VNAA
Visiting Nurse Associations of America

April 5, 2016

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: Form Number: CMS-10599 (OMB Control Number: 0938—NEW)

To Whom It May Concern:

On behalf of the Visiting Nurse Associations of America (VNAA), we write to express strong opposition to the Medicare Prior Authorization of Home Health Services Demonstration. The proposal dramatically overhauls Medicare payment policy for all home health agencies (HHAs) in the impacted states and does so at the direct expense of beneficiaries who qualify for Medicare home health services. VNAA strongly opposes this demonstration and recommends that CMS immediately rescind this proposal. In addition, we raise concerns about the Medicare Probable Fraud Measurement Pilot.

VNAA is a national organization that supports, promotes and advances mission-driven providers of home and community-based health care, hospice and health promotion services to ensure access and quality care for their communities. VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicare, Medicaid, privately insured and uninsured patients. VNAA members provide high quality, patient-centered care at home as well as offer support for family caregivers. They primarily serve the most clinically complex and vulnerable patients who are by definition homebound and who will benefit from having closely integrated health exchange between all members of the care team. Home-based care providers work to improve the management of patients with chronic conditions, thus addressing some of the greatest challenges in healthcare today, including medication management, uncoordinated transitions of care, and high rates of unnecessary hospital and emergency department utilization. VNAA members provide high quality care. In CMS' first release of the Home Health Compare Star Ratings, the percentage of VNAA members earning four to five stars was nearly double the national average.[1]

[1] Visting Nurse Associations of America analysis of 2015 Medicare Home Health Compare, www.medicare.gov/homehealthcompare

Medicare Prior Authorization of Home health Services Demonstration

VNAA recommends that CMS immediately withdraw the prior authorization for home health services demonstration project for the following reasons.

Negative Impact on Beneficiary Access to Care

VNAA Comment: Mandatory prior authorization programs negatively impact beneficiary access to timely care and can impose significant delays in receiving needed services. Imposing this requirement could add extra time in in-patient settings while waiting for a prior authorization. It could also result in a patient discharges to the home without the necessary supports and services in the home, could increase unnecessary and costly rehospitalizations, and/or could decrease patient satisfaction when such requirements result in discharge to more intensive, facility-based settings rather than to home health.

CMS cites a comparison between home health and power wheel chairs as justification for this program. While power chairs are beneficial quality of life equipment, the lack of a power chair rarely is proximal cause of harm. Without a power chair, other modes of transportation are utilized. A patient may wait longer to engage in activities but delay rarely results in harm or loss. The same cannot be said about home care. Hospital readmission data demonstrates the riskiest time for readmission is in the first days after discharge. Reoccurrence of symptoms, medication related problems and numerous patient safety issues occur in the days after hospitalization. This is when beneficiaries are weakest and most vulnerable. A delay in the arrival of home care can reasonably be expected to cause harm.

Beneficiaries who qualify are entitled to receive care in setting of their choice, including the home. Creating unnecessary delays or perverse incentives for facility-based care go against the goals of the Medicare program, of consumer choice, and of allowing beneficiaries to receive care in their home and community.

Home Health Services Vary Based on Patient Needs

VNAA Comment: CMS has proposed this pilot program and cited as precedent the prior authorization program for power mobility devices. Home health care services are not comparable to devices such as power mobility devices and the prior authorization process cannot be similarly applied to the skilled and clinical home health services. Whereas there is consistency to what a power wheelchair is, home health services delivered vary based on the patient's needs. This tailored, patient-centric approach is regulatory required by the Medicare home health benefit, and is consistent with the goals of health care transformation. As a result, each beneficiary's care plan will differ based on the beneficiary's unique needs.

The unique beneficiary care plan will make prior authorization impossible to process promptly because each patient will need to be uniquely evaluated and matched to each unique plan of care. In other words, there is no simple algorithm possible for home health services, with easy

inputs that lead to standardized items or services. Prior authorization as applied to home health services is therefore not appropriate (if not impossible) from a practical and administrative standpoint.

Disruption to Beneficiary-Provider Relationship

VNAA Comment: Prior authorization for home health services creates unnecessary administrative hurdles between physicians and their patients—and puts health care decisions in the hands of Medicare contractors, rather than the medical care team. Physicians who order home health services and the receiving home health agencies are already required to provide significant documentation of the need for home health services. Prior authorization will supersede that relationship and put a Medicare contractor between the provider, the HHA and the beneficiary.

HHAs are currently implementing the new Medicare face-to-face encounter requirement, a measure designed to address and document appropriate use of services. The purpose of the face-to-face requirement was to eliminate fraud by ensuring that home health services were appropriate and necessary. Adding an additional layer of administrative burden is unnecessary (and untenable) for home health agencies (HHAs); the face-to-face requirement provides the proof of needed services. Further, the proposed prior authorization requirements could directly and adversely impact HHAs ability to comply with Medicare's Home Health Conditions of Participations (COPs) that require initiation as ordered by the physician or within 48 hours (whichever comes first).

Penalizes Good Actors While Doing Little to Identify New Fraud

VNAA Comment: This proposal adds an increased paperwork burden on both physicians and HHAs while adding little additional value for identifying and preventing fraud. VNAA supports a wide range of policies to combat waste, fraud and abuse, and our members are committed to improving the integrity of the Medicare home health program. We have strongly endorsed home health moratoriums, outlier caps, and other data-driven tools that are effective at stemming fraud in a targeted and direct manner.

However, it is critically important that policy designed to combat fraud not deter or hinder beneficiary access to care or unnecessarily burden providers with layers of bureaucratic paperwork. The prior authorization demonstration in this regulation is a blunt policy instrument that targets all providers and puts a disproportionate burden on good actors. At the same time, nothing in the prior authorization process will stop bad actors from submitting falsified claims; prior authorization programs have no mechanism to identify these bad actors. In this way, prior authorization will add little additional value in stopping fraud. CMS has stronger, data-based tools that can target fraud without subjecting all agencies to an additional burden.

Increases in Medicare Costs

VNAA Comment: Because prior authorization programs will result in barriers to services in the home, there may be an increase in the number of patients discharged to more intensive facility-based settings that are more expensive for Medicare. Consistent with the goals of delivery system reform, home health provides care in the home and community and provides high quality care in the least expensive setting. Policies that result in more expensive, less efficient care, such as this home health prior authorization demonstration, run counter to the CMS' health care transformation goals.

CMS Lacks Legal Authority

VNAA Comment: The Paperwork Reduction Act notice and the accompanying Supporting Statement describe CMS' plans to pursue a demonstration project that would require prior authorization for all home health agency services in five states. CMS states that the legal basis for the demonstration is in statute at 42 U.S.C. § 1395b-1(a)(1)(J), which gives the Secretary authority "to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by this chapter."

In VNAA's view, CMS does not have legal authority to pursue a prior authorization demonstration for home health services because the proposed prior authorization demonstration is not a means of either investigation or prosecution of fraud. What is proposed in the notice and the Supporting Statement is a program to screen every home health service through a prior authorization process for the five identified states. The proposed demonstration tests a method of screening and utilization management, not a method for investigation or prosecution of fraud.

CMS states that "the proposed demonstration will help assist in developing improved methods to identify, investigate, and prosecute fraud in order to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments." The law at 42 U.S.C. § 1395b-1(a)(1)(J), however, does not authorize Secretarial authority to test methods to identify fraud in the manner set forth in this proposal. The Secretary's legal authority would permit "investigation and prosecution of fraud", not universally pre-screening all home health services through a broad utilization management program.

Moreover, the demonstration as proposed is not a method of fraud investigation because there is no evidence used as a basis of investigation. To constitute "investigation," there must be some evidence of fraud and the demonstration as proposed does not meet this criteria. The proposed method of screening and utilization management applied across the board to all home health agency services in the identified states is simply not a method of investigation or prosecution of fraud and therefore as proposed does not appear to be authorized by 42 U.S.C. § 1395b-1(a)(1)(J).

Based on the concerns outlined above, CMS should fully rescind this request for information and not proceed with a prior authorization demonstration program for home health. We stand ready to work with policy makers to advance appropriate and targeted program integrity measures, within CMS's authority, to identify and eliminate fraud and abuse.

Medicare Probable Fraud Measurement Pilot

VNAA recommends that CMS rescind the Medicare Probable Fraud measurement pilot for the following reasons.

Duplicative Data Collection

VNAA Comment: CMS's proposed "Medicare Probable Fraud Measurement Pilot" is an unnecessary and duplicative data collection exercise masquerading as a fraud prevention program. CMS already has ample existing data to identify and target fraudulent home health agencies (HHAs)—additional data collection is not needed. In addition, the vast majority of current improper payments are due to documentation issues (namely, face-to-face) rather than fraud. Collection of information from an unquantified "random national sample" of HHAs, referring physicians AND beneficiaries is not realistic, will significantly raise administrative costs and provide little to no return in the form of improved patient care and outcomes.

Additional Burden on Providers

VNAA Comment: HHAs and referring physicians will be forced to redirect staff time away from clinical beneficiary care and support to instead comply with additional, onerous and duplicative administrative requirements.

CMS will be forced to devote considerable resources to develop and manage an untargeted national program instead of devoting appropriate resources to fraudulent providers easily identified by existing fee-for-service claims data. CMS will create another barrier to innovation in Medicare by imposing additional administrative burdens on agencies instead of supporting programs that reduce hospital admissions and readmissions or identify value-added opportunities for community-based home health services.

CMS should rescind this duplicative data collection and instead focus resources on existing data sources and targeted data-driven efforts to enforce program integrity measures.

VNAA has long supported program integrity measures and has been an active participant in curbing waste, fraud and abuse. However, we strongly maintain that beneficiaries access should be protected and needed home health services be delivered without delay. Reforms should be data-driven and targeted to the few providers most likely to be participating in waste, fraud and abuse.

This misguided prior authorization policy, proposed with no stakeholder input, will not achieve

its policy goals and CMS must pull it back. Instead, VNAA supports a broad discussion on home health program integrity measures and encourages CMS to bring HHAs, providers and other healthcare professionals together with government officials to analyze the practical implications of a rule before it is implemented and to ensure proposals achieve the intended results of reducing waste, fraud and abuse and protecting services to patients.

Sincerely,

Tracey Moorhead
President and CEO