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, post-payment, 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.

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

Sincerely,

/s/
Jennifer Schiller
Director, Policy Communications & Research