E-Alliance Extra

***Missouri Alliance for* Home Care**
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February 15, 2016

In This Edition

MO General Assembly Update

The General Assembly is beginning their 7th week of session. Ethics reform was one of the first items that both the House and Senate dealt with. If you recall last year the Speaker of the House Republican John Diehl resigned after admitting to an inappropriate relationship with a college intern. In addition, Senators LeVota and President Pro Tem of the Senate, Tom Dempsey resigned their positions. This year members of the General Assembly wanted to be proactive and pass ethics reform legislation. The focus on ethics however has not slowed the legislative process down. Currently MAHC is following a number of bills and appropriations requests of interest to home care providers and consumers. A brief summary follows:

APRN (HB 1866) – this bill, in part, would give full prescriptive authority to APRNs and removes the requirement that collaborative practice agreements be written. The bill was heard in the Professional Registration Committee on January 21st and is waiting a committee vote to determine if the bill will proceed to the full House for debate.

Appropriations – the Governor's budget gives a 3% Medicaid rate increase to all home and community based programs, including home health. The funds for this 3% come out of General Revenue. The 3% increase from last year, which was to go into effect on 1/1/16 was from a fund called "tax amnesty" which is a one-time fund and therefore not a reliable source. With the Governor's budget putting the 3% in General Revenue, the funding is coming from a more stable source. The end result, if the General Assembly passes this 3%

request, will be a 2% increase to the rate that providers have been receiving since the 1% increase went into effect on 1/1/16. Private duty nursing received a 4% increase on 1/1/16 and it appears that private duty nursing will receive an additional 1% or possibly 2%. This is somewhat unclear in the budget but we are seeking clarification on the private duty nursing rate.

Increase Asset Limits for Medicaid Eligibility – (HB 1565) Rep. Engler is sponsoring this bill that would raise the asset amount for Medicaid eligibility from $1,000 to $2,000 for a single person and from $2,000 to $4,000 for a couple. This bill should have passed last year, but was delayed due to the filibuster in the Senate in the final week of the session. We anticipate this bill will pass.

Structured Family Caregiver – (HB 1753) Rep Bahr has again this year sponsored this expansion of home care options legislation. The bill would establish a "structured family caregiver" option for consumers. The bill is somewhat like Consumer Directed Services (CDS) however, the caregiver lives with the recipient and is paid a daily stipend. There is a vendor who is responsible for oversight and the fiscal intermediary functions. The bill was heard in committee and may be voted out later this week. MAHC testified for "information purposes only" and we are working with the sponsor and others to have some additional requirements put into the bill, including criminal background and similar training requirements for the current in-home and CDS programs.

Private 3rd Party Benefit Eligibility Contractor – The Senate has given first round approval to a plan that would require the Department of Social Services to contract with a company to verify whether Missourians are eligible for Medicaid, child care subsidies and food stamps. The bill's purpose is to save dollars by identifying recipients who do not qualify for one of the benefits; a good goal. However, MAHC is concerned about the privatization of this service in light of the problems the state has had in recent years with private contracts like SynCare and the recently abandoned contract for authorizations and re-authorizations for Medicaid. Both of these private contracts did not work out as intended when originally passed and unfortunately, in both cases, thousands of eligible individuals lost their Medicaid coverage causing in some cases grave harm.

Managed Care – Statewide for Kids and Mom's – the RFP for the expansion of Medicaid managed care for kids and moms is moving forward and should be released sometime this spring or early summer.

DMH/DD Rebasing for Medicaid Rates – home care providers who are currently providing services to clients of the Dept. of Mental Health/Division of DD through the Regional Centers will be pleased to know that the Governor is supporting a budget request to "rebase" the rate structure to bring the Regional Centers' contracted rates with providers up to the state rate being paid for PC and APC. This funding has not passed but is included in the budget and is expected to pass.

Medicaid Home Health 1% Increase Effective 1/1/16 – It was unclear if the Medicaid Home Health rate would be increased 1% in January like the In-Home and CDS rates. The state sent out a notice to providers advising them that there would be a rate increase of 1% effective 1/1/16. Claims billed at the lower rate after January 1st will be adjusted automatically.

Medicaid Face-to-Face for Home Health – CMS has released the final rule for the implementation of Face-to-Face for Medicaid Home Health. MAHC will be working with the state to write the regulation and policies for this new requirement. Home Health providers who have suggestions about how F2F should be implemented in the Medicaid program are encouraged to get those suggestions to mary@homecaremissouri.org at MAHC. Meetings to begin developing the regs and policies will begin shortly. Your comments and suggestions for how to make F2F as easy as possible for the HHA and the doctor are welcome.

Pediatric Home Care Task Force Update – the MAHC Pediatric Home Care Task Force has been busy over the past several months. Among the issues the Task Force is working on are: content and practice standards for the expansion of managed care statewide; increased and/or restructured reimbursement for pediatric private duty nursing; expansion of training for nurses on pediatric care; working with the major children's hospitals to identify barriers to home care; and much more. If you provide pediatric home care and would like to join the Task Force email mary@homecaremissouri.org to be added.

An educational conference: *Pediatric Home Care Essentials – Complex Care for the Pediatric Patient* is being sponsored by Children's Mercy in Kansas City on April 21st. The registration form and information is available at:

http://www.homecaremissouri.org/mahc/documents/PediatricHomeCareEssentials2016-DM-HIGHRES.pdf

Bed Bugs – A troubling problem without an easy solution! MAHC is working with the state in an attempt to bring attention to this problem and at a minimum, identify resources for home care providers and patients. More will be coming on this issue. If you did not complete the MAHC survey about bed bugs there is still time. The survey is available at: https://www.surveymonkey.com/r/MNTRRMX

CMS Has Added a New Five-Star Ratings Tool to Help Patients Compare and Choose Among HHAs

By Jeff Brecht*

On January 28, the Centers for Medicare & Medicaid Services (CMS) added a new and useful five-star ratings comparison tool to the Home Health Compare system. According to CMS, the new comparison tool will help patients "quickly and easily assess the patient experience of care information provided on Home Health Compare."

The new five-star scale ratings tool is tied directly to patient experiences, and it is the first such star rating tool for Home Health Compare. The star ratings are derived from the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey, a national, standardized, 34-item survey specifically designed to measure the experiences of people receiving home health

care from Medicare-certified home health agencies (HHAs). The HHCAHPS survey is conducted for HHAs by approved HHCAHPS Survey vendors.

Star rating comparison information available under the new tool compliments and expands on the other comparison information that CMS makes available to patients and their families. The new tool provides (HHCAHPS) survey star ratings for HHAs in the following categories: (1) care of patients; (2) communication between providers and patients; (3) specific care issues; (4) overall rating of care provided by the home health agency (i.e., an HHCAHPS global component); and (5) Survey Summary Star rating. The Survey Summary Star rating is based on the four HHCAHPS survey measures (the three composites and the one global component) that receive Star Ratings. The Survey Summary Star averages these ratings and rounds the score using normal rounding rules. As one would expect, more stars indicates better quality care, and five stars is the best rating.

CMS intends for patients who use the new five-star comparison tool to learn how well HHAs care for their patients, how often each agency uses best practices when caring for its patients, whether patients improve in certain important areas of care, and what other patients have said about their recent home health care experience. Currently, 6,000 HHAs have patient care experience star ratings, and that number will increase as additional data from patient surveys is available. CMS will regularly update its website to add more agencies.

Access full details on the Home Health Compare tool.

**We would like to thank Jeff C.D. Brecht (Lane Powell PC, Portland, OR) for providing this email alert.*

CMS Issues Final Rule for Self Reporting Overpayments

From NAHC Report

The Centers for Medicare & Medicaid Services (CMS) has issued a final rule for provider and supplier self reporting overpayment requirements.

The rule clarifies requirements for the reporting and returning of self-identified overpayments. Health care providers and suppliers have been and will continue to be subject to potential False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from federal health care programs for failure to report and return an overpayment.

The major provisions of this final rule include clarifications around: the meaning of overpayment identification; the required look back period for overpayment identification; and the methods available for reporting and returning identified overpayments to CMS.

An overpayment must be reported and returned by the later of: (i) the date which is 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding

cost report is due, if applicable. This final rule states that a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

In the rule, CMS finalized a look back period of 6 years, rather than the proposed 10 years, for reporting and returning overpayments.

Providers and suppliers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. In addition, if a health care provider or supplier has reported a self-identified overpayment to either the CMS or the Office of the Inspector General (OIG) using the Self-Referral Disclosure Protocol, the provider or supplier is considered to be in compliance with the provisions of this rule as long as they are actively engaged in the respective protocol.

Home health and hospice providers raised concerns with the proposed rule regarding the rule's effect on the hospice annual cap, the home health outlier revenue cap, and requests for anticipated payments (RAPs). Hospices and home health agencies have no way of knowing whether they have received a cap overpayment, or the amount, until they are notified by the MAC. CMS clarified in the rule that hospice and home health cap determinations are made at the end of the year and it is possible that the provider may not be aware of the cap status until their MAC calculates the final cap amount. Therefore, the provider is not responsible to report and refund the overpayment until they have received the cap determination from their MAC. There can be no applicable reconciliation until the final cap amount is determined.

CMS also clarified that overpayments as a result of PIP payments would be reported and returned at the time the initial cost report is due. There is no applicable reconciliation until the PIP payments are dealt with in the cost report process. However, if a provider is aware that their PIP payment may not be accurate, they should continue with normal business practices and inform its MAC of the issue.

The National Association for Home Care & Hospice will continue to evaluate the final rule and provide any additional analysis specific to home health and hospice providers.

CMS Issues a New Condition Code for Home Health Claims

From NAHC Report

The Centers for Medicare & Medicaid Services (CMS) has issued Change Request(CR) 9497 which adds a new condition code for home health (HH) claims, addresses unintended consequences of the implementation of new Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing visits, and contains a number of routine maintenance revisions to home health billing instructions manual.

CMS will be implementing a new condition code 54 “No skilled HH visits in billing period” effective on July 1, 2016, that permits HH claims for subsequent episodes to process even if they do not contain any skilled services. Currently, any HH claim submitted without a skilled visit is automatically returned to the provider. Although this is always appropriate for claims for episodes that are the first episode in a sequence of episodes or are the only episode of care, claims for subsequent episode are also being returned if they do not include a skilled visit.

There may be circumstances which prevent the home health agency (HHA) from delivering the skilled services planned for a subsequent episode, such as an unexpected inpatient admission.

Determining whether payment is allowable requires the agency to submit supporting documentation to the Medicare Administrative Contractor (MAC) for review, which is a burdensome process for both the agency and the MAC.

Condition code 54 will streamline claims processing for both the payer and provider. Claims without skilled visits that are submitted without the new condition code will be returned to the provider. This will allow the HHA to either:

- Add any accidentally omitted skilled services to the claim;
- Submit the claim as non-covered, if appropriate; or
- Append the new condition code.

These actions will prevent unnecessary reviews and denials for the HHA and allow Medicare to better target medical review resources.

The CR also corrects an unintended consequence of terminating HCPCS code G0154 and replacing it with two new codes, G0299 and G0300. During the implementation of this change which went into effect Jan 1, 2016, CMS discovered several other processes affected by this coding change:

- G0299 and G0300 were previously used to describe defibrillator services. An edit in Medicare systems requires certain diagnosis codes appropriate to support the need for a defibrillator. This edit would set inappropriately on all home health and hospice claims with dates of service on or after January 1, 2016.
- Another edit in Medicare systems currently requires that revenue code 055x is always reported with HCPCS G0154 on hospice claims. This edit would set inappropriately on all hospice claims with dates of service on or after January 1, 2016.

CMS had instructed the contractors to temporarily deactivate these two edits to prevent Medicare from returning claims in error.

In addition, Medicare systems also use HCPCS code G0154 in the criteria for identifying skilled nursing as the earliest visit when calculating low utilization payment adjustments (LUPA) add-on amounts. Since HHAs can no longer report G0154, skilled nursing visits reported with G0299 or G0300 cannot be used in the calculation. This has resulted in some claims not receiving LUPA add-on amounts or receiving a payment based on the wrong service discipline. The error has been corrected and contractors have been instructed to adjust home health claims.

Lastly, the CR contains a number of routine maintenance revisions to home health billing instructions. The revisions include reformatting the presentation of remittance advice codes and ensuring code pairs are compliant with industry standards. They also include an update to the Pricer logic section to reflect case-mix scoring changes for calendar year 2016 and to correctly reflect LUPA add-on calculations which were effective January 1, 2014.

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