

# 5 REASONS

## Pre-Claim Review Is Bad for Medicare Home Health Services

The Centers for Medicare & Medicaid Services (CMS) recently proposed a pre-claim review demonstration for Medicare home health services, upon which approximately 3.5 million Medicare beneficiaries depend. These beneficiaries have been documented as being older, poorer, sicker, and more likely to be disabled, a member of an ethnic or racial minority, or female than all other Medicare beneficiaries combined. The demonstration is set to start no earlier than August 1 in the entire state of Illinois, and shortly thereafter apply to every claim made by every home health agency in Florida, Texas, Michigan and Massachusetts.

**The following are the top five reasons CMS should rescind this proposal and develop targeted alternatives in coordination with stakeholders to protect and strengthen Medicare program integrity.**

1

### **Pre-Claim Review Will Not Reduce Fraud and Abuse**

Pre-claim review policies will not stop bad actors who are intent on defrauding the Medicare program. Instead, bad actors will continue to submit false information that satisfies the new requirements. Home health leaders caution that the demonstration is not an effective measure for investigating and prosecuting fraud in the home health benefit.

2

### **CMS is Not Prepared to Manage Such a Large, Sweeping Demonstration**

The pre-claim review process will increase the workload of Medicare Administrative Contractors (MACs) by 40-fold, according to estimates. MACs will be required to review more than 1 million claims per year, as opposed to the approximate 25,000 claims currently being reviewed annually. Home health leaders are concerned that CMS does not have the appropriate qualified workforce to properly manage this demonstration to ensure that home health agencies providing advanced clinical care can be assured of payment for the skilled services they provide.

3

### **It Will Impose Significant Financial and Administrative Burdens**

Pre-claim review will lead to higher costs, as patients who would otherwise be served in their home are denied access by the third-party contractor. Further, this policy would increase the administrative burden on physicians and home health agencies that already face a confusing array of requirements associated with the “face to face” encounter.

4

### **It Could Have a Negative Impact on Patient Outcomes and Experience**

Pre-claim review will hinder the ability of home health agencies to provide seamless, integrative high quality skilled health care to patients transitioning from the acute care setting to the home. The threat of care delays and interruptions could negatively impact patient outcomes and the care experience.

5

### **Providers and Patient Advocates Want to be Part of the Solution**

Home healthcare leaders and other key stakeholders would welcome the opportunity to collaborate with CMS on the development and implementation of appropriate and targeted program integrity measures that fall within CMS’s authority and that would effectively identify and eradicate fraud and abuse without exposing patients to any risk or taxpayers to any increased cost.

**PLEASE URGE CMS TO RESCIND ITS PRE-CLAIM REVIEW DEMONSTRATION AND INSTEAD DEVELOP TARGETED PROGRAM INTEGRITY REFORMS**