Home Health Providers Under the Microscope -- The Review Choice Demonstration Project is Here

(October 4, 2018): Last week, the Centers for Medicare & Medicaid Services (CMS), confirmed that it intends to initiate the ***Review Choice Demonstration for Home Health Services*** project on December 10, 2018. The Review Choice Demonstration project is slated to initially begin in Illinois. This initiative is the renamed, repackaged version of the prior ***Pre-Claim Review Demonstration*** project that was initiated, then placed on hold (due in large part to provider protests), in April 2017. This article provides an overview of the long and sorted history leading up to the Review Choice Demonstration project.

I. Although Dropping, the Improper Payment Rates for Home Health Services Remain Excessive:

The last few years have been rough on home health providers. As the government has been quick to note, one of the primary components of the Medicare Fee-for-Service (FFS) improper payment rate has consistently been the excessive level of improper payments made for home health services. Broken down by fiscal year, the improper payment rates for home health services have included:

FY 2014	July 1, 2012 – June 30, 2013	51.4%

FY 2015	July 1, 2013 – June 30, 2014	59%
FY 2016	July 1, 2014 – June 30, 2015	42%
FY 2017	July 1, 2015 – June 30, 2016	32.3%

Although the improper payment rate for home health services has dropped considerably from FY 2015 to FY 2017, it still constitutes a major portion of the overall Medicare FFS improper payment rate. During the FY 2017 report period, it is estimated that more than $6.1 billion in improper payments was made by Medicare for home health services. When reviewing the improperly paid claim lines associated with FY 2017, the Comprehensive Error Rate Testing (CERT) contractor tasked with this project found that more than 89% of the errors were due to documentation deficiencies.

II. Overview of Corrective Actions and Initiatives Taken by CMS to Address Home Health Documentation Deficiencies:

The FY 2017 CERT contractor findings with respect to documentation have merely further strengthened the government's long-standing belief that home health providers (and referring physicians), need ongoing education and guidance with respect to the medical necessity, documentation, coverage and payment requirements that must be met. Over the last few years, CMS and its contractors have implemented a variety of corrective actions intended to address documentation and medical necessity deficiencies that have been identified in connection with Medicare home health claims. Examples of these actions have included ***Probe and Educate Reviews***[1], the initiation of the ***Pre-Claim Review Project***[2], the development of ***Home Health Plan of Care / Certification and Progress Note Clinical Templates***[3], and the establishment of a ***Home Health Recovery Audit Contractor***[4]. CMS also revised the ***Physician Face-to-Face Narrative Requirement***[5] for home health services. Several of these corrective initiatives are discussed in more detail below:

A. Probe and Educate Reviews.

In late 2015, home health Medicare Administrative Contractors (MACs) began pulling five claims sample from each home health agency in their jurisdiction for prepayment review purposes. The claims subject to review covered episodes of service beginning on or after August 1, 2015. The purpose of the Probe and Educate Review initiative was to better ensure that home health agencies were fully complying with applicable medical necessity, documentation, certification, coverage and payment requirements.[6] Systemic problems identified by home health MACs through the Probe and Education Review process has included:

1. Failure to comply with face-to-face requirements. For example, in some cases, the certifying physician signature was missing. In other cases, the encounter notes did not document the elements required to show that the patient was eligible for home health services.
2. Failure to identify an estimate of time for continued need when recertifying the medical necessity of services.
3. Failure to fully complete and / or properly complete the initial certification documentation required.
4. Bailure to timely respond to an Additional Documentation Request (ADR) request from a Medicare contractor in a timely fashion.

B. Pre-Claim Review Demonstration Project.

Section 402(a)(1)(J) of the Social Security Amendments of 1967 authorizes the Secretary, HHS, to:

‘‘develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act (the Act).’’

Using this authority, and inn consideration of the excessively high home improper payment rate for home health services, in June 2016, CMS announced[7] the initiation of a new Pre-claim Review Demonstration project. Theoretically, the demonstration project was not intended to create any new clinical home health documentation requirements. Home health agencies covered by the demonstration project would be required to submit supportive medical documentation to the CMS contractor for review prior to being paid. This approach was intended to help educate providers and better ensure that home health claims qualified for coverage and payment. The demonstration project was also intended to test whether the use of a pre-claim review process would improve the government’s ability to identify, investigate, and prosecute home health fraud. Originally, the demonstration project was scheduled to be put into place in five states. CMS and its contractors planned on rolling out the project over a six-month period:

- **Illinois:** August 1, 2016
- **Florida:** October 1, 2016
- **Texas:** December 1, 2016

- **Michigan and Massachusetts:** January 1, 2017

Two months later, CMS took its first steps towards putting the planned three-year project into place by implementing it in Illinois. To characterize the implementation as "problematic" would be generous. From its very start, Illinois home health providers, both large and small, experienced significant problems meeting the reviewer's documentation requirements, thereby resulting in significant provider payment delays. Bending under political pressure, the planned roll-out in Florida was placed on hold. This effectively delayed implementation in the remaining three states as well. After several false starts, the initiative was ultimately placed on hold in March 2017. For a more detailed discussion of the Pre-Claim Demonstration project, please see the following article. Additional information may also be found here.

C. Home Health Plan of Care / Certification and Progress Note Clinical Templates:

As required under **42 CFR 484.60,** ***Condition of participation: Care planning, coordination of services, and quality of care***, Medicare patients are accepted for treatment on the reasonable expectation that a home health agency can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. In order to accomplish this:

"Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice."

Similarly, **42 CFR 424.22**, ***Requirements for home health services,*** mandates that a physician certify and recertify a patient's eligibility for home health services in order to qualify for coverage and payment by Medicare. Additional certification and recertification requirements are set out under the regulations.

Finally, CMS develop a template **Progress Note** that could be used by a physician and, when permitted under state law, by a physician assistant, a nurse practitioner, a clinical nurse specialist and / or a certified nurse midwife to document that home health services are medically necessary and appropriate and to confirm that a Medicare patient is, in fact, homebound.

III. Rise of the Review Choice Demonstration Project:

In consideration of the various challenges encountered when trying to roll-out the Pre-Claim Review Demonstration project, CMS ultimately placed the initiative on hold in April 2017. It is important to keep in mind that the underlying problem that gave rise to the Pre-Claim Review

Demonstration project – an excessively high improper payment rate associated with home health services – was still (and continues to be) a serious program integrity concern. Additionally, it was abundantly apparent that wholesale changes would need to be made if the initiative were to be reintroduced.

Over the next year, CMS completely reworked its prior initiative in an effort to provide additional flexibility for home health agencies that may be covered by an updated version of the project. As reflected in the Federal Register, the "new and improved" initiative was named the ***Review Choice Demonstration*** project. As with its earlier iteration, the revised version of the demonstration project is intended to:

"help assist in developing improved procedures for the identification, investigation, and prosecution of potential Medicare fraud. The demonstration would help make sure that payments for home health services are appropriate through either pre-claim or postpayment review, thereby working towards the prevention and identification of potential fraud, waste, and abuse; the protection of Medicare Trust Funds from improper payments; and the reduction of Medicare appeals."

CMS has again proposed that the demonstration project will be implemented in five states. Much to the dismay of Illinois, Florida and Texas home health providers, they are STILL on the list of targeted states. Michigan and Massachusetts are no longer slated to be part of the demonstration. In their place, CMS has substituted Ohio and North Carolina. CMS has stated that the new list of five states are:

"known areas of fraudulent behavior and had either a high home health improper payment rate or a high denial rate during the home health Probe and Educate reviews."

Notably, CMS has indicated that there is the possibility that the Review Choice Demonstration project may later be expanded to other states in the Palmetto / JM jurisdiction.

As set out in the September 28th Federal Register notice, CMS intended to implement the Review Choice Demonstration project in Illinois on December 10, 2018.

A. The Review Choice Demonstration Project is Intended to Offer Flexibility to Home Health Providers.

CMS has designed the Review Choice Demonstration project so that home health agencies in affected states have several ways that they may show their "compliance with CMS' home health policies." Options available to home health providers include[8]:

Option 1a: 100% Pre-Claim Review.

Home health providers may participate in either 100% pre-claim review. Under the pre-claim review option, HHA will send the pre-claim review request along with all required documentation to the Medicare contractor for review prior to submitting the final claim for payment. If a claim is submitted without a pre-claim review decision on file, the Medicare contractor will request the information from the home health agency to determine if payment is appropriate.

OR

Option 1b: 100% Postpayment Review.

Home health providers may participate in a 100% postpayment review. For the postpayment review option, the Medicare contractor will also request the information from the home health agency that submitted the claim for payment, to determine if payment was appropriate.

AND

If either of the first two options are selected, pre-claim or postpayment review will be required for every episode of care. A home health provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the demonstration project.

ADDITIONALLY

Home health providers may participate in either 100% pre-claim review. Under the pre-claim review option, HHA will send the pre-claim review request along with all required documentation to the Medicare contractor for review prior to submitting the final claim for payment. If a claim is submitted without a pre-claim review decision on file, the Medicare contractor will request the information from the home health agency to determine if payment is appropriate.

Option 2: 25% Payment Reduction and Possible RAC Review.

Providers who do not wish to participate in either 100% pre-claim or 100% postpayment reviews have the option to furnish home health services and submit the associated claim for payment without undergoing such reviews. However, they will receive a 25% payment reduction on all claims submitted for home health services and may be eligible for review by the Recovery Audit Contractor.

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[1]
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Home_Health_Medical_Review_Update.html

[2]
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html

[3]
https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/Downloads/Home-Health-Services-Plan-of-Care-Certification-Template-Draft-20180709-R20.pdf

[4]
https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/

[5]
https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/Downloads/Home-Health-Services-F2F-Encounter-Template-Draft-20180709-R20.pdf

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/Downloads/Home-Health-Services-F2F-Encounter-Template-Draft-20180214-R10d.pdf

[6] Additional information regarding the Probe and Educate process is outlined in MLN Matters, **MLN Matters ® Number:SE1524.**

[7] 81 Fed. Reg. 37598. June 8, 2016.

[8] **83 Fed. Reg. 48818.** September 27, 2018.