April 5, 2016

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Prior Authorization of Home Health Services Demonstration (CMS-10599)

The (Medicare Rights) is pleased to submit comments on the Centers for Medicare & Medicaid (CMS) proposal to test prior authorization for Home Health Care (HHC) services. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to over two million Medicare beneficiaries, family caregivers, and professionals annually.

The following comments are informed by our experience working with Medicare beneficiaries and their families. For additional information, please contact Casey Schwarz, Senior Counsel for Education & Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271 and Stacy Sanders, Federal Policy Director at SSanders@medicarerights.org or 202-637-0961. Medicare Rights requests that CMS withdraw the proposed demonstration. We are concerned that the process outlined by CMS is insufficiently targeted to address fraudulent submissions and may have the unintended consequence of creating barriers to necessary care.

Specifically, we do not believe that simply adding more documentation requirements and altering the timing of the submissions will deter bad actors who are currently able to submit fraudulent, but complete, paperwork. Furthermore, with ongoing care like HHC—unlike high-cost durable medical equipment—there is minimal value for beneficiaries and health care providers in obtaining pre-service determinations. Below we provide more detailed comments outlining these concerns.

Background: On February 5, 2016, CMS published a Paperwork Reduction Act (PRA) notice in the Federal Register announcing the agency's effort to seek approval from the Office of Management and Budget (OMB) to "collect information" relating to a demonstration project. Pursuant to the project, CMS would identify, investigate, and prosecute fraud among Medicare home health agencies by performing

prior authorization before processing claims for home health services in several states.[1] CMS also published a Supporting Statement further describing the demonstration.[2]

Targeting "high risk fraud states," the three-year demonstration would occur in two phases: Phase I in Florida, Texas, and Illinois and Phase II in Michigan and Massachusetts. CMS notes that it would establish a prior authorization procedure that is similar to the Prior Authorization of Power Mobility Device (PMD) Demonstration, implemented in 2012.

Prior Authorization May Create Barriers to Necessary Care: First and foremost, we are concerned that a blanket, state-wide prior authorization program applied to all home health services (as outlined by the PRA notice) may lead to unnecessary delays in access to home health services. Such barriers could affect both those who need home health care on a short-term basis as well as those who have ongoing, chronic care needs. Individuals who need home health care are often at their most medically vulnerable, including those awaiting discharge from a hospital or skilled nursing facility, and these beneficiaries require physician-ordered care without delay.

HHC and High-Cost Power Wheelchairs are Not Equivalent Services: Whereas some suppliers are reluctant to provide high-cost equipment, like power wheelchairs, to beneficiaries who may not qualify for Medicare coverage, we are unfamiliar with any similar concerns among home health care providers. We support targeted Prior Authorization programs where pre-service information about coverage can provide predictability and access for beneficiaries and providers. For instance, prior authorization for power wheelchairs can prevent circumstances where a beneficiary is expected to pay the full cost for medical equipment once Medicare coverage is denied. We are more cautious with respect to HHC—where pre-service determinations are unlikely to benefit consumers in the same manner.

Documentation Problems Do Not Always Indicate Fraud: In the PRA notice, CMS states that the purpose of this proposal is to "assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs [Home Health Agencies] providing services to Medicare beneficiaries." We do not believe the proposed Prior Authorization demonstration will ultimately advance this cause. CMS' statement in support indicates that 90 percent of the improper payments for HHC were the result of insufficient documentation. Yet, some insufficient documentation is caused by mistakes in the process of documenting the need for the equipment or supply: a doctor leaves off a date or a therapist doesn't complete a field. These are clerical errors, not fraud.

From 2011 through 2014, CMS required, as part of the face-to-face encounter documentation, a physician narrative statement describing how the clinical findings from the encounter supported the patient's homebound status and need for skilled services. During this period, payments made in situations where a

[1] 81 Fed Reg 6275 (February 5, 2016).
[2] "Supporting Statement Part A – Medicare Prior Authorization of Home Health Services Demonstration" CMS-10599 (February 5, 2016): https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-10599.zip.

patient's medical record supported home care but the additional narrative statement was incomplete or not immediately preceding the physician signature, were deemed improper.[3]

CMS eliminated the narrative statement from the face-to-face encounter documentation requirement effective January 2015.[4] As such, the high rate of improper payments and documentation errors cited in the supporting statement may be documentation failures related to this additional narrative requirement, rather than fraud. CMS should analyze data from 2015 and 2016 to see if the increased improper payment rates found in 2014 decreased after the narrative statement requirement was removed.

Prior Authorization Programs are Resource Intensive for Providers and for Medicare: CMS' supporting statement estimates a cost to providers of over $25 million and a cost to CMS of $223 million to carry out the proposed demonstration. These costs are not insignificant; given our concerns about the efficacy and appropriateness of the demonstration, we encourage CMS to seriously consider these costs.

In closing, we urge CMS to reconsider the proposed demonstration. Requiring prior approval for every prospective home health recipient in a state for the provision of critically important services may effectively delay and deny needed home health coverage. We respectfully request that CMS withdraw the proposed prior authorization demonstration. At minimum, as described above, we encourage CMS to review claims data from more recent years as the agency evaluates whether or not to pursue the demonstration.

[3] Department of Health and Human Services "Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies; Final Rule" 79 Fed. Reg. 66043. Nov. 6, 2014.

[4][4] See, id.; Medicare Benefits Policy Manual, Ch. 7, §30.5.1.2.