



April 5, 2016

VIA ELECTRONIC SUBMISSION

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Probable Fraud Measurement Pilot; CMS-10599 Medicare Prior Authorization of Home Health Services Demonstration

Dear Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the notice entitled, *Medicare Probable Fraud Measurement Pilot; CMS-10599 Medicare Prior Authorization of Home Health Services Demonstration* (“the Notice”). CPR is a coalition of national consumer, clinician, and membership organizations that advocates for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions can regain and/or maintain their maximum level of health and independent function.

CPR believes in maintaining the integrity of the Medicare home health benefit. But we believe that a prior authorization requirement for home health care would delay beneficiary access to needed services, expose patients to potentially unnecessary services, increase costs to the Medicare program and to taxpayers, and miss the mark in terms of curtailing fraud and abuse. Applying prior authorization to home health services creates a dangerous precedent. We urge you to rescind this proposal and instead engage stakeholders in developing targeted solutions to protect and strengthen the integrity of the Medicare home health benefit.

A. Prior Authorization Would Adversely Affect Patient Care

Prior authorization under private insurance coverage usually consists of confirmation that a particular patient is covered by a particular health plan and that the category of benefits being prescribed are generally considered a covered benefit. The prior authorization proposed for Medicare home health services appears to be modeled after the recently published final rule on prior authorization for durable

medical equipment, prosthetics, orthotics, and supplies (DMEPOS).¹ We note that Congress authorized CMS to conduct prior authorization of certain durable medical equipment in the Social Security Act, Section 1834(a)(15). However, there is no statutory authorization for CMS to conduct prior authorization for any other Medicare services, such as home health care.

The form of prior authorization proposed under the Notice for home health care differs markedly from simple confirmation of basic facts and coverage for each patient. It consists of pre-approval of physician prescribed services before a patient may obtain access to such care. This essentially equates to Medicare contractors practicing medicine. For this reason alone, the CPR Coalition has serious concerns with this proposal.

Were CMS to move forward with prior authorization of home health services, the Medicare program would set a new precedent. It would establish a program that inappropriately expands the existing prior authorization program from devices only (e.g., certain DME) to prior authorization for clinical services. Patients would be in the position of only being permitted access to needed care if its contractor authorizes access beforehand. This would place tremendous clinical authority in the hands of Medicare Administrative Contractors to supersede the medical judgment of physicians and other providers. Additionally, it would open the door to application of this concept of pre-approval to virtually any service provided to patients under the Medicare program.

In the rehabilitation context, this proposal would seriously delay access to home health services at the very time that all of organized medicine is developing and implementing alternative payment models designed to decrease hospitalization and increase independent living in the home and community environment. Home health services help achieve savings to the health care system. We do not believe that additional barriers should be placed on accessing these services, as this is at cross-purposes with contemporary health care policy.

The most problematic consequence of prior authorization is the delay in access to home health services that patients will inevitably encounter. For instance, the final DMEPOS prior authorization rule states that once all the paperwork is submitted to a Medicare Administrative Contractor, the prior authorization decision must be made within ten (10) business days. A resubmitted request for prior authorization may take up to twenty (20) business days. An expedited review is only required when applying these timeframes seriously jeopardizes the life or health of the beneficiary.²

These timeframes would seriously hamper the ability of patients to be discharged to the home environment for home-based care once their acute care hospital, rehabilitation hospital or unit, or skilled nursing facility stay is no longer considered medical necessary. These institution-based providers would be forced to anticipate well in advance the day a patient would be appropriate for discharge to the home and begin the prior authorization process. If an approval were not secured at the time when it is no longer medically necessary to keep the patient in the inpatient setting, a decision would have to be made to either keep the patient unnecessarily (thereby risking denial of these claims for reimbursement), send the patient to another, less intense setting (thereby churning the patient through another setting of care unnecessarily), or sending the patient home without the home health services necessary to safely and effectively reintegrate the patient back into the community. This also

¹ Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, December 30, 2015, *Federal Register*, Vol. 80, No. 250, page 81674.

² *Id.*

risks increasing the rates of readmission to acute care hospitals, one of the most prevalent indicators of poor quality care.

Medicare patients following major surgery, trauma, frail patients with dementia, individuals with musculoskeletal disorders, brain injuries, spinal cord injuries, Alzheimer's Disease, and other physical, mental, and emotional challenges depend on *immediate* home health care when other care providers are no longer appropriate. A prior authorization process does not lend itself to timely access of home health services. In fact, prior authorization of home health services will likely result in the unintended consequences of increased costs to the Medicare program through unnecessary referrals to settings of care other than home health, and readmission to the acute care setting when the receipt of home health services could have prevented readmission.

B. Capacity of Contractors to Timely Decide Prior Authorization Requests

Under the current prior authorization demonstration projects for certain mobility devices and related DME, Medicare contractors process several thousand prior authorization requests per year. In comparison, the magnitude of Medicare home health claims in five major states, as proposed under the Notice, is daunting. CMS and its contractors simply do not have the capacity to process, in a timely manner, prior authorization requests for home health services that would be expected to number in the hundreds of thousands, perhaps millions, annually.

The delay in obtaining approval would be significant and detrimental to patients. Consider the million case backlog at the Office of Medicare Hearings and Appeals and the extensive delay this has caused to imagine the potential delay in access to care under this proposal. In addition, claims submitted without prior approval would be denied, assuming the home health requirements were consistent with the final rule for DMEPOS prior authorization. This would place Medicare patients and providers in an untenable situation.

The delay in approval is not just a function of how quickly a Medicare contractor would be able to assess submitted documentation on each patient and render a coverage decision on home health care. The delay stems in part from the requirement on providers to collect the required documentation and submit it while care is being rendered at the bedside. Health care professionals would be forced to break from direct patient care in order to file the paperwork and arrange for the submission of sufficient proof that a treatment plan that includes home health care is permissible in the eyes of the Medicare contractor. This is unacceptable and will not serve the stated purpose of this prior authorization requirement, which is to reduce fraud and abuse.

C. Prior Authorization Would Not Reduce Fraud and Abuse

To the extent that fraud and abuse in the home health benefit continues to be a problem under the Medicare program, there are more targeted approaches to reducing such behavior than delaying and denying care to Medicare beneficiaries who need these services. We believe that prior authorization will not reduce fraud and abuse in home health. More prudent fraud and abuse policy would include more effective targeting of aberrant billing and utilization, insufficient qualifications and background checks, and geographic areas prone to fraud and abuse.

Implementing a system of prior authorization for home health services would not address the population of those who prey upon the Medicare program and defraud Medicare by filing false claims.

These individuals will simply continue to submit false claims that seemingly comply with CMS' documentation requirements. Prior authorization would merely delay receipt of the improper payments. CPR would welcome the opportunity to work with CMS to develop program integrity measures that fall within CMS's authority and that would more effectively target fraud and abuse.

For the reasons stated above, we urge CMS to rescind this request for information and not proceed with a prior authorization program or demonstration project for home health services under the Medicare program.

Signed,

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Endorsing Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Center for Medicare Advocacy
Child Neurology Foundation
Child Neurology Society
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Easter Seals
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council on Independent Living
National Disability Rights Network
National Multiple Sclerosis Society
National Stroke Association
Paralyzed Veterans of America
Parkinson's Action Network
Uniform Data System for Medical Rehabilitation
United Spinal Association