Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-03-070 **Date: AUGUST 8, 2003**

CHANGE REQUEST 2804

SUBJECT: Inclusion of the State of New York in Demonstration for Settlement of Payments for Home Health Services to Dual Eligibles and Instructions for Processing Fiscal Year 2000 Claims Under the Demonstration. Regional Home Health Intermediaries (RHHIs) Only.

I. GENERAL INFORMATION

A. Background: Program Memorandum A-03-046, (Change Request 2710) published May 30, 2003, provided instructions for a demonstration project to utilize a sampling approach to determine the Medicare share of the cost of claims that were submitted to and paid by State Medicaid agencies for home health services provided to Medicare-Medicaid dual eligible beneficiaries. The demonstration outlined in PM A-03-046 applied to dual eligible beneficiaries in the States of Connecticut and Massachusetts. As of the effective date below, this demonstration will also include the State of New York. Requirement one below instructs the RHHIs to expand the demonstration to New York claims. Requirements two and three below modify the instructions in PM A-03-046 that pertain to the sampling methodology and to reconsiderations for Federal fiscal years (FFY) 2002 and after.

The demonstration project for Connecticut claims applies to FFY 2001 to 2005. However, the demonstration project for Massachusetts and New York applies to FFY 2000 to 2004. The Medicare basis of payment for home health services changed effective October 1, 2000 to a prospective payment system (PPS) from a cost-based system which was in place in FFY 2000. Requirements four through six below instruct the RHHIs to modify the demonstration process outlined in PM A-03-046 for FFY 2000 claims only, to account for this change in Medicare's basis of payment.

B - Policy: CMS and the State of New York have committed to this demonstration project through the signing of a Memorandum of Understanding.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
2804.1	RHHIs shall apply all requirements published in PM A-03-046, as modified in this PM, to home health claims from the State of New York for FFY 2001 and after.	All RHHIs
2804.2	For FFY 2002 and after, the demonstration RHHI shall complete reconsiderations of denied sample claims prior to reporting the Medicare payment amount for the sample to CMS	Demo RHHI
2804.2.1	For FFY 2002 and after, the demonstration RHHI shall increase the Medicare payment amount for the sample to reflect any denials reversed upon reconsideration.	Demo RHHI
2804.3	The demonstration RHHI shall apply the revised sampling methodology attached to this PM to all claims processed under this demonstration.	Demo RHHI
2804.3.1	The demonstration RHHI shall disregard requirement 2710.13.1 of PM A-03-046, replacing it with the following: 'The demonstration RHHI shall project the	Demo RHHI

	sample results to the universe as specified in the revised sampling methodology."	
2804.4	Servicing RHHIs shall apply all requirements published in PM A-03-046 for receipt and cleansing of the claims universe to Massachusetts and New York claims for FFY 2000.	Servicing RHHIs
2804.5	Except as modified in this PM and as described below, the demonstration RHHI shall apply all requirements published in PM A-03-46 for review of the claims sample and calculating the associated Medicare payment to Massachusetts and New York claims for FFY 2000.	Demo RHHI
2804.5.1	The demonstration RHHI shall require that Medicare claims for FFY 2000 be submitted in accordance with the billing instructions effective in FFY 2000.	Demo RHHI
2804.52	The demonstration RHHI shall perform medical review of the sample or oversample cases in accordance with all medical review policies effective in FFY 2000.	Demo RHHI
2804.5.3	The demonstration RHHI shall calculate Medicare payment amounts due for each sample or oversample claim according to the Medicare interim payment rate effective in FFY 2000.	Demo RHHI
2804.5.3.1	The demonstration RHHI shall not apply per visit or per beneficiary cost limits effective in FFY 2000.	Demo RHHI
2804.5.3.2	The demonstration RHHI shall contact the servicing RHHIs as needed to determine the FFY 2000 interim rates to apply for providers that normally bill the servicing RHHIs.	
2804.6	The demonstration RHHI shall not apply any requirements published in PM A-03-46 regarding research of home health consolidated billing to Massachusetts and New York claims for FFY 2000.	Demo RHHI

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2804.4	Requirements for receipt and cleansing of the claims universe are found in PM A-03-046 at 2710.2 through 2710.6.1
2804.5	Requirements for review of the claims sample and calculating the associated Medicare payment are found in PM A-03-046 at 2710.8 through 2710.14
2804.6	Requirements regarding research of home health consolidated billing are found in PM A-03-046 at 2710.15. The home health consolidated billing policy does not apply to services prior to FFY 2001.

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Financial reporting and workload considerations outlined in PM A-03-046 apply to processes described in this instruction.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. ATTACHMENT (S) -- REVISED SAMPLING METHODOLOGY

Version: Final July 9, 2003 Implementation Date: August 28, 2003 Discard Date: August 8, 2008 Pre-Implementation Contact: Wil Gehne, (410) 786-6148	Effective Date: August 28, 2003 Funding: These instructions should be implemented within your current operating budget. Post-Implementation Contact: Appropriate regional office

Attachment

REVISED SAMPLING METHODOLOGY

Universe: Dually-eligible beneficiaries and any services provided by Home Health Agencies which were paid by the State Medicaid Agency for which the State now seeks Medicare payment. Not included in the universe: ineligible Medicare beneficiaries; duplicate beneficiaries, claims or services; services previously adjudicated by Medicare (paid or denied); and services to beneficiaries who opt out; services by excluded providers.

Sample Unit: *Medicare HICN (Health Insurance Claim Number) designating a dually eligible Medicare beneficiary*

Time Frames: – *Separate sample for each State and each fiscal year for each for the five demonstration years.*

Sample Size: 200 for each year *plus 15 additional over-sampled cases per year.*

Sampling Technique: Systematic sampling (Interval sampling using random start.) The universe will be arranged in ascending order according to the amount paid for each case. If it becomes necessary to use the 15 over-sampled cases, each time a case is needed it will be randomly drawn from the remaining over-sampled cases.

Review Criteria*: Based on its review of Medicare claims and related medical records and other information submitted by providers, Associated Hospital Service will make a determination for each of 200 sampled (or oversampled) cases of the dollar amount Medicare would have paid ("Approved Medicare reimbursement amount') compared to what Medicaid paid.*

Estimation Technique: A statistical estimator will be used to project the sample results (*total Medicare payment compared to the total Medicaid payment*) for the entire universe of claims, i.e., to determine a total amount that Medicare would have paid for the entire universe. The statistical estimator used for this purpose will be the one of the following which yields the greater level of precision: the "ratio" estimate or the "bootstrap" estimate.

Cases Lacking Proper Documentation: For sampled cases where the *provider* is unable to provide coding information and/or medical record documentation sufficient for AHS to make a payment determination, a substitute case must be picked from a 15 case "pool" which has been randomly selected in addition to (and separately from) the original sample of 200. The substitute cases must be randomly selected from the pool each time a substitute case is needed. If all 15 cases in the pool become exhausted, no further substitutions are allowed. *Once an original case has been replaced by a substitute case, it is eliminated from the sample and cannot be re-submitted at a later time.*