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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.

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.

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.

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

[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/