April 1, 2016

U.S. Centers for Medicare and Medicaid  
Office of Strategic Operations and Regulatory Affairs  
Division of Regulations Development  
Room C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Attention: CMS-10599

Dear Sir/Madam:

The Home Care Association of New York State (HCA) appreciates the opportunity to comment on the proposed Information Request for the “Medicare Prior Authorization of Home Health Services Demonstration” (CMS – 10599).

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 300,000 Medicare and Medicaid patients in New York State. HCA’s members include Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCP) providers, Licensed Home Care Services Agencies (LHCSAs), providers of various waiver programs, Managed Long Term Care plans, hospices and others. HCA’s home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

While we support efforts by the U.S. Centers for Medicare and Medicaid Services (CMS) to address billing, payment and service integrity in the Medicare program, we strongly object to the proposed “Medicare Prior Authorization of Home Health Services Demonstration” and call for it to be rescinded.

General Comments

As part of the demonstration, CMS would perform prior authorization before processing claims for home health services in Florida, Texas, Illinois, Michigan and Massachusetts (though it is possible that this pilot would be extended to New York and other states as well).

This proposal would create altogether unnecessary obstacles in access to care, increase system-wide costs, and jeopardize the quality of care that patients receive.
The following is a description of additional reasons why CMS should reject this misguided proposal.

**Access to Care**

Mandatory prior-authorization programs can negatively impact beneficiary access to care by imposing significant delays in receiving needed services. At a time when health care transformation efforts are seeking to improve discharge planning and referral to community settings, prior-authorization adds a new layer of obstacles to receiving needed services. These barriers force patients and providers to await presumptive decisions by outside contractors (regarding the suitability of care) when the demands to initiate services are often urgent.

Delays in prior authorization can result in patients being kept in hospitals unnecessarily or being discharged home without the services and supports they need, thus increasing the risk of unnecessary and costly rehospitalizations.

Prior-authorization can also impede the timely delivery of vital home health services to individuals living at home who did not have a prior inpatient stay but who – in the professional judgment of physicians and care planners – are deemed to need home care to remain safe and healthy in the community setting.

**Prior authorization is counter to CMS’s stated goals**

In its “supporting statement” for the proposal, CMS states that this demonstration will assist in analyzing the effectiveness of a prior-authorization process in increasing the ability to identify, investigate and prosecute fraud as well as to reduce improper payments.

CMS justifies the demonstration by pointing to a high improper payment rate for home health agencies (HHAs). From fiscal years 2013 to 2014, the improper payment rate for HHA claims increased from 17.3 to 51.4 percent, according to Comprehensive Error Rate Testing (CERT) reports.

However, 90 percent of those errors were due to insufficient documentation, predominantly in the face-to-face (F2F) narrative requirement, which is the subject of intense provider and policymaker discussion regarding its efficacy and necessity. Prior authorization will not address this major driver of denials at a time when the required documentation of F2F remains mired in dispute, due to conflicting information and direction by Medicare Administrative Contractors (MACs), inadequate physician education and engagement. While a large number of payments have been retrospectively disallowed on the basis of F2F, these disallowances are technical and bureaucratic in nature, rather than resulting from evidence that services were not needed or provided.
These CERT findings aside, the major areas of HHA fraud are not documentation issues, but billings for “phantom” patients and referral kickbacks conducted by a few bad actors in the system; none of these cases would be addressed by a prior-authorization system.

**Prior authorization is duplicative of existing CMS audit activities and controls**

CMS already has many existing tools and auditing entities at its disposal to address Medicare integrity issues, including Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), state-level surveillance agents (targeting Conditions of Participation adherence), third-party liability payment auditors, the Office of the Inspector General, the MACs’ “Probe-and-Educate” audits, and others.

In an environment where audit and integrity programs are already robust, this new demonstration is even less discriminating in its targeting. The initiative unfairly and arbitrarily scrutinizes and delays service authorizations for all HHAs, even those who have a long-established record of compliance with existing rules and regulations and may already be scrutinized by retrospective audits from other entities.

CMS’s time and resources would be better allocated targeting those specific HHAs, regions, or utilization bands suggesting fraudulent activity, rather than punishing all agencies with a time-consuming and costly effort that burdens and delays access to care across-the-board for all Medicare home health beneficiaries.

**Prior authorization jeopardizes and contradicts the design of existing CMS innovations and goals**

Regrettably, this demonstration works in direct opposition to the current orientation of our health care environment, where CMS’s “Triple Aim” and associated programs are focused on delivering services in the most appropriate care setting at the lowest cost.

The bottleneck created by prior-authorization contradicts the very goals, procedures and technical designs of CMS’s own innovations, be it value-based payment, bundling initiatives, Accountable Care Organizations or other specific new pilots like the Comprehensive Care for Joint Replacement (CJR) program – all of which rely on the smooth, expeditious and flexible assignment or discharge of patients.

**Prior authorization takes care-planning decisions away from professionals in the field who have direct knowledge of urgent care demands and consequences**

This demonstration process redirects care-planning decisions from the patient’s care team to the Medicare contractors. These government contractors are not directly liable for the timely initiation of care at the clinical level and they are not intimately involved in urgent clinical
decisions where time is of the essence, especially during discharge from hospitals on weekends and evening hours and in other critical circumstances.

**Prior authorization increases costs to Medicare, its providers, its contractors and will worsen an already massive backlog of appeals**

By denying an expeditious discharge or referral to cost-effective home care settings, this proposal will substantially escalate the cost of services. It will drive longer inpatient stays in facilities (be it prolonged hospital stays or incentives for admission to other post-acute facilities) while patients await authorization for services in the home, where post-acute care is most cost-effective. Statistical models bear this out. According to a 2012 study by Dobson DaVanzo and Associates, home care accounts for nearly 40 percent of hospital discharge episodes to a post-acute setting; yet these episodes represent less than 30 percent of Medicare episode payments (costs). In contrast, skilled nursing facilities represent 50 percent of post-discharge episodes and approximately 50 percent of episode payments (costs).

This demonstration will also significantly raise administrative costs for agencies tasked with new paperwork requirements. HHAs and referring physicians will be forced to redirect staff time away from the beneficiary’s clinical care and toward compliance with onerous and duplicative documentation and clinical records requests. As it stands, providers are already stretched thin in the “paper chase” for signed physician orders, face-to-face encounter documentation, and physician validation under the Provider Enrollment Chain and Ownership System (PECOS). This demonstration offers a duplicative process of oversight that will only add to the paper chase that already plagues providers.

Meanwhile, home health agencies are subject to devastating rebasing reductions and other reimbursement cuts that already underpay these existing cost obligations, not to mention the new cost obligations of a prior-authorization process, which has a direct impact on the initiation of services.

Lastly, the demo will result in many additional requests for administrative appeals from beneficiaries, further increasing an already massive backlog of appeals. The Congressional Budget Office has noted that there is currently a delay of about five months in entering new appeals cases into the Administrative Law Judge docket and the average processing time for an appeal in fiscal year 2015 was about 550 days.

**Prior authorization runs counter to and contradicts quality measures and regulatory requirements for timely initiation of services, undermining patients’ satisfaction with care**

Under Medicare Home Health Compare, CMS has established a performance measure for timely initiation of care that counts the “percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within two days of the referral date or inpatient discharge date, whichever is later.” Thus, a prior-authorization process for home health care will force agencies to choose between initiating care
promptly at financial risk, or else placing their quality measurement in jeopardy by awaiting a
determination from the contractor. An additional layer of administrative burden will decrease
patients’ satisfaction with their home health benefit and the agency, affecting the agency’s
survey results and ratings.

More importantly, any policy mechanism delaying timely initiation of care runs directly
counter to CMS’s own indicators and regulations for quality care. This includes the Medicare
Conditions of Participation (CoPs), which require home health agencies to initiate care and
perform an initial patient assessment within 48 hours of referral, upon a patient’s return to
home, or a future date specified by the physician’s order.

Some states have more stringent requirements, such as a New York State regulation that
requires agencies to conduct an initial patient visit within 24 hours of receipt and acceptance of
a community referral or return home from institutional placement.

This proposal offers no assurances that prepayment authorization would be rendered timely
within such a strict window of time, again putting decisions in the hands of outside
contractors who have no liability for meeting CoPs or other demands for timeliness of services.

In Conclusion

On behalf of New York State’s entire home care community, we strongly urge CMS to rescind
this proposed Demonstration and solicit feedback from the provider community on other, more
appropriate ways to address Medicare integrity issues. Given that documentation is the key area
of alleged noncompliance, CMS should instead opt for education, clear guidelines and
compliance standards, and provider support in place of this prior-authorization proposal, which
will have many adverse and unintended consequences including the jeopardizing of access to care,
the increase of system and operational costs, and a negative impact on quality of care.

Thank you for the opportunity to offer our comments. If you have any questions or need
additional information, we can be reached at (518) 426-8764.

Sincerely,

Andrew Koski
Vice President for Program Policy & Services

Alexandra Blais
Director of Public Policy