



CMS Restarts Pre-Claim Review Demo without Addressing Problems That Halted It

CMS proposes to reboot its pre-claim review demonstration even after serious problems were identified in the first round of the demo launched in Illinois two years ago. Those serious problems prompted a suspension of the program entirely, and a delay in its rollout to four other states in March of 2017.

This newly revamped version of pre-claim review will again begin in Illinois (no earlier than October 2018) but it also pivots to some new states.

Though New York is not one of the states, CMS holds open the possibility of expanding this newer version of the demo, potentially spreading some of the problems that have beleaguered the program to date without any serious effort on CMS's part to be transparent and accountable about those problems.

CMS must: release a thorough data report on the findings of its original demo; consider the industry's alternative methods for ensuring medical necessity of home care services; and examine the lessons learned for correcting the nominal errors that have already been identified as comprising the vast majority of findings (and causes for denials of claims) in the first iteration of this administratively cumbersome process.

Original Pre-Claim Review

The original pre-claim review demo started in August of 2016 in Illinois. It was scheduled to spread to Texas, Florida, Michigan and Massachusetts before CMS suspended it in March 2017. It required home care providers to submit documentation to third-party Medicare contractors who were tasked with making a provisional decision on whether home care coverage is allowed/medically necessary before a claim could even be submitted for payment. This is a radical shift from prior Medicare integrity efforts, which had exclusively used targeted post-payment audits.



CMS Restarts Pre-Claim Review Demo without Addressing Problems That Halted It

What's New in the Revamped Version?

CMS proposes to include some different states for the new demo.

This newer version of the demo would also provide two options, including an avenue for post-payment review. Providers could either: 1) submit **all** claims for review either before or after payment has been made; or 2) undergo minimal post-payment review of a **smaller portion of claims** but with an accompanying 25% cut in payment. Such a massive reduction is an unprecedented condition for an agency to still nevertheless undergo payment review; and these changes do not altogether address the essential problems underpinning this demo.

Problems

One reason why pre-claim review was halted in 2017 is that it did **not** find evidence of unnecessary care or ineligible services. Instead, the demo merely found correctable documentation issues unrelated to the suitability of care provided or the inherent need for home health services to beneficiaries.

HCA and partners have advanced several proposals for improving and streamlining documentation standards for medical necessity. Documentation has long been known to be the overwhelming cause of nominal “errors” in payment, as identified by Medicare contractors outside of pre-claim review. A pre-claim review process was not necessary to identify these issues, which the industry has long attempted to resolve, though the demo nevertheless put payments at even greater risk for such problems that are substantially the responsibility of CMS in its unclear, convoluted and duplicative requirements.

Reports from Illinois show that claim denials and affirmations during the original demo were inconsistent, with some home health agencies submitting claims, getting rejections, and then resubmitting the same claims unchanged, only to have them approved.

CMS has yet to provide meaningful data and analysis on these experiences in Illinois to substantiate the need or justification for reinstating this demo. More time is needed to conduct this analysis before reinstating the demo and potentially repeating the same problems that caused it to be halted to begin with.

CMS should instead concentrate its resources on pursuing outliers – those organizations with a claims processing or service pattern history indicative of potential fraud or abuse, and not all providers in the demo region. Just as important is the streamlining and improving of documentation requirements so that they aren't substantially programmed for “error” or subject to such vast differences in interpretation.

HCA urges New York's Congressional Delegation to press for a rigorous CMS review of the data experience from the initial demo and to prevent any further extension to other states, like New York, until a more reasonable, vetted process has been explored.



388 Broadway
Fourth Floor
Albany, New York 12207
P • (518) 426-8764 F • (518) 426-8877
W • www.hca-nys.org