October 29, 2018

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
725 17th Street NW
Washington, D.C. 20503

Submitted electronically to OIRA_submission@omb.eop.gov

RE: Agency Information Collection Activities: Submission for OMB Review; Document Identifier CMS-10599, OMB Control Number: 0938-1311

Dear Sir or Madam,

The Home Care Association of Florida (HCAF) is the statewide trade association representing Florida’s 1,034 Medicare-certified home health agencies (HHA) that are dedicated to providing high-quality, cost-effective health care at home to more than 349,000 Medicare beneficiaries each year. As the Centers for Medicare & Medicaid Services (CMS) continues the approval process for the Review Choice Demonstration for Home Health Services (RCD), HCAF appreciates this additional opportunity to comment on behalf of our membership.

A. Florida HHAs Already Disproportionately Subject to Multiple, Simultaneous Federal Mandates

As expressed in our comments on the original proposed rule announced earlier this summer, we are concerned about: (1) the necessity and timing of the RCD, which ignores the flaws of the Pre-Claim Review Demonstration (PCRD) during its implementation period in Illinois; and, (2) that RCD is yet another costly and complex program that targets Florida HHAs, who have long been disproportionately subjected to multiple and simultaneous pilot programs, demonstrations, new and revised regulations, and increased and aggressive auditing practices. As one of five states subject to the RCD, mandated initiatives already in effect or effective soon in Florida include:

- The five-year Home Health Value-Based Purchasing Model in nine states (including Florida), with reimbursement tied to quality at a maximum adjustment of +/- 5% next year and eventual maximum adjustment of +/- 8%;
- Administrative and education costs expended to prepare for implementation of the now-withdrawn Pre-Claim Review Demonstration, which targeted Florida and four additional states;
- Rampant and aggressive auditing practices by SafeGuard Services, LLC, the Zone Integrity Program Contractor (ZPIC), which has focused much of their efforts in Florida based on industry leader discussions;
- Expansion of the Targeted Probe and Educate (TPE) audit strategy by Medicare Administrative Contractors;
- New Medicare Conditions of Participation, revised for the first time in three decades;
- Transition to Outcome and Assessment Information Set Version D (OASIS-D); and, most recently,
- The proposed Patient-Driven Groupings Model, widely seen as the most dramatic overhaul to the Medicare home health payment system since implementation of the Prospective Payment System in 2000.

B. RCD Disregards the Flawed, Ineffective Pre-Claim Review and its Congressional Critics

Although Florida was spared from enforcement of the PCRD in 2017, lessons learned during the chaotic demonstration period while in effect in Illinois cannot be ignored while considering the burdens the RCD will have on HHAs. According to media reports and industry analyses, the PCRD proved to be an overly complex and
administratively time-consuming requirement for providers that increased costs and resulted in cash flow losses totaling between $114 million and $122 million over the eight-month demonstration. Furthermore, the Illinois PCRD experience found that any identified concerns were merely limited to correctable paperwork errors. As it relates to access to care for Medicare beneficiaries, utilization data shows a more than 21-percent reduction in services, suggesting that the cumbersome and onerous pre-claim process stemmed access for Illinois’s sickest and poorest seniors.

Last month, the vast majority of Florida’s congressional delegation echoed our concerns in a letter to CMS Administrator Seema Verma that inquired about the necessity of the RCD following the unsuccessful PCRD demonstration, posing the questions below. Although CMS has yet to respond to the 26 bipartisan Senators and Representatives, we offer some insights below as the Office of Management and Budget finalizes its deliberations.

1. What types and incidences of fraud or improper payments were uncovered through PCRD in Illinois from its initiation in August 2016 until its suspension in March 2017? Please provide separate responses on fraud and improper payments. CMS did not identify any fraud during the PCRD in Illinois, and virtually all claims errors found related to documentation which were ultimately correctible, therefore rendering the program an ineffective tool to reduce fraud, improper payments, and lower Medicare appeal rates.

2. How did the PCRD program impact patients’ access to home health care, including the number of patients served and their ability to quickly receive care? How do these results compare to the 12 months prior to PCRD’s implementation in Illinois? Illinois utilization data during the PCRD shows a more than 21-percent reduction in services, suggesting that the cumbersome and onerous pre-claim process stemmed access for Illinois’s sickest and poorest seniors. All told, thousands of beneficiaries lost access to services as the volume of claims significantly declined, suggesting patients obtained services in more costly settings such as hospitals.

3. What other information from the PCRD program did CMS use in developing RCD program integrity measures in home health services? Please specify these measures. Not publicly-available information.

4. How did CMS use the PCRD program results to determine the need for implementation of an RCD program? Not publicly-available information.

5. Which alternative program integrity measures to RCD were considered by the agency and why were these programs not selected? Not publicly-available information.

6. Which stakeholder groups and/or representatives, if any, were consulted in the consideration of the RCD program? HCAG, Florida’s premiere trade association for the state’s home health care industry, has not been contacted regarding the RCD, despite representing providers located in one of the five states targeted for the program.

7. Has CMS considered whether other regulatory requirements, such as the face-to-face requirements, or a lack of clarity surrounding existing policies could be revised to improve efficiency and reduce improper payments? Although the Bipartisan Budget Act of 2018 (BBA) included provisions to reform the face-to-face encounter requirement, which was implemented in 2011 and created tighter and more burdensome supervision and physician signature requirements, the changes did not go far enough. The BBA allowed instead of required CMS to consider the entire patient’s record when deciding if a patient is eligible for home health care services, thus ensuring that the patient’s condition and status is fully understood while also reducing the burden for the home health agency and certifying physician. This question posed by lawmakers is particularly prescient considering the obvious administrative challenges HHAs will face during the RCD.

C. Recommendations

In light of the mandatory policies and programs listed in Section A of these comments — consisting of costly, complex, and mostly unfunded mandates piling on too quickly — we strongly urge CMS to reconsider its hasty
implementation of the RCD, a program that will cost CMS $400 million to administer with no promise of being an effective tool to protect program integrity considering the outcome of the PCRD.

We respectfully maintain that the RCD will overwhelm HHAs with exponentially increased paperwork burdens, which proved to increase costs and harm access to care for patients in Illinois and oppose the program’s implementation. As explained in these comments, errors noted in claims submitted in Illinois during the PCRD proved to be caused by little more than correctable paperwork errors, which can more effectively be remedied by additional training and education by the MACs through the TPE audit strategy, among other auditing programs.

We strongly support CMS Administrator Verma’s March 2017 announcement to suspend the PCRD and make it an optional program for HHAs, as it also should be for the RCD. Unfortunately, the RCD will amount to little more than a reboot of a failed, costly, and burdensome program that did nothing to combat waste, fraud, and abuse.

In closing, we will continue to oppose unnecessary government regulations and mandates that increase costs, generate little or no value for patients, and make it more difficult to provide high-quality care in the cost-effective, patient-preferred home setting.

Sincerely,

Bobby Lolley, RN
Executive Director

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