5 REASONS

Pre-Claim Review Is Bad for Medicare Home Health Services

The Centers for Medicare & Medicaid Services (CMS) recently proposed a pre-claim review demonstration for Medicare home health services, upon which approximately 3.5 million Medicare beneficiaries depend. These beneficiaries have been documented as being older, poorer, sicker, and more likely to be disabled, a member of an ethnic or racial minority, or female than all other Medicare beneficiaries combined. The demonstration was implemented in August 2016 across the entire state of Illinois, and will shortly thereafter apply to every claim made by every home health agency in Florida, Texas, Michigan and Massachusetts.

The following are the top five reasons CMS should rescind this proposal and develop targeted alternatives in coordination with stakeholders to protect and strengthen Medicare program integrity.

1

Pre-Claim Review Will Not Reduce Fraud and Abuse

Pre-claim review policies will not stop bad actors who are intent on defrauding the Medicare program. Instead, bad actors will continue to submit false information that satisfies the new requirements. Home health leaders caution that the demonstration is not an effective measure for investigating and prosecuting fraud in the home health benefit.

2

CMS is Not Prepared to Manage Such a Large, Sweeping Demonstration

The pre-claim review process will increase the workload of Medicare Administrative Contractors (MACs) by 40-fold, according to estimates. MACs will be required to review more than 1 million claims per year, as opposed to the approximate 25,000 claims currently being reviewed annually. Home health leaders are concerned that CMS does not have the appropriate qualified workforce to properly manage this demonstration to ensure that home health agencies providing advanced clinical care can be assured of payment for the skilled services they provide.

3

It Will Impose Significant Financial and Administrative Burdens

Pre-claim review will lead to higher costs, as patients who would otherwise be served in their home are denied access by the third-party contractor. Further, this policy would increase the administrative burden on physicians and home health agencies and comes as the direct result of the ill-defined and poorly implemented "face-to-face" requirements.

4

It Could Have a Negative Impact on Patient Outcomes and Experience

Pre-claim review will hinder the ability of home health agencies to provide seamless, integrative high quality skilled health care to patients transitioning from the acute care setting to the home. The threat of care delays and interruptions could negatively impact patient outcomes and the care experience.

5

Paperwork Does Not Reduce Improper Payments

Sweeping, across-the-board regulatory paperwork requirements do not reduce improper payments or weed out the bad actors who intentionally commit fraud, but instead cause best-in-class providers to shoulder additional administrative burdens that jeopardize timely patient care and increase costs to taxpayers. Home healthcare leaders and other key stakeholders should collaborate with CMS on the development and implementation of appropriate and targeted program integrity measures that protect patients and taxpayers, while identifying and eradicating fraud and abuse.

PLEASE URGE CMS TO RESCIND ITS PRE-CLAIM REVIEW DEMONSTRATION AND INSTEAD DEVELOP TARGETED PROGRAM INTEGRITY REFORMS