CMS has Ended its Moratorium on New Home Health Agencies in Texas, Illinois, Michigan and Florida. Unfortunately, the Lifting of the Moratorium Isn't Necessarily a Good Thing for Existing Home Health Agencies.

(February 19, 2019): CMS has now ended, at least for the current time, the moratorium that it placed on the approval of new home health agencies. At the same time, home health providers that operate in Illinois, Ohio, North Carolina, Florida and Texas, and potentially other states within the Palmetto/JM jurisdiction (Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, and Tennessee) face the likelihood that a revised pre-payment demonstration model will be implemented in the near future.

I. Lifting of the Moratorium:

Effective January 30, 2019, CMS has officially ended the “temporary” moratorium on new home health agencies, sub-units and branch locations (collectively referred to as “HHAs,” “home health agencies,” or “agencies”) in Illinois, Michigan, Texas and Florida.[1] This means that there is no longer in effect a federal prohibition on enrolling new home health agencies in the Medicare program in these or any other states, and that agencies in these states that wish to enroll in Medicare can now begin the process of doing so.

II. Background of the Home Health Agency Moratorium:

CMS initially imposed a temporary moratorium to prevent the enrollment of new home health agencies in Miami-Dade County, Florida and Cook County, Illinois and surrounding counties in 2013. CMS then extended the existing moratoria and expanded them to cover Broward County, Florida, Dallas and Harris Counties, Texas, Wayne County, Michigan and surrounding counties. Finally, in August 2016, CMS extended and expanded the moratoria on new HHA’s to Florida, Illinois, Michigan and Texas, and further extended those moratoria through January 2019. CMS has justified the imposition of the moratoria and selection of the geographic areas based on its view that those areas were especially at high risk for fraud, waste, and abuse. Finally, CMS lifted the moratorium on home health agencies in these states effective January 30.

III. What is the Anticipated Impact of Lifting the Moratorium?

As noted, above, this means that providers that wish to enroll new home health agencies in Medicare in these states may now begin that process. However, experience has demonstrated that CMS is not reticent to take these, and other, actions when the agency believes that there is a high risk of fraud and abuse in particular localities. Additionally, federal law and regulations require states to impose temporary moratoria on enrollment in the Medicaid and CHIP programs except in certain circumstances in areas and over time periods where Medicare takes these actions. Finally, this relief affects only CMS approval. It does not eliminate the need to check and comply with any restrictions that state or local governments may place on the establishment of new agencies. Thus, as always, we continue to recommend to all home health agency providers that they establish and maintain strong compliance programs to alleviate the perceived need of moratoria in the future, and also to minimize the likelihood that their agencies will be the subject of investigation or sanctions.

IV. CMS's Review Choice Demonstration Project:

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What is Review Choice Demonstration Project?
","acceptedAnswer":{"@type":"Answer","text":"CMS's Review Choice Demonstration Project is an outgrowth of the what was called the Pre-Claim Review Demonstration Project. In August 2016, CMS initiated the Pre-Claim Review Demonstration Project for Illinois home health agencies under which these agencies were required to submit all of their Medicare claims and documentation for a pre-claim review prior to submitting them for payment. It was only after the claim was "affirmed" that the agency could submit it for payment. Have more questions? call us at (202) 298-8750 for free initial consultation"}}]}

CMS's Review Choice Demonstration Project is an outgrowth of the what was called the Pre-Claim Review Demonstration Project. In August 2016, CMS initiated the Pre-Claim Review Demonstration Project for Illinois home health agencies under which these agencies were required to submit all of their Medicare claims and documentation for a pre-claim review prior to submitting them for payment. It was only after the claim was "affirmed" that the agency could submit it for payment.

Initially, according to CMS, there was a wide variation of affirmation rates among agencies. However, according to CMS, by the end of the first six-month period, agencies had on the average much higher affirmation rates. The demonstration project was paused in April 2017 and has not been re-instituted or expanded past Illinois.

In light of the various problems encountered when implementing the Pre-Claim Review Demonstration Project, CMS has chosen not to re-initiate the program. Instead, CMS revised its approach and announced that a new initiative, the Review Choice Demonstration Project was

being implemented. Once it goes “live” in a state, the Review Choice Demonstration Project will be in effect for five years. As noted above, the Review Choice Demonstration Project is scheduled to cover services provided in Illinois, Ohio, North Carolina, Florida, and Texas, with the option to expand it to other states under Palmetto’s jurisdiction.

The Review Choice Demonstration Project was initially scheduled to be implemented in December in Illinois, with a rollout in other states to follow with a 60-day advance notice. However, the Illinois rollout has been delayed awaiting approval under the Paperwork Reduction Act, after which the agency will announce the start date for the demonstration in Illinois.

Under the Review Choice Demonstration Project, agencies will have their choice of three options for the first six-month period: (1) 100% Pre-Claim Review; (2) 100% Post-Payment Review; or (3) Minimal review with an automatic 25% payment reduction.

V. Initial Options Under the Review Choice Demonstration Project:

Under the Review Choice Demonstration Project, a home health agency will have the option of choosing among three alternatives with respect to how its claims will be handled. These three alternatives include the following:

- **Option #1: 100% Pre-claim Review**

Under the first option, a home health agency will submit the pre-claim with all relevant documentation. If the pre-claim receives an affirmation notice, the agency can submit the claim and will receive full payment, and absent evidence of possible fraud or gaming, the claim will not be subject to post-payment review by the MAC, RAC or Supplemental Medical Review Contractor. If a pre-claim receives a non-affirmative decision, it can be submitted again for pre-claim review with additional documentation or explanation. If a claim is submitted with a non-affirmative pre-claim decision, it will be denied with full appeal rights. Claims submitted without receiving a pre-claim determination will be subject to prepayment review and even if determined to be payable, will be subject to a 25% reduction in payment rate.

After six months, the agency will have its affirmation rate calculated. If it has submitted at least 10 claims and if it obtains at least a 90 % affirmation rate, the agency will be allowed to continue in this option or to choose between two other options, described, below. If the agency’s affirmation rate for the six-month period was lower than 90% or it did not submit 10 claims during that period, it must choose between one of the three initial options.

- **Option #2: 100% Post-Payment Review**

Under this option, the agency will be paid in the normal course, but will have all of its claims during a six-month period undergo complex medical review. Subsequent to the review, the MAC will

recover for any claims that it has paid during this period that it finds not to meet Medicare requirements, and the agency may appeal the decision through the normal appeals process. If the agency has obtained at least a 90% approval rate during the six-month period, it will be able to choose either option one or one of the additional two options discussed, below. Otherwise, it will have the option of choosing one of the initial three options for the next six-month period.

- **Option #3: Minimal Review with 25% Payment Reduction**

An agency that chooses this option will have its claims reviewed under the normal process, but the payment amount will have an automatic 25% reduction. Claims will not be subject to post-payment MAC reviews but will be subject to RAC and UPIC review under the normal review process, and any denied claims will be subject to the normal appeal process. The 25% reduction in payment amount, however, is neither transferable to the beneficiary nor subject to appeal. Any agency that chooses this option will not be able to change options for later periods and will remain under this option for the entire five-year "demonstration."

VI. Subsequent Options Under the Review Choice Demonstration Project:

An agency that has selected either Option 1 or 2, above ***and that has an affirmation rate of at least 90%*** in the prior six-month period may choose either Option 1, above – 100% Prepayment Review, or one of the two options, below – Options 4 (selective post-payment review) or 5 (spot check review).

- **Option #4: Selective Post-Payment Review**

Under Option #4, the agency will be paid under normal claim processing procedures. However, the MAC will select "a statistically valid random sample" every six months for complex review. An agency selecting this option at any time will not be able to change options at a later point in time.

- **Option #5: Spot-Check Review**

Under Option #5, the MAC will select 5% of claims to be subject to pre-payment review every six months. The agency is able to remain in this option for the remainder of the demonstration provided that "the spot check shows that the agency is compliant with Medicare coverage rules and policy." If the agency fails to meet that standard, it will then be required to choose between the first three options for the next six-month period.

VII. Recommendations:

For those agencies in one of the states selected for the demonstration, the selection of an option – whether initial or subsequent – will require some thought and analysis. For example, Option 1 could well affect agency's cash flow depending upon its ability to submit quickly the necessary

documentation in a manner that clearly demonstrates coverage. While CMS has suggested that the MAC will make every effort to review and make pre-claim determinations within 10 days of the first submission and within 20 days of subsequent submissions for the same claims, the continued ability of the MAC to meet these time frames will also have an impact upon cash flow.

In contrast, Option #2 will subject the agency to complex review of every claim that it submits and as those agencies that have been through the appeals process understand, the backlog of appeals has caused a substantial delay in resolution no matter how worthy the appeal on its merits. Thus, unlike the pre-claim review process, the agency may not have the opportunity to correct its documentation and correct errors for a substantial period.

Option #3 guarantees a 25% payment reduction for all claims, while Option #4 will result in the selection of what the government may argue is a statistically valid random sample for purposes of any subsequent denials.

Under these circumstances, several things are clear. Now more than ever, agencies in these states must have procedures in place to properly document coverage for all cases that they handle, and also a form and process to be able to support coverage and simplify the process for the MAC to come to that determination quickly and without the need for appeal or multiple submissions, depending upon the option chosen.

Liles Parker attorneys have substantial experience in working with agencies in the enrollment process for Medicare certification. Additionally, a number of our attorneys are also certified coders and have substantial experience in developing a format to justify coverage of claims.

Any person wishing a free consultation in either area should contact the author and Co-chair of our Health Care Group, Michael Cook. Michael can be reached at (202) 298-8750 or mcook@lilesparker.com**.**

[1] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html.