PROTECT PATIENT ACCESS TO HOME HEALTH CARE

Dear Colleague,

We invite you to sign a letter calling to the Centers for Medicare & Medicaid Services (CMS) to rescind its prior authorization notice for the Medicare home health benefit. As drafted, we have significant concerns that the notice threatens patient care, imposes significant costs and does nothing to target or stop fraud and abuse.

Today, skilled home health professionals serve 3.5 million home health beneficiaries who make up one of Medicare's most vulnerable patient populations. In fact, recent data compiled by Avalere Health found that Medicare home health beneficiaries are more likely to be older, in poor health with more chronic conditions, lower income, female, minority and disabled compared to all other beneficiaries in the Medicare program combined.[1]

In February, CMS issued a Paperwork Reduction Act Notice proposing to impose prior authorization for home health services under a Medicare demonstration project. We are deeply concerned that prior authorization would delay and impede access to services while potentially increasing costs to the Medicare program and taxpayers, by placing burdensome requirements on providers and jeopardizing patient safety and care continuity.

Negative Impact on Patient Care and Outcomes:

- Prior authorization will result in unnecessary disruptions in the continuity of patient care for especially vulnerable beneficiaries and may result in adverse events occurring during the transition from hospital to home, putting patients at risk for missing medications or exacerbating a chronic condition.
- Prior authorization will impede the timely delivery of care due to requiring physician-ordered services be reviewed and approved prior to care initiation. Adding extensive documentation to already highly regulated care is counterproductive.

Imposition of Costs to Medicare and Administrative Burden:

- Prior authorization could have the counterproductive effect of increasing costs to Medicare by delaying hospital discharges and burdening a system currently focused on transformative new care models, such as Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA).

We urge you to sign this letter to encourage CMS to rescind the proposed demonstration and work toward targeted solutions that address program integrity measures more effectively rather than impeding patient care, jeopardizing patient safety and preventing the independence of receiving care in the most clinically appropriate, cost effective setting, which is often the comfort of a patient's own home.

Please contact Carla DiBlasio with Rep. Tom Price (Carla.DiBlasio@mail.house.gov or x5-4501) or Jennifer Chandler (Jennifer.Chandler@mail.house.gov or x5-6101) with Rep. Jim McGovern to sign on.

Yours Truly,

Congressman Tom Price

Congressman James P. McGovern

[1] Medicare Beneficiary Analysis: Key Differentiating Characteristics of Medicare Home Health Beneficiaries. Study conducted by Avalere Health. March 2014. See http://homehealth4america.org/media-center/attach/207-1.pdf

May__, 2016

Sylvia Mathews Burwell
Secretary
Department of Health and Human Services
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Andrew M. Slavitt
Administrator (Acting)
Centers for Medicare and Medicaid Services
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Dear Secretary Burwell and Acting Administrator Slavitt:

Home health is a critical service for seniors and people with disabilities that allows them to stay in their home and remain active in the community. The Centers for Medicare and Medicaid Services (CMS) recently issued in its Paperwork Reduction Act Federal Register Notice (PRA Notice) a potential mandatory prior authorization for home health as a demonstration in five states.[2] The Medicare home health benefit allows beneficiaries to receive medically necessary services at home, in the least costly setting, and can support improved care transitions that help to prevent expensive hospital readmissions. Prior authorization has never been applied to post-acute care within fee-for-service Medicare. We encourage you to refrain from moving forward with the proposed demonstration project in order to avoid delays or a disruption in patient care and prevent restrictions on patient access to home health services.

We are concerned that a demonstration project centered on prior approval or "prior authorization" of home healthcare would interfere with the patient-doctor relationship and is in conflict with the policy goal of moving toward patient-centered care. Stated simply, prior authorization of home healthcare imposes a requirement that prevents a patient from receiving home health services after the physician orders home healthcare unless and until an intermediary has reviewed and approved the order.

Under the proposal, a home health agency would be penalized if it attempted to proceed and care for a patient without delay. Under the proposed demonstration, a home health agency that provides care without prior authorization would be penalized with a 25 percent payment reduction, even if the claim were approved as appropriate and payable.[3]

We are most concerned with the potential impact of a prior authorization demonstration on access to care. Requiring prior approval for every home health patient across five states for critically important

[2] The proposed demonstration is described in the Paperwork Reduction Act notice in the Federal Register from February 5, 2016. The five states captured by the demonstration include Florida, Texas, Illinois, Michigan and Massachusetts.
[3] *Supporting Statement Part A – Medicare Prior Authorization of Home Health Services Demonstration*," CMS-10599 (Feb. 5, 2016), retrieved from: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-10599.zip

services that keep people in their homes rather than institutions, often when they are at their most medically vulnerable, will effectively delay and deny home health coverage for countless Medicare beneficiaries. Under this demonstration project, CMS would have to review more than 900,000 claims each year before each patient could receive care. Today, approximately 3.5 million of Medicare's most vulnerable beneficiaries depend on home healthcare services. These patients are often elderly, low income patients with serious illnesses, who are more likely to be disabled, a minority, or female than all other Medicare populations combined.[4] An unwarranted disruption and delay in patient care will put the oldest and frailest Medicare beneficiaries at greatest risk.

This demonstration project could limit access to home health services, while generating longer and costlier hospital stays and potentially increasing readmission rates. Many patients find themselves in the most clinically fragile condition during the week following a hospital discharge. It is vitally important that we continue to meet the care needs of Medicare patients during this critical transition time post-hospital discharge.[5]

We are also concerned about what a prior authorization proposal will mean to the taxpayer. CMS estimates that administrating this demonstration project would cost taxpayers more than a quarter of a billion dollars.[6] CMS aims to reduce fraud and improper payments within home health agency claims; however, it is unclear to what extent this proposal would actually prevent fraud and the submission of faulty paperwork or claims. Rather than a more focused approach targeting bad actors, this proposal will put a tremendous administrative burden on agencies with absolutely no track record of fraud. Physicians and home health agencies are already required to provide significant documentation for each patient in order to demonstrate a clinical need for home health services. A prior authorization demonstration as proposed would add an increased administrative burden on both physicians and home health agencies, while likely adding little value for identifying and preventing fraud. Further, prior authorization would be a duplicative process as CMS already reviews claims on a pre-payment basis.

Finally, we are concerned about the authority stated by CMS in pursuing prior authorization for home health services. The authority cited in the rule for implementing the program 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 (emphasis added)."[7] The proposal to screen every home health service through a prior authorization process for the five identified states, however, tests a method of screening and utilization management, not a method for investigation or prosecution of fraud. Apart from the question of authority, the PRA Notice is insufficient from an administrative perspective to promulgate such a wide-reaching program. A full notice and comment rulemaking process, allowing stakeholders to comment with specificity on the details of a proposed demonstration project, would be required.

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[4] Avalere Health, *Medicare Beneficiary Analysis: Key Differentiating Characteristics of Medicare Home Health Beneficiaries*. March 2014 http://homehealth4america.org/media-center/attach/207-1.pdf

[5] Medicare certified home health agencies are required in the conditions of participation to conduct the initial assessment visit "either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date." A prior authorization process could delay care for as long as 10 to 20 days, directly counter to CMS's regulation. Additionally, CMS created a home health performance measure for timely initiation of care that measures 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 2 days of the referral date or inpatient discharge date whichever is later." This National Quality Forum (NQF) endorsed measure has also been included on the Home Health Compare website. Thus, a prior authorization process for home health care would be inconsistent with CMS's measure of quality in home health care.

[6] CMS estimates that the costs associated with performing prior authorization for home health services would be approximately $223 million in Phase I and an additional $71.4 million in Phase II over the 3-year demonstration period for just five states. Future expansion of this rule to all 50 states would cause the costs to escalate dramatically.

[7] 42 U.S.C. Section 1395b-1(a)(1)(J)

This demonstration project imposes costs on patients, providers and taxpayers. Delaying patient care while waiting for CMS to approve home health services may put patient health in jeopardy and cause patients to stay in the hospital longer than necessary. We ask you to withdraw the proposed demonstration for prior authorization of home health services in order to avoid health risks to patients, delays or disruptions in patient care and unnecessary restrictions on patient access to home health services.

Sincerely,

Tom Price
Member of Congress

James P. McGovern
Member of Congress