Appendix 1 – Response to 60-day Comments

CMS Responses to Public Comments Received for CMS-10599: Review Choice Demonstration For Home Health Services

Responses for the HH PRA comments
CMS received two comments in response to the 60-Day FR Notice.

The first comment expressed concern about the cost of the Review Choice Demonstration for Home Health Services (RCD) to Home Health Agencies (HHAs) and the federal government.

Response: In an effort to create a process that balances provider burden while continuing our fiduciary responsibility to lower the home health improper payment rate and prevent fraud, waste and abuse, the Review Choice Demonstration (RCD) includes increased flexibility, provider choice, as well as additional risk-based changes. CMS also believes that the choice of review options, along with the ability to opt out of most reviews once a provider demonstrations compliance with Medicare offers providers the flexibility to choose a review option that will work for them based on their resources and financial needs.

CMS developed this demonstration to ensure a positive Return on Investment (ROI) to offset the cost of implementation in the demonstration states. As part of the renewal of the Paperwork Reduction Act approval for the demonstration, CMS updated its estimated costs based on the change to 30-day billing periods under the Patient-Driven Groupings Model (PDGM) and our experience so far. CMS continues to estimate a positive ROI for the remainder of the demonstration.

The recommendation also asked that should CMS decide to expand the demonstration to additional states in the Palmetto/JM jurisdiction, that CMS first issue a notice of proposed rulemaking announcing plans to expand, and give new states at least six months to prepare.

Response: At this time, CMS does not have plans to expand the demonstration to additional states. However, prior to any expansion occurring, CMS will ensure that the states receive sufficient notice and education about RCD.

The first commenter recommended that CMS report the annual cost of RCD to HHAs and the federal government and report annual updates of potential return on investment for the demonstration. The second commenter also recommended that CMS report data on the impact of RCD on patients and HHAs, such as the number of affirmed requests and information about patient access to care.

Response: Due to the pause for the Public Health Emergency for COVID-19 and the delay in implementing the demonstration in Florida and North Carolina, CMS has not yet shared demonstration data from all five states on its website[1]. As all five states are now fully implemented, CMS will consider sharing updates and information for RCD on the demonstration

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services.html

website.

The second comment included a concern that CMS had underestimated the administrative burden of the demonstration. With the change from a 60-day episode to a 30-day billing period under the Patient-Driven Groupings Model (PDGM), the commenter was concerned that the second submission packet for admission affirmation is an unnecessary and burdensome step for providers as it contains the same clinical documentation sent for the initial period.

Response: CMS understands that the move to a 30-day billing period has changed the way HHAs submit claims. CMS has updated the burden estimate for the renewal of the Paperwork Reduction Act approval to include this change. Under the pre-claim review option in RCD, HHAs may submit more than one 30-day billing period on a pre-claim review request. HHAs that submit multiple billing periods in one submission only need to submit the plan of care for the additional billing periods. If a HHA submits a pre-claim review request for two 30-day billing periods that are part of the same 60-day plan of care, no additional documentation is needed. If a HHA's plan of care only spans 30 days, they would need to upload the second plan of care in order to determine the continued need for home health; the start of care documents do not need to be submitted again.

The commenter was also concerned that working with referral sources to get needed documentation, including documentation to support the face-to-face encounter is a frequent cause of non-affirmations, as the burden is on the HHA and not the referral source, which can cause delays in payment. The commenter recommended that CMS do more education to referral sources in RCD states and refine the processes to address the concern.

Response: While CMS understands that it can be difficult to get the necessary supporting documentation from referral sources, such as physicians, we remind commenters that certification of eligibility for home health services is a condition of payment for HHAs. If a HHA has continuous problems getting documentation from a referral source, the HHA can reach out to the MAC and/or CMS for assistance. CMS will continue educating practitioners who order home health services on their responsibility to provide the documentation.

The second comment mentioned that there is ambiguity in the process for transitioning between cycles of RCD and that HHAs are confused about what to do when the cut-off date to begin a new cycle does not align with their c claim submissions. The commenter stated that that this issue leads to delays in payment and unnecessary burden through duplicate submission.

Response: The date of submission of a pre-claim review request or claim determines what cycle requirements the HHA should follow. If the date of submission for a pre-claim review request or claim is during the time period between cycles, HHAs should follow the requirements of the review choice selection they were in for the cycle that just ended. If the HHA selects a new review option for their next cycle, they will begin following those requirements on the day the new cycle starts, for all claims submitted on or after that date. The HHA should not need to submit a duplicate submission. To reduce confusion, CMS and the MAC will provide additional education for HHAs to ensure they understand the timing of submissions and what requirements

they should follow between cycles.

The commenter was also concerned that HHAs have had claims that were affirmed through RCD be subject to additional postpayment review through the Uniform Program Integrity Contractor (UPIC). They are concerned this increases administrative burdens for the HHA and recommended CMS eliminate the duplicate reviews for RCD claims.

Response: While participation in the demonstration generally limits claims with a provisional affirmation from being selected for additional medical review, a UPIC may conduct a claim review if they feel there is evidence of fraud or gaming. To help reduce the potential for duplicate reviews, CMS has developed a process in the RCD for a provider to be excluded from review under the demonstration following notification by the UPIC. To further reduce the chances of duplicative reviews, CMS works with our UPIC partners to ensure that they understand how to identify claims that have gone through pre-claim review, so they can select other claims (in most cases, for prepayment review), in the event they feel there is a provider concern that warrants further investigation. There are some circumstances however, where postpayment reviews will remain standard practice, like in situations involving provider payment suspensions. CMS will continue to collaborate with our UPIC partners to minimize the amount of review overlap to the greatest extent possible.

The second commenter expressed concern that there were increased non-affirmations due to new review staff at the MAC having a lack of familiarity with coverage of the home health benefit during the initial months of expansion into a new RCD state. The commenter stated that this led to additional burden on the HHAs who had to clarify existing policy and resolve issues. They recommended more comprehensive training for MAC reviewers on coverage requirements, as well as standardized training and ongoing oversight to ensure review criteria is applied consistently.

Response: CMS understands that there is a learning curve for both MAC reviewers and HHAs when the demonstration is implemented in a new state. The MAC reviewers undergo training to ensure consistency prior to beginning the reviews. Both the MAC and CMS monitor the reviewers' accuracy throughout the demonstration. In addition, CMS staff conduct reviews on a selection of requests/claims to ensure the MAC decisions are accurate and consistent across reviewers. CMS ensures there is continued oversight of all MAC activities under this demonstration. HHAs should notify CMS if there are continued concerns with MAC reviewers.

The second comment also included concerns that the IT infrastructure for RCD could be updated and improved to reduce the burden and work more efficiently for HHAs. They were concerned that the process for submitting pre-claim review requests is not fully automated and that HHAs must manually upload/download each file and piece of documentation for the portal, which takes time. The commenter was concerned that the automated system required duplicate submissions, as well as information that is no longer required as part of the demonstration. The commenter also noted that there is no Application Programming Interface (API) option in the system for RCD. This creates a risk with respect to Protected Health Information (PHI).

Response: Pre-claim review requests submitted via the MAC's online provider portal (EDI gateway) are only allowed from validated submitters who can send/receive data for the provider. This is the same process utilized for electronic claims submissions (837 and 276 submissions). The submission follows the CMS required security mandates for protecting PHI/PII.

Both CMS and the MAC have gained experience as the demonstration is now active in all five states. As part of that experience, the MAC has made a number of improvements to increase the efficiency of its online provider portal and has resources dedicated to helping providers navigate the portal, make their review choice, and submit documentation and pre-claim review requests. The MAC will continue to listen to feedback and make additional changes to enhance the user experience of their portal. CMS will work with the MAC to ensure information and documentation no longer required as part of the demonstration is not needed for submission of a request. In addition, CMS is working to optimize efficiencies as well by moving towards greater interoperability, automation, and through other potential system enhancements.