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A MEDICARE LEARNING NETWORK® (MLN) EVENT

Review Choice Demonstration for Home Health Services

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Acronyms in this Presentation

- ABN: Advanced Beneficiary Notice
- ADR: Additional Documentation Request
- HHA: Home Health Agency
- MAC: Medicare Administrative Contractor
- PCR: Pre-Claim Review
- RAC: Recovery Audit Contractor
- RAP: Request for Anticipated Payment
- SVRS: Statistically Valid Random Sample
- TPE: Targeted Probe and Educate

Agenda

- To invite home health agencies and Medicare practitioners to discuss the Review Choice Demonstration (RCD) for Home Health Services

Disclaimer: The information provided in this presentation reflects current understanding of how CMS and Palmetto GBA expect to implement the demonstration, pending full Paperwork Reduction Act approval.

Why is CMS Conducting this Demonstration?

- Based on our previous experience, Department of Health and Human Services Office of Inspector General reports, Government Accountability Office reports, and Medicare Payment Advisory Commission findings, there is extensive evidence fraud and abuse in the Medicare home health program, in particular, in the chosen demonstration states.

- Insufficient documentation for home health claims continues to be prevalent as well, despite an improper payment rate decrease. The primary reason for these errors was that the documentation to support certification of home health eligibility requirements was missing or insufficient.

- CMS implemented a Pre-Claim Review Demonstration for Home Health Services in Illinois on August 3, 2016, which was paused April 1, 2017 and was not expanded to other states.

- CMS has revised the demonstration to offer more flexibility and choice for providers, as well as risk-based changes to reward providers who show compliance with Medicare home health policies.

What is the goal of this Demonstration?

This demonstration will:

- Establish a 5 year Review Choice Demonstration for Home Health Services
- Test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in the home health program while maintaining or improving the quality of care provided to Medicare beneficiaries

Who is Involved?

- CMS will implement a 5-year Review Choice Demonstration for the Home Health and Medicare Administrative Contractor (MAC) Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas, with the option to expand to other states in the Palmetto/JM Jurisdiction

- Home Health Agencies (HHAs) who render services to Medicare fee-for-service beneficiaries in the demonstration states and submit claims to Palmetto

- Beneficiaries using the Medicare fee-for-service benefit to receive home health services in the demonstration states

When Does the Demonstration Begin?

- Targeted start dates:
  - Illinois – No earlier than December 10, 2018
  - Demonstration will be phased into the other states with at least 60 days' notice before implementation

- Duration of the demonstration: Five years

What are the Requirements for the Medicare Home Health Benefit?

To qualify for the Medicare Home Health benefit, under 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security requirements:

- Be confined to the home at the time of services;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled services;
- Have a face-to-face encounter with an allowed provider type as mandated by the Affordable Care Act. This encounter must:
  - occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care; and
  - be related to the primary reason the patient requires home health services and was performed by a physician or non-physician practitioner.

The Review Choice Demonstration Process

How Does the Demonstration Work?

HHAs can choose between three initial choices:

- **Choice I:**
  - Pre-claim review of all claims
  - Follows process implemented under the initial Pre-Claim Review Demonstration
  - Allows unlimited resubmissions of non-affirmed requests
  - Allows for multiple episodes to be requested on one pre-claim review request for a beneficiary

- **Choice II:**
  - Postpayment review of all claims
  - Follows current postpayment medical review processes
  - Default option if no selection made

- **Choice III:**
  - Minimal review with payment reduction
  - All home health claims receive a 25% payment reduction
  - Claims are excluded from MAC targeted probe and educate review, but may be selected for Recovery Audit Contractor (RAC) review

Choice I: Pre-Claim Review

- The HHA (or beneficiary) will submit a request for a pre-claim review, which may contain more than one episode for a beneficiary
- The MAC will review the request and supporting documentation and make a decision using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies
- The MACs will send back a decision letter provisionally affirming or non-affirming the pre-claim review request

Choice I: Pre-Claim Review

- A provisional affirmed decision means the claim will be paid as long as all other Medicare requirements are met
- A non-affirmed decision means the request did not demonstrate that Medicare home health coverage requirements were met
- If a pre-claim review request is non-affirmed:

1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the pre-claim review request
    - Unlimited resubmissions are allowed prior to the submission of the claim
    - Pre-claim review decisions cannot be appealed

    or

2. The submitter can provide the service and submit a claim:
    - The claim will be denied
    - All appeal rights are available

Choice I: Pre-Claim Review

- A pre-claim review request may be submitted for more than one episode for a beneficiary as long as the documentation supports the need for multiple episodes
- The pre-claim review decision can, justified by the beneficiary's condition, affirm some or all of the episodes requested
- For any additional provisionally affirmed episodes included in the request, a valid plan of care must be submitted prior to claim submission
- A pre-claim review request can be resubmitted for any additional episodes not provisionally affirmed prior to the episode's final claim being submitted for payment

Choice I: Pre-Claim Review

- **Initial Requests**
  - The first pre-claim review request for any episode
  - The MAC will make every effort to review the request and postmark decision letters within **10 business days**

- **Resubmitted Requests**
  - The request submitted with additional documentation after the initial pre-claim review request was non-affirmed
  - The MAC makes every effort to review the request and postmark decision letters within **20 business days**

Choice I: Pre-Claim Review

- Decision letters are sent to the:
    - Home Health Agency
    - The beneficiary
- Decision letters include the pre-claim review Unique Tracking Number (UTN) that must be submitted on the claim
- Decision letters that do not affirm the pre-claim review request will:
    - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met

Choice I: Pre-Claim Review

If a HHA chooses choice I: Pre-Claim Review and does not submit a pre-claim review request before submitting the final claim:

1. The subsequent claim will be stopped for prepayment review

2. If the claim is determined to be payable, it will be subject to a 25% payment reduction
    - The 25% payment reduction is non-transferable to the beneficiary
    - The 25% payment reduction is not subject to appeal

Choice II: Postpayment Review

- The HHA will follow its standard intake, service, and billing procedures, and the claims will pay according to normal claim processes
- The MAC will conduct complex medical review on the claims submitted during a 6-month interval
- The MAC will send the HHA an Additional Documentation Request (ADR) letter following receipt of the claim for payment
- HHAs who do not select an initial choice will default to this option

Choice III: Minimal Review with 25% Payment Reduction

- The HHA will follow the standard intake, service, and billing procedures, and the claims will pay according to normal claim processes
- HHAs will receive an automatic 25% reduction on all payable home health claims
- Claims falling under this choice will be excluded from regular MAC Targeted Probe and Educate (TPE) reviews but may be subject to potential RAC review
- Any denied claims will retain all normal appeal rights
- HHAs will remain in this option for the duration of the demonstration and will not have an opportunity to select a different choice later

Compliance with Pre-Claim and Postpayment Review

- For choices I and II, an affirmation rate/claim approval rate will be calculated every 6 months

- If rate is 90% or greater (based on a 10 request/claim minimum), HHAs can select a subsequent review choice:
  - Pre-Claim Review
  - Selective Postpayment Review
  - Spot Check Review

- IL HHAs who participated in the initial PCR Demonstration and reached the 90% provisional full affirmation rate (minimum of 10 requests) can start the process with the subsequent review choices

Additional Options
Choice IV: Selective Postpayment Review

- The HHA will follow the standard intake, service, and billing procedures, and the claims will pay according to normal claim processes
- After 6 months, the MAC will select a Statistically Valid Random Sample (SVRS) for postpayment review
- The MAC will send the HHA an ADR letter and follow CMS postpayment review procedures
- The HHA will remain in this option for the remainder of the demonstration and will not have an opportunity to select a different review choice later
- HHAs who do not select a subsequent choice will default to this option

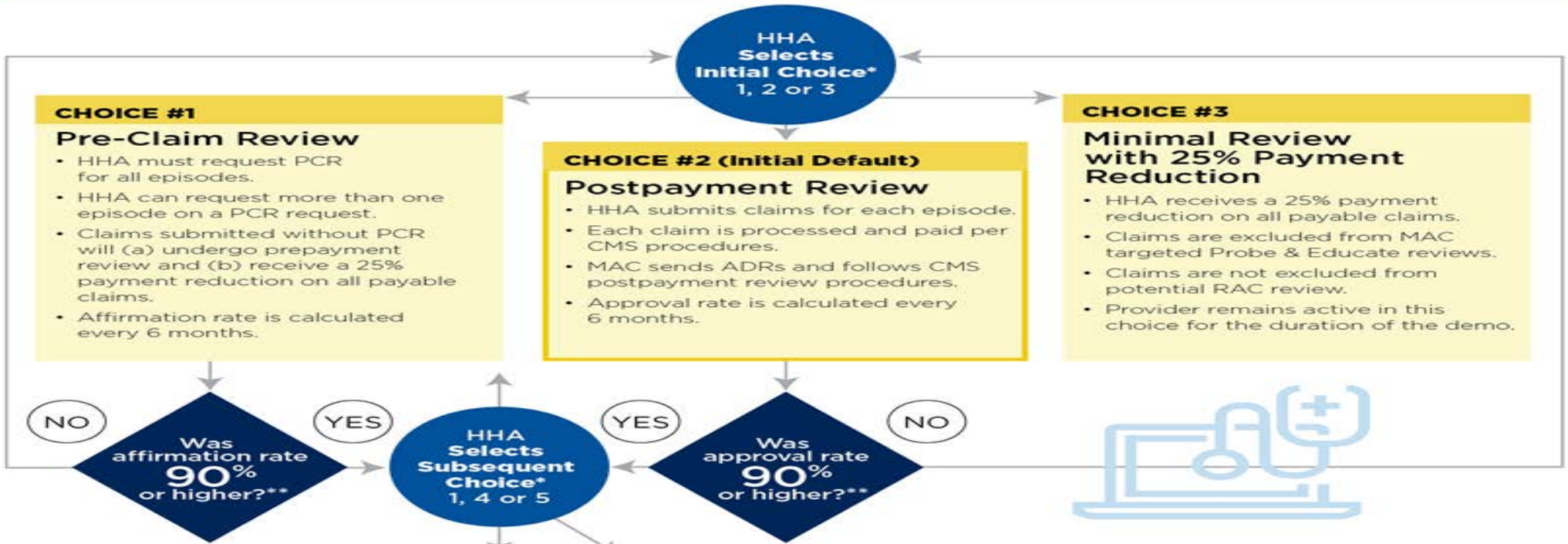
Choice V: Spot Check Review

- The HHA will follow the standard intake, service, and billing procedures
- The MAC will randomly select 5% of the submitted claims for prepayment review every 6 months
- The HHA may remain with this choice for the remainder of the demonstration as long as the spot check shows the HHA is compliant with Medicare rules
- If the HHA is not in compliance, the HHA must select again from one of the initial three review choices

Choice Selection Procedure

- Once the selection period begins in their state, HHAs will have until two weeks prior to the start of the demonstration to select an initial review choice
- HHAs will make their choice selection through the eServices online provider portal: www.palmettogba.com/eservices
- IL HHAs who participated in the initial demonstration and reached the 90% provisional full affirmation rate (minimum of 10 requests) may select a subsequent review choice

Review Choice Demonstration for Home Health Services



CHOICE #4 (Subsequent Default)

Selective Postpayment Review

- MAC reviews a SVRS every 6 months.
- Provider remains active in this choice for the duration of the demo.

CHOICE #5

Spot Check

- MAC selects 5% of HHA claims every 6 months.
- MAC sends ADRs and follows CMS prepayment review procedures.

* If HHA doesn't make an initial choice selection, choice 2 will be automatically selected. If HHA doesn't make a subsequent choice selection, choice 4 will be automatically selected.

** Minimum submission of 10 requests/claims required. Affirmation rate is based on full affirmations only.

Illinois HHAs that participated in the initial pre-claim review demo and reached 90% full provisional affirmation rate (minimum 10 requests) can start the process with the subsequent review choices 1, 4 or 5.

GLOSSARY

HHA: Home Health Agency
MAC: Medicare Administrative Contractor
ADR: Additional Documentation Request
RAC: Recovery Audit Contractor
PCR: Pre-Claim Review
SVRS: Statistically Valid Random Sample

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Home Health Coverage

- Medicare coverage policies are unchanged
- The demonstration does **not** create any new documentation requirements
- HHAs will still be able to submit their Request for Anticipated Payment (RAP) in the same manner and subject to the same rules as they would without the demonstration being in place

Home Health Coverage

- All Advanced Beneficiary Notice (ABN) policies
- Claim appeal rights
- Dual eligible coverage
- Private insurance coverage
- Access to care and services should not be delayed for people with Medicare's home health benefit

CMS Oversight

- CMS will:
  - Regularly assess pre-claim affirmation and claim approval rates
  - Review a sample of MAC decisions to ensure review accuracy
  - Contract with an independent evaluator to review the demonstration

For More Information

- Review Choice Demonstration website
- Questions should be sent to homehealthRCD@cms.hhs.gov
- CMS and Palmetto will continue to provide educational opportunities

Question & Answer Session

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