April 5, 2016

Submitted via regulations.gov

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: Home Health Prior Authorization

Dear Sir or Madam:

The Council of State Home Care Associations, representing over 15,000 homecare associations, appreciates the opportunity to respond to the Centers for Medicare and Medicaid’s request for comments on the Federal Register notice announcing CMS’ intention to collect information pertaining to a Medicare prior authorization of home health services demonstration, 81 Fed. Reg. 6275 (Feb. 5, 2016). We are deeply concerned CMS’ proposals will negatively impact beneficiaries and home health agencies, create delays in access to services, and increase costs for providers and Medicare.

Nationwide, approximately 500,000 skilled professionals are providing home health services to more than 3.5 million Medicare beneficiaries who require acute, chronic, or rehabilitative care. We recognize the need for intelligent policies to combat fraud, waste, and abuse, but the proposed program would be ineffective in accomplishing this goal.

In light of these factors and the specific issues detailed below, we therefore urge you to rescind this proposal and instead engage stakeholders to develop innovative reforms to improve the program integrity, quality, and efficiency of home healthcare.

1. **Prior Authorization is Not A Targeted Program Integrity Measure**

Before imposing additional measures like prior authorization on patients, we believe it is important for CMS to evaluate other measures it has already put in place to assure high quality care and prevent fraud. Medicare home health services already have a thorough authorization process in place that includes a signed plan of care and the physician’s signature on the plan of care, signifying that the patient meets the Medicare certification requirements. At the same time these programs have been ineffective in preventing fraud and abuse because they do not target the types of fraud that actually do occur.

We are particularly concerned about the potential harm prior authorization would cause to beneficiaries in light of other program requirements which have created a tangled web for beneficiaries to receive care. As one of many examples, a CMS contractor recently denied authorization for home healthcare for a frail older patient with clearly documented dementia who was hospitalized because she mismanaged her prescription drugs. Upon discharge, she was sent home with a home healthcare referral for skilled nursing, medication management, and physical therapy. Although the record submitted to CMS included physician documentation on the patient’s diagnosis and the issues that necessitated home healthcare, and even though the hospital physician and community physician certification corroborated the record, the contractor declined to authorize home healthcare, placing the patient at heightened risk of another medical crisis and readmission.

In the case of the face-to-face requirement which was added to prevent fraud and abuse, the requirement has caused more harm than good. Providers have faced complicated and confusing documentation requirements along with a haphazard review process. At the same time, face-to-face, much like a prior authorization requirement, merely delays improper payment to schemes involving fraudulent signatures or billing for services not provided, it does not effectively prevent improper payment.

The home healthcare industry understands the integrity concerns of CMS relative to home health services and has requested for some time that CMS develop targeted program integrity programs based on data that they clearly own that shows exactly what and where questionable home healthcare is being provided. A targeted review would be far more beneficial than implementing administrative roadblocks that cast a wide net with questionable return.

1. **Prior Authorization Would Harm Patient Care and Increase Costs**

It is critical to note that Medicare’s various programs treat vastly different patients and operate in vastly different ways. CMS appears to suggest a prior authorization program is appropriate for home healthcare patients because it is appropriate for patients receiving power mobility devices. This analysis is a troubling prospect for continuity of patient care for a number of reasons.

While patients in need of power mobility devices are able to wait for CMS to complete a 10 day authorization review, such a wait is unacceptable for a patient requiring home health post an acute care episode. Home health agencies are often expected to provide services within 24 hours of a patients’ discharge from the hospital. Such delays would require patients to stay in the short-term acute care hospitals for 10 days (pending prior authorization approval) or be sent instead to a facility-based setting that would be more costly for Medicare.

The implications of prior authorization to the Comprehensive Care for Joint Replacement (CJR) model offers a timely example of the counterproductive effect prior authorization would have in increasing costs to Medicare. CMS itself noted in its November 2015 report on CJR that home healthcare will be critical to hospitals’ ability to achieve savings within the CJR bundled payments. While the CJR model and star rating system prioritize patients being timely discharged from hospitals to home healthcare, prior authorization would create barriers of delay for providers. The resulting delay in care initiation may lead to higher readmission rates, since patients discharged to the home could experience a worsening in their condition or a health emergency as they await the initiation of home healthcare.

Further, prior authorization would be neither manageable nor realistic for an already strained-CMS. In order to not interrupt patient care, CMS will have to come up with considerable resources to simply manage a pre-authorization process with such a broad scope at a time when there are already major issues with responsiveness and payment lag times.

1. **Prior Authorization Would Harm Small Home Health Agencies**

According to the Paperwork Reduction Act notice and the accompanying Supporting Statement, Medicare’s costs alone for this program are forecast at an early estimate of $250 million annually. It is our belief the provider costs would far exceed that amount. We would ask that prior to any such program being implemented, CMS publish what evidence exists to support that the program is worth such a costly investment. In the present climate, home health agencies face further closures and patient dislocation, which jeopardizes the health and well-being of America’s most vulnerable elderly and disabled Medicare beneficiaries.

Even without prior authorization being implemented, home health agencies face real challenges to keep staffing levels adequate, quality high, and their doors open. Further challenges, such as a prior authorization requirement, for beneficiaries to access our services would pose even greater challenges for our providers, particularly those serving rural communities.

We urge CMS to rescind this request for information and not proceed with a prior authorization demonstration program for home health. We and our colleagues throughout home healthcare 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.

The Council of State Home Care Associations appreciates the work that CMS does as well as the opportunity to respond to this proposal. Please contact me if you have questions or if we can be of assistance.

Sincerely,