HCA UPDATE

Patrick Conole

Senior Vice President, Finance
and Management
Home Care Association of NYS

State Medicaid Issues

HCA
EDUCATION AND RESEARCH

State Medicaid Issues

CHHA Episodic Pricing System (EPS) Overpayment Audit

- In December 2016, the NYS Office of State Comptroller issued a Certified Home Health Agencies (CHHA) Episodic Payment System (EPS) Audit Report which can be found at: http://www.osc.state.ny.us/audits/allaudits/093017/16s4.pdf

- The Comptroller's Audit involves 95 CHHAs statewide and between $15-16 million over a 3.5 year period.

- According to DOH, the issues identified in this audit were raised during the construction of the EPS. However, insufficient resources and the EPS billing configuration prevented the development of effective eMedNY system controls to prevent the overpayments. The Comptroller made recommendations to the Department to recover the improper Medicaid payments (through the OMIG) as well as to develop and implement mechanisms to identify and recover future improper billings.

HCA
EDUCATION AND RESEARCH

State Medicaid Issues

CHHA Episodic Pricing System (EPS) Overpayment Audit – *continued*

- In June, DOH posted a Dear Administration Letter (DAL) to the Health Commerce System (HCS) regarding the Comptroller's review of overpayments within the CHHA EPS from May 1, 2013 to December 31, 2016.

- The identified overpayments fell into one of the following 3 categories:

    1. Improper use of discharge code when a Medicaid Recipient is transferred to a Managed Long-Term Care (MLTC) Plan;

    2. CHHA Provider paid for multiple episodic payments within 60 days;

    3. Improper use of discharge code when a Medicaid Recipient subsequently obtains services from a different CHHA.

- In July and August, the OMIG began issuing individual draft audit reports to the 95 CHHAs impacting by the audit.

HCA
EDUCATION AND RESEARCH

State Medicaid Issues

CHHA Episodic Pricing System (EPS) Overpayment Audit – *continued*

- The majority of the issues that CHHAs are disputing involve the Season Reason where the audit maintains that in some cases CHHAs were paid for multiple Episodic Payments within 60 Days.

- Specifically, this involves cases where CHHAs were providing services to dually eligible (Medicare & Medicaid) patient(s) where the CHHA was first only billing Medicare and then sometime during that 60-day HH PPS Medicare episode the patient becomes no longer Medicare eligible (i.e. no longer homebound) and the CHHA subsequently bills Medicaid for the remaining care – but when switching to Medicaid, tries to align or synched up their CHHA EPS Medicaid episode time period with the Medicare PPS episode – which is what they were instructed to do by DOH when CHHA EPS was first implemented in 2012, thus resulting in the first CHHA EPS episode being Partial Episodic Payment (PEP)

- HCA has had multiple discussions with senior OMIG officials and have asked the OMIG to not recoup any so-called CHHA EPS overpayments when CHHAs were just following the billing guidance issued by DOH on synching up Medicare PPS episodes with Medicaid EPS episodes.

State Medicaid Issues

DOH Posts Medicaid Face-to-Face (F2F) Guidance

- In its July Medicaid Update (https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-07.htm), DOH posted long-anticipated guidance on implementation of the federally-required face-to-face (F2F) requirements for Medicaid home health cases, distinct from and in addition to the long-standing F2F requirement for Medicare home health. The requirement went into effective **July 1, 2017**.

- HCA and the Medical Society of the State of New York (MSSNY) worked in partnership to draft guidelines well before the July 1 effective date for DOH to use as the basis for Medicaid F2F. Our purpose was to ensure a streamlined process for physicians and home care agencies, and the narrowest applicability of the requirements to avoid the kinds of extensive, onerous, duplicative and confusing standards set by the U.S. Centers for Medicare and Medicaid Services (CMS) in the case of F2F for Medicare home health services.

State Medicaid Issues

DOH Posts Medicaid Face-to-Face (F2F) Guidance – *continued*

- DOH's adopted Medicaid F2F requirements will apply **only to CHHA fee-for-service (FFS) cases**, not to mainstream managed care or managed long term care plan cases, significantly reducing the applicability and potential burden of Medicaid F2F, given that the majority of home care falls under managed care. **The requirements also do not apply F2F to personal care-only cases.** HCA has also confirmed that the adopted managed care exemptions also include FIDA, special needs managed care plans and PACE plans.

- Importantly, the requirement only applies to the initial ordering of services and F2F need not be conducted at recertification. **This one-time applicability of F2F (at start of services) also extends to dual-eligible cases.** However, if the patient "is discharged and care is subsequently restarted, the F2F encounter must be completed at the start of the new episode of care.

- The timeline for obtaining the F2F documentation is similar to the Medicare requirement (within 90 days before or 30 days after start of services). And the guidelines permit certain non-physician practitioners to conduct the F2F encounter (though a physician must sign-off on the certification).

State Medicaid Issues

Other State Medicaid Issues

- **Standardization of Medicaid Managed care billing / revenue codes** - As part of the 2015-16 final budget DOH was required to do this and HCA has been part of a Workgroup that has developed rate/billing codes which have been shared with the plan associations. There have been multiple delays but it is HCA understands that DOH will be requiring the implementation of these rates / billing codes by January 1, 2018, and will request status updates on November 1, 2017 and December 1, 2017.

- **Third Party Liability (TPL) Update -** The OMIG and UMMS last month sent provider case selection report letters to many Medicare certified providers that includes a listing of all cases that need to be demand billed to Medicare for the first half of FFY 2017 only. Dates of service for this period include October 1, 2016 thru March 31, 2017.

State Medicaid Issues

Other State Medicaid Issues – *continued*

- **2% Across the Board (ATB) Medicaid Reduction** - Effective May 8, 2015, the 2 percent ATB Medicaid payment reduction was eliminated for claims with service dates on or after April 1, 2015. However, impacted providers are still due the retroactive repayment of the reduction taken over the period April 1, 2014 through March 31, 2015. DOH has received federal approval from CMS on this repayment and has indicated to HCA that they will be moving forward with their payment process over the next few weeks. HCA will notify the membership once DOH sends a notice out to providers via eMedNY that includes a payment cycle # and date.

HCA EDUCATION AND RESEARCH

Federal / Medicare Issues

HCA
EDUCATION AND RESEARCH

Federal Medicare Issues

CMS's Proposed CY 2018 HH PPS

General Overview

- On July 25, 2017, CMS published in the Federal Register the proposed rule for the CY 2018 Medicare Home Health PPS. This was about a month later than normal and delays the comment period until September 25, 2017.

- HCA provided the membership with a detailed Public Policy Memorandum on CMS's proposed rule (in handouts) which can be accessed at: http://hca-nys.org/wpcontent/uploads/2017/08/CMS2018ProposedRuleMemoFinal.pdf

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Details on the Proposed Rate

- CMS projects that Medicare payments to HHAs in CY 2018 would be reduced by 0.4 percent, or $80 million, based on the proposed policies.
- The proposed decrease reflects the effects of:
  - A 1 percent home health payment update percentage ($190 million increase);
  - A -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and
  - The sunset of the rural add-on provision ($100 million decrease) on December 31, 2017.

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Details on the Proposed Rate – *continued*

- Includes another recalibration of the HHPPS case-mix weights (CMWs), using the most current cost and utilization data. CMS's goal is to have an overall average case-mix score of 1.0 nationally.
-
- Updates the HHPPS wage index for CY 2018, which are fully based on the revised OMB delineations adopted in CY 2015. There are now 15 CBSA wage index designations for HHAs in New York. **In this proposal, 8 CBSAs are expected to see decreases while 7 CBSAs are expected to see increases.** HCA is particularly disappointed that the Albany-Schenectady-Troy designation is proposed to have a -0.46 decrease while the NYC designation is proposed to have a -0.49 decrease in CY 2018. Both of these designations have had repeated decreases over the past 4-5 years.
-
- Importantly, the proposed rule introduces a significant, new, and complex change for 2019; CMS plans to change the unit of payment from a 60-day episode of care to a 30-day period of care, starting **January 1, 2019**, which is estimated to reduce Medicare home health payments nationally by **$950 million.**

Federal Medicare Issues

Proposed Home Health Groupings Model (HHGM)

- The proposed new system would maintain the same basic principle of paying a percentage of a national average payment amount based on a set of weighted patient characteristics. Includes:
  - Adjustments for low utilization (LUPA) but includes a new threshold of visits;
  - Partial episodic Payments (PEPs); and
  - Outliers.

- However, the new unit of payment based on a 30-day episode vs. the current 60-day episode under HHPPS.

- There would be 144 new Home Health Resource Groups (HHRGs) that determine the percentage of a standardized 30-day standardized, national payment rate that incorporates consideration of average agency resource use and costs, including those for non-routine medical supplies.

Federal Medicare Issues

Proposed Home Health Groupings Model (HHGM) – *continued*

- It would eliminate therapy visits as a factor in the scoring.
- The group would be determined by:
  - Whether the patient is admitted from community or from an institution (hospital or SNF).
  - Whether the patient is in first 30-day episode or a continuing episode (early vs late).
  - Patient placement into one of the following 6 broad clinical categories determined by the primary diagnosis (Musculoskeletal Rehab, Neuro Rehab, Complex Nursing Interventions, Wound, Behavioral Health and Medication Management, teaching and Assessment).
  - Patient placement in one of 3 broad (low, medium or high) functional levels based on OASIS data.
  - Whether there is a relevant comorbidity justifying upward adjustment.

Federal Medicare Issues

Other Highlights of the Proposed Rule

- Continues the implementation of a new standard for the submission of the Outcome and Assessment Information Set (OASIS) to avoid payment rate reductions. In the first year (CY 2017), CMS imposed a 70 percent compliance standard for the number of OASIS submitted (using a "Quality Assessment Only" formula), which rises to **80 percent in the second year (CY 2018)** and caps out at 90 percent in the third year (CY 2019).

- Once again, makes no comment or policy changes regarding F2F. CMS's intentions appear to maintain the current F2F requirements, along with the changes implemented for 2015, which eliminated the physician narrative requirement but still require physicians (or an approved non-physician practitioner) to certify that a F2F patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days after the start of home health care.

Federal Medicare Issues

Other Highlights of the Proposed Rule – *continued*

- Includes some important updates to its value-based purchasing pilot proposal which is currently operating in nine randomly selected states. New York is still not one of the nine states (Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee). CMS's proposal would move to 40 surveys from 20 surveys and remove the OASIS-Based measure - Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care.

Federal Medicare Issues

HCA's Advocacy on CMS's CY 2018 HHPPS Proposed Rule

- On September 11-12, HCA will be participating in a Federal Advocacy Day in Washington DC in conjunction with the Forum of Statewide Home Care Associations to advocate all of our concerns about CMS's proposed regulations – with the focus being on asking for Congressional assistance in revising the burdensome F2F requirement, extending the 3% rural add-on and eliminating, delaying or revising CMS's proposed new Home Health Groupings Model for CY 2019.

- HCA will be submitting comments to CMS on the on the proposed CY 2018 HH PPS by the September 25, 2017 deadline and we encouraged providers to do so as well.

Federal Medicare Issues

HCA's Advocacy on CMS's CY 2018 HHPPS Proposed Rule – *continued*

With regards to the proposed new HHGM, HCA will provide the following comments to CMS:

- The proposed new HHGM is too big of a change, too quickly and is untested. It shifts an entire health care industry and delivery segment to an untested payment model. There is no precedent for this in any other health care delivery segment. Agencies need significant more time to work with their Clinical and software billing vendors before implementing such a change.

- The new HHGM methodology is a radical shift, eliminating the therapy visit volume payment determinant in the current model, instead using an entirely different case mix model focused on patient characteristics.

Federal Medicare Issues

Comments to CMS – *continued*

- This change has only been modeled on paper and has never been tested by any agency in any area of the country.
- CMS estimates that moving to this model will remove $950 million in CY 2019 Medicare home health payments and asserts it will not impact access to home health care. After 4 years of rebasing and reductions in payment - another cut of this significance will severely impact patient's access to home care in New York, since our operating margins continue to be much lower than other areas of the country.
- CMS could propose a voluntary demonstration that would allow for this new model to be tested, reviewed and, if necessary, revised based on the trial before national implementation.

Federal Medicare Issues

Other Areas of Concerns to be Included in our Comments:

- CMS does not include the costs of the following HHA regulatory obligations within the HHPPS: the new Conditions of Participation (CoPs), the ongoing F2F requirement, PECOS enrollment mandate, CAHPS patient surveys, and ICD-10.

- CMS's approach ignores regional differences in home health operating margins. In previous rulemaking, CMS estimated that 43 percent of all HHAs would face negative Medicare margins at the end of rebasing. However, an HCA analysis earlier this year found that approximately 70% of NY home care providers were operating at a loss across all payors in 2015, not just Medicare.

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Other Areas of Concerns to be Included in our Comments – *continued*

- CMS does not include the costs of the following HHA regulatory obligations within the HHPPS: the new Conditions of Participation (CoPs), the ongoing F2F requirement, PECOS enrollment mandate, CAHPS patient surveys, and ICD-10.

- CMS's approach ignores regional differences in home health operating margins. In previous rulemaking, CMS estimated that 43 percent of all HHAs would face negative Medicare margins at the end of rebasing. However, an HCA analysis earlier this year found that approximately 70% of NY home care providers were operating at a loss across all payors in 2015, not just Medicare.

  The trend of HHAs in New York experiencing negative operating margins will probably only worsen especially considering the state's implementation of a phased-in $15 per-hour minimum wage hike, the balance of which is unfunded by Medicare. All of these costs leave HHAs with no resources for capital and modernization through technology (i.e. home telehealth and electronic health records).

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Other Areas of Concerns to be Included in our Comments – *continued*

- CMS does not include the costs of the following HHA regulatory obligations within the HHPPS: the new Conditions of Participation (CoPs), the ongoing F2F requirement, PECOS enrollment mandate, CAHPS patient surveys, and ICD-10.

- CMS's approach ignores regional differences in home health operating margins. In previous rulemaking, CMS estimated that 43 percent of all HHAs would face negative Medicare margins at the end of rebasing. However, an HCA analysis earlier this year found that approximately 70% of NY home care providers were operating at a loss across all payors in 2015, not just Medicare.

  The trend of HHAs in New York experiencing negative operating margins will probably only worsen especially considering the state's implementation of a phased-in $15 per-hour minimum wage hike, the balance of which is unfunded by Medicare. All of these costs leave HHAs with no resources for capital and modernization through technology (i.e. home telehealth and electronic health records).

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Other Areas of Concerns to be Included in our Comments – *continued*

- CMS is once again ignoring the systematic problems of the Medicare F2F requirement which continue to plague providers with administrative costs, payment problems, and access-to-care burdens.

  HCA believes CMS made this home health F2F physician encounter requirement much more burdensome than the ACA ever intended and that physicians conducting the F2F encounter should be able to simply sign and date the beneficiary's plan of care which would serve as an attestation that the F2F encounter has been met.

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

Final 2018 Hospice Payment Rule

- On August 1, the U.S. Centers for Medicare and Medicaid Services (CMS) published in the Federal Register a final rule (CMS-1675-F) updating the Medicare hospice wage index and cap amount for fiscal year (FY) 2018. HCA's hospice members can download the FY 2018 final rule at: https://s3.amazonaws.com/publicinspection.federalregister.gov/2017-16294.pdf

- As finalized, hospices nationally would see an estimated 1.0 percent ($180 million) increase in Medicare payments for FY 2018. In addition, the rule makes changes to the Hospice Quality Reporting Program (Hospice QRP), including new quality measures utilizing data collected in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey.

- The hospice payment system also includes a statutory aggregate cap. The aggregate cap limits the overall payments made to a hospice annually. The cap amount for FY 2018 will be $28,689.04 (2017 cap amount of $28,404.99 increased by 1 percent).

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

NGS Update: Probe and Educate Audit

- Beginning in December 2015 and throughout 2016, NGS conducting the first round of a medical review and audit initiative under the Home Health Probe and Educate medical review strategy outlined in CMS final rule for Calendar Year 2015 HHPPS.

- CMS implemented this Probe and Educate medical review strategy to assess and promote provider understanding and compliance with the Medicare home health eligibility requirements, including documentation of the F2F physician encounter.

- As part of this probe and educate audit process, CMS has instructed every home health MAC in the country to select a sample of 5 claims for pre-payment review from every HHA within its jurisdiction.

- In January 2017, NGS began implementation of the Second Phase (or Round 2) of the Probe and Educate Audit. HCA has heard that the number of denials in Round 2 of the Audit has decreased considerably from Round 1.

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

NGS Update: Probe and Educate Audit – *continued*

- According to NGS, the following are the main reasons why claims selected for the Probe and Educate audit were denied:
  - Insufficient F2F documentation from the physician such as clinical notes or discharge summaries;
  - Community physician not identified when hospitalist completes the F2F encounter;
  - Untimely signature of the F2F documentation from certifying physician;
  - Insufficient homebound documentation;
  - Providers not responding to NGS's ADR request within 45 days; and
  - Documentation does not adequately describe the reasons and medical necessity for home health services.

HCA EDUCATION AND RESEARCH

Federal Medicare Issues

NGS Update: Probe and Educate Audit – *continued*

- Based on the results of these reviews / denials, NGS and other MACs will conduct provider specific educational outreach. CMS has instructed MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the HHA, which will be sent at the conclusion of the probe review.

- HCA encourages members to appeal any Round 2 denials where you believe your Medicare eligibility documentation is adequate. Many agencies have been successful in overturning their initial denials from NGS.

- Last month, CMS released updated information on their Targeted Probe and Educate Medical Review Strategy which can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

HCA EDUCATION AND RESEARCH

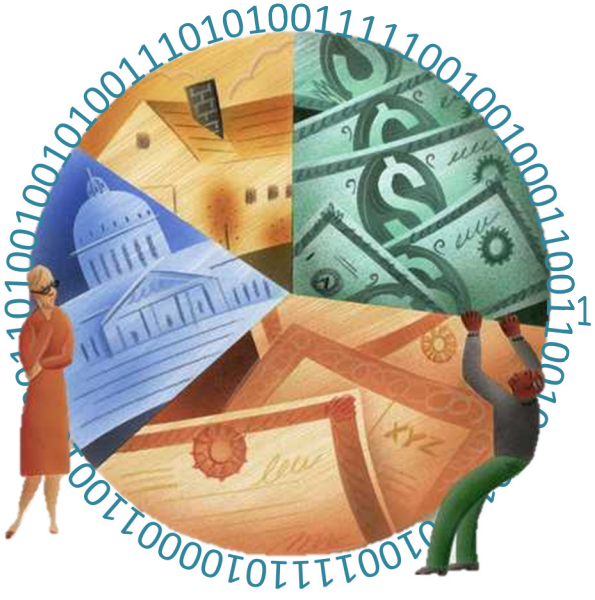
Federal Medicare Issues

NGS Update: Probe and Educate Audit – *continued*

- In this update it states the following: “This program began as a pilot in one MAC jurisdiction in June 2016 and was expanded to three additional MAC jurisdictions in July 2017. As a result of the successes demonstrated during the pilot, including an increase in the acceptance of provider education as well as a decrease in appealed claims decisions, CMS has decided to expand to all MAC jurisdictions later in 2017.”

- HCA has requested information from NGS as to how this new program will be rolled out for home health agencies in Jurisdiction 6 and will update the membership as soon as additional info becomes available.

HCA EDUCATION AND RESEARCH



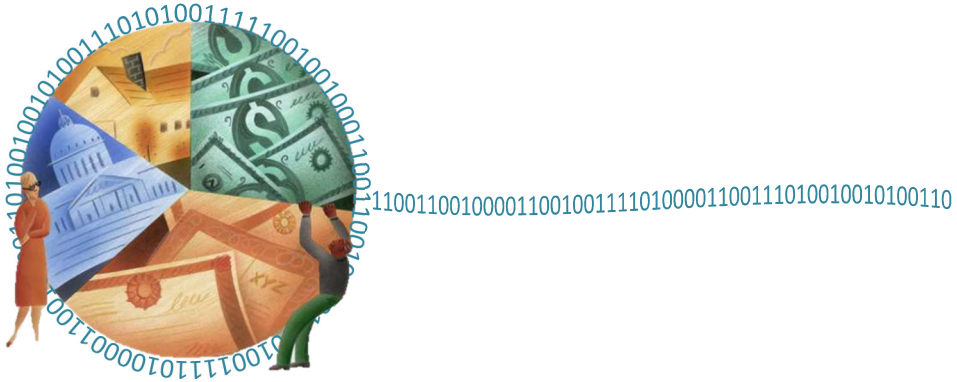
HCA's Data Webpage

1100110010000110010011110100001100111010010010100110

HCA
EDUCATION AND RESEARCH

- In 2013, HCA introduced a new members-only web page called "HCA Data at: http://hca-nys.org/hca-data

- The site includes links to data reports that will assist home care, hospice and managed care members in their benchmarking efforts, understanding of system-wide trends and access to reimbursement and premium rates.



HCA's Data Webpage includes the following resources:

- Home Health Medicaid Data Resources such as the CHHA & LTHHCP Medicaid Cost Report Summaries, DOH links to FFS Rates and the latest home care and hospice Directories from DOH.

- Medicaid Managed Care Operating Report (MMCOR) Data for MLTCS & PACE programs. Includes information on premium rates, percent of PMPM spent on Medical Services such as home health and unit cost and utilization data.

- Home Health Medicare Resources including the latest home health Utilization data from NGS, as well as NYS Medicare Cost Report Data from CMS.

- MLTC and Managed Care Resources – includes links from DOH's website that provides key information on Managed Care quality performance, access and utilization and beneficiary satisfaction.

- HCA regularly updates the Data Webpage. Over the summer we have entered the 2015 CHHA & LTHHCP Medicaid Cost Report data. We hope to have soon the 4th quarter 2016 MLTC & PACE MMCOR data from DOH.

Thank you.

HCA
EDUCATION AND RESEARCH