Home Health Services: Review Choice Demonstration Call

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® events.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you, you may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I'd like to welcome you to this Medicare Learning Network call on the new Review Choice Demonstration for Home Health Services.

This demonstration will develop improved procedures for the identification, investigation and prosecution of potential Medicare fraud through either pre-claim or post payment review. The demonstration will begin in Illinois and expand to Ohio, North Carolina, Florida and Texas. It can be expanded to other states in the same Medicare Administrative Contractor jurisdiction, if there is increased evidence of fraud.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL go.cms.gov/npc. Again, that URL is go.cms.gov/npc. Today's event is not intended for the press and the remarks are not considered on the record.

If you are a member of the press, you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries, contact press@cms.hhs.gov.

At this time, I would like to turn the call over to Amy Cinquegrani, Director of Division of Payment Methods and Strategies in the Center for Program Integrity.

Presentation

Amy Cinquegrani: Thank you, Leah. And thank you all for joining us on this call today. We're excited to have the opportunity to talk to you about the new Review Choice Demonstration for Home Health Services.

I'll refer to the slide number in the presentation, so hopefully you're able to follow along today. And again, my name is Amy Cinquegrani, and I'm with the Center for Program Integrity in the Division of Payment Methods and Strategies.

So, slide 2 just have some acronyms that we will refer to throughout the presentation. I think a lot of you on the phone are probably used to CMS in the alphabet soup that we talk in, but just wanted to provide a reference for you for some of the acronyms that we will refer to multiple times throughout the presentation.

So, slide 3 has our agenda. Obviously, the reason you're all here is to learn more about our new demonstration, the Review Choice Demonstration for Home Health Services.

If you are an Illinois provider, there's a good chance that you may have already attended a presentation by Palmetto, the home health Medicare Administrative Contractor that's going to help implement this demonstration with us.

But at CMS, we haven't really had a chance to speak to a large group about this. We've provided some information on our website and through the Paperwork Reduction Act approval process.

So we did want to take this opportunity to provide more of an overview about how we're planning to implement the demonstration as it stands now, but especially to get your feedback, as we finalize some of our demonstration details and develop supporting documentation, such as frequently asked questions and an operational guide and some other helpful things that we'll plan to post on our website and develop, in conjunction with Palmetto.

You'll notice the disclaimer on the bottom of page 3, and that's really important. And I just want to mention that because right now we do not currently have Paperwork Reduction Act approval for the demonstration, but we did want to take the opportunity to start the conversation with you.

Obviously, Palmetto has started educating on how we are planning to implement the demonstration, as it currently stands, but we will not actually proceed with operationalizing the demonstration until we have that full Paperwork Reduction Act approval, which we'll talk about a little bit later when we are referring to the start date of the demonstration.

So please keep that in mind. This is the proposed process for the demonstration and things are still subject to change.

So, moving on to slide 4, we have some information about why we're conducting this demonstration, based on previous experience in Medicare, the Office of Inspector General and the Government Accountability Office, as well as MedPAC and other reviewing and oversight entities.

There's a lot of evidence of fraud, waste, and abuse within the Medicare home health benefit, specifically in the targeted demonstration states.

Insufficient documentation tends to be one of the major reasons for improper payments in home health claims. Even though the improper payment rate has decreased over the last several years, there still remains a concern about improper payments within the benefit.

The primary reason for these insufficient documentation errors is that information to support certification of home health eligibility is either missing or, again, insufficiently provided.

So, backing up a little bit and a little history lesson on the initial demonstration. We implemented a Pre-Claim Review demonstration for home health services in August of 2016 in Illinois.

The demonstration was paused at the beginning of April in 2017 and was not expanded to the other states that we had planned. We received a lot of feedback about the original demonstration.

And over the past year, so we made some changes and improvements to address that feedback, so we could continue with a similar demonstration moving forward.

And so, we revised the demonstration to offer more flexibility and choice for Home Health Agencies and providers, as well as incorporate risk-based changes to reward those providers who show compliance with Medicare home health policies. And Jennifer McMullen will go into more details about the choices and the review process in a few slides.

So similar to the original Pre-Claim Review demonstration, the new Review Choice Demonstration will continue to test improved methods for identifying, investigating and prosecuting Medicare fraud occurring in the home health program, while maintaining the quality of care provided to Medicare beneficiaries.

Moving on to slide 6, some information about which providers are involved in the demonstration. And this will include Home Health Agencies in the state of Illinois, Ohio, North Carolina, Florida, and Texas, and only those Home Health Agencies who submit claims that are process to Palmetto GBA, who is the Jurisdiction M MAC in those states.

If you are located in those states and you are submitting claims to a different MAC, you will not be part of this demonstration. Again, this is only for those Palmetto providers.

And we do have the option to expand the demonstration to other states within the Palmetto J/M Jurisdiction, if we're aware of increased concern about fraud, waste, and abuse in those states as well.

Moving on to the next slide, we're on slide 7.

The demonstration is scheduled to begin no earlier than December 10th in Illinois, and it will be phased into other states one at a time with, at least, 60 days' notice before implementation in each state, and the demonstration is scheduled to run for five years.

And as I mentioned before, we will not proceed until we have that official PRA approval. So, December 10th is still our targeted start date for providers to begin making their choice selections for the demonstration, but that could be subject to change, depending on the final PRA approval when we get that approval.

When we do get that approval, we'll announce the date when provider can begin making their choice selection and the date where reviews under the demonstration will start.

We want to make sure that Home Health Agencies have ample time to make their choice selection and Palmetto needs time as well to finalize in their system, making sure that everyone is in the right choice and documentation will go to the correct place and the systems are set up appropriately.

We also understand that holidays are coming up soon and we are – will be sensitive to that as we finalize some of our start dates. So, we're still working towards December 10th. But again, that is subject to change.

Moving on to slide 8, we have some information about the requirements for the Medicare home health benefit. And as part of the demonstration just like in any other medical review process, the documentation and coverage requirements about a particular benefit are not changing.

These are the same home health payment policies that you would have to follow to receive payments for your home health claims. And they're the same policies that — and documentation requirements that you would need to follow if your MAC was doing a prepayment review, or if the RAC was doing a Postpayment Review.

Those things aren't changing in this demonstration. What is changing is just the time at which you'll provide the information, the documentation to support payment for the services.

And so, we do have some information on slide 8. I'm not going to read every bullet but, essentially, you have to be homebound at the time of the services and you have to be under the care of a physician.

You need to have a plan of care established and you have to be in need of skilled services. You also have to have a face of – face-to-face encounter as established in the regulations.

We understand that the calendar year payment policy rules were recently finalized, and we are working to make sure with our payment policy staff that – to make sure that the demonstration can work, in conjunction with all of those policies. So again, the typical coverage and documentation requirement will continue under this demonstration.

And now moving on, I will turn the call over to Jennifer McMullen, who will go into more details about the demonstration and the choices. Thank you.

The Review Choice Demonstration Process

Jennifer McMullen: Thank you, Amy. My name is Jennifer McMullen. I'm going to walk you through a little bit about the demonstration process.

So, starting on slide 9 or 10, we talk about the three initial choices that Home Health Agencies can choose between.

The first choice is Pre-Claim Review of all claims. It will follow the process implemented under the initial Pre-Claim Review demonstration and will allow for unlimited resubmission following a non-affirmed request. With the new demonstration, it will also allow for multiple episodes to be requested on one Pre-Claim Review request for a beneficiary.

Choice II is Postpayment Review of all claims. It will follow the current post-payment medical review processes, and this will be the default option if no initial choice selection is made.

Choice III is minimal review with a payment reduction. All home health claims will receive a 25 percent payment reduction. The claims will be excluded from MAC targeted probe and educate review but maybe selected for Recovery Audit Contractor review.

On slide 11, we start to talk about the Pre-Claim Review option. Home Health Agencies or beneficiaries will submit a request for Pre-Claim Review. This can contain more than one episode for beneficiary.

The MAC will review the request and supporting documentation and using CMS policies, all applicable tools and regulations, national coverage determinations and local coverage determinations will make a decision. The MAC will then send a decision letter either provisionally affirming or non-affirming that Pre-Claim Review request.

On slide 12, we talk about the decision. A provisional affirmed decision means that the claim will be paid as long as all other Medicare requirements are met. A non-affirmed decision means the request did not meet the Medicare home health coverage requirement.

If a request is non-affirmed, the submitter can resolve the non-affirmed reasons described in the decision letter and resubmit the Pre-Claim Review request. Unlimited resubmissions are allowed before the submission of the claim for payment, a Pre-Claim Review decision cannot be appealed.

The submitter can also provide the service and submit a claim. The claim will be denied, and all appeal rights are available.

On slide 13, we talk about the choice a little bit more. 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 decision can – justified by the beneficiary's condition, affirm some or all of the episodes requested.

For any additional provisionally affirmed episodes, a valid plan of care must be submitted, prior to the claim submission. And a Pre-Claim Review request can be resubmitted for any additional episodes that were not provisionally affirmed, prior to the episodes final claim being submitted for payment.

On slide 14, we talked about initial and resubmitted request. An initial request is a – the first Pre-Claim Review requests for any episode. And the MAC will make every effort to review their request and postmark decision letters within 10 business days.

A resubmitted request is a request submitted with additional documentation after the initial Pre-Claim Review request was not affirmed. The MAC will make every effort to review their request and postmark decision letters within 20 business days.

On slide 15, we talk about the decision letters. These letters are sent to the Home Health Agency and the beneficiary. The decision letter will include a Pre-Claim Review unique tracking number.

This tracking must be submitted on the claim and decision letters that are for non-affirmed request will provide a detailed written explanation, outlining specific policy requirements that were not met.

On slide 16, we talk about what happens if a Home Health Agency chooses choice I Pre-Claim Review but does not submit a Pre-Claim Review request before submitting the final claim. In this case, the subsequent claim will be stopped for prepayment review.

If the claim is determined to be payable, it will be subject to a 25 percent payment reduction. The payment reduction is nontransferable to the beneficiary and the payment reduction is not subject to appeal.

Again, this is only for Home Health Agencies, who have chosen the Pre-Claim Review option but did not submit a Pre-Claim Review request.

On slide 17, we talk about choice II – Postpayment Review. Under this option, the Home Health Agency will follow the standard intake service and billing procedures and claims will pay according to normal claims processes.

The MAC will conduct complex medical review on the claims submitted during a 6-month interval. MAC will send the Home Health Agency an additional documentation request letter following receipt of the claim for payment and Home Health Agencies who do not make an initial choice selection will default to this option.

On slide 18, we talk about choice III – Minimal Preview with a 25 percent Payment Reduction. Under this option, the Home Health Agencies will follow their standard procedures and the claims will pay according to normal claim processes. Home Health Agencies will receive an automatic 25 percent reduction on all payable Home Health claims.

Claims falling under this choice will be excluded from the regular MAC targeted probe and educate review but may be subject to potential RAC review. Any denied claims will retain all normal appeal rights. And Home Health Agencies, who choose this option, will remain here for the duration of the demonstration and will not have an opportunity to select a different choice later.

On slide 19, we talk about compliance with their Pre-Claim Review and Postpayment Review options. For choices I and II, an affirmation rate or claim approval rate will be calculated every 6 months. If the rate is 90 percent or greater, based on a 10 requests or claim minimum, Home Health Agencies can select a subsequent review choice.

These choices are Pre-Claim Review, Selective Postpayment Review or a Spot Check Review. Illinois Home Health Agencies, who participated in the initial Pre-Claim Review demonstration and reached the 90 percent provisional full affirmation rate, based on a 10 request minimum can start the process with one of the subsequent review choices.

On slide 20, we talk about choice for Selective Postpayment Review. Under this option, Home Health Agencies will follow the standard intake service and billing procedures, their claims will pay according to normal claim processes.

After 6 months, the MAC with select a statistically valid random sample for Postpayment Review. The MAC will send the Home Health Agencies an ADR letter and follow Postpayment Review procedures.

Home Health Agencies in this option will remain here for the remainder of the demonstration and will not have an opportunity to select a different review choice later. Home Health Agencies who do not select a subsequent choice will default to this option.

On slide 21, we talk about choice V, the Spot Check Review. The Home Health Agency will follow the standard intake service and billing procedures. The MAC will randomly select 5 percent of the submitted claims for pre-payment review every 6 months.

The Home Health Agencies may remain with this choice for the remainder of the demonstration, as long as the Spot Check shows that Home Health Agency is compliant with Medicare rules and coverage policies. If the Home Health Agency is not compliant, they must again select from one of the initial three review choices.

On slide 22, we talked about the choice selection procedure. Once the selection period begins in their states, Home Health Agencies will have until two weeks, prior to the start of the demonstration to select an initial review choice.

Home Health Agencies will make their choice selection through the eServices online provider portal. And on slide 22, we have the link to that portal. Illinois Home Health Agencies who participate in the initial demonstration and receive the 90 percent provisional full affirmation rate with a minimum of 10 requests may select a subsequent review choice.

On slide 23, we have a chart that shows the choice selection option and the process from the beginning of the initial choice, all the way through the subsequent review choices.

Slide 24, we talk about Home Health Coverage. Medicare coverage policies are not changing, that this demonstration does not create any new documentation requirements.

And currently, Home Health Agencies will still be able to submit their Request for Anticipated Payment, the RAP, in the same manner and subject – the same rules as they currently do.

On slide 25. We talk about All Advanced Beneficiary Notice policies, claim appeal rights, dual eligible coverage and private insurance coverage and they – none of those will be changing either. And access to care services should not be delayed for people with Medicare's home health benefit.

On slide 26, we talk about CMS oversight. CMS who regularly assess pre-claim affirmation and claim approval rates will review a sample – a MAC decision to assure review accuracy. And we will contract with an independent evaluator to review the demonstration.

On slide 27 we talk about where you can find more information. We have a demonstration website. And we also have a dedicated email box for questions on the demonstration. The links to both are on slide 27. And also, CMS and Palmetto will continue to provide additional educational opportunity.

I will now turn it back over to Leah for questions.

Question & Answer Session

Leah Nguyen: Thank you, Jennifer. We will now take your questions. As a reminder, this event is being recorded and transcribed. An effort to get to as many questions as possible, each call is limited to one question.

To allow more participants, the opportunity to ask questions, please send questions specific to your organization to the resale – resource mailbox on slide 27, so our staff can do more research. Preference will be given to general questions applicable to a larger audience and really mindful of the time spent on each question.

All right, Dorothy, we're ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key.

Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard in the conference.

If you have more than one question, press star one to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A a roster.

Your first question comes from the line of Tina Ketchum.

Tina Ketchum: Hello. Can you hear me okay?

Leah Nguyen: Yes, we can.

Tina Ketchum: Hi. I'm Tina Ketchum with Home Touch Healthcare out of Illinois, and we are one of the agencies that had a 90 percent affirmation rate when the Pre-Claim Review was going on before. My question is when will we know when we can choose our subsequent choice?

Jennifer McMullen: This is Jennifer McMullen. The MAC will be sending you information on which choices you can select from and the time that you can select when the period will open.

Tina Ketchum: Oh, and that …

Jennifer McMullen: And this …

Tina Ketchum: Oh, I'm sorry. Go ahead.
Jennifer McMullen: No, no, no. Go ahead.

Tina Ketchum: They'll send that to eServices?

Jennifer McMullen: Krisdee, did you mind taking that?

Krisdee Foster: Yes. Hi. This is Krisdee Foster with Palmetto GBA. We will be mailing a letter to all providers notifying them of their selection dates, as well as their affirmation rate if you are an Illinois provider.

Tina Ketchum: Oh, perfect. Okay. Well, thank you very much.

Operator: Your next question comes from the line of Bob Moss.

Bob Moss: Hi, this is Bob Moss with E-Solutions. I am aware that pre -claim can be submitted to Palmetto through different pathways. Just wondering if you could cover those pathways and specifically note, whether that will include secure file transfer and esMD.

Jennifer McMullen: Sure. Request can be either mailed, faxed, submitted through the portal or through esMD. Krisdee, do you know about the secure file transfer?

Krisdee Foster: No, we do not.

Bob Moss: You do not know or it will not be accepted that way?

Krisdee Foster: Currently it's not accepted that way.

Bob Moss: Okay. On the original pre-claim, there was that capability, so.

Krisdee Foster: If something of that changes, we'll definitely notify everyone.

Bob Moss: All right.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Krista Schmidt

Krista Schmidt: Hello, this is Krista Schmidt. I'm with Brookdale Home Health of Chicago. I was wondering with the decisions, it appears that those will be mailed by U.S. Postal Service to the agencies only. In the original review, they were able to find the affirmations or non-affirmation status via eServices. Is that still available or will that be per letter only?

Jennifer McMullen: I believe they will – also they will be either mailed or sent through eServices. Is that correct, Krisdee?

Krisdee Foster: Yes, that's correct. You will receive your notice back however you send it into us. So, if a provider is sending something into us through eServices through what we call green mail, which is the message selection choice in eServices, you'll see all your messages that pertain to any affirmations, UTNs and things like that.

If you submit to us hardcopy meaning mail or through fax, then you would be receiving that information back the same way that you submitted to us in the first place.

Krista Schmidt: Thank you.

Operator: As a reminder if you would like to ask a question, please press star then the number one on your touch tone phone.

Your next question comes from the line of Matthew Baird.

Andrew Baird: Hello. This is Andrew Baird from Encompass Health. Hello?

Leah Nguyen: We can't understand you. Can you speak up?

Andrew Baird: Yes. Can you hear me now?

Leah Nguyen: No. Can you come off speaker?

Dorothy, can we take the next question, please?

Operator: Your next question comes from a line of Karen Splaingard.

Karen Splaingard: Hi, this is Karen Splaingard of SSM Health at Home. Can you hear me? Okay?

Leah Nguyen: Yes, we can.

Karen Splaingard: Okay. My question stems from we have – we offer home care services in Illinois. And prior when it was Pre-Claim Review, we were subject to the audits. And we do not submit to Palmetto. We only submit our home health claims to CGS. So, we were questioning on the slides where we saw that only if we submit our claims through Palmetto, are we subject to this. So, we're questioning if we would really be subject to RCD at this time.

Jennifer McMullen: This is Jennifer McMullen. No, if you do not submit to Palmetto, you will not be subject to the demonstration at that time.

Karen Splaingard: Okay. Is there anywhere I can find that out on the – out so I can show it in writing to leadership? Is there somewhere in writing I can find that besides your slides?

Jennifer McMullen: I believe our – so we have some FAQs and documentation on our demonstration website that may indicate that.
Karen Splaingard: Thank you so much.

Operator: For next question comes from a line of Sarah Ratcliffe.

Sarah Ratcliffe: Hi, everybody. Thanks for the opportunity today. My question is about the differences between choice IV and choice V. Choice V seems like it is also an ADR, except that the timing is different in that it comes before payment. So, I am asking can you speak a little bit more about that?

Jennifer McMullen: Yes. This is a Jennifer McMullen. I guess there is a difference in that choice IV, is a Postpayment Review after the claims have been submitted, whereas choice V is a prepayment review.

And also, the amount of claim review could be different under the choice V. It's a 5 percent, whereas under the choice IV, it's a statistically valid random sample so that could be a larger number.

Sarah Ratcliffe: Okay. But the documentation that you're going to ask for is that the same for both choices IV and V?

Jennifer McMullen: Yes, the documentation is – would be the same.

Sarah Ratcliffe: Okay. And then just a follow-up question, if I could. So, choice IV, if that choices chosen, then the provider is stuck in that choice for the remainder of the demonstration for five years.

For choice V, if they choose that, are they – are they there for the next five years? Or is there an option to change? Say, they tried that they don't like it. They want to go back to Pre-Claim Review, is that it – is that an option?

Jennifer McMullen: Yes, under choice V, they would have that option.

Sarah Ratcliffe: Okay. Thank you. Thank you so much.

Operator: Your next question comes from the line of Cynthia Fitzgerald.

Cynthia Fitzgerald: Hello. Thank you for the opportunity to participate as well. I'm calling from the State of Texas.

I know that the rollout in Illinois did not go as smoothly as you'd anticipated. Can you tell us what steps or what things have changed to ensure that it'll have a smoother roll out this time?

Amy Cinquegrani: Hi. This is Amy Cinquegrani. Sure. We have learned lots of lessons from the initial the demonstration that we have incorporated, just as far as education. Palmetto has been speaking about the demonstration, how we've proposed it.

As it stands now, we're trying to talk as much as possible about the demonstration, incorporating your questions, where we can on this forum, and we plan to have additional forums to speak and hear feedback.

There's been additional work in review consistency and ensuring that the MAC reviewers are consistently trained in the home health policies, taking feedback as far as options and flexibility and not requiring all providers to stay

in the pre-claim options throughout the entirety of the demonstration. We understand that there were – we had a lot of feedback on those issues in the demonstration. And so, we've taken those into account.

We also plan to release data as we did in the initial demonstration. I know there was feedback people wanted to know how the demonstration was going, how affirmation rates were looking, and so we plan to continue to be transparent and the amount of information that we can provide once operations start.

Cynthia Fitzgerald: Thank you. I appreciate the full response.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Liz Vogt.

Liz Vogt: Hi, thank you, CMS, for hosting the call today. I'm from the Illinois Home Care and Hospice Council. And I just wanted to clarify one thing that was said previously.

Amy, I think you mentioned that you're looking at the December 10th start date in Illinois as the start of the selection period, rather than the start of the actual demonstration for review purposes.

And I realized that you're waiting on approval from OMB under the Paperwork Reduction Act to have a firm timeline in place, but could you provide a little bit of clarity around what that December start date if it is, in fact, December 10th, if that would be the start date for providers in Illinois to make their selection for the next 30 days, with more like a January 10th actual review start date or would the December 10th date actually be the date that you're thinking that the review would start?

Amy Cinquegrani: Hi, Liz. This is Amy. So originally when we put out the December 10th date, we were thinking that it would be the date that the actual implementation of the demonstration, submitting review requests and post payment reviews, based on episodes of care that start as that December 10th timeframe.

As time has went on, we're at the point now where – since we don't have Paperwork Reduction Act approval currently that it doesn't look likely that December 10th can be that start date for those episodes of care because of what I mentioned before.

We want to make sure that providers have ample opportunity to make their selection. And we think you know, at least, two weeks would be our hope and possibly even a greater than two-week time period, and then Palmetto need some additional time to make sure that if – their systems are working appropriately once people have made those selections.

And so, factoring in time for the holidays coming up that's where it's looking less likely that December 10th could be for episodes of care. So, like I said, this is all very fluid and subject to change.

And it kind of depends on where we are at that particular minute with our – with our PRA approval, but we would still like to keep the December starts – December 10th start date – excuse me. But possibly have that be where providers could start their selection process.

And then like (cross talk) …

Liz Vogt: Okay.

Amy Cinquegrani: … additional weeks later would be the actual, start date for episodes of care.

Liz Vogt: Great, thank you. We appreciate that clarification. And certainly, we've communicated to you guys in the past that we would be supportive of a delayed start date just to give providers complete time to understand what the final program looks like and make an informed selection and make sure that we're not rushing to implement. So, thank you for that clarification.

Amy Cinquegrani: Thank you.

Operator: Your next question comes from a line of Andrew Baird.

Andrew Baird: Hi there. Can you all hear me? I got disconnected earlier. I apologize.

Leah Nguyen: Yes, we can hear you.

Andrew Baird: Thank you. I had a question. You said that about the affirmation rate for Illinois providers. You said that that was going to be based on, initially, the affirmation rates in the initial PCRD. Is that same type of preliminary affirmation approval going to be available for providers in other states when the program expands to those other states?

And then the sort of follow-up question up to that is for those folks who are in the 90 percent affirmation choice with the spot checks, are those spot checks going to require 100 percent compliant special order or 80 percent or is there are threshold associated with those projects as well? Thank you.

Jennifer McMullen: Hello, this is Jennifer McMullen. The 90 percent threshold would be available to other states after they go through an initial first round, like a first 6 months. If they show the 90 percent compliance after that first round, they could choose a subsequent review option, which would include these spot checks.

Right now, we are planning on having the spot check subject to the 90 percent of approval rate as well.

Andrew Baird: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from a line of Deb Walker.

Deb Walker: Hello. This Deb Walker from NHRMC. I think most of my questions have been asked – answered, but I did have one regarding choice number II. I want to make sure that I am – my assumption is correct. That is going to be 100 percent review of all claims.

Jennifer McMullen: This is Jennifer McMullen. Yes, it will be 100 review or 100 percent of claims.

Deb Walker: All right, thank you.

Operator: Your next question comes from the line of Deirdre Enclay.

Deirdre Enclay: Good afternoon. Thank you so much. This is Deirdre Enclay. I have a question, please. I have – I know that there are some agencies in Illinois that have not received their affirmation rate as of yet. I'm not sure though if they've gone on eServices. So, if this – how long will it take to get the affirmation rates to let us know whether or not which selection we will be in?

Jennifer McMullen: This is Jennifer McMullan. We have not sent that out yet, so, it …

Deirdre Enclay: Okay.

Jennifer McMullen: Nobody has received their rates yet. We will make sure they are sent out in plenty of time for agencies to review their options prior to the selection period. We don't have a set time for that quite yet. That'll be based on getting our Paperwork Reduction Act approval but is going to be – we'll make sure you have plenty of time to review the options before making the selection.

Deirdre Enclay: All right. Thank you.

Operator: Your next question comes from a line of Monet Menotti.

Monet Menotti: Hello. Can you hear me? Okay.

Leah Nguyen: Yes, we can hear you.

Monet Menotti: Hi. Good afternoon. So, my question is during the PCR demo, the Palmetto reviewers have been calling the agency of their decision, may it be partial or non-affirmation. So, if the person they are looking for or the person who submitted these documents is not available during that call, what is their timeframe? Can the agency call the reviewers back and show them where the documentation can be found? And if, so are we going to speak with the same reviewer?

Jennifer McMullen: This is Jennifer …

Krisdee Foster: Hi …

Jennifer McMullen: (Inaudible).

Krisdee Foster: Go ahead, Jennifer.

Jennifer McMullen: The Home Health Agency – I'm sorry – the MAC will be reaching out to the Home Health Agencies for non-affirmed or personally affirmed decisions to walk you through what you choose their work.

Krisdee, do you have the exact process that they can follow?

Krisdee Foster: Hi, yes, it will be the same as it was last time. So, nurse review – nurse reviewer will be reaching out. They do look at who requested it. In other words, when they said in a PCR, they will be looking at the requester name and telephone number. We encourage you that you would put a direct line on that, so it's easier for the nurse reviewer to get in touch. And normally, at least last time they made a couple of attempts if you weren't around.

You also have a note section in there that you can add the best timeframe to be called or the nurse reviewer will leave information based on when she would be able to call back as well.

Monet Menotti: Okay, so at least it's not just a one-time thing. There will be several attempts. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kathleen Semmerling.

Kathleen Semmerling: My question was answered already. I tried to push the star thing and, I guess, it didn't hang up on me.

Leah Nguyen: Thank you.

Operator: As a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad.

Your next question comes from the line of Mandy Fordie. Mandy, your line is open.

Mandy Fordie: Sorry, I was talking on mute. I have a question in regards to the date of the claims. So, when the Pre-Claim Review starts, will that be episodes beginning of a certain date or is it just any claim is filed after you're on the Pre-Claim Review? Hello?

Jennifer McMullen: Oh, I'm sorry this – I was on mute as well. This is Jennifer McMullen. Under the Pre-Claim Review option, it will be – should be episodes that start on the – on or after the start date of the demonstration.

Mandy Fordie: Episodes that start on or after the date of the demonstration. And if you're in the second-round meeting, you were part of the Pre-Claim Review initially. You have your 90 percent affirmation. I would assume the same applies for that – the episodes beginning the date of that you initiated the review and after?

Jennifer McMullen: I believe it depends on which option you select for your subsequent review option. It would, in that case, it may be the date that the claim was submitted for payment.

Mandy Fordie: Oh, Okay. Good to know. And then I just have one other question, if I may. Slide 15 referred to that specific info was going to be provided if you were not affirmed. I guess I would just like to know how specific that information is because many times you just get like the whole section say it's your face to face, and it just tells you the requirements for the entire face to face not exactly where is – you fell out, whether they feel homebound wasn't covered, or something of that nature.

Jennifer McMullen: The decision should provide enough detail that you're able to tell what the actual issue was, not just kind of definitely what it was. And the follow-up call from the MAC will be able to provide even further clarification on the issues as well.

Mandy Fordie: Okay. All right. Thank you.

Operator: Your next question comes from the line of Jackson Yang.

Jackson Yang: Hi, this is Jackson Yang. Thanks for your time. My question is, understanding that the timing for the implementation of the RCD is still fluid. But assuming that it does get implemented in Illinois sometime in December, January, do you have any clarity on when they may get rolled out to the other states and more specifically to Texas?

Amy Cinquegrani: Hi, this is Amy. At this point we don't have any specifics beyond what we've provided. We plan to give, at least, 60 days' notice before beginning in a different state and possibly greater than 60 days' notice but nothing additional at this point.

Jackson Yang: Okay. And just as a follow up to that well, do you know the rollout will be sequential sort of state by state or will the roll out to the remaining states sort of be in one fell swoop like all together?

Amy Cinquegrani: This is Amy again. It will be one state at a time.

Jackson Yang: Got it. Thank you.

Amy Cinquegrani: Uhum.

Operator: Your next question comes from the line of Maria Avers.

Maria Avers: Yes, this is Maria Avers and I was calling to ask how are the pre-claim affirmation rates calculated? Is it by the claim or by the attempts of the request for the pre-claim number?

Jennifer McMullen: Krisdee, do you want to talk about how that rate will be calculated?

Krisdee Foster: The rate is calculated by the claim —number of claims reviewed versus non-affirmed.

Leah Nguyen: Thank you.

Operator: There are no further questions at this time, I'll turn the call back over to you, Leah.

Additional Information

Leah Nguyen: Thank you. We hope you will take a few moments to evaluate your experience. See slide 29 for more information.

An audio recording and transcript will be available in about two weeks at go.cms.gov/npc. Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the Review Choice Demonstration. Have a great day, everyone.

Operator: Thank you ladies and gentlemen. Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.