

Home Health Providers and Verification Organizations Questions/Comments and Answers

#	Question/Comment	Answer
1	<p>Providers already experience long delays in reimbursement and associated cash flow problems in managed care payments; the new requirement (which imposes an added step to an already negotiated and non-fee-for-service reimbursement model) risks further delays. Respectfully, OMIG must include provisions preventing further delays and cash flow problems, perhaps turnaround time limits for VO claims review. Agency and patient service impact are legitimate concerns here.</p>	<p>The legislation has a clear expectation that the verification organization verifies every service or item within a claim or encounter submitted by a participating provider prior to the submission of the claim.</p> <p>The electronic visit verification is performed close to real time. The home care provider should be able to determine if a service identified with an exception was actually performed in a timely manner.</p>
2	<p>Obtaining timely authorizations from managed care plans is already a major issue faced by home care providers, whose concerns are elevated that electronic visit verification may deny claims where providers have verbal, but not written authorizations. What is OMIG's plan for preventing this?</p>	<p>Participating providers in FFS or managed care are required to provide the services in accordance with Medicaid policy (FFS) or as noted in their contractual obligations with their managed care plan(s). The VO ensures proper authorization based on these requirements.</p>
3	<p>Other states, including (we have been told) Illinois, Texas, Tennessee, Florida among others, require but fund the cost of the VO process. This expansion represents an additional unfunded mandate for home care providers who currently are facing serious negative margins and fiscal challenges. New York state should either directly or through adjusted managed care plan premiums fund this requirement.</p>	<p>We are aware that other states may pay for part or all EVV costs but the implementation in NYS is considered a cost of participating in the NYS Medicaid program. It is hoped that for agencies already employing a vendor to meet HRA's longstanding rules, that there will be minimal additional costs. Providers are encouraged to share their experiences in this area to keep us abreast of the market conditions.</p>

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4	<p>Applying electronic visit verification to professional services (nursing, therapies) is very different from application to personal care aide services (as this model was taken from the original HRA program which provided only personal care and not professional services). Nursing and therapies are by the visit, not the hour, and are dynamic in response to patients' needs. We cannot see how the OMIG plans to conduct a program for these professional visits analogous to the program for personal care aides and request information on how the OMIG plans to do so.</p>	<p>At present HHA and PCA are the only required verifiable services. Participating providers and VO's are encouraged to work toward including EVV for all services as a best practice.</p>
5	<p>EVV conducted for home care fee-for-service is based on entirely different structure and relationship between provider and state payment than under managed care. The latter is based on the payment/assurance relationship between the state and the managed care plan, and the plan in turn has responsibility for its contracted services. Assurances related to service delivery and billing by providers under managed care should remain between the providers and the plans as part of negotiated provisions of their contracts; assurances required by the plans for the state's payment to them should be between plans and the state.</p>	<p>As noted in # 1, the legislation has a clear expectation that the verification organization verifies every service or item within a claim or encounter submitted by a participating provider prior to the submission of the claim.</p>
6	<p>Given the changing nature of Medicaid payment – i.e., DOH in its waiver agreement with CMS is shifting virtually all payments from fee-for-service and “volume based payment” to “value based payment,” including sub capitation and other non-fee-for-service payment methods – on what basis would the VO measure “per service” billing when the system has moved to a completely different basis for billing and payment.</p>	<p>The verification organization is verifying that a scheduled service is provided in accordance with the plan of care. This process not only validates that a service has been rendered, as ordered, before it is billed but helps to identify potential discrepancies between what a physician orders and what is actually being provided.</p>

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7	What instrument does the OMIG plan to use to determine how much reimbursement home care providers received from managed care plans and for which services provided now and, especially when per-service reimbursement is replaced with other reimbursement methods?	<p>For Managed Care, OMIG is using the amount paid to the provider per service as reported by managed care plans on home care encounters to identify those providers who meet the threshold. Home care encounters are defined based on the service classification described in the NYSDOH MEDS III and MMCOR COS Service Utilization and Cost Reporting Guide for Medicaid Managed Care Health Plans (Version 1.3 December 2013).</p> <p>For Fee-for-service claims, providers are identified by the home health rate codes they are billing, excluding consumer directed services. When the claims are episodic payment system claims, the revenue codes that accompany the home health rate codes (excluding consumer directed services) are used to identify the home health providers.</p>
8	Can OMIG please provide to HCA OMIG's most current Calendar Year list of home care and personal care providers that have reached the threshold of \$15 million in Medicaid reimbursement?	The OMIG will notify the participating providers. Once the participating providers have been notified the OMIG will provide the list of participating providers.
9	Providers Meeting Statutory Threshold – Home care providers need to understand the process and how they can resolve eligibility determinations.	<p>Providers are deemed eligible if the total dollars from both Managed Care and Fee-for-Service claims exceed the defined threshold.</p> <p>Also see # 7</p>
10	Preclaim review – We are concerned that this process will delay payments to home care providers. We believe this represents an unfunded mandate adding unnecessary additional cost to the not-for-profit home care system that continues to operate within a very thin margin.	Please see # 1.

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11	<p>Attachment 2: Requirements for Verification Organizations (#4) – We are concerned with the requirement that the “VO must ensure that the recipient has proper authorization, both for enrollment and any utilization limits, that the service schedule is consistent with the plan of care and has had proper authorization and signoff. “Home care providers already face a challenge in securing doctor’s order and signoff. Often the logistical issues surrounding doctor’s verbal orders, written orders and having the acceptable doctor’s face-to- face narrative results in a significant burden for home health agencies. The addition of this extra hurdle can only serve to make the issue worse.</p>	<p>Participating providers in FFS or managed care are required to provide the services in accordance with Medicaid policy (FFS) or as noted in their contractual obligations with their managed care plan(s). The VO ensures proper authorization based on these requirements.</p>
12	<p>Attachment 2: Requirements for Verification Organizations (#20) – We request that the “trending analysis” across their entire Medicaid participating provider customer base be made available in a format that home care providers can analyze the trends and take any corrective action.</p>	<p>Each participating provider would need to discuss with their chosen VO the reports that they would like to receive.</p>
13	<p>Attachment 2: Requirements for Verification Organizations (#21) – We are interested in learning what other verifiable services might be forthcoming.</p>	<p>Please see # 4 above.</p>

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14	<p>As currently drafted, there remain some questions regarding the service types that are covered under the requirements. For instance, a frequently asked questions (FAQs) document posted on OMIG's website and associated with the current requirements states that, "For initial implementation [emphasis added], CDPAP claims will be exempted from Covered Provider calculations." It is not clear in the revised requirements whether reimbursements for consumer directed personal assistance services (CDPAS) continue to remain outside the purview of the pre-claim review requirements and reimbursement calculations.</p>	<p>The CDPAP claims are exempted from the current Participating Provider calculations. These services continue to remain outside the purview of the pre-claim review requirements and reimbursement calculations.</p>
15	<p>As drafted, the revised requirements do not address the timeframe within which newly-covered home care agencies must have implemented the pre-claim review process to ensure statutory compliance. For those agencies that have never before been subject to the process, it will take time to research, select and contract with a VO vendor, and in some cases an electronic visit verification (EVV) vendor, and to get the proper systems in place and operational.</p>	<p>If a participating provider does not already have a VO, they will be required to contract with one within forty-five days of the date on their notification letter. Once a VO has been selected it is the VO's responsibility to develop a custom implementation schedule in a reasonable time frame not to exceed six months from the date on the participating providers' notification letter.</p>
16	<p>In order to fully comply with the requirements of the pre-claim review verification process, providers are subject to steep costs stemming from required contracts with VOs and EVV vendors. These costs contribute to the mounting expenses that providers across the State must absorb in order to comply with new and ongoing unfunded regulatory mandates at the State and Federal level, and add to the fiscal distress and instability that providers are facing.</p>	<p>Please refer to # 3.</p>

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17	<p>The transition to managed care has increased the number of stakeholders involved in the care delivery process, and there are many home care providers that continue to experience issues related to managed care billing processes and the ability to secure timely reimbursement for services provided. With the inclusion of managed care Medicaid reimbursements now contributing to the \$15 million pre-claim review threshold, VOs will now be required to submit reviewed claims directly to managed care plans. Accordingly, it is crucial that managed care plans fully understand the pre-claim review process and the distinct roles and responsibilities of providers, VO and EVV vendors, and plans.</p>	<p>The OMIG will collaborate with OHIP to provide the MLTC's with the necessary resources. Based on OMIG's current analysis, approximately half of the participating providers identified in managed care already have EVV's and a VO.</p>