Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-59 **Date: AUGUST 31, 2000**

CHANGE REQUEST 1315

SUBJECT: HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HHPPS) PHASE IN PLAN, CONTINGENCY PLAN, AND INSTRUCTIONS

Background

The Home Health Prospective Payment System (HHPPS) has been legislatively mandated to begin on October 1, 2000. In order to assure that implementation of the system proceeds smoothly, we have developed a plan, entitled **Phase-In Plan (Plan One)**, which phases in the operational implementation of the system over the full month of October. In phasing in implementation, our first priority has been to assure Home Health Agency (HHA) cash flow during the beginning weeks of HHPPS is adequate for the transition of the payment systems.

In addition, in the event that Home Health Agencies (HHAs) are not prepared to submit bills properly in a HHPPS environment, a **Contingency Plan (Plan Two)** has been developed to process payments for those providers that cannot bill at the onset of PPS (October 1, 2000).

General Information

For the purposes of Plan One (Phase-In) and Plan Two (Contingency) of this Program Memorandum (PM), the following definitions and assumptions are provided for clarification:

- A RAP (Request for Anticipated Payment) is defined in the HHPPS rule as a “request for payment of anticipated services”. A “claim” is defined in the HHPPS rule as a “final request for payment including all of the utilization data for the episode”.

- A RAP is not subject to the usual payment floor because it is a request for anticipated payment and is not considered to be a “claim” (see definition above).

- In the HHPPS rule, we have committed to paying providers a split percentage payment for initial episodes. The rule provides for an initial percentage payment for initial episodes at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate. To remain consistent with our commitment to pay 60 percent for an initial percentage payment, we are using the same percentage when paying RAPs in a phase-in and/or contingency plan.

- RAPs and claims will continue to be submitted electronically.

- Every home health patient receiving home health care as of October 1, 2000 would generate a RAP.
- There is no co-pay or deductible for beneficiaries under a Medicare Home Health Plan of Care (Part A or Part B). These services are billed on Type of Bill (TOB) 32x and 33x.
- Services provided that are not under a Plan of Care, and billed on TOB 34x, will continue to be processed and paid as usual.
- HHPPS is fully operational when all Medicare claims systems are prepared to process RAPs and claims under the HHPPS methodology.
- A home health provider cannot receive payments under the Phase-In Plan if they are receiving payment under the Contingency Plan.

PLAN ONE - PHASE-IN - Medicare Systems Delay

Claims Processing During the Phase-In Period:

1. **Suspension of submitted HHPPS RAPs and claims:** As of October 1, 2000, providers may submit RAPs and claims to the Regional Home Health Intermediary (RHHI) for each patient on service. The RAPs and other home health PPS (Prospective Payment System) claims would be suspended in Medicare systems. Standard Systems (SS) Maintainers will install a hook before all the drivers in the claims system to identify all claims with TOB 32x and 33x with dates of service on or after 10/01/2000. These claims will be suspended in discrete locations in a manner that ensures that they can be released in manageable quantities when the HHPPS system is fully operational. Suspense locations must also be designed to ensure that the suspended claims will be processed on a first in, first out order, when they are released.

2. **Automated counting of submitted RAPs:** On a weekly basis, beginning on October 9, 2000 a report must be run against the suspense files to identify and count all HHPPS RAPs (records with TOB 322 or 332) with the same provider number and with receipt dates after any prior report date and on or before the date of the current report. In making the count, the HIC number on each RAP will be compared to all other HIC numbers previously counted for a particular provider number. If a match is found, the RAP with the duplicate HIC number will not be counted. Once the report is complete, the provider specific counts must be written to a file on which a payment calculation can be performed. HHPPS claims (TOB 32x and 33x) with any other third digit frequency code than 2 will be held in suspense locations until the HHPPS system is fully operational, and will not yield a special payment.

3. **Automated calculation of special phase-in payments:** Once the RAPs are counted, the Standard Systems will then multiply each provider's total number of RAPs by the standardized (budget neutral

episode payment) rate of $2115.30 and multiply that amount by the current RAP payment percentage of 60%. The resulting dollar figure will be the special payment amount to be made to that provider.

4. **Automated issuance of phase-in payments:** The Standard Systems must then move the special payment amount into their financial system and populate the field for accelerated payment amounts with the special payment amount and set an effective date for future withholding. A payment for the special payment amount will be issued to the provider. Since this is a lump sum payment based on the number of RAPs identified and not made on specific claims, the provider's remittance advice will show the single special payment and will not show any detailed information regarding the RAPs submitted.

   NOTE: Special payments available under the HH PPS Phase-In and Contingency Plans are similar, but are not the same as accelerated payments which have long been available by regulation (42 CFR 413.64(g)). Accelerated payments are available on an as-needed basis for a provider experiencing financial difficulties due to a delay by its intermediary in making payments or in exceptional situations for a provider experiencing a temporary delay in preparing and submitting bills beyond its normal billing cycle. To be eligible for accelerated payments, the requesting provider must meet conditions in §2412 of the Provider Reimbursement Manual, Part 1 (PRM). Those conditions, in part, require that the provider has experienced a financial difficulty related to Medicare billing.

   Special payments pursuant to the HHPPS Phase-In and Contingency Plans serve the same general purpose as accelerated payments - making appropriate estimated payments to providers outside normal payment processing procedures because regular payments are significantly delayed due to intermediary or provider claims processing problems. However, due to the nature of the national implementation of HHPPS, the requirements for special payments pursuant to the HHPPS phase-in and contingency plans, the calculation, the method of disbursement, duration of the payments and the recovery of the payments are not the same as the procedures for accelerated payments in PRM §2412.

5. **Release of suspended claims when HHPPS is fully operational:** When all Medicare claims systems are prepared to process RAPs and claims under the HHPPS methodology, the suspended RAPs and claims will be released in the first in, first out order. The special payment will be recovered by 100% withholding against the HHPPS payments calculated for each RAP or claim as it is processed. (Refer to Transition section, page 5, for further clarification.)

6. **Reconciliation and Recovery of overpayments:** We intend all special payments will be reconciled with RAPs and claims within 90 days. Recovery of any overpayments will be made against subsequent RAPs and claims submitted by the provider and will begin on the day that the system is fully operational. (Refer to Transition section, page 5, for further clarification.)

<u>**NOTE**</u>**: Issuance of the special payments to home health agencies and the recovery of the special payments against claims will not require manual intervention on your part.**

7. **Extended repayments:** A provider with extenuating circumstances is permitted to request an extended repayment plan for repayment beyond the above noted 90 days. Since the extended repayment plan will be for less than 12 months, you have the authority to approve or deny such requests. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223 and 2224.

8. **Communication with providers:** Keep providers current with information regarding the status of HHPPS claims processing through your web site and provider bulletins.

<u>Eligibility for Special Phase-In Payments</u>:

1. We are not asking the providers to submit an application or special request to receive payment under Plan One. However, we do recognize that home health providers must refund any overpayments timely. Therefore, to be eligible for special payments, a provider must submit a statement indicating their understanding that we are giving them special payments and they must acknowledge that recovery will be made by withholding 100 percent from Medicare home health payments, that recovery of all payments is to be completed within 90 days from the date that HH PPS systems are fully operational, and that the provider will make a good faith effort to assure that recovery is made within that time frame. **An original signed statement must be received before any special payments can be released.** The statement must be signed by an official of the provider who is legally authorized to commit the provider to repayment of these special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer. (Attachment One is a letter to be sent to all home health providers informing them of the HHPPS Phase-In. <u>**Do not add or change the content of the letter.**</u> Attachment Two is a letter that can be sent to home health providers for providers to return as their acknowledgment letter. If you send this letter to providers, <u>**do not add or change the content of the letter.**</u>)

2. You may accept a provider's acknowledgement letter as soon as September 15, 2000. A provider may e-mail or fax a copy of its request ahead of the original document to facilitate the initiation and preparation of the special payment. **However, you may not make any special payments to a provider that has not submitted an original acknowledgement letter.**

3. You may approve special payments under Plan 1 without the approval of your Regional Office.

4. Do not make payments to a provider that is not currently receiving Medicare payments or would not be receiving payments during the period for which it would be receiving payments under this phase-in plan.

5. If a provider is currently under withhold for any reason, such withhold continues to be applied against these payments.

6. Payments are to be released upon receipt of a provider's initial acknowledgement (however, not before October 9, 2000) and weekly thereafter until HHPPS claims can be processed.

7. Special payments will end when HHPPS is fully operational.

Transition from the Phase-In to full HHPPS

1. Backlog:

a) The RAPs and claims previously held in suspense from 10/01/00 to 10/29/00 will be considered your backlog.
b) Any new RAPs and claims that come in after 10/30/00 will be held as if the phase-in continues and will be added to the backlog.
c) That is, pay post 10/29/00 RAPs using the phase-in methodology (#2 and #3 in Claims Processing During Phase-In Period) until the entire backlog has been processed.

2. **Claims Release:**

a) HHPPS is fully operational when all Medicare claims systems are prepared to process RAPs and claims under the HHPPS methodology, the backlog of suspended RAPs and claims will be released in the first in, first out order, using the receipt date
b) Begin working off the backlog on 10/30/00 and continue until the entire backlog is worked off and you are current.

3. **Reconcile, Recovery and Offset:**

a) As the RAPs and claims backlog is released, reconcile RAPs and claims to determine what should have been paid in HHPPS versus what was paid as a special payment during phase-in.
b) This reconciliation will occur at the end of a payment cycle based on what has been processed for a given provider, consistent with the special phase-in payment amounts.

- If the special payment made during phase-in exceeds the amount due to the provider under the fully adjusted HHPPS payments, withhold 100% against current and, if necessary, against future payments.
- If the special payment made during the phase-in is less than the amount due to the provider under the fully adjusted HHPPS payments, send a check for the amount due to the provider immediately.

c) Each RHHI will begin 100% withholding against current payments once its own backlog has been completely processed if there is any remaining amounts of overpayments due.

4. **Remittance Advice:** The remittance advice will show HHPPS payments offset by phase-in payments.

PLAN TWO – Contingency for Provider Billing Failure

1. If the provider notifies you that it is unable to submit RAPs or claims electronically as of October 1, 2000, they must then submit documentation to the RHHI requesting an alternate method for submitting RAPs and claims. The documentation must include a work plan and/or timeline that indicates when it's billing systems are operational. This contingency payment is only available to providers for the time period of October 1, 2000 through November 29, 2000. Attachment Three is a letter that is to be sent to all providers advising of the opportunity for a special payment. **Do not add to or change the content of the letter.** Attachment Four is a letter that can be sent to providers for providers to return as their request for a special payment under the contingency plan. **If you send this letter, do not add to or change the content of the letter.**

2. An RHHI estimates the number of RAPs the provider is experiencing in the first month of PPS by:

    a. Dividing agency visit volume for the provider from the most recent data for a prior year by six, and

    b. Dividing the resulting number of visits for the average 60-day episode by the average number of visits in the PPS episode (26.85).

3. The RHHI then multiplies the provider's total number of estimated RAPs by the standardized rate published in the final rule ($2115.30) and multiplies that amount by the current RAP payment percentage of 60% and makes one special payment.

4. Do not make payment to a provider that is not currently receiving Medicare payments or would not be receiving payments during the period for which it would be receiving payments under this contingency plan.

5. If a provider is currently under withhold for any reason, such withhold continues to be applied against this contingency payment.

6. **There will only be one special payment under this contingency plan.** Therefore, to be eligible for a contingency payment, a provider must submit an **original signed request.** A provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, an original signed paper request must be received before the special payment can be released. The request for a special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**.

As part of the request, the provider must acknowledge that recovery will be made by withholding 100 percent from Medicare home health payments, that recovery is to be completed within 90 days of the payment, and that the provider will make a good faith effort to assure that recovery is made within that time frame. The provider must refund the balance of any special payments that cannot be offset against payments within that 90 days.

7. In addition, under Plan 2, the provider must report to you the exact nature of its HHPPS billing problems, that it currently cannot submit bills to receive payment, and the status of its correction of the billing problems. Further guidance will be provided to you and to Regional Offices regarding criteria for evaluating a provider's billing problems.

8. Under Plan 2, the Regional Office must approve the special payment. Submit your recommendation of approval or disapproval with the reason(s) to the Regional Office, typically to the Division of Financial Management (to the Division of Health Plans and Providers in the Kansas City Regional Office), following existing regional office accelerated payment procedures, no later than 48 hours from receipt of the original signed request. The Regional Office must turn around the request in 48 to 72 hours from receipt of your recommendation. You have 7 workdays from receipt of the Regional Office's decision to release the special payment to the provider.

9. In any case in which you recommended and the regional office disapproved a special payment (or in which you recommended approval but the regional office disapproved), the provider may re-request the payment which originally was disapproved, supporting that it has made further progress in resolving its claims problems. If you are satisfied that payment is warranted, recommend Regional Office approval, with your reasons. If not, recommend disapproval with your reasons.

10. As under Plan 1, a provider under Plan 2 with extenuating circumstances is permitted to request an extended repayment plan for repayment beyond the above noted 90 days. Since the extended repayment plan will be for less than 12 months, you have the authority to approve or deny such requests. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223 and 2224.

Reporting Requirements

Following are reporting requirements developed to capture vital information during HHPPS phase-in:

1. The following information/data is required from each RHHI on a weekly basis beginning September 18, 2000. Reports are due to CCMO staff by noon every Monday. (An Excel spreadsheet will be developed by HCFA CO detailing the format to collect the data and will be distributed to all FIs through the CCMOs.) CCMO staff will forward the spreadsheet to CHPP/CCPG/DCPC and OFM/FSG/DFI (Debt Management).

2. Provider Notice:
   # of acknowledgements sent (baseline data)
   # of acknowledgements received (by date)
   # of requests for contingency "special payments" approved or disapproved

3. Payments:
   Retain by Provider:
      Number of RAPs submitted per provider
      Date and amount of each payment sent

The *effective date* for this PM is October 1, 2000.

The *implementation date* for this PM is October 1, 2000.

This PM may be discarded after September 30, 2001.

Funding will be provided through the normal budget process.

If you have any questions, contact your regional office.

Attachments
1— Letter to Providers for Phase-In
2— Letter from Providers for Phase-In
3— Letter to Providers for Contingency Plan
4— Letter from Providers for Contingency Plan

Attachment 1

Fiscal Intermediary Letterhead

Date

Dear Medicare Provider,

The Home Health Prospective Payment System (HHPPS) has been legislatively mandated to begin on October 1, 2000. However, the Health Care Financing Administration (HCFA) has decided to phase-in its systems' implementation of the HHPPS in the first month of the new payment system (October 1 through October 31, 2000). This is to assure that implementation of the system proceeds smoothly and that the software systems supporting HHPPS are fully functional.

HCFA has developed a phase-in plan by which providers can receive special payments based on their submitted Requests for Anticipated Payment (RAP) during the phase-in period. Special payments are based on the concept of accelerated payments in the Provider Reimbursement Manual, Part I, §2412. However, due to the circumstances associated with the phase-in process of HHPPS, the requirements for special payments pursuant to the HHPPS Phase-in Plan, the calculation, the method of disbursement, duration of the payments and the recovery of the payments are not the same as the procedures for accelerated payments in PRM §2412.

To be eligible for special payments, providers must submit a statement indicating their acknowledgement of the following:

1. They are receiving special payments and acknowledge that recovery will be made by withholding 100 percent from Medicare home health payments;
2. That recovery of all payments is to be completed within 90 days from the date that the HHPPS systems and claims processing are fully operational; and
3. That the provider will make a good faith effort to assure that recovery is made within the 90-day time frame.

An original signed statement acknowledging the above three items must be received before any special payments can be released. The statement must be signed by an official of the provider who is legally authorized to commit the provider to repayment of these special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer.

Special payments are calculated by multiplying each provider's total number of RAPs by the standardized rate ($2115.30) published in the final rule, then multiplying that amount by the current RAP payment percentage of 60%. Payments will be made weekly during the phase-in period.

We intend to reconcile all special payments and recover any overpayments, nevertheless, providers with extenuating circumstances may request an extended repayment plan beyond the above noted time period. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223, and 2224. Extended repayment plans will not exceed 12 months.

If you have questions, please contact (insert FI's name, department and phone number). Also, refer to HCFA's web site: http://www.hcfa.gov. Look on the homepage for the link to HHPPS information.

Thank you for your patience and cooperation.

Sincerely yours,

Attachment 2

Provider Letterhead

Date

Provider #:

Dear Fiscal Intermediary,

I am writing to request special payments associated with the phased-in implementation of the Home Health Prospective Payment System (HHPPS). I understand the special payments will be made only during the phase-in period of HHPPS. I understand that the special payments are made weekly and are calculated based on the total number of Requests for Anticipated Payment (RAP) submitted, times $2115.30, and paid at 60%.

I understand that recovery of these payments will begin as soon as HHPPS is fully operational and must be fully settled within 90 days of the HHPPS becoming operational. Recovery will be made by withholding Medicare home health payments at 100 percent until the special payments have been recouped. We will be responsible for the refund of any outstanding special payment balance that could not be withheld from payments during those 90 days. I understand that if the recovery withholding poses a difficulty, I may request an extended repayment plan.

I certify that I am legally authorized to make financial commitments and assume financial obligations on behalf of this provider of care. If you have questions you may contact me at (insert phone number.)

Sincerely yours,

Name and Title of Individual Signing on Behalf of the Medicare Provider

Attachment 3

Fiscal Intermediary Letterhead

Date

Dear Medicare Provider,

As of (insert date), we have begun processing claims under the Home Health Prospective Payment System (HHPPS). If you are unable to submit claims properly in a HHPPS environment, according to the contingency plan developed by the Health Care Financing Administration (HCFA), you may submit an original signed request to receive a special payment. Special payments will only be made for a limited time (October 1 through November 29, 2000).

The request for a special payment must be sent in writing and must state the exact nature of the HHPPS billing problem(s) you are experiencing. The letter must also include a description of actions being taken to correct the billing problem(s). In addition, the letter must state that you acknowledge that recovery of this special payment is to be completed within 90 days of the payment and that you will make a good faith effort to assure that recovery is made within that time frame. For providers currently under withhold for any reason, such withholding will continue to be applied against the payments. Your request will be forwarded to the regional office for approval. (A sample special payment request letter is attached). An original signed request is always required, but a provider may e-mail or fax a copy of its request ahead of the original copy to facilitate the initiation and preparation of the special payment. **However, a provider must submit an original signed paper request before the special payment can be released. The request for special payment must be signed by an official of the provider who is legally authorized to commit the provider to the repayment of special payments: that is, the administrator, chief executive officer, chief operating officer, or chief financial officer**.

The special payment is calculated by using the estimated number of RAPs the provider would experience in the first month of HHPPS. This is determined by using data on agency visit volume from the most recent data for a prior year, divided by six. The total number of visits for the average 60-day episode is determined by dividing the total number of visits by the average number of visits in the PPS (26.85) episode. This equals the estimated number of RAPs the provider would be generating. The provider is then paid a special payment that is based on the total number of estimated RAPs, times the standardized rate ($2115.30), times 60%.

We intend that the special payment will be recovered by withholding 100% from Medicare home health payments and the provider must refund the balance of any special payments that cannot be offset against payments within 90 days. Nevertheless, providers with extenuating circumstances may request an extended repayment plan beyond the above noted 90 days. Approvals are expected to be very limited and are subject to the extended repayment schedule procedures outlined in the Medicare Intermediary Manual, Part 2, §§2219, 2223, and 2224. However, extended payments will not exceed 12 months.

If you have questions, please contact (insert FI's name, department and phone number). Also, refer to HCFA's web site: http://www.hcfa.gov. Look on the homepage for the link to HHPPS information. Thank you for your patience and cooperation.

Sincerely yours,

Attachment 4

Provider Letterhead

Date

Provider #

Dear Fiscal Intermediary,

I am writing to request a special payment under the HHPPS Contingency Plan because (state the exact nature of the HHPPS billing problem and steps taken to correct the problems). I understand that the special payment is calculated based on the total number of visits for the average 60 day episode divided by the average number of visits in the PPS episode which equals the estimated number of RAPs, times the standardized rate of $2115.30, times 60%. I understand that we may receive no more than one special payment under the HH PPS Contingency Plan.

I understand that recovery of the special payment must be made within 90 days of the payment. Recovery will be made by withholding Medicare Home Health payments at 100 percent until the special payment has been recouped, or through direct refund if not entitled to an equal or greater amount of payment during that 90 days. I understand that if the recovery withholding poses a difficulty I may request an extended repayment plan.

I certify that I am legally authorized to make financial commitments and assume financial obligations on behalf of this provider of care. If you have questions you may contact me at (insert phone number.)

Sincerely yours,

Name and Title of Individual Signing on Behalf of the Medicare Provider