DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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FACT SHEET

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Pre-Claim Review Demonstration of Home Health Services Expands to Florida

Home Health Agency services are a critical part of the health care continuum and are instrumental in helping a patient with Medicare benefits recover after an illness or injury. The Medicare home health benefit allows beneficiaries who are deemed homebound to receive certain medically necessary services in their homes, which is a preferred setting for many beneficiaries.

In August 2016, the Centers for Medicare & Medicaid Services (CMS) took an important new step to provide timely and appropriate home health services to Medicare beneficiaries, while protecting the Medicare Trust Funds and taxpayer funds from fraud and improper payments. By implementing a new pre-claim review demonstration in five states -- Illinois, Florida, Texas, Michigan, and Massachusetts -- CMS will help make sure that home health services are medically necessary without delaying or disrupting patient care or access. The pre-claim review demonstration began in Illinois on August 3, 2016, and will expand to Florida for episodes of care beginning on or after April 1, 2017. The start dates for the remaining states have not yet been announced.

Maintaining Beneficiary Access to Care

Under this demonstration, physicians and clinicians enrolled in Medicare will continue to make health care decisions in coordination with their patients, including creating a care plan for the types of home health services a beneficiary needs. Once home health services are ordered by a Medicare physician, eligible beneficiaries should be able to receive Medicare's home health services immediately. The main change under this demonstration is that Home Health Agencies will submit the supporting documentation prior to submitting the final claim for payment. This earlier submission of documentation will undergo the new "pre-claim review." Pre-claim review does not change beneficiary eligibility standards or Medicare's documentation requirements for home health care.

In most cases, the Home Health Agency providing the care will gather all of the required documentation and submit it for pre-claim review. This is the same documentation they currently gather for payment, only Home Health Agencies will submit it earlier in the process. A beneficiary may also submit documentation for pre-claim review. Information on the procedure for submitting pre-claim review requests can be found in the Operational Guide on the CMS demonstration website.[1] Medicare will review the documentation to determine if coverage requirements for home health services are met and will issue a pre-claim review decision generally within 10 days. If the documentation submitted was not sufficient, then the Home Health Agency (or beneficiary) may submit additional documentation to support the claim. Once sufficient documentation is submitted, Medicare will make timely payment on the home health services claim following the standard process.

If you are a Medicare beneficiary looking for further information about the home health benefit, see Chapter 7 of the Medicare Benefit Policy Manual[2], or visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Avoiding Errors in Home Health Claims

In 2015, home health claims had a 59 percent improper payment rate, and a large proportion of the improper payment rate was because of insufficient documentation. The pre-claim review demonstration will, among other things, help educate Home Health Agencies on what documentation is required and encourage them to submit the correct documentation, while still allowing the Home Health Agencies to begin providing services. It is also important to note that this demonstration does not change the process of submitting the Requests for Anticipated Payment (RAPs). A RAP is a split percentage payment approach to ensure adequate cash flow to Home Health Agencies. The split percentage occurs through the RAP at the start of the episode and the final claim at the end of the episode. The demonstration also aligns Medicare's payment requirements and approach with commercial insurers, including some Medicare Advantage plans.

A Home Health Agency may resubmit the supporting documentation as many times as necessary during the pre-claim review process. During the pre-claim review, Medicare will work closely with the Home Health Agency to explain what documentation is needed and why a prior submission was insufficient. Currently, the opportunity to fix home health documentation and resubmit a claim for payment is rare, and is typically only available in the administrative appeal process after a claim has been denied. The pre-claim review resubmission process helps Home Health Agencies successfully submit the necessary documentation before submitting a final claim for payment. This new process should decrease improper payments because of insufficient documentation, as well as reduce the need for Home Health Agencies to appeal claims.

[1] The CMS demonstration website can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html.
[2] Chapter 7 of the Medicare Benefit Policy Manual can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf.

If a pre-claim review request is ultimately not approved during the pre-claim process, then the final claim for payment will be denied, but the Home Health Agency may appeal that determination. If the Home Health Agency fails to submit a request for pre-claim review, but the final claim is submitted for payment, the final claim will be subjected to a pre-payment medical review. If a final claim is never submitted, the standard procedures will be followed in regards to recouping the RAP payment. In most cases, a beneficiary would not be liable for expenses in a home health claim that has been denied.

After the first three months of the demonstration in each participating state, if the claim is submitted without a pre-claim review and is determined to be payable, it will be paid with a 25 percent reduction of the full claim amount. This payment reduction is not subject to appeal and cannot be recouped from or otherwise charged to the beneficiary.

Protecting Taxpayer Funds

In recent years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift away from a "pay and chase" approach to focus on preventing fraud. Previous reports from the Office of Inspector General, the Government Accountability Office, and the Medicare Payment Advisory Commission show evidence of fraud and abuse in Medicare's home health benefit. Most of the demonstration states have also been identified as high-risk states under the temporary moratoria on home health provider enrollment authorized under the Affordable Care Act.

The pre-claim review process will be an additional and valuable tool in combating improper payments, while ensuring beneficiaries continue to receive certain medically necessary services within their homes in a timely manner. Many other health plans, including Medicare Advantage plans use a similar process for home health services. CMS has closely monitored the demonstration since it began in Illinois and has worked with the Medicare Administrative Contractors to provide additional education. CMS has also created a Special Tracking Tool that allows CMS to make sure beneficiaries are not experiencing access to care issues. This tool allows CMS to focus on distinguishing between those beneficiaries whose documentation shows that they are not eligible for Medicare home health services and those that may be eligible, but the documentation is lacking in some way. CMS has initiated this new process with the Medicare Administrative Contractors (MACs) to help identify those individuals who appear that they may qualify for the Medicare benefit and provide direct education to the Home Health Agencies so they can address the relevant errors with their pre-claim review requests to receive provisionally affirmed decisions. Due to the educational efforts, use of the Special Tracking Tool, and increased Home Health Agency experience with submitting requests, as of Week 18, which ended on 12/03/2016, 87 percent of pre-claim review requests in Illinois received provisional affirmation, including both fully affirmed or partially affirmed decisions.

Through this demonstration, CMS aims to test the level of resources required for the prevention of fraud instead of engaging in "pay and chase" and to determine the feasibility of performing

pre-claim review to prevent payment for services that have high incidences of fraud. We will have robust monitoring in place to make adjustments if needed and maintain prompt beneficiary access to care. This monitoring will include surveying some of the physicians that ordered home health services and some of the home health agencies that provided home health services in the five states during the demonstration. We look forward to feedback and public input as we move forward with the demonstration.

Additional details on the pre-claim review demonstration for home health services can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html and click on the tab titled, "Pre-Claim Review Initiatives."

The pre-claim review demonstration for home health services will be discussed on an upcoming Special Open Door Forum call which will be announced on the CMS website http://www.cms.gov/OpenDoorForums/.

Specific questions about the demonstration should be sent to HHPreClaimDemo@cms.hhs.gov. CMS will respond to these questions by posting more "Frequently Asked Questions" at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html and click on the tab titled, "Pre-Claim Review Initiatives."

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