SENIOR FINANCIAL MANAGERS RETREAT

Patrick Conole
Vice President, Finance and Management
Home Care Association of NYS

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

STATE MEDICAID ISSUES

2% Across the Board (ATB) Medicaid Reduction Resolution

- 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 were still owed the retroactive repayment of the reduction taken over the period April 1, 2014 through March 31, 2015.

- DOH received federal approval from CMS on this repayment.

- According to DOH, this restoration of funds were paid back to personal care and home care providers over the following two cycles:

  - Cycle 2131: check date of 6/25/18 and check release date of 7/11/18
  - Cycle 2132: check date of 7/2/18 and check release date of 7/18/18

- If you have questions or concerns about your 2% ATNB payback: Contact Financial Support eMedNYFinancialSupport@csra.com. You will need to provide your specific MMIS ID.

Third Party Liability (TPL) Update: Settlement Agreement & Traditional Process Occurring

- Starting in Fall of 2017: The state Office of the Medicaid Inspector General (OMIG) is working with CMS under a Settlement Conference Facilitation (SCF) pilot to overcome the significant delays in receiving Medicare coverage determinations for appeals filed as part of the TPL process.

- The current backlog of appeals resides at the federal Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (Council). To help reduce the current backlog, CMS and OMIG have reached an agreement that will produce settlement payments to home health providers that have appeals pending at OMHA and Council.

- According to the DOH Medicaid Update article, “The original pending appeals included in this agreement will be formally dismissed by Medicare, and settlement payments will commence directly to home health providers from the MAC in the Fall of 2017.

Third Party Liability (TPL) Update: Settlement Agreement & Traditional Process Occurring – *continued*

- Due to the fact that all providers have been compensated in-full via the Medicaid payment, any Medicare payments received through this process are required to be returned to the state."

- UMass will issue notification letters to all home health providers that receive a Medicare payment as a result of this settlement. These letters will contain detailed information, including instructions on remitting the settlement payment to OMIG.

- HCA members involved in the TPL project can also expect to receive a detailed letter from the Office of Medicare Hearings and Appeals entitled "**Notice of Dismissal**" which will inform you of agency-specific cases that are part of this settlement agreement between OMIG and CMS.

Third Party Liability (TPL) Update: Settlement Agreement & Traditional Process Occurring – *continued*

- Some HCA members have **recently** received new "Notice of Dismissal" letters so it appears this TPL Settlement process is still in progress.

- **Traditional Bi-Annual Appeals Process** - 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 2018 only. Dates of service for this period include October 1, 2017 thru March 31, 2018.

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

FEDERAL MEDICARE ISSUES

SENIOR FINANCIAL MANAGERS RETREAT

CMS's CY 2019 HH PPS Proposed Rule

General Overview

- On July 2, 2018, CMS put on display the proposed rule for the CY 2019 Medicare Home Health PPS.
- CMS subsequently published the proposed rule in Federal Register on July 12 – at:

  https://www.gpo.gov/fdsys/pkg/FR-2018-07-12/pdf/2018-14443.pdf
- HCA provided the membership with a detailed Public Policy Memorandum on CMS's proposed rule (in handouts) which can be accessed at:

  https://hca-nys.org/wp-content/uploads/2018/07/CMS2019ProposedRuleMemo.pdf

HCA EDUCATION AND RESEARCH

The Big Change: Proposed CY 2020 Payment Reform – Patient Driven Groupings Model (PDGM)

- The rule, if adopted, once again proposes significant case-mix and HHPPS methodological changes, this time called the Patient Driven Groupings Model (PDGM) beginning in 2020. Under PDGM, CMS is once more proposing a significant change in the unit of payment from a 60-day episode of care to a 30-day period of care, beginning on or after **January 1, 2020**.

- Unlike its precursor, the proposed Home Health Groupings Model (HHGM) proposal, PDGM aligns with the Medicare Budget Act requirement for **budget neutrality**. HCA strongly urged a budget-neutral approach on HHGM prior to CMS's withdrawal of HHGM and we support true budget neutrality as a precondition for any payment changes under consideration.

- While its supposedly being implemented in a budget-neutral manner, CMS is including a **behavioral adjustment** provision, repeatedly opposed by HCA, to allow for predictive changes in payments based on assumptions about provider "behavior changes" that could occur. This overly subjective provision could result in an estimated -4.66 percent reduction in base payment rates, as modeled in the rule.

Other PDGM Highlights

- 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 proposes various thresholds of visits per HHRG;
  - 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.
- Costs during an episode/period of care are estimated based on the concept of resource use, which measures the costs associated with visits performed during a home health episode/period. For the current HHPPS case-mix weights, CMS utilizes Wage Weighted Minutes of Care (WWMC), which uses home health data from the Bureau of Labor Statistics (BLS). For PDGM, CMS is proposing to shift to a Cost-Per-Minute plus Non-Routine Supplies (CPM+NRS) approach, which uses information from the Medicare Cost Report.

Other PDGM Highlights – *continued*

- There would be 216 new Home Health Resource Groups (HHRGs) that determine the national payment rate.
- 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.
  - Finally, PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses. CMS proposes that, depending on a patient's secondary diagnoses, a 30-day period may receive "no" comorbidity adjustment, a "low" comorbidity adjustment, or a "high" comorbidity adjustment.

Details on the CY 2019 Proposed Rule (Page 3 in Memo)

- Under the CY 2019 proposed rule, CMS projects that total Medicare payments to Home Health Agencies (HHAs) in 2019 will be **increased by $400 million nationally**, based on the net impact of positive and negative rate adjustments. Specifically, this aggregate increase reflects the cumulative impact of the following:

- A 2.1 percent home health payment rate increase (a $400 million increase), using a newly re-based proposed market-basket update of 2.8 percent, minus a 0.7 percentage point for “multifactor productivity”;

- A 0.1 percent increase in payments due to a decrease in the FDL ratio. This FDL ration change aims for outlier payments to comprise no more than 2.5 percent of total payments (a $20 million increase); and

- A 0.1 percent decrease in payments due to the new rural add-on policy mandated by the BBA of 2018 for CY 2019 (a $20 million decrease).

Re-Based CY 2019 Market Basket Update (Page 7-8 in Memo)

- CMS proposes to “re-base” the CY 2019 market basket using 2016 Medicare Cost Report data compared to the current 2010 data.
- CMS is rebasing the detailed wages and salaries and benefits cost weights to reflect 2016 BLS Occupational Employment Statistics (OES) data on HHAs. The current home health market basket uses 2010 BLS OES data on HHAs.
- Results in 2.1% update when using the 2.8 percent update and then applying the -0.7 percent productivity adjustment.

Updated CY 2019 HHPPS Payment Rates

- Proposed CY 2019 60-Day HHPPS Episodic Payment Update - **$3,151.22** (See Page 9 in Memo).
- Proposed CY 2019 National Per Visit or LUPA Rates (Page 10 in Memo).
- 2 percent reduction to those CHHAs not submitting 90% of their OASIS data.
- Updated 2019 Non-Routine Supply (NRS) Calculation (Page 10-11 in Memo).

Updated Rural Add-On Provisions (Page 8 in Memo)

- Beginning in CY 2019 and onward, CMS will place rural counties into one of the following three categories for purposes of the home health rural add-on payment:
  - **High Utilization** – For rural counties in the highest quartile of home health usage per 100 people, based on 2015 data, the rural add-on will be 1.5 percent in 2019; 0.5 percent in 2020; and 0 percent in 2021 and 2012.
  - **Low Population Density** – For rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area (also known as a "frontier county") based on 2010 Census data, the rural add-on will be 4 percent in 2019; 3 percent in 2020; 2 percent in 2021; and 1 percent in 2022.
  - **All Other** – For patients being serviced in all other rural counties (outside of the previous tiers mentioned above), the add-on will be **3 percent in 2019; 2 percent in 2020; 1 percent in 2021; and 0 percent in 2022**.
- Based on HCA's analysis, it has been determined that **Hamilton County will fall under the "Low Population Density" or Frontier category, while the remaining 23 rural counties in New York will fall under the "All Other" category.**

HCA EDUCATION AND RESEARCH

Updated Outlier Formula (Pages 11-12 in Memo)

- In its CY 2017 final rule, CMS finalized significant but budget-neutral changes to its outlier methodology while maintaining that the total outlier fund will remain **at 2.5 percent of total estimated home health expenditures**.

- Loss Sharing Ratio remains at 80 percent meaning Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount.

- **Proposes to change the Fixed Dollar Loss (FDL) ratio from 0.55 to 0.51. A lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.**

- CMS will continue using the cost per 15 minute unit approached finalized in the CY 2018 final rule.

Recalibration of the Case Mix Weights for CY 2019 (Pages 6-7 and Appendix B in Memo)

- 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.

- See Appendix B for summary but wait until Final Rule is issued in the fall to make any billing software changes.

Updated Wage Index (Page 13-14 and Appendix C in Memo)

- Updates the HHPPS wage index for CY 2019, 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 -0.64 decrease while the NYC designation is proposed to have a -0.37 decrease in CY 2019. Both of these designations have had repeated decreases over the past 4-5 years.

- Note: All CY 2019 proposed wage indices can change in the final rule, so these should only be used for preliminary budget purposes.

Physician Certification / Recertification Documentation Standards (Pages 5-6 in Memo)

- CMS's proposed rule makes a nominal change in the physician certification process, acting on a provision of the BBA of 2018. In the rule, CMS proposes to allow for the home health record to be used along with the physician record when determining a patient's eligibility for the Medicare home health benefit.

- Specifically, it would allow CMS to determine home health eligibility through a review of the entire patient medical record, including the HHA's patient record. In places where the physician's record may be insufficient to determine eligibility, the home health agency's record **may** be used as supporting material to attest eligibility for home health services.

- HCA and NAHC strongly advocated that this section of the BBA be modified so the physician certification documentation provisions used the term "shall" rather than "may" – i.e., to require the documentation. Unfortunately, this did not occur and HCA believes the term "**may**" will only codify CMS's existing standard, continuing to create unnecessary paperwork for providers.

- CMS's proposed rule also eliminated the statement that physicians estimate how much longer skilled services will be needed as part of the re-certification process.

Remote Patient Monitoring Proposal (Pages 18-19 in Memo)

- For patients receiving care under the Medicare home health benefit, section 1895(e)(1)(A) of the Act **prohibits payment for services** furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care certified by a physician.

- CMS is proposing to allow these costs to be included as administrative cost on the Medicare Cost Report.

- Proposes also allows these costs (remote monitoring) to be factored into the Cost Per Visit calculation.

- However, it still may not substitute for an in-person home health visit.

HCA Comments on the Proposed Rule

- On August 31st, HCA submitted detailed comments to CMS on the CY 2019 HHPPS proposed rule (See handout in packet).

- Our comments include numerous concerns about the PDGM such as:
  - Issues with the Admission source category;
  - Bundling of NRS into Base PPS rate;
  - Assumed negative adjustment for provider behavior;
  - Too many episodes (over 50%) fall into the Medication Management, Teaching and Assessment (MMTA) clinical diagnosis;
  - LUPA Adjustment is too complicated;
  - Will there be RAPS?
  - Possible access to care issue for patients needing therapy services;
  - Providers need adequate time to change their software systems and need substantial education on new methodology.

- Ongoing problems with the F2F encounter;

HCA Comments on the Proposed Rule – *continued*

- Dislike for the new rural add-on (that includes phase out provision);
- HCA continues to disagree with CMS's continuation of the 10 percent threshold cap;
- HCA Urges Wage Index Refinements to More Accurately Reflect Local Market Conditions;
- HCA Supports Remote Patient Monitoring Definition under the Medicare Home Health Benefit, Urges Corresponding Rate Support; and,
- HCA strongly encourages CMS and HHS to provide Home Health HIT and EHR grant funding to help promote interoperability and Electronic Healthcare Information Exchange.

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

FINAL 2019 HOSPICE PAYMENT RULE

FINAL 2019 HOSPICE PAYMENT RULE

- On August 2, the U.S. Centers for Medicare and Medicaid Services (CMS) published in the Federal Register a final rule (CMS-1692-F) updating the Medicare hospice wage index and cap amount for fiscal year (FY) 2019. HCA's hospice members can download HCA Policy Memo on the FY 2019 final rule at: https://hca-nys.org/wp-content/uploads/2018/08/CMS-Final-FY-2019-Hospice-Rule.pdf

- As finalized, hospices nationally would see an **estimated 1.8 percent ($340 million) increase in Medicare payments for FY 2019.** It also confirms that physician assistants (PAs) may be considered the Attending Physician, and it finalizes changes to the Hospice Quality Reporting Program (HQRP), including: a new factor for HQRP measure removal; new data review and correction timeframes for data submitted using the Hospice Item Set (HIS); changes to the quality measures displayed on Hospice Compare in FY 2019; and updates to the public display of HIS Measures.

- 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 2019 will be $29,205.44 (2018 cap amount of $28,404.99 increased by 1.8 percent).

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

NGS UPDATES: NEW TARGETED PROBE & EDUCATE (TPE) INITIATIVE

NGS UPDATES: NEW TARGETED PROBE & EDUCATE (TPE) INITIATIVE

Background

CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

Who will be reviewed?

NGS uses data analysis to identify providers and suppliers who have high claim and/or payment error rates or unusual billing practices, and items and services that have high national error rates and are a financial risk to Medicare.

NGS UPDATES: NEW TARGETED PROBE & EDUCATE (TPE) INITIATIVE

The following is an overview of the TPE process:

- **Notification**: Providers will receive a letter from NGS informing them that they have been chosen for review and that they can expect to receive between 20 and 40 ADRs.
- **ADR**: The Medicare system will generate ADRs and the provider has 45 days to respond with the requested medical records. No response counts as an error.
- **Validation**: NGS will review the provider's documentation for compliance with the home health regulations. If the provider's documentation is compliant, the agency will not be reviewed again for at least one year on the selected topic.
- **Calculation**: NGS will calculate the Payment Error Rate (PER) to determine whether or not the provider will be released from medical review. The PER is calculated by taking the dollars that Medicare would have paid the provider versus the dollars denied to obtain a percentage. **The PER must be below 15% for the provider to be released from the TPE**.

NGS UPDATES: NEW TARGETED PROBE & EDUCATE (TPE) INITIATIVE

Overview of the TPE process – ***continued***

- **Results Letter**: At the conclusion of a round of review, providers will receive a letter that will outline the targeted probe and educate process, reason for denials including the Medicare regulations, denial rates (PER) that are too high, release or retention from medical review, and the offer for one-on-one education information.

- **Education**: One-on-one education between NGS medical reviewers and the provider.

- **What if a provider's error rate still doesn't improve?** Any providers that fail to improve after three rounds of education sessions will be referred to CMS for next steps. These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action as determined by CMS.

NGS to Suppress RAPs for Agencies with High RAP Cancelling Percentages

- CMS Recently Issued Transmittal 817 - instructing MACs on various corrective actions they may take when HHAs are found to have a 50 percent or higher RAP cancelation rate.

- Transmittal 817 can be downloaded at: https://www.cms.gov/Regulationsand-Guidance/Guidance/Transmittals/2018Downloads/R817PI.pdf

- CMS notes in its revisions to the Program Integrity Manual that RAP cancellations "should be rare and includes, but is not limited to, situations where an HHA exhibits a high rate of final claims not being filed."

- In response to HCA's inquiry, NGS stated that it began identifying providers with high RAP cancel percentages back in March of this year, and NGS has been notifying providers monthly based on their cancel rates. According to NGS, there are some HHAs that bill RAPs, let them auto cancel, bill them again (sometimes several times) and either never submit final claims or submit very few final claims to match all the RAPs they submit.

NGS to Suppress RAPs for Agencies with High RAP Cancelling Percentages – *continued*

- NGS is placing HHAs into one of the following three groups with regards to RAP cancellation percentages:
  - HHAs with RAP cancellation percentages of 50 percent or greater will face immediate RAP suppression.
  - HHAs with RAP cancellation percentages between 30 and 49 percent will receive a notification letter that explains how NGS will be monitoring their billing practices.
  - HHAs with RAP cancellation percentages below 30 percent will not be impacted.
- NGS said that in order to be removed from RAP suppression, impacted HHAs must have their RAP cancel percentage fall below 20 percent for three consecutive months. HHAs impacted by immediate RAP suppression will receive a letter from NGS which includes an NGS e-mail address so HHAs can request further education.
- HCA has learned that five CHHAs in New York are currently impacted by RAP suppression.

SENIOR FINANCIAL MANAGERS RETREAT

HCA's DATA WEB PAGE

SENIOR FINANCIAL MANAGERS RETREAT

HCA's Data Webpage

- 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 Cost Report Summaries 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 NYS Medicare Cost Report Data from CMS.
- MLTC and Managed Care Resources from DOH.

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

HCA regularly updates the Data Webpage.

Over the summer we have entered:

- 2016 CHHA Medicaid Cost Report data.
- The 4th quarter 2017 MLTC & PACE MMCOR data from DOH. New Data on MMCORs – Escrow, Contingent Reserves, CDPAP Costs and Utilization & More.
- The 2015 LHCSA Statistical Report data.
- New Analysis of CMS's Proposed PDGM: Impacts on all CHHAs in NYS

HCA EDUCATION AND RESEARCH

HCA EDUCATION AND RESEARCH

SENIOR FINANCIAL MANAGERS RETREAT

THANK YOU!