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Advancing Health in America

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Seema Verma
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.

Dear Ms. Verma:

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) agency information collection notice on the home health "Review Choice" demonstration. Specifically, the agency would revise the original demonstration, initially implemented in Illinois from August 2016 through April 2017, and implement it on or after Oct. 1, 2018. CMS states that the purpose of this demonstration is to improve procedures for the identification, investigation, and prosecution of potential Medicare fraud in the home health field.

In summary, the AHA urges CMS to not re-implement this demonstration as proposed. First, we cannot support any reduction in access to care for beneficiaries seeking services from HH agencies with no indication of fraud. Second, the across-the-board design would needlessly impose significant and unwarranted burden on providers with no history of fraud. Third, despite the far-reaching impact of the proposed demonstration, the agency's notice does not provide a commensurate level of detail regarding either the rationale for 100 percent review or the proposed implementation plan. Finally, we also are concerned that the demonstration runs counter to CMS-led efforts to improve the HH prospective payment system (PPS) and episodes of care involving home health services.

Instead, the AHA urges CMS to share its findings from the first iteration of the demonstration. Doing so would help fulfill the purpose of a demonstration, which is to study and, if possible, refine a potential future policy. In particular, the field has found that the initial demonstration did result in improved documentation practices, which raised the acceptance rate for pre-claim review submissions from 40 percent to more than 90 percent. However, we have no indication from the agency regarding any corresponding reduction in fraudulent behavior. The types of correctable documentation changes that occurred should be studied by CMS and shared with the national provider community. Doing so would be more fruitful than furthering the proposed, and likely ineffective, fraud reduction demonstration.

Background. The initial version of this demonstration, launched in Illinois in August 2016, required Medicare's pre-claim review for all HH services provided in five states: Florida, Illinois, Massachusetts, Michigan, and Texas. When it was paused in April 2017, it was active in Illinois and about to launch in Florida. The original demonstration was the subject of extensive concern from Congress, the AHA and the HH field based on its overly broad focus, targeting almost 1 million claims per year when fully implemented. Instead, we advocated that the agency should rely on available data analysis tools to specifically target the subset of providers with a high risk of fraud.

The proposed new version of the demonstration would present three options to HH agencies in Florida, Illinois, Ohio, North Carolina, and Texas:

- Participate in 100 percent pre-claim review until a certain "target affirmation" or "claim approval" rate is reached;
- Participate in 100 percent post-payment review until a certain "target affirmation" or "claim approval" rate is reached; or
- Submit claims without undergoing such reviews, but receive a 25 percent payment reduction on all claims and remain eligible for review by a recovery audit contractor (RAC).

We note that in the target states, of the 4,986 HH agencies, 179 are hospital-based providers. CMS states that the demonstration would run for five years and begin on or after Oct. 1, 2018 in Illinois, and would next expand to Ohio and North Carolina.

The Demonstration Would Reduce Beneficiary Access to Care

This demonstration would reduce access to care, especially for beneficiaries seeking care from smaller or mid-size home care providers. As we saw in Illinois during the initial demonstration, smaller providers are often unwilling to begin providing services until pre-claim review is completed. Specifically, they determined that beginning care prior to the completion of a pre-claim review was too financially risky.

In other words, they lacked the capacity to bear the risk associated with commencing care without reasonable assurance that Medicare payment would be provided. As a result, beneficiaries either were not able to use their HH agency of choice, or experienced delays in receiving care. In fact, more than 40 smaller HH agencies in the Illinois demonstration closed, in large part due to this problem. **These access challenges could be greatly mitigated by only implementing this demonstration for HH agencies with history of fraud or evidence of fraud risk.**

100 Percent Claims Review Is Excessive and Would Penalize Providers with No History of Fraud

The AHA strongly supports efforts to reduce fraud and abuse in the Medicare program. However, this demonstration would not focus on likely sources of HH fraud and abuse identified through data analytics. As such, rather than the proposed 100 percent audit approach, we encourage CMS to focus on interventions that target specific HH agencies, specific forms of fraudulent activities, or specific areas with likely fraudulent practices, as identified by the agency's analysis of Medicare claims. Such an approach would avoid burdening the entire HH field and all HH beneficiaries in the demonstration states, as well as already-overloaded Medicare contractors.

While we do not support the proposed version of the demonstration, should the agency proceed, we urge alignment between the chosen fraud-reduction intervention and known forms of fraud. Unfortunately, for either the initial or the proposed version of the demonstration, CMS did not discuss the prevalence of particular types of fraud in the demonstration states or how 100 percent claims audits would curtail such fraud in a manner more effective than other approaches. However, as reported by U.S. Assistant Attorney Stephen Chahn Lee in his *Law-Enforcement Observations About Home-Health Fraud*[1] presentation to stakeholders during a CMS open door forum, common forms of home health fraud include the following:

- HH agencies paying kickback fees to primary-care physicians for referrals;
- Marketers shopping for physicians with no relationship to the patient who will certify a patient as being medically necessary for HH services;
- Nurses lying about patients' conditions during assessments to make patients seem sicker than they actually are;
- HH agencies creating false documentation to indicate that doctors and nurses are discussing patients' conditions and care, such as fake telephone orders;
- Nurses falsifying documentation to indicate that routine checkups are necessary; and

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Downloads/Special-Open-Door-Forum-on-Home-Health-Fraud.pdf.

- Agencies discharging and then re-admitting patients at the same or related agency when there is no intervening change in the patient's medical condition;

As such, before advancing any new HH fraud intervention, we encourage CMS to detail which particular forms of fraud are being pursued and the evidence for the particular approach/es relative to the goals of identifying, investigating, and prosecuting HH fraud.

In addition, CMS states that the audits are partially designed to determine "if there is a suspicion of fraud." **However, imposing a 100 percent audit rate when the agency admittedly is still seeking evidence of fraud would be premature, excessive, and an irresponsible imposition of burden on beneficiaries as well as agencies with no history or evidence of fraud.**

Fortunately, there is a plethora of alternative interventions already underway by multiple fraud-fighting agencies. For example, since its inception in March 2007, the Medicare Fraud Strike Force charged more than 3,500 defendants who falsely billed the Medicare program for over $12.5 billion, as reported by the Department of Justice (DOJ) in May 2018. This laudable outcome reflects the joint initiative between the DOJ Criminal Division Fraud Section and the Department of Health and Human Services (HHS) to prevent and deter fraud and enforce current anti-fraud laws around the country. Another example of a multi-agency fraud initiative is the Health Care Fraud Prevention Partnership (HFPP). This involves CMS, DOJ, HHS Office of Inspector General (OIG), the Federal Bureau of Investigation, private insurers, states, and associations in the HFPP to prevent health care fraud on a national scale. To detect and prevent payment of fraudulent billings, the HFPP exchanges information and best practices across the public and private sectors, and, since 2013, has conducted eight studies that enabled substantive actions, such as payment system edits, revocations, and payment suspensions to stop fraudulent payments and improve the government's collective forces against fraud, waste, and abuse. The amount of data collected in support of HFPP studies increased by 300 percent in fiscal year (FY) 2016, leading to the performance of new studies, the replication of prior studies with new data and the attainment of actionable leads.

Under another tool, CMS targets particular providers through the agency's use of the Affordable Care Act authority to suspend Medicare payments to providers during an investigation of a credible allegation of fraud. CMS also has authority to suspend Medicare payment if reliable information of an overpayment exists. For example, CMS reports that during FY 2016, there were 508 payment suspensions that were active at some point during the fiscal year. These evidence-based interventions are clearly reducing Medicare crime, including HH fraud. **Given their success, the use of measures such as these, which stem from the detailed study of specific HH Medicare fee-for-service (FFS) claims patterns, should be expanded in lieu of across-the-board approaches.** We also continue to support proven tactics to

change HH payment policy, such as reducing the occurrence of HH high-cost outlier claims, and continuing the current moratorium on new HH Medicare provider licenses in high-fraud areas.

In addition, we urge CMS to look to the common-sense, intermediate measures already suggested by the field, including the following that the AHA supports:

- Targeting the subset of providers across the country, conditions, or specific areas for which CMS has evidence of fraud risk; or
- If CMS is determined to continue with implementing the proposed demonstration:
    - Mitigating administrative burden for non-fraudulent providers by lowering the targeted rate of claims review to a level far below 100 percent;
    - Shifting the focus of the demonstration to identifying and disseminating opportunities to improve documentation; or
    - Implementing optional pre-claim review, which would both reduce burden while still generating process and documentation improvement insights to share with the overall field.

Proposed Demonstration Misaligned with Other Reform Efforts

HH PPS Reform. **We also are concerned that the timing of the demonstration would result in unprecedented upheaval for the HH field given the pending overhaul of the HH PPS and other marketplace reforms.** Specifically, CMS has proposed a major re-engineering of the HH PPS for calendar year (CY) 2020. This follows extensive research that yielded a payment model shared with the field in 2016, proposed for implementation July 2017, and then withdrawn in November 2017. The scope of CMS's proposed reforms for CY 2020 cannot be overstated – they would be a complete departure from the payment model in effect since 2000. The proposed new HH PPS case-mix system would replace the reliance on a single payment driver – a patient's utilization of therapy – with a more comprehensive clinical profile. This new system design, which relies on a multitude of distinct factors to set payment, may reduce the prevalence of certain types of fraud. Regardless, transitioning to this new payment model would require comprehensive education and training. **As such, asking every HH agency in the demonstration states also to undergo 100 percent claims review would be excessive, especially for smaller providers.**

Alternative Payment Models. Many HH agencies are partnering with other providers, including hospitals, in new ways to improve clinical outcomes and lower overall spending. The resulting new protocols and clinical care pathways, as encouraged by CMS, often focus on more strategic use of the HH setting and are garnering the attention and resources of many of the top HH agencies in the nation. Unfortunately, the proposed demonstration, which targets a problem perpetrated by only a subset of HH agencies, would reduce the time and funds available to the agencies working

to improve episodes of care that involve HH services. **In other words, the proposed demonstration runs counter to CMS-sponsored efforts to improve episodes of care by streamlining transitions to home care, improving care protocols and reducing avoidable readmissions to hospitals.**

Information Collection Request Does Not Contain Adequate Level of Detail

The information collection request provides an inadequate level of detail given the complex scope of the proposal that would affect every HH agency in the targeted states.

Insufficient Detail Included in Notice. In CMS's one-and-a-half page notice describing the demonstration, the agency fails to describe lessons learned from the initial demonstration. It also fails to include an explanation of why the agency moved away from a sole focus on pre-claim review to also include a second option of post-payment audits. Further, CMS had indicated to the field that it was considering additional alternatives, such as not requiring 100 percent audits, but these options were not shared. This lack of information is insufficient to support such a broad demonstration.

In addition, CMS also failed to share information on:

- The amount and types of HH fraud in the targeted states compared to that of other states, in terms of number of claims and dollar impact;
- The amount of HH fraud within the targeted states, county, or local area, in terms of number of claims and dollar impact;
- The amount of HH fraud for particular conditions in the targeted states, county, or local area, in terms of number of claims and dollar impact; and
- The estimated cost-benefit ratio for a typical targeted fraud-fighting program, such as the DOJ and OIG examples noted above, versus across-the-board programs, such as this demonstration.

Notice Lacks Burden Estimate. As discussed, we expect that the proposed demonstration would cause excessive burden for both beneficiaries and providers, as well as CMS and its contractors engaged in both administering claims and appeals. Yet, the information collection notice provides no estimate of burden or, alternatively, alignment with the agency's paperwork reduction goals. The notice also lacks an estimate of claims that would be affected, although the agency estimated that the initial demonstration would affect 900,000 per year, when fully implemented. In addition, for any provider that opts out of 100 percent review to pursue the 25 percent penalty in combination with RAC review, we are concerned that an uptick in audits, denials, and appeals would tax the current Medicare appeals process for HH claims, which could contribute to an appeals backlog that threatens the financial wherewithal of smaller providers.

Lack of Detail on Transitioning from 100 Percent Review to Targeted Checks. Further, the notice's one sentence explanation of the mechanism proposed to allow HH agencies to reach a certain "target affirmation" or "claim approval" falls far short of the detail needed by stakeholders to understand the impact of the proposed demonstration. For example, it is unclear whether CMS or the contractor would set the target rates, what they would be, and whether all agencies across the demonstration states would be subject to the same or different rates.

Given our concerns with the proposed demonstration described above, if the agency wishes to proceed, the AHA urges CMS to re-issue another iteration of the proposal that takes into account the field's concern with the program and operational details.

We appreciate your consideration of these issues. Please contact me if you have questions, or feel free to have a member of your team contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations & Public Policy