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Pre-Authorization Comment Letter

CMS has published a notice pursuant to the Paperwork Reduction Act (PRA) regarding the institution of a Prior Authorization (PA) demonstration program for Medicare home health services. The PRA Notice Supporting Statement indicates that CMS would run the demo in 5 states—including Illinois. It would be applicable to all claims submitted by HHAs. CMS estimates that 908,000 claims annual would be processed through the PA model. Failure to submit a PA request would result in a 25% payment rate reduction in the event that the claim was determined covered by Medicare.

CMS has changed the name from Prior Authorization to Pre-Claim Review to identify that home health agencies should begin services and take on the financial risk of providing care to beneficiaries while waiting for a Pre-Claim Review to scrutinize physician and agency paperwork for any possible errors that could allow them to deny care or require additional documentation. This puts agencies' in a very risky situation when making a decision to accept a patient for care, particularly from physicians who are still providing agencies with handwritten documentation. However, electronic documentation presents problems as well. For example, a recent physician's note on a patient recovering from a subdural hematoma from a fall identified that the physician checked or did not check gait problems, which reads "no gait problems," however, the physician wrote on the Face-to-Face encounter, "Very weak, unable to ambulate without maximum assist. Not able to leave home without significant assistance." Home health agencies have no control over physician's documentation and the quality of their notes. This patient had a very comprehensive 6 page note from the physician, but the exact reason for home nursing services was not clearly defined, but implied by the complexity of the patient's condition. The patient required several medication changes for HTN and had a UTI during the episode. Physical therapy services were ordered and provided. However, I am not sure reviewing the physician's documentation, how a reviewer would interpret the physician's note and the patient's need for nursing and PT services. The face-to-face encounter note originally was ordered for just nursing and PT ordered after the RN –SOC visit. Orders were obtained and signed by the physician, but that was after the F-2-F was signed.

The physicians and home health agencies are being expected to have psychic powers to anticipate patient's every need in advance and it is unclear what is required, when patients' conditions change during the episode and the patient requires more or less therapy services, which would change the HHRG. Does the Pre-Claim Review have to be resubmitted?

Is the Face-to-Face encounter documentation going to be resubmitted each episode?

Fraudulent providers will figure out how to create perfect documentation. Legitimate providers will be overwhelmed with trying to provide quality care and dealing with this onerous and burdensome requirement that is

poorly planned and places the viability of many home health agencies in question. A hospital based agency in Chicago has decided to close. While this may be a vehicle to close small providers, the burden to submit this level of documentation is onerous and the cost is greatly underestimated. In addition, agencies are facing a rate cut for episodes ending 1/1/17 and after.

The implementation of this is being done with inadequate time for software vendors to modify systems to support this in a meaningful way. There are too many questions left unanswered to think that this can be implemented August 1, 2016. CMS informs us that agencies can submit Pre-Claim Reviews July 15. Please explain how that is possible following their rules requiring a start of care or first visit in a recertification period be made August 1 or after for a RAP to be billed??? This kind of chaotic and poorly thought out implementation of regulations and instructions is unacceptable and wastes health care resources.

CMS is telling agencies that LUPA cases do not need Pre-Claim Review. However, patients with catheters that frequently have LUPA episodes also are at high risk for UTIs and their episodes frequently turn into full episodes. CMS has not provided any guidance on how this will be handled. Does the claim then need to be submitted for Pre-Claim review?

Our software system only prints the therapist's orders for physician's signature, not the entire evaluation note. With the Pre-Claim Review, the reviewers are only looking at documentation signed by the physician. This requires software changes or more administrative time printing and faxing another document to the physician for signature. Physicians will be overwhelmed with more home health paper-work. Additionally, the only way an OASIS assessment will be considered is if the physician signs it. In our system, that may be a 38 page document. Physicians will love receiving these and reviewing this document for limited information. Even when this is done, there is no opportunity in the eServices electronic submission to Palmetto GBA to provide a cover letter identifying which information supports the claim. Do we really think reviewers are going to carefully go through all 38 pages to find the 1 or 2 pages that are significant? This is a massive deforestation and wasteful project, because much of this will need to be printed and faxed and records of the submission maintained. Even when done electronically, it will be very time consuming. Allowing software vendors more time to incorporate these new procedures may make this more efficient.

CMS is again issuing an industry-wide regulation as opposed to targeting the specific organizations with suspicious utilization and billing practices for fraud and abuse. This approach does little to stem fraud and abuse and adds more bureaucratic red-tape for all law abiding HHAs. The wording and lack of a clear mechanism for Pior-Authorization-Pre-Claim Review has great potential to result in many of the same problems as the Face-to-Face (F-2-F) regulation.

I support the F-2-F requirement for several reasons. However, the implementation of it has been chaotic, confusing, arbitrary and capricious. CMS's implementation of the Pre-Claim Review appears to be more of the same and will certainly decrease home health services. The process for re-submitting documentation and having to provide each document with a new name will be very time consuming. The administrative burden of this is greatly under-estimated.

Software systems need time to upgrade their systems to meet these ever changing requirements.
There are still too many questions unanswered for this to be implemented without causing serious delays in processing Pre-Claim reviews and billing. This will be an enormous cash flow problem for most home health agencies.

Nurses and therapists are getting harder to recruit to work in home health. They are frustrated with the over emphasis on paperwork as opposed to patient care. This proposal will worsen the morale issues in the home health industry, at a time when the number of Medicare beneficiaries is increasing. Physicians will be reluctant to order home health care when they are getting repeated requests for ever increasing documentation of homebound status.

The Pre-Authorization requirement will result in another massive amount of confusion and delays in implementing home health care for Medicare beneficiaries. What education level will these reviewers have? This is a cost cutting measure under the guise of fraud and abuse. This proposal does nothing to improve patient outcomes and has a great probability in harming many patients due to delays and denials of services. Another problem with the pre-authorization approach is the rapid changes our elderly patients experience. This proposal further reduces physicians' ability to identify patients' problems/needs and appropriate care spontaneously and adds more

bureaucracy and paper-work to the process. The end result will be delays in getting services started and increased hospitalizations and probably mortality related to sepsis, falls, CHF, etc.

Home health agencies have significant problems getting discharge and F-2-F documentation for patients discharged from facilities over the weekend. Patients are being discharged very sick and using our limited resources to obtain a pre-authorization is not the best way to combat fraud. Fraudulent providers always figure out how to get their paperwork right.

This proposed pre-authorization requirement would be another unfunded mandate and would result in a very large and under-estimated administrative burden with no benefit to Medicare beneficiaries. This is another regulatory burden that creates government administrative jobs and reduces direct care resources. This will ultimately increase Medicare costs related to administrative expenses and additional hospitalizations and morbidity requiring more intensive services. CMS needs to fight fraud effectively, not by creating more paperwork burdens on honest providers! Medicare beneficiaries are encountering increasing delays in obtaining home health and DME due to the paperwork burdens on physicians and providers. This is causing increasing frustration and need for facility care.

I strongly request that CMS reconsider this onerous proposal that would be harmful to the Medicare beneficiaries residing in Illinois and other affected states. At the very least, delay the start of this program in Illinois until the many questions providers are asking are clearly thought out and work with the industry and software vendors to develop a more organized implementation of this program. The continual chaotic regulatory changes by CMS have been very confusing and are wasting precious health care resources. They are causing death by regulatory strangulation!

Sincerely,

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President