

April 5, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; CMS—10599 Medicare Prior Authorization of Home Health Services Demonstration.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,100 hospital-based home health (HH) agencies, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposal to collect new information to develop and implement a demonstration project that requires prior authorization for all HH services provided in five states. The agency indicated that this project seeks to improve procedures for identifying, investigating and prosecuting Medicare fraud among HH agencies.

The AHA strongly supports efforts to reduce fraud and abuse in the Medicare program. However, we are concerned that issuing a proposal for such a broad demonstration through an information collection request, rather than through formal rulemaking, is inappropriate. Specifically, CMS's notice stated that Medicare contractors would conduct prior authorization before processing claims for all HH services provided in Florida, Illinois, Massachusetts, Michigan and Texas. The notice also estimated that when fully operational, the demonstration would affect more than 900,000 HH claims per year. For any HH claims in these states processed outside of the prior authorization demonstration and found to be medically necessary, a 25 percent penalty would be assessed. **Given that the proposed demonstration would represent a major change to the HH prospective payment system, the AHA urges CMS to re-issue this proposal through a notice of proposed rulemaking (NPRM).**



In addition, we believe this proposal should be re-tooled to target the specific types and locations of HH fraud and abuse in the specified states. We urge CMS to focus on interventions that target HH agencies with likely fraudulent practices, based on an analysis of Medicare claims. Such an approach would be more effective than using an across-the-board prior authorization, which would burden the entire HH field in these states, as well as already-overloaded Medicare contractors. CMS also must include comprehensive protections for beneficiaries who would likely be affected by this policy, such as provisions to ensure timely prior authorization coverage decisions and beneficiary appeals – details of which are absent from this proposal.

REPLACE INFORMATION COLLECTION REQUEST WITH AN NPRM

Given the magnitude of this demonstration, it is inadequate to issue the proposal through an information collection request. This proposal would be a significant change for the HH field, and its scope exceeds the role intended for information collection requests under the Paperwork Reduction Act. Specifically, we are concerned that imposing prior authorization on every HH service in five states would disrupt the clinical care of every beneficiary transitioning from a hospital to home care. Adding this new stage runs counter to efforts to streamline transitions of care, including hospital discharges to post-acute settings, as we move to alternative payment and care delivery models. In addition, prior authorization of every HH service in the target states would dramatically increase the administrative burden for hundreds of HH agencies and the multiple Medicare contractors administering claims payment and appeals. Yet, there is no evidence that the contractors processing Medicare claims in the proposed demonstration states have the capability of handling over 900,000 prior authorization requests per year. On the other hand, there is ample evidence that the Medicare contractors administering the fee-for-service (FFS) appeals process have little ability to handle an additional cohort of appeals, given the current, multi-year appeals backlog.

REPLACE STATE-WIDE PRIOR AUTHORIZATION WITH TARGETED INTERVENTIONS

CMS should identify explicitly how this demonstration would meet each of its stated goals of identifying, investigating and prosecuting HH fraud. As currently described, this proposal is unlikely to reduce fraud. HH convictions in recent years indicate that the most common fraud and abuse practices include billing Medicare for services that were never provided, overstating charges on claims and using referral kickbacks. It is unclear to us how prior authorization would prevent these fraudulent practices, and CMS provided no discussion in the rule of either the particular types of fraud found in the five states or how the demonstration would curtail them.

CMS's rationale for this across-the-board demonstration is unconvincing. For example, the agency cited national comprehensive error rate testing (CERT) for HH agencies, which showed an error rate that increased from 17.4 percent in fiscal year (FY) 2013 to 51 percent in FY 2014. However, CMS also noted that 90 percent of these errors were due to insufficient documentation. To be clear, documentation errors do not equate to fraud. Rather, the HH documentation errors that occurred during this time period were largely due to the difficulty providers faced complying with the HH face-to-face (F2F) encounter requirement. Under the F2F encounter policy, which was mandated by the Affordable Care Act and implemented by CMS in 2011, agencies were initially required to include a physician "narrative" when documenting a patient's need for HH services. This requirement led to prolific HH documentation problems, and, as a result, in January 2015, the narrative requirement was rescinded. Given these widely recognized HH documentation compliance challenges, it is inappropriate for the agency to cite CERT data as a rationale for this demonstration.

Furthermore, prior authorization for the HH field would not align with the timing criteria in the statutory F2F policy, which allows the encounters and the certification of HH eligibility to occur as late as 30 days *after* the start of HH care. CMS's demonstration proposal fails to explain how the agency would reconcile this F2F compliance window with the narrower and earlier prior authorization window. Further, CMS does not describe how the combined impact of the F2F policy and prior authorization – two overlapping efforts to ensure the medical necessity of HH services – would reduce the particular types of fraud found in the proposed demonstration states.

We urge the agency to, as it has in the past, implement anti-fraud interventions that target particular providers and areas deemed to be at high risk of fraud. Successful and proven tactics are available, based on the use of data analytics to hone in on particular providers and areas, such as counties. Some of these interventions include changing HH payment policy to reduce the occurrence of high-cost outlier claims by HH providers in selected areas and placing a moratorium on new HH licenses in high-fraud areas. For example, in 2013 CMS implemented temporary moratoria on new HH agencies in and around Miami and Chicago, and in 2014, announced new HH moratoria in Fort Lauderdale, Detroit, Dallas and Houston.

In addition, CMS has partnered with the Department of Health and Human Services (HHS) Office of the Inspector General and the Department of Justice (DOJ) to identify patterns of HH fraud through the analysis of claims data, and to pursue the perpetrators. In June 2015, the HHS Secretary and U.S. Attorney General announced the success of the joint Medicare Fraud Strike Force. Their announcement noted, "Every day, the Criminal Division is more strategic in our approach to prosecuting Medicare Fraud... We obtain and analyze billing data in real-time. We target hot spots – areas of the country and the types of health care services where the billing data shows the potential for a high volume of fraud – and we are speeding up our investigations. By doing this, we are increasingly able to stop schemes at the developmental stage, and to prevent them from spreading to

Andrew M. Slavitt
April 5, 2016
Page 4 of 4

other parts of the country.” This task force is part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint HHS and DOJ initiative, announced in May 2009, which has included HH as part of its focus. **To further reduce HH fraud and abuse, any new HH fraud fighting initiatives should follow the course already set by these existing, successful anti-fraud campaigns, which are based on the detailed study of specific HH Medicare FFS claims patterns.**

Thank you for your consideration of our comments. We look forward to working with you and your staff on this issue. If you have any questions, please contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President