih-a5mk
Page Count: 1
Total Page Count
Including Attachments:
1

Submitter Info

Comment: The previous rollout of the pre-claim demonstration in Illinois was unsuccessful and CMS even admitted that by pausing the efforts and stopping the rollout to other states. They indicated further education would be need to providers but have never provided any further education and are now looking to start back up the same initiative but calling it something slightly different and changing some of its requirements. It overburdens agencies with additional administrative staff and requirements. Any additional resources an agency hires should be directed at improving patient care and service to the community. We thank you for the opportunity to comment on CMS 10599 "Home Health Review Choice Demonstration"
First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Florida
ZIP/Postal Code: 33330
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0416
Current Document ID: CMS-2018-0071-DRAFT-0416
Title: IL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: I personally feel that this is unfair to Illinois to be the first to demonstrate AGAIN for pre claim review. The reviewers were not trained properly, one person would approve home health and another wouldn't. It is a waste of time to send the same documents over and over again for different questions can they not use the same document to answer their questions? Furthermore, the doctors need trained as far as what needs to be in their documentation for home health to be warranted. Also, as far as body structures effected by illness you have billers answering something nurses should be answering which is wrong. You already know who the fraudulent agencies are, go after them, instead of wasting everyone's time and taxpayer dollars to hire reviewers who were not educated enough. We got a letter stating that we were a low risk for fraud and would not be receiving anymore ADR's. Look at your high risk agencies and have them demonstrate with PCR. The little agencies who are by the book are the ones who are suffering from this unfair program. The last time Illinois was the only state to do this program the other states never got a chance to demonstrate, which then it was found that PCR was a non

workable program that did not cut fraud. AGAIN, a waste of taxpayer dollars. Medicare is denying patients the care that they need through this PCR program, and denying providers payment for services that they provided in good faith due to uneducated reviewers. Are you trying to discontinue home health care? Because it sure looks that way, considering that it is cheaper than permanent Nursing Home Placement or hospitalization on Medicare.

First Name: Pamela
Last Name: Bennett
City: Benton
Country: United States
State or Province: Illinois
ZIP/Postal Code: 62812
Email Address: pbennett@bicountyhealth.org
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94if-6str
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: I personally feel that this is unfair to Illinois to be the first to demonstrate AGAIN for pre claim review. The reviewers were not trained properly, one person would approve home health and another wouldn't. It is a waste of time to send the same documents over and over again for different questions can they not use the same document to answer their questions? Furthermore, the doctors need trained as far as what needs to be in their documentation for home health to be warranted. Also, as far as body structures effected by illness you have billers answering something nurses should be answering which is wrong. You already know who the fraudulent agencies are, go after them, instead of wasting everyone's time and taxpayer dollars to hire reviewers who were not educated enough. We got a letter stating that we were a low risk for fraud and would not be receiving anymore ADR's. Look at your high risk agencies and have them demonstrate with PCR. The little

agencies who are by the book are the ones who are suffering from this unfair program. The last time Illinois was the only state to do this program the other states never got a chance to demonstrate, which then it was found that PCR was a non workable program that did not cut fraud. AGAIN, a waste of taxpayer dollars. Medicare is denying patients the care that they need through this PCR program, and denying providers payment for services that they provided in good faith due to uneducated reviewers. Are you trying to discontinue home health care? Because it sure looks that way, considering that it is cheaper than permanent Nursing Home Placement or hospitalization on Medicare.

First Name: Pamela
Last Name: Bennett
City: Benton
Country: United States
State or Province: Illinois
ZIP/Postal Code: 62812
Email Address: pbennett@bicountyhealth.org
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0415
Current Document ID: CMS-2018-0071-DRAFT-0415
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: Dear Administrator Verma, Thank you for the opportunity to submit comments regarding the Medicare Pre-Claim Review Demonstration. As an employee of a home care agency which serves rural communities, I am concerned about the negative impact of the Review Choice Demonstration on our patients. CMS continues to subject home health agencies to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program will further increase the administrative and financial burdens on agencies without addressing the home health systems vulnerabilities. This Demonstration is unreasonable because these states already have Targeted Probe and Educate occurring on multiple agencies and some of these states are already under Value-Based Purchasing. This Demonstration inhibits patient choice and access to care, especially in the rural areas we serve. While home care agencies strive to achieve higher quality care with increased efficiencies and less reimbursement, the added administrative costs of this Demonstration pose an additional financial burden on agencies. This Demonstration project unduly targets compliant agencies instead of targeting cities

where known fraud exists. This Demonstration unfairly and arbitrarily scrutinizes all home health care providers in the selected states, even those who have a long established record of compliance with existing rules and regulations. Additionally, this Demonstration is contradictory to CMSs top priority to put patients first. As it has been previously suggested, CMS should develop, in conjunction with the home care community, a less burdensome approach to fraud and abuse. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. I recommend a trial process with a few home care providers before statewide implementation to remove inconsistencies and assure accuracy and timeliness of the review process. This Demonstration would hurt access and peoples ability to get care. I recommend CMS allow reimbursement while home care services are provided in good faith during the pre-claim review waiting period. Rather than using this Demonstration to remedy non-compliance with documentation requirements, I recommend CMS provide clarified and consistent standards with education to the home care community and MACs. Because the home care agency provides medically necessary services in good faith of receiving reimbursement, I recommend CMS provide reimbursement for all services rendered until the provider receives the pre-claim review decision. While I appreciate the options presented to home care agencies by allowing choice of pre-claim or post pay review, both options increase the administrative burden and costs to agencies. If the Demonstration project is implemented, I agree with the proposed recommendation of the home care provider being removed from pre-claim or post-pay review after they achieve a 90% approval rate. After the home care provider achieves the targeted affirmation or claim approval rate, I further recommend an established frequency of annual spot checks be conducted on a maximum of 5% of claims (not to exceed a total of 20 claims per home care provider). Prior to any implementation of this Demonstration, CMS must provide clear guidance on the achievement and calculations of such thresholds.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 79106
Email Address:
Organization Name:

Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ig-yp8n
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Dear Administrator Verma, Thank you for the opportunity to submit comments regarding the Medicare Pre-Claim Review Demonstration. As an employee of a home care agency which serves rural communities, I am concerned about the negative impact of the Review Choice Demonstration on our patients. CMS continues to subject home health agencies to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program will further increase the administrative and financial burdens on agencies without addressing the home health systems vulnerabilities. This Demonstration is unreasonable because these states already have Targeted Probe and Educate occurring on multiple agencies and some of these states are already under Value-Based Purchasing. This Demonstration inhibits patient choice and access to care, especially in the rural areas we serve. While home care agencies strive to achieve higher quality care with increased efficiencies and less reimbursement, the added administrative costs of this Demonstration pose an additional financial burden on agencies. This Demonstration project unduly targets compliant agencies instead of targeting cities where known fraud exists. This Demonstration unfairly and arbitrarily scrutinizes all home health care providers in the selected states, even those who have a long established record of compliance with existing rules and regulations. Additionally, this Demonstration is contradictory to CMSs top priority to put patients first. As it has been previously suggested, CMS should develop, in conjunction with the home care community, a less burdensome approach to fraud and abuse. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. I recommend a trial process with a few home care providers before statewide

implementation to remove inconsistencies and assure accuracy and timeliness of the review process. This Demonstration would hurt access and peoples ability to get care. I recommend CMS allow reimbursement while home care services are provided in good faith during the pre-claim review waiting period. Rather than using this Demonstration to remedy non-compliance with documentation requirements, I recommend CMS provide clarified and consistent standards with education to the home care community and MACs. Because the home care agency provides medically necessary services in good faith of receiving reimbursement, I recommend CMS provide reimbursement for all services rendered until the provider receives the pre-claim review decision. While I appreciate the options presented to home care agencies by allowing choice of pre-claim or post pay review, both options increase the administrative burden and costs to agencies. If the Demonstration project is implemented, I agree with the proposed recommendation of the home care provider being removed from pre-claim or post-pay review after they achieve a 90% approval rate. After the home care provider achieves the targeted affirmation or claim approval rate, I further recommend an established frequency of annual spot checks be conducted on a maximum of 5% of claims (not to exceed a total of 20 claims per home care provider). Prior to any implementation of this Demonstration, CMS must provide clear guidance on the achievement and calculations of such thresholds.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 79106
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0414
Current Document ID: CMS-2018-0071-DRAFT-0414
Title: TX
Number of Attachments: 0
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: CMS continues to subject home health agencies to complex and burdensome Medicare pilot programs and demonstrations. Imposing another program will further increase the administrative and financial burdens on agencies without addressing the home health systems vulnerabilities. This Demonstration will erode beneficiaries access to home care services and prevent home health care providers from providing care and services to medically complex, functionally impaired patients. This Demonstration will take care planning decisions away from the home health clinicians. It is my responsibility, as a home care clinician, to make judgments that are in the best clinical interests of my patient. However, this Demonstration effectively overrides my clinical judgment and redirects the care decision-making process to Palmettos medical review staff, individuals who frequently make medical denial decisions without consideration of the beneficiarys total condition and individual need for care. As a clinician, it is my responsibility to exercise professional judgment to treat the beneficiary in accordance with Medicare coverage guidelines. However, this Demonstration replaces my clinical

judgment with the decisions made by PGBAs medical review staff. As it has been previously suggested, CMS should develop, in conjunction with the home care community, a less burdensome approach to fraud and abuse. Rather than create this broad-spectrum Demonstration, I recommend CMS utilize data to identify high risk situations and target program integrity measures. I recommend a trial process with a few home care providers before statewide implementation to remove inconsistencies and assure accuracy and timeliness of the review process.
First Name: Peggy
Last Name: Simpson
City: McLean
Country: United States
State or Province: Texas
ZIP/Postal Code: 79057
Email Address:
Organization Name:
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/27/2018
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Status Set By: Public
Component:
File Code:
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Submitter Info

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Last Name: Simpson
City: McLean
Country: United States
State or Province: Texas
ZIP/Postal Code: 79057
Email Address:
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Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0411
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Title: MD
Number of Attachments: 1
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Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: Dear CMS Office of Strategic Operations and Regulatory Affairs Staff, The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and compliance professionals, together with the Board of Medical Specialty Coding and Compliance (BMSC), the credentialing arm of AHCC, appreciate the opportunity to comment on the Review Choice Demonstration Project. The original Pre-Claim Review Demonstration Project caused many problems in Illinois due to operational issues. Reimbursement claims for legitimately necessary and compliantly supplied services were delayed and denied. There was a huge backlog of claims needing review that further delayed payment. As agencies worked to make corrections to their claims and processes, reviewers gave varying answers to the same questions. Overall, in the early weeks and months of the project, home health agencies struggled to receive payment for legitimate claims due to technical documentation errors that did not alter the patient's eligibility or medical need for the services. How will the new project address these issues? In the end, it isnt clear that the original project prevented

the problem it was supposed to prevent fraud. How will this project be different? We understand that the new project will move agencies from 100% review to a spot check of their claims once they reach the target pre-claim review affirmation or post-payment review claim approval rate. What is the target affirmation or approval rate? We assume that it will be less than 100%, because 100% compliance is extremely difficult to achieve and, as noted above, many mistakes that would prevent a provider from achieving 100% compliance are technical issues that do not alter the eligibility or medical necessity for care. (Similar to the recently discontinued physician estimate of the need for continued care.). We suggest that 85% approval would be an appropriate and achievable goal. Unfortunately, the publication provided few details regarding the mechanics of this process. One issue that will have a significant impact is the sample size or number of records that must be reviewed before the error rate can be determined. The larger this initial sample, the more burdensome this process will be for providers who are not engaged in fraud, but simply trying to provide high quality care and comply with Medicare requirements. Once a provider has completed the "initial assessment," it will be important to define the follow-up "spot check" to balance the burden on providers and the programs goals. If the spot checks are too frequent, the program will be functionally no different from the previous pre-claim review demonstration. It will also be important to carefully define the scope of records reviewed during the follow-up. We suggest an annual follow up of no more than 20 records will be a sufficient frequent probe to verify ongoing compliance. When deciding whether to deny a claim, we believe the review should focus on core payment issues such as Medicare eligibility. If the goal is to avoid paying erroneous claims and/or identifying fraudulent claims, review should not focus on technical documentation issues, but on substantive issues that would call into question the legitimacy of the claim. For example, if there is no 485, that claim would not demonstrate the patients eligibility and a denial would be appropriate. Or if there was a statement that therapy goals had been met, but therapy continued there would be a problem with the claim. Or if the description of the patient's home bound status was obviously deficient, there would be reason for questioning the claim. But if the issue is instead technically deficient face to face documentation for a patient who clearly had a face to face encounter with the physician, the claim should not be denied. Finally, we hope that CMS will take into account the likelihood that this project will result

in an increase in appeals. Given the already over-burdened Medicare appeals process, we hope the agency will examine the current appeals processes and make adjustments to accommodate increased requests. Providers should not have their rights to due process further burdened by additional appeals generated by a poorly conceived or implemented process. Sincerely, Jan Milliman Chief Executive Officer The Association of Home Care Coding and Compliance On behalf of The Association of Home Care Coding and Compliance

First Name: Jan
Last Name: Milliman
City: Gaithersburg
Country: United States
State or Province: Maryland
ZIP/Postal Code: 20878
Email Address: jmilliman@decisionhealth.com
Organization Name:
Category:
Cover Page:

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Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94ic-hs78
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Total Page Count Including Attachments:
1

Submitter Info

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First Name: Jan
Last Name: Milliman
City: Gaithersburg
Country: United States
State or Province: Maryland
ZIP/Postal Code: 20878
Email Address: jmilliman@decisionhealth.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0411
Current Document ID: CMS-2018-0071-DRAFT-0411
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

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instead of targeting cities where known fraud exists. While I appreciate no delay in the provision of medically necessary care for Medicare beneficiaries, this Demonstration poses an undue financial burden on an agency who will not receive reimbursement for a non-affirmed pre-claim review. This Demonstration 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 pre-claim review decision. Further, home care agencies will discharge Medicare beneficiaries from skilled services when a pre-claim review is returned non-affirmed. Such barriers may result in increased hospital stays and increased re-hospitalizations. Agencies will incur the cost for skilled services provided in the event a pre-claim review is non-affirmed. While I support all efforts to prevent fraud and abuse in the home health care industry, such efforts should target abusive providers and not decrease access to care for our most vulnerable population at home As a clinician, it is my responsibility to exercise professional judgment to treat the beneficiary in accordance with Medicare coverage guidelines. However, this Demonstration replaces my clinical judgment with the decisions made by PGBAs medical re Rather than using this Demonstration to remedy non-compliance with documentation requirements, I recommend CMS provide clarified and consistent standards with education to the home care community and MACs. view staff. Because the home care agency provides medically necessary services in good faith of receiving reimbursement, I recommend CMS provide reimbursement for all services rendered until the provider receives the pre-claim review decision

First Name: Aimee
Last Name: Davidson
City: Lubbock
Country: United States
State or Province: Texas
ZIP/Postal Code: 79423
Email Address: aimee.davidson@fms-regional.com
Organization Name: Accolade Home Care
Category:
Cover Page:

Document Optional Details

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Status Set By: Public
Component:
File Code:

Tracking Number: 1k2-94if-j10n
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Total Page Count
Including Attachments:
1

Submitter Info

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First Name: Aimee
Last Name: Davidson
City: Lubbock
Country: United States
State or Province: Texas
ZIP/Postal Code: 79423
Email Address: aimee.davidson@fms-regional.com
Organization Name: Accolade Home Care
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0410
Current Document ID: CMS-2018-0071-DRAFT-0410
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/27/2018
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Submission Type: API
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priority to put patients first. As it has been previously suggested, CMS should develop, in conjunction with the home care community, a less burdensome approach to fraud and abuse.

First Name: Anonymous
Last Name: Anonymous
City:
Country: United States
State or Province: Texas
ZIP/Postal Code: 76210
Email Address:
Organization Name:
Category:
Cover Page:

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Component:
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Submitter Info

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City:
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ZIP/Postal Code: 76210
Email Address:
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Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0402
Current Document ID: CMS-2018-0071-DRAFT-0402
Title: OH
Number of Attachments: 0
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Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/25/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: Thank you for giving me the opportunity to provide comments on the proposed Review Choice Demonstration (RCD). As an individual that works in the home health field, I recognize that there is a need to crack down on bad-actors that commit fraud and also address waste and abuse. However, the proposed RCD is a one-size-fits-all approach and not the appropriate way to address the problem. It will drive good providers out of business, leaving vulnerable Ohioans without necessary access to care. As you know, soon after beginning the previous demonstration, the "Pre-Claim Demonstration for Home Health Services," issues quickly became apparent in the State of Illinois. Due to numerous complications, CMS put the demonstration on hold before moving into the other four demonstration states. While I appreciate that CMS has proposed new options for providers under the proposed RCD, the return of this type of policy will cause serious administrative burdens that will ultimately hurt the individuals we serve. Home health providers have among the lowest reimbursement rates of any provider, and a lot of good agencies struggle to meet financial obligations. There are better and more targeted

ways to address fraud, waste, and abuse that won't be as detrimental to the individuals we serve. As of today, it doesn't matter if you're a good or bad provider; everyone receives the same rates. If CMS implemented some type of quality incentive, such as paying more for quality, the result would be three-fold: -Bad actors will become more apparent to CMS, allowing a more targeted crackdown on people committing fraud; -Market forces will drive low-quality providers out of the field; and -Providers that practice in good faith will be incentivized to submit clean claims and improve quality, providing more value to the Medicare system. As you're aware, our 65 and older population is set to double in the immediate future. It is irresponsible to drive a policy that will create delays in care or lack of access for Ohio's seniors. Ohio is a unique state. Although our metropolitan areas provide individuals with many care options, some of the state's rural areas are health care deserts. Again, I have a strong belief that CMS and the industry needs to address fraud, waste, and abuse. The vast majority of providers share that setiment and practice in good-faith, wanting the bad actors forced out of the industry. The proposed RCD is an overaggressive approach that will put good people out of business. I ask that you please cancel the proposed demonstration and work with leaders in the home health industry to find other ways to crack down on fraud and address waste and abuse. Some of Ohio's most vulnerable individuals are relying on your decision, individuals that are served in their homes.

First Name: Annette
Last Name: Jackson
City: Lorain
Country: United States
State or Province: Ohio
ZIP/Postal Code: 44052
Email Address: amjackson0@mercy.com
Organization Name:
Category:
Cover Page:

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Component:
File Code:
Tracking Number: 1k2-94hb-zdsy
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1

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First Name: Annette
Last Name: Jackson
City: Lorain
Country: United States
State or Province: Ohio
ZIP/Postal Code: 44052
Email Address: amjackson0@mercy.com
Organization Name:
Category:
Cover Page:

5225 Pooks Hill Rd | Suite 627S
Bethesda, MD 20814
T 301.530.7846 | C 301.802.1410
marcia@nusgartconsulting.com

July 22, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-10599
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically to www.regulations.gov

RE: Agency Information Collection Activities; Proposed Collection; Comment Request: CMS-10599: Pre-Claim Review Demonstration for Home Health Services

Dear Administrator Verma:

The Coalition of Wound Care Manufacturers ("Coalition") is submitting the following comments in response to the CY 2019 Interim Final Rule regarding DME. The Coalition represents leading manufacturers of wound care products used by Medicare beneficiaries for the treatment of wounds including but not limited to Negative Pressure Wound Therapy and surgical dressings.

The Coalition urges CMS to withdraw this policy. As you may recall, Congress urged CMS to suspend the original demonstration citing administrative burdens and patient access issues. In the letter to CMS, Congress stated, "This demonstration project imposes costs on patients, providers, and taxpayers. Delaying patient care while waiting for CMS to approve home health services may put patient health in jeopardy and cause patients to stay in the hospital longer than necessary." CMS has done little to allay industry concerns as there are few details surrounding the operations of this demonstration project. Moreover, we have grave concerns regarding the lack of transparency that CMS has exhibited regarding this project.

This notice provides little detail regarding:

- Timeline for implementation of this demonstration

- Creation of an impact analysis regarding the administrative costs to providers

 Problems the demonstration project will create regarding access and disruption of care for patients

 CMS's timelines in processing the pre and post payment audits/review

 Details regarding the timeliness of reimbursement for providers

 Timeframe by which CMS will be required to issue a pre-review determination or the guidelines it will use to make the determinations.

All of this information should have been provided in a proposed document affording the public the right to provide meaningful comments.

While it appears that CMS is trying to curb what it perceives is fraud and abuse in the home health sector, CMS should simply utilize data and resources it already has on hand to target specific types home health agencies whose behavior indicates that there may be fraudulent activity rather than implement a wide spread demonstration project which will overburden and penalize home health agencies that have no record or patterns of fraud and abuse.

While we appreciate that the Agency will offer 100% post claim review as an "alternative" to 100% pre claim review, this still is not a significant change and CMS has not provided the clear and specific guidance necessary to roll out this demonstration project.

As such, we request that until more detailed information is provided, CMS withdraw this demonstration project altogether. CMS has not provided any additional detailed information regarding how this demonstration will be implemented causing significant concerns given the failed first attempt. The Coalition recommends that CMS reach out to stakeholders with vested interest in this issues such as home health agency associations (e.g., Elevating HOME, NAHC) as well as ourselves for some suggestions in how to address the perceived fraud and abuse issues as well as recommendations on how to implement a limited demonstration project.

The Coalition appreciates the opportunity to provide CMS with our comments. We recommend that CMS will withdraw this demonstration and instead use the data it has to target questionable home health agencies rather than subjecting all home health agencies to yet another burdensome process and impacting patient care and access along the way.

Sincerely,

Karen Ravitz, JD
Health Care Policy Advisor

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0401
Current Document ID: CMS-2018-0071-DRAFT-0401
Title: AZ
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 07/25/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: API
Number of Submissions: 1

Document Optional Details

Submitter Info

Comment: This regards the new regulations proposed in the "Patients Over Paperwork" act- a very Orewellian title and sickeningly, ironically appropriate for this dystopian Trump government. This program has nothing to do with patient care, and is obviously simply an effort to cut Medicare payments for more complex care (Level 5 visits reimbursed as Level 3 in this plan?!!), particularly for primary care physicians, reducing costs for the insurance companies that provide "Medicare Advantage" programs that medicare sells out to (I mean contracts with.) Ultimately what this will contribute to is even fewer physicians entering the ranks of primary care, as it will further reduce the viability of primary care as a profession for physicians. This, of course will further the ultimate dream of the money grubbing insurance executives to have primary care be completely devoid of doctorally trained professionals so they can pay a pittance for the pretense of medical care provided by under-educated and under-qualified non-physicians. This is ultimately penny-wise and pound-foolish for the actual public who will receive worse care, but will further enrich insurance stock holders. I am

strongly against these changes.
First Name: Daniel
Last Name: Schulte
City: Phoenix
Country: United States
State or Province: Arizona
ZIP/Postal Code: 85048
Email Address: dlschulte@msn.com
Organization Name: N/A
Category:
Cover Page:

Document Optional Details

Status Set Date: 07/25/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-94h9-b1dw
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: This regards the new regulations proposed in the "Patients Over Paperwork" act- a very Orewellian title and sickeningly, ironically appropriate for this dystopian Trump government. This program has nothing to do with patient care, and is obviously simply an effort to cut Medicare payments for more complex care (Level 5 visits reimbursed as Level 3 in this plan?!!), particularly for primary care physicians, reducing costs for the insurance companies that provide "Medicare Advantage" programs that medicare sells out to (I mean contracts with.) Ultimately what this will contribute to is even fewer physicians entering the ranks of primary care, as it will further reduce the viability of primary care as a profession for physicians. This, of course will further the ultimate dream of the money grubbing insurance executives to have primary care be completely devoid of doctorally trained professionals so they can pay a pittance for the pretense of medical care provided by under-educated and under-qualified non-physicians. This is ultimately penny-wise and pound-foolish for the actual public who will receive worse care, but will further enrich insurance stock holders. I am strongly against these changes.
First Name: Daniel
Last Name: Schulte

City: Phoenix
Country: United States
State or Province: Arizona
ZIP/Postal Code: 85048
Email Address: dlschulte@msn.com
Organization Name: N/A
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0003
Current Document ID: CMS-2018-0071-DRAFT-0003
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 05/31/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

Status Set Date: 05/31/2018
Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-93gk-tx9l
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Ii is already hard enough to find a Home Health Nursing agency for my grandparents without medicare holding more payments from the agencies. This is not good policy. This only hurts small nursing agencies. Like I said, it is already hard enough to find good home health agencies in Texas. This will not help. There are already enough ways for medicare to audit these agencies. The state audits them as well. I heard about Illinois and Pre-claim review.... almost all the adencies went out of business because medicare held there payments for months....just another way for the government to squeeze the

little guy.
First Name: K
Last Name: B
City: Liberty
Country: United States
State or Province: Texas
ZIP/Postal Code: 77575
Email Address:
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0004
Current Document ID: CMS-2018-0071-DRAFT-0004
Title: TX
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 05/31/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

Document Optional Details

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Current Assignee: Simon, Carlos (CMS)
Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-93gk-z621
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: This is an unnecessary regulation that would directly affect patient care whereby care would be delayed and significantly increase re-hospitalizations (which Medicare is trying to reduce). This regulation will lead to an opposite result of what CMS is trying to do.
First Name: Muffi
Last Name: Bootwala
City: Richardson
Country: United States
State or Province: Texas

ZIP/Postal Code: 75081
Email Address: mbootwala@amcarepro.com
Organization Name:
Category:
Cover Page:

Document Details

Docket ID: CMS-2018-0071
Docket Title: þÿ C M S - 1 0 5 9 9 _ P r e - C l a i m R e v i e w D e m o n s t r a t i o n f o r Services
Document File:
Docket Phase: ICR 60 day
Phase Sequence: 1
Original Document ID: CMS-2018-0071-DRAFT-0005
Current Document ID: CMS-2018-0071-DRAFT-0005
Title: FL
Number of Attachments: 0
Document Type: PUBLIC SUBMISSIONS
Document Subtype: Public Comment
Comment on Document ID: CMS-2018-0071-0001
Comment on Document Title: Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status: Draft
Received Date: 05/31/2018
Date Posted:
Posting Restriction: No restrictions
Submission Type: Web
Number of Submissions: 1

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Status Set By: Public
Component:
File Code:
Tracking Number: 1k2-93gl-5jkn
Page Count: 1
Total Page Count Including Attachments:
1

Submitter Info

Comment: Everyone understands that CMS comes under intense pressure each time the OIG publishes their faulty home health fraud report. CMS must actively refute the OIG and MedPac by stating that home healthcare is far less costly than nursing home or hospital care. Home healthcare helps prevent costly rehospitalizations. Home healthcare is preferred by seniors. Pre-claim review (pre or post) as demonstrated in Illinois was flawed because different surveyors could rule differently on the very same claim. Pre claim review will force seniors into more costly settings because of the complex nature and

burdensome paperwork requirements thanks to the new conditions of participation. Both choices, pre or post, is the wrong way to handle so-called fraud in the home health industry. I urge CMS to schedule a meeting with home health leaders including myself to address the issue of fraud and jointly come up with a solution that will protect our patients, not harm them. Pre claim review is not the answer, and I know that our elected officials feel the same way.

First Name: Scott
Last Name: Lara
City: Jacksonville
Country: United States
State or Province: Florida
ZIP/Postal Code: 32225
Email Address: slara1961@gmail.com
Organization Name:
Category:
Cover Page: