Supporting Statement Part A
Medicare Prior Authorization of Home Health Services Demonstration

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is requesting the Office of Management and Budget (OMB) approval for the Medicare Prior Authorization of Home Health Services Demonstration. This demonstration would help assure that payments for home health services are appropriate before the claims are paid, thereby preventing fraud, waste, and abuse.

As part of this demonstration, CMS proposes performing prior authorization before processing claims for home health services in: Florida, Texas, Illinois, Michigan, and Massachusetts. CMS would establish a prior authorization procedure that is similar to the Prior Authorization of Power Mobility Device (PMD) Demonstration, which was implemented by CMS in 2012. This demonstration would also follow and adopt prior authorization processes that currently exist in other health care programs such as TRICARE, certain state Medicaid programs, and in private insurance.

Targeting Fraud

Previous CMS experience, Office of Inspection General (OIG) reports, Government Accountability Office reports, and Medicare Payment Advisory Commission reports show there is extensive evidence of fraud and abuse in the Medicare home health benefit for treatment performed in these target states. These states have been identified as high risk fraud states in the 2013 Affordable Care Act enrollment moratoria. Further, home health services have historically been vulnerable to fraud, waste, and abuse and as such been the subject of multiple fraud alerts since at least 1990.[1]

This 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. In fact, this demonstration would add to the efforts that CMS and its partners have taken in implementing a series of anti-fraud initiatives in these states.

Tackling Improper Payments

The improper payment rate for Home Health Agency (HHA) claims has been increasing over the past several years. During fiscal year (FY) 2014 report period, Comprehensive Error Rate Testing (CERT) reported that the improper payment rate for HHA claims increased to 51.4 percent, representing approximately $9,395,609,515 in improper payments. In comparison, the improper payment rate for HHA claims was 17.3 percent during the FY 2013 report period. The Types of Errors included in the 51.4 percent error rate are:

[1] http://oig.hhs.gov/oei/reports/oei-04-93-00260.pdf

Insufficient Documentation Errors (90%)
Medical Necessity Errors (8.9%)
No Documentation Errors (0.4%)
Incorrect Coding (0.1%)
Other Errors (0.6%)

We believe this demonstration design will assist CMS in analyzing the effectiveness of a prior authorization process in increasing the ability to identify, investigate, and prosecute fraud as well as reduce improper payments. CMS believes that this demonstration will provide a wealth of data to analyze, and through that data new avenues for identifying, investigating, and combating fraudulent behavior will be identified. CMS will share data developed from this demonstration within the agency and with our law enforcement partners for further investigation. CMS believe that data evidencing changes in HHAs billing practices resulting from this demonstration could provide investigators and law enforcement with important information to determine how to focus their investigation activities to identify home health fraud. For instance, results from this demonstration could potentially identify HHAs that are bad actors, those that serve beneficiaries that are not homebound and those that serve an anomalous percentage of beneficiaries with no corresponding office visit. This, in turn, could assist investigators and law enforcement in modifying their investigation activities.

Additionally, such data may provide specific leads for investigators and law enforcement personnel to pursue. For instance, where a HHA provider that prior to the demonstration frequently submitted claims for home health services, stops submitting HHA claims during the demonstration, it may be evidence of home health fraud. Based on this information, law enforcement may determine it prudent to investigate that HHA provider further.

CMS will conduct Phase I of the demonstration in Florida, Texas, and Illinois and Phase II in Michigan and Massachusetts. The goal of this three-year prior authorization demonstration is to develop improved methods for the investigation and prosecution of home health fraud. This project is being proposed to, in the end, better enable CMS to detect and deter such conduct.

To initiate the prior authorization process, the HHA provider or the beneficiary submits a prior authorization request with all relevant documentation based on applicable Medicare rules and policy requirements, to a contractor. The contractor will review the prior authorization request to determine whether the service for the beneficiary complies with applicable Medicare coverage, coding, and payment requirements. The contractor will communicate a decision that provisionally affirms or non-affirms the request for prior approval for the services to the requestor.

The following explains the various prior authorization scenarios:

When a submitter submits a prior authorization request to the Medicare Administrative Contractor (MAC) with appropriate documentation and all relevant Medicare coverage and documentation requirements are met for the home health service, then an affirmative prior

authorization decision is sent to the HHA and the Medicare beneficiary. When the HHA submits the claim after delivering the home health service(s) to the MAC, it is linked to the prior authorization via the claims processing system and so long as all requirements are met, the claim is paid.

When a submitter submits a prior authorization request with complete documentation but all relevant Medicare coverage requirements are not met for the home health service, then a non-affirmed prior authorization decision will be sent to the HHA and the Medicare beneficiary advising them that Medicare will not pay for the treatment. If the claim is still submitted by the HHA to the MAC for payment, it will be denied. The HHA and/or the beneficiary can appeal the claim denial.

In cases where documentation is submitted, but is incomplete, the prior authorization request is sent back to the submitter for resubmission and the HHA and the Medicare beneficiary are notified.

When the HHA provides the treatment to the beneficiary and submits the claim to the MAC for payment without a prior authorization request being submitted, the home health claim will be reviewed. If the claim is determined to be payable, it will be paid with a 25 percent reduction of the full claim amount. The 25 percent payment reduction, which applies for failure to receive a prior authorization decision, is non-transferrable to the beneficiary. This payment reduction, which will be beginning three months into the demonstration in each state, is not subject to appeal. After a claim is submitted and processed, appeal rights are available as they normally are.

Justification

1. Need and Legal Basis

Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)(J)) authorizes the Secretary 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 the Social Security Act (the Act)." Pursuant to this authority, the CMS seeks to develop and implement a Medicare demonstration project, which CMS believes will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs providing services to Medicare beneficiaries.

2. Information Users

The information required under this collection is requested by Medicare contractors to determine proper payment or if there is a suspicion of fraud. Medicare contractors will request the information from HHA providers submitting claims for payment from the Medicare program in advance to determine appropriate payment.

3. Improved Information Techniques

Some of this collection of information could involve the use of electronic or other forms of information technology at the discretion of the submitter. Requesting specific information from a specific provider in some cases can be submitted through electronic means. CMS offers electronic submission of medical documentation (esMD) to providers who wish to explore this alternative for sending in medical documents.

4. Duplication and Similar Information

CMS as a whole does not collect the information in any existing format. With the exception of basic identifying information such a beneficiary name, address, etc., there is no standard form or location where this information can be gathered.

5. Small Businesses

This collection will impact small businesses or other entities to the extent that those small businesses bill Medicare in a manner that triggers prior authorization. Consistent with our estimates below, we believe that the total claims impact on all businesses is less than one-tenth of one percent of claims submitted. We do not have the number of small business that will be impacted. This collection will only impact small business and all respondents in that they must work with providers to obtain the necessary medical documentation to support their claims. CMS welcomes comments from the public on ways to make the reviews conducted under the demonstration less burdensome while also accomplishing our other goals.

6. Less Frequent Collections

For the prior authorization demonstration, since home health represent an area where a history of program vulnerabilities exist, less frequent collection of information on these items would be imprudent and undermine the demonstration.

7. Special Circumstances

More often than quarterly
Information will be requested frequently. The process will occur on a continual basis, and delaying the collection of the required information would undermine the demonstration.

More than original and one copy
There is no requirement to submit more than one copy of the requested documentation.

Retain records for more than three years
There are no new or additional record retention requirements beyond those requirements currently in place.

Conjunction with a statistical survey
Prior authorization of medical records is not performed to create statistical pictures of Medicare utilization.

Use of statistical data classification
This collection does not require a statistical data classification.

Pledge of confidentiality
This collection does not require a pledge of confidentiality.

Confidential information
The Health Insurance Portability and Accountability Act Privacy Rule allows for the disclosure of health records for payment purposes. Medicare contractors have procedures in place to assure the protection of the health information provided.

8. Federal Register Notice

The 60-day Federal Register notice will publish on XXXXXXX.

9. Payments or Gifts to respondents

No payments or gifts will be given to respondents to encourage their response to any request for information under this control number.

10. Confidentiality

Medicare contractors will safeguard all protected health information collected in accordance with HIPAA and Privacy Act standards as applicable.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this information collection.

12. Burden Estimate

The burden associated with this prior authorization is the time and effort necessary for the submitter to locate and obtain the supporting documentation for the Medicare claim and to forward the materials to the Medicare contractor for review. CMS expects that this information will generally be maintained by providers as a normal course of business and that this information will be readily available.

CMS estimates that average time for office clerical activities associated with this task to be 30 minutes, equivalent to that for prepayment review. Based on Bureau of Labor Statistics information we estimate an average hourly rate of $15.89 with a loaded rate of $31.78. [2] This equates to a cost of $21.6 million (908,740 x .5) for 3 years. This impact is allocated across providers and nationwide.

[2] http://www.bls.gov/oes/current/oes_nat.htm and the "May 2014 National Occupational Employment and Wage Estimates" report. Fringe benefit estimates were taken from the BLS March June 2015 Employer Costs for Employee Compensation report.

Activity	Responses Per Year (i.e. number of reviewed claims)	Time Per Response (hours)	Total Burden Per Year (hours)	Total Burden Hours Per Year ($)
Home Health Demonstration	908,740	0.5	454,370	$ 7,219,939.30

The estimate above is based on the highest of the 3 years within the demonstration period. Since the demonstrations must ramp up, year 1 numbers are expected to be lower than year 3, however we assumed year 3 numbers for the purposes of estimating.

CMS also estimates the cost of mailing medical records to be $5 per request for prior authorization. CMS now offers esMD to providers who wish to use a less expensive alternative for sending in medical documents. Additional information on esMD can be found at www.cms.gov/esMD. CMS estimates that there are 908,740 claims therefore; the total mailing cost is estimated to be $4.5 million.

13. Capital Costs

There are no capital cost associated with this collection.

14. Costs to Federal Government

CMS estimates that the costs associated with performing prior authorization for home health services would be approximately $223 million in Phase I and $71.4 million in Phase II over the 3-year demonstration period. Additionally, approximately $267,000 would be required to make the necessary systems changes.

15. Changes in Burden/Policy

This is a new collection.

16. Publication or Tabulation

There are no plans to publish or tabulate the information collected.

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.