



## FACT SHEET

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### **Pre-Claim Review Demonstration of Home Health Services (CMS-6069-N)**

Home Health Agency (HHA) 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.

Today, the Centers for Medicare & Medicaid Services (CMS) is taking important new steps 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 will begin in Illinois no earlier than August 1, 2016, and the remaining states will phase in during 2016 and 2017.

#### ***Maintaining Beneficiary Access to Care***

Under this demonstration, physicians and clinicians participating 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 their Medicare physicians, the eligible beneficiary should be able to receive Medicare's home health services immediately. The main change under this demonstration is that HHAs will submit the supporting documentation while beneficiaries are receiving care. 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 HHA 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 HHAs will submit it earlier in the process. A beneficiary may also submit documentation for pre-claim review. Medicare will review the documentation to determine if all 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 HHA (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, or visit [Medicare.gov](http://www.Medicare.gov) or call 1-800-MEDICARE (1-800-633-4227).

### ***Helping Home Health Agencies Avoid Errors***

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 help educate HHAs on what documentation is required and encourage them to submit the correct documentation, while still allowing the HHA to begin providing services and receive initial payments prior to the pre-claim review decision. The demonstration also aligns Medicare's payment requirements and approach with commercial insurers, including some Medicare Advantage plans.

A HHA may resubmit the supporting documentation as many times as necessary during the pre-claim review. During the pre-claim review, Medicare will work closely with the HHA 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 typically only available in the administrative appeal process after a claim has been denied. This resubmission process helps HHAs 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 HHAs to appeal claims.

If a claim is ultimately not approved during the pre-claim process, then the final claim for payment will be denied, but the HHA may appeal that determination. If the HHA fails to submit a request for pre-claim review, but the final claim is submitted for payment, then the final claim will be subjected to a pre-payment medical review. 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 these 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.

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](mailto: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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