April 5, 2016

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10599 and CMS–10406
Room C4–26–05
7500 Security Boulevard
Baltimore, MD  21244–1850


Submitted electronically via www.regulations.gov

Dear Mr. William Parham:

UnityPoint Health (“UPH”) appreciates the opportunity to provide comments on the proposed Medicare Probable Fraud Measurement Pilot and Medicare Prior Authorization of Home Health Services Demonstration. UPH is one of the nation’s most integrated healthcare systems. Through more than 30,000 employees, our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities, and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin.

UnityPoint at Home is the UPH health home agency with nine locations across Illinois and Iowa. Across all locations, UnityPoint at Home served more than 16,800 patients, of which 81% were Medicare beneficiaries. We serve 12 counties in Illinois and 61 in Iowa. Our readmission rates are lower than the national average – 11% for 30-day readmissions and 14.6% for 60-day readmissions. As a system, all locations earned 4 stars or more on each STAR indicator. In central Illinois, UnityPoint At Home – Peoria provides home health services to approximately 3000 patients annually in a nine-county service area. This service area is comprised of both urban and rural geographies. Of the patients served, 92% are
Medicare beneficiaries - 73% are traditional fee-for-service beneficiaries and 19% are served by HMOs – with an average length of stay of 45 days. UnityPoint at Home – Peoria prides itself in providing high quality services and outcomes. In 2015, our 30-day readmission rate was consistently less than 10%, the rate of emergent care without hospitalization was less than 4%, and our STAR ratings were 4 stars or above. In terms of patient satisfaction, 92% of respondents rated care as 9 or 10 on a ten-point scale, and 94% of respondents indicated that they would be likely to recommend UnityPoint at Home for home health services.

In general, UPH is interested in assuring that our Home Health agency is enabled to continue efforts to provide timely services and support high quality outcomes, including the prevention of avoidable readmissions. UPH is concerned that both the Pilot and Demonstration have not been fully vetted and will divert our Home Health Agency from its vision of providing the best outcome for every patient every time. The proposed Pilot is duplicative of Home Health Medicare Administrative Contractors (HH MACs) efforts and will add time and expense with little, if any, extra value. We are also gravely concerned that the pre-authorization requirement and its methodology will further impede our ability to provide timely services and prevent avoidable readmissions. UPH’s comments on the proposed Pilot and Demonstration are as follows:

**CMS–10406: MEDICARE PROBABLE FRAUD MEASUREMENT PILOT**

The stated purpose of the Pilot is to “establish a baseline estimate of probable fraud in payments for home health care services in the fee-for-service Medicare program.” In particular, CMS is proposing to use a national random sample of home health claims to collect further information from home health agencies, referring physicians and Medicare beneficiaries. As a result, the Pilot will estimate the percentage of total payments and the percentage of all claims associated with probable fraud.

**Necessity and Utility of Proposed Information Collection** - Collecting data from home health agencies and referring physicians in a national random sample of home health claims duplicates work currently being asked of all HH MACs for investigation of face-to-face encounter accuracy. UPH recommends that these same claims could be used to establish the baseline data being referenced in the Pilot and that home health agencies, referring physicians, and Medicare beneficiaries do not need to expend resources and time to provide any additional information. Using this data recognizes the work of the HH MACs to create such baseline and subsequent trend data.
CMS–10599: MEDICARE PRIOR AUTHORIZATION OF HOME HEALTH SERVICES DEMONSTRATION

The stated purpose of the Demonstration is to develop “improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among Home Health Agencies providing services to Medicare beneficiaries.” In particular, CMS is proposing a prior authorization process to assure that payment for home health services is appropriate before claims are paid. The proposed procedure is modeled after the Prior Authorization of Power Mobility Device (PMD) Demonstration project. Illinois is among the five states targeted for this Demonstration.

Necessity and Utility of Proposed Information Collection – At the core, CMS seeks comment on the necessity of prior authorization. We believe that prior authorization processes are ill-suited to home health services and emphasize the potential for fraud over the potential readmission prevention and poor outcomes related to untimely care. Prior authorization not only adds unacceptable service delays, but it does not recognize the value of the in-home assessment. UnityPoint at Home strives to see patients within 48 hours of discharge upon physician order. This 48-hour timeframe is not arbitrary. The initial home health visit enables a total patient assessment, both clinical and functional, which relies upon conversing with the patient in their environment. Can the patient reasonably achieve care plan objectives? Initial home health visits are the forum to establish home health services and rapport, reconcile medication, initiate telemonitoring for appropriate high-risk/complex conditions, and emphasize behavioral modification for daily assessments.

We believe the utility of prior authorization for home health services is questionable. Generally, prior authorization does not make sense for home health services, unless it is limited to the continuation/recertification of home health services. Volume of home health visits is not a good measure of fraud. The payment structure for home health services is such that the home health agency gets paid the same after five visits in 60 days unless therapy is involved or the episode qualifies for an outlier payment. There is no value in authorizing visits beyond that timeframe when the payment remains the same. As for the initiation of home health services, CMS is already limiting and monitoring such services through the face-to-face encounter requirements and associated audits. This process is detailed and time-consuming and the addition of another review layer to initiate services will further delay services and impede our ability to timely prevent avoidable readmissions.

We also largely question the applicability of a prior authorization procedure based on the CMS Prior Authorization of PMD Demonstration and in deference to processes used by TRICARE, certain state Medicaid programs, and private insurance. First and foremost, home health services are not akin to
power mobility devices. Fundamental distinctions include home care “services” needs versus medical equipment needs, duration of care (relatively short-term home health episodes of care versus permanent mobility needs), and urgency of service (i.e. delays in PMB do not equate to exacerbating health conditions and escalating readmissions risks). Second, the aforementioned programs and processes are not “models” of care and do not favor patients or home health agencies. The TRICARE process requires agencies to submit faxed documentation and provides authorization five to seven days later. This delay leaves patients without needed care and/or agencies without reimbursement for care provided. Additionally, many commercial insurance or Medicaid managed care plans do not promote optimal care. Instead of relying on physician judgment and shared decision making for home health referrals, many plans use computerized algorithms that base authorization strictly on diagnoses. Frequently, patients are discharged from home health before they have met all of their goals because their specific diagnosis only allows for a limited number of visits. Obtaining prior authorization also delays care, and for some patients, this results in additional more costly inpatient days.

In addition, CMS through its Innovation Center has mandated participation by nine states in the Home Health Value Based Purchasing (HHVBP) Model. This model is designed to pay the home health agency on quality outcomes instead of volume-based payments. UnityPoint at Home is participating in the HHVBP Model through its Iowa agencies, and we are encouraged that CMS is emphasizing high-quality care. Two states (Massachusetts and Florida) are mandated to participate in both the HHVBP Model and this Demonstration. It is uncertain, as best, how the prior authorization requirement will impact HHVBP objectives and outcomes. On a related note, UnityPoint Health – Peoria (Methodist Medical Center of Illinois) is participating in the Innovation Center’s Bundled Payments for Care Improvement Model 2 Initiative for Chronic obstructive pulmonary disease, bronchitis and asthma, Congestive heart failure, Simple pneumonia and respiratory infections, and Major bowel procedure. BPCI Model 2 involves a retrospective bundled payment arrangement for acute and post-acute care episodes where actual expenditures are reconciled against a target price for an episode of care. UnityPoint at Home plays a major role in reducing costs and avoiding readmissions under the BPCI Model 2. Like the HHVBP Model, it is uncertain how this Demonstration will impact BPCI Model 2 objectives and outcomes. We urge CMS to prioritize the HHVBP Model and BPCI Model 2 over this Demonstration and request that CMS clarify how these initiatives will interact prior to implementing this prior authorization Demonstration.
**Accuracy of Estimated Burden** – The proposed Demonstration will result in home health agencies spending more money on administrative staff and significantly increase the administrative burden. Currently, when a payer requires a prior authorization, it is not unusual for an employee of a home care agency to wait on the phone and work through the process for 10-40 minutes per patient. After the initial authorization, the agency is responsible for monitoring authorized services and obtaining more authorization if the patient does not progress as initially expected. This triggers the authorization process again, creating additional time and administrative burden. Many small, rural agencies may not be able to afford this potential added administrative requirement while balancing the risk of not being authorized for care that patients need.

In our Peoria region, we anticipate that 1 additional FTE will be required to comply with this requirement for our fee-for-service Medicare beneficiaries. High-performing agencies are looking for ways to put more resources into clinical areas of the agency to improve outcomes and patient experience. The cost to implement prior authorization for Medicare home health will make expanding programming in these important areas prohibitive.

**Enhance Quality, Utility, and Clarity of Collected Information** – As proposed, this Demonstration does not appear to be tailored to its purpose of identifying and investigating fraud – ALL home health agencies within identified five states are required to submit prior authorization to CMS and obtain approval before providing home health services for ALL Medicare beneficiaries. We oppose the blanket approach that requires all agencies practicing within the guidelines of the Medicare Benefit Policy Manual to perform prior authorizations. Instead, we firmly believe that the development of a program to identify fraud will be more effective if it is based on specific indicators of fraudulent billing practices. This can be accomplished by leveraging existing regulatory practices to identify high-risk agencies. Existing practices include:

- Current HH MACs structure to target home health fraud. HH MACs are conducting a Probe and Educate audit of all home health agencies with follow-up auditing. On an individual basis, CMS could apply a more stringent fraud investigation to home health agencies that continue to fail follow-up audits.
- Trend of indicators at risk for improper Medicare payments in the Program for Evaluating Payment Patterns Electronic Report (PEPPER). At-risk indicators include high case-mix scores, multiple 5-6 visit episodes, a large percentage of high therapy utilization episodes, a large number of 20-therapy visit episodes, high percentage of outlier payments, use of up-
codes or down-codes, or any combination of the above. While PEPPER reports are evaluated annually, the frequency of this screening could be increased to identify potential high-risk agencies. Based on at-risk indicators, agencies could be identified for fraud investigation.

- On-site reviews by state licensure and other accreditation agencies. Rather than reviewing what are often duplicative documents reviews, we would suggest that CMS consider deferring to findings from onsite audits from state regulatory agencies and private accreditation organizations to determine whether home health agencies are high-risk agencies requiring special fraud monitoring/reporting. For instance, in Illinois, home health agencies are required to be licensed with the public health department. The health department then works with CMS to perform onsite reviews every one to three years. Additionally, some agencies are further accredited by private organizations. As an example, UnityPoint at Home is accredited by the Joint Commission that includes a periodic review of documents and site visit.

The above alternatives are existing methods that could be leveraged to target agencies at-risk for fraud. Placing additional reporting burdens on at-risk agencies relative to a heightened probability of identifying fraud, waste and abuse seems a reasonable trade-off as opposed to subjecting all home health agencies regardless of history or risk factors to additional and unnecessary administrative burdens associated with fraud investigation.

Should CMS decide to move forward with this Demonstration, we also request that CMS consider delaying this Demonstration until the benchmarks, proposed in CMS—10406, are established. These benchmarks would be useful to determining trends and measuring progress during this Demonstration.

**Minimize Collection Burden through Information Technology** – While automated collection of requested information could reduce reporting burdens, this assumes that home health agencies have standardized methods to collect, track and disseminate information in an accurate and timely manner. It also assumes that our healthcare partners, such as referring physicians, have similar capabilities. At this time, we do not believe there is a good standardized tool that provides adequate information in a timely manner to establish appropriate plans of care and authorization of visits for a home health episode. We are also weary of solutions that mandate new information technology solutions without extensive stakeholder input and review, as infrastructure is often costly and requires intensive and ongoing staff and provider training.
Regulatory Authority for Prior Authorization Demonstration – We question the underlying sufficiency of the notice and comment process in support of this Demonstration. Although purportedly patterned after the Prior Authorization of PMD Demonstration, this Demonstration was not separately published outside the notice under the Paperwork Reduction Act of 1995. The PMD Demonstration was the subject of a more thorough publication process, which enabled meaningful stakeholder input and actually resulted in a delay in project implementation to address stakeholder concerns. Specifically, this notice lacks full disclosure and rulemaking intent relating to background, legislative authority, and provisions of the notice. Without this detailed information, it is difficult adequate for CMS to adequately solicit meaningful stakeholder input. There is no discussion of rationale underlying this Demonstration, its use of the PMD Demonstration prior authorization methodology, the selection of particular states, and the development of reporting mechanisms and associated penalties for noncompliance. We believe this notice falls short of the full public notice and comment process that are within the intent of the Administrative Procedures Act and the Medicare Act of 1965.

Conclusion

We appreciate the opportunity to provide comments to the proposed Medicare Probable Fraud Measurement Pilot and Medicare Prior Authorization of Home Health Services Demonstration. For the Pilot, we recommend that CMS establish benchmarks using claims and information already gathered by the HH MACs. As for the mandatory Demonstration, we urge CMS to reconsider this proposal in its entirety or to delay its implementation until active stakeholder input is sought to more narrowly tailor the scope of the Demonstration to high-risk agencies and benchmarks are determined. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and Government Payors at Sabra.Rosener@unitypoint.org or 515-205-1206.

Sincerely,

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