HOME HEALTH SUMMER CAMP

Continuing Education

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• Nurse attendees may earn a maximum of **15.5 contact hours**
• Accountant attendees can earn up to **18.9 CPEs**

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NAHC is [also] approved by the California Board of Registered Nursing, provider #10810.

Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
# SPEAKERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>David C. Macke, MBA, CHFP, FHFMA</td>
<td>VonLehman CPA &amp; Advisory Firm</td>
<td><a href="mailto:dmacke@vlcpa.com">dmacke@vlcpa.com</a></td>
</tr>
<tr>
<td>Thomas Boyd, MBA, CFE, CHFP</td>
<td>Simione Healthcare Consultants, LLC</td>
<td><a href="mailto:tboyd@simione.com">tboyd@simione.com</a></td>
</tr>
<tr>
<td>Tammy Ross, SVP</td>
<td>Axxess Technology Solutions</td>
<td><a href="mailto:tross@axxess.com">tross@axxess.com</a></td>
</tr>
<tr>
<td>Melinda A. Gaboury, CEO</td>
<td>Healthcare Provider Solutions, Inc.</td>
<td><a href="mailto:info@healthcareprovidersolutions.com">info@healthcareprovidersolutions.com</a></td>
</tr>
<tr>
<td>Elizabeth Pearson, Esq.</td>
<td>Pearson &amp; Bernard PSC</td>
<td><a href="mailto:liz@pblaw.org">liz@pblaw.org</a></td>
</tr>
</tbody>
</table>

**Medicare Cost Report as a Management Tool: Compliance Responsibilities**  
Dave Macke, VonLehman CPA & Advisory Firm
Objectives

• Demonstrate how information from the Medicare cost report can be a useful management and operational tool
• Discuss the value of benchmarking and the use of the cost report for that purpose
• Discuss the filing of the cost report for regulatory compliance
• MCReF (Medicare Cost Report E-Filing)

“Success is the result of perfection, hard work, learning from failure, loyalty, and persistence.”
- Colin Powell
Management Use of Cost Report

• Form CMS 17828-94 – Home Health
• The Medicare Cost Report is not just a “compliance” requirement that must be filed with CMS but can be a valuable tool to assist in budgeting, pricing, benchmarking and strategic analysis
• This is the one industry consistent tool but it is not perfect
• Provides analysis of cost and utilization
• Some Medicare Cost Reports have bad / inaccurate data

Management Use of Cost Report

• The Medicare Cost Report is not true actual cost method but based on system of averages but a good starting point
• A complete and accurate Medicare Cost Report will permit an organization to benchmark their data against information provided by their prior history and the cost reports for the industry (state and nation)
• Dependent on good and accurate financial statement data
• Medicare “reimbursable cost” – add back non reimbursable expenses (marketing, donations, etc.)
Management Use of Cost Report

• Benchmark against the industry and your self
  o Direct and indirect costs by discipline (per hour and per visit)
  o Fixed and variable costs
  o Non-routine medical supplies
  o Cost per episode / Medicare margin
  o Cost, revenue and margin by payer
  o Service utilization per episode

Management Use of Cost Report

<table>
<thead>
<tr>
<th>Salary Cost per Visit</th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care</td>
<td>$49.37</td>
<td>$50.38</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$67.35</td>
<td>$70.86</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$67.96</td>
<td>$66.15</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$73.13</td>
<td>$68.30</td>
</tr>
<tr>
<td>Medical Social Service</td>
<td>$57.42</td>
<td>$74.07</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$20.94</td>
<td>$22.27</td>
</tr>
</tbody>
</table>

Salaries - Worksheet A, column 1, Visits Worksheet
S-3, Part I, column 5
### Management Use of Cost Report

#### Direct cost per Visit

<table>
<thead>
<tr>
<th>Service</th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care</td>
<td>$59.45</td>
<td>$60.08</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$80.11</td>
<td>$81.48</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$81.15</td>
<td>$77.15</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$85.24</td>
<td>$77.58</td>
</tr>
<tr>
<td>Medical Social Service</td>
<td>$67.32</td>
<td>$87.37</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$30.95</td>
<td>$30.66</td>
</tr>
</tbody>
</table>

Worksheet A, column 10 or Worksheet B, column 0

### Management Use of Cost Report

#### Direct vs. Indirect

<table>
<thead>
<tr>
<th>Service</th>
<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care</td>
<td>$59.45</td>
<td>$27.48</td>
<td>$86.93</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$80.11</td>
<td>$37.03</td>
<td>$117.14</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$81.15</td>
<td>$37.51</td>
<td>$118.66</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$85.24</td>
<td>$39.40</td>
<td>$124.64</td>
</tr>
<tr>
<td>Medical Social Service</td>
<td>$67.32</td>
<td>$31.12</td>
<td>$98.44</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$30.95</td>
<td>$14.30</td>
<td>$45.25</td>
</tr>
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</table>

Worksheet B, column 6 versus Column 0
## Management Use of Cost Report

### Total Cost per Visit

<table>
<thead>
<tr>
<th>Service</th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care</td>
<td>$86.93</td>
<td>$88.25</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$117.14</td>
<td>$119.70</td>
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<tr>
<td>Occupational Therapy</td>
<td>$118.66</td>
<td>$113.33</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$124.64</td>
<td>$113.96</td>
</tr>
<tr>
<td>Medical Social Service</td>
<td>$98.44</td>
<td>$128.35</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$45.25</td>
<td>$45.04</td>
</tr>
</tbody>
</table>

Worksheet C, Part I, Column 4, Lines 1-6

### Average visits per episode

<table>
<thead>
<tr>
<th>Service</th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care</td>
<td>7.75</td>
<td>7.78</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>7.59</td>
<td>7.73</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>2.93</td>
<td>3.09</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>1.04</td>
<td>1.09</td>
</tr>
<tr>
<td>Medical Social Service</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>0.47</td>
<td>0.69</td>
</tr>
<tr>
<td>Total</td>
<td>19.82</td>
<td>20.42</td>
</tr>
</tbody>
</table>

Total episodes including LUPA's – Worksheet S-3, Part IV
Management Use of Cost Report

<table>
<thead>
<tr>
<th>Episode by Type</th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full w/o Outlier</td>
<td>91.75%</td>
<td>91.50%</td>
</tr>
<tr>
<td>Full with Outlier</td>
<td>01.23%</td>
<td>01.83%</td>
</tr>
<tr>
<td>LUPA</td>
<td>05.50%</td>
<td>06.17%</td>
</tr>
<tr>
<td>PEP</td>
<td>01.52%</td>
<td>00.50%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Worksheet S-3, Part IV

Management Use of Cost Report

<table>
<thead>
<tr>
<th></th>
<th>Full w/o Outlier</th>
<th>Full with Outlier</th>
<th>LUPA</th>
<th>PEP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCR Reimb</td>
<td>$4,451,876</td>
<td>$93,326</td>
<td>$32,535</td>
<td>$26,632</td>
<td>$4,604,369</td>
</tr>
<tr>
<td>Less: Sequestration</td>
<td>$ 89,037</td>
<td>$ 1,867</td>
<td>$ 651</td>
<td>$ 533</td>
<td>$ 92,088</td>
</tr>
<tr>
<td>Net MCR Reimb</td>
<td>$4,362,839</td>
<td>$91,459</td>
<td>$31,884</td>
<td>$26,099</td>
<td>$4,512,281</td>
</tr>
<tr>
<td>MCR Cost</td>
<td>$2,734,997</td>
<td>$97,958</td>
<td>$20,115</td>
<td>$27,354</td>
<td>$2,880,424</td>
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<tr>
<td>MCR Profit (before Seq)</td>
<td>$1,716,879</td>
<td>$(4,632)</td>
<td>$12,420</td>
<td>$(722)</td>
<td>$1,723,945</td>
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<tr>
<td>MCR Profit (after Seq)</td>
<td>$1,627,842</td>
<td>$(6,499)</td>
<td>$11,769</td>
<td>$(1,255)</td>
<td>$1,631,857</td>
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</tbody>
</table>

Medicare Reimbursement – Worksheet D, Part II – Cost – Worksheet C, Part IV
## Management Use of Cost Report

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue per Episode</td>
<td>$3,267.40</td>
<td>$3,284.79</td>
</tr>
<tr>
<td>Cost per Episode</td>
<td>$2,085.75</td>
<td>$2,143.81</td>
</tr>
<tr>
<td>Profit per Episode</td>
<td>$1,181.65</td>
<td>$1,140.98</td>
</tr>
</tbody>
</table>

Revenue – Worksheet D  
Cost – Worksheet C  
Episode – Worksheet S-3, IV

### Cost Analysis

<table>
<thead>
<tr>
<th>Cost Analysis</th>
<th>Cost</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Costs (Bldg &amp; MME)</td>
<td>$48,241</td>
<td></td>
</tr>
<tr>
<td>Plant Operation &amp; Maint</td>
<td>$3,082</td>
<td></td>
</tr>
<tr>
<td>Administration &amp; General</td>
<td>$1,749,344</td>
<td></td>
</tr>
<tr>
<td>Total Overhead Costs</td>
<td>$1,800,667</td>
<td>31.61%</td>
</tr>
<tr>
<td>Direct Patient Costs</td>
<td>$3,895,778</td>
<td>68.39%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$5,696,445</td>
<td>100.00%</td>
</tr>
<tr>
<td>Net Patient Revenue</td>
<td>$6,699,233</td>
<td></td>
</tr>
<tr>
<td>Admin Costs as % of Revenue</td>
<td></td>
<td>26.11%</td>
</tr>
</tbody>
</table>
Management Use of Cost Report

- All of the above analysis can be done from the Medicare Cost Report
- Comparisons can be made to your own agency year over year
- Comparisons can also be made to industry cost report data
- NAHC has Cost Report Data from HCRIS (CMS database)
- Revenue, Cost, Profit and Utilization - NAHC
  - Freestanding, Hospital based and All
  - Urban and Rural
  - State by State and National
  - Not detailed cost by cost center
Management Use of Cost Report

The NAHC COST REPORT DATA COMPRENDIUM is an in-depth analysis of Medicare cost reports filed by home health agencies since the beginning of the HH PPS payment system in October 2000. NAHC has acquired nearly 150,000 filed cost reports to develop this Compendium.

The Compendium is a valuable tool for providers of services, consultants, health policy planners, home care advocates, investors, and trade associations looking to gain an understanding of the financial status of home health agencies. However, it must be understood this tool is not intended to be used to affect the planning and delivery of care to individual patients. It must be further understood that while the methodology used by NAHC to conduct this analysis has been validated the cost report data used is unaudited.

http://hhfma.org/memberresources/
Management Use of Cost Report

- Other sources
  - National data analytics companies
  - Billing companies – check with your vendor
- Access to Cost Reports
  - Local competition – cost reports Freedom of Information Requests
- Good benchmarking is local versus National

Cost Report Compliance
Cost Report Compliance

• Cost Reports are subject to False Claims Act Provisions

Cost Report Compliance

• Compliance

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.
Cost Report Compliance

- Compliance

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF THE PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by (Provider name(s) and number(s)) for the cost reporting period beginning and ending and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Cost Report Compliance

- Compliance

☐ I have read and agree with the above certification statement. I certify that I transmit my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)

Chief Financial Officer or Administrator

Title

Date
Cost Report Compliance

- PPS Rebasing in CY 2014 – many problems with cost reports
- Why Now? – CMS 6.42 % behavioral adjustment factor
- Cost Report Audits
  - Verify integrity of cost report data and assess validity of trimming method
  - MAC were to audit 100 HH cost reports from 2010
  - CR’s with 95 or fewer episodes were excluded
  - MAC completed 98 audits (2 providers did not provider requested info)

Cost Report Compliance

- Cost Report Audits (Continued)
  - Majority of cost reports overstated cost by 8%
  - Non allowable costs
  - Insufficient documentation to justify allowable costs
  - 8 HHA’s referred to ZPIC Contractor for further fraud investigation
Cost Report Compliance

• Cost Report Audits (Continued)
  o The trimmed sample resulted in slightly higher than average cost per episode when compared to the pre-audit sample
  o Pre-audit to Post–audit results
    ▪ 8% to 9% average reduction in cost per visit for all disciplines except MSW (5% reduction)
    ▪ Cost per episode reduced by 7.8%

Cost Report Compliance

• Rebasing of Standard Rate
  o FY 2011 cost report data as of 12/31/2012
  o 10,327 total cost reports in the sample
  o 6,252 cost reports were used (4,075 not used)
  o Cost reports with missing, incomplete or questionable data were trimmed out (2 tier process)
Cost Report Compliance

• Rebasing of Standard Rate (Continued)
  o Tier 1 – large year-to-year discrepancies or questionable data
    ▪ 2,519 cost reports eliminated
    ▪ 2,348 missing episode counts
    ▪ 1,629 missing data on total costs or payments
    ▪ 171 significant episode variances

Cost Report Compliance

• Rebasing of Standard Rate (Continued)
  o Tier 2 – cross sectional trims
    ▪ 1,556 cost reports eliminated
    ▪ Cost reports not settled (freestanding only)
    ▪ Missing visits when costs are reported or vice versa
    ▪ <10 or >14 months in the cost report
    ▪ Top and bottom 1% of costs / episodes
Cost Report Compliance

• Cost Report Problem – Non Routine Medical Supplies
  o 1,756 cost reports had charges for non routine medical supplies on claims (PSR) but listed $-0- on the cost report
  o Some hospital based agencies do not properly report cost and charges for non routine medical supplies on Worksheets H and H-3
  o Worksheet H Total Cost
  o Worksheet H-3  Total Charges and Medicare Charges

Cost Report Compliance

• The Medicare cost report does not generate a financial settlement due to or from the Medicare program except for flu vaccines
• However, the cost report is still subject to False Claims Act provisions
• PPS is a different payment methodology, not a change in reimbursement rules
• Provider Reimbursement Manual (PRM 15-1) – Medicare reimbursement rules
• Provider Reimbursement Manual (PRM 15-2) – cost report instructions – Home Health is Chapter 32
E-Filing cost reports - MCReF

MCReF – E-Filing Medicare Cost Report

- Electronic Cost Report Signature
  - IPPS Hospital Final Rule (August 2, 2017)
  - Effective for cost reporting periods ending on / after 12/31/2017
  - Original ink (“wet”) signature no longer required but still an option
  - Signed by Officer or Administrator (CFO)
  - Can upload scanned signature page or system generated page
  - Submit through MCReF application – log in through EIDM system
MCReF – EIDM

• Approved MCReF E-Filer
  o Must be registered in MCReF application as MCReF filer in EIDM
  o Approved by Security Official
  o Users must be approved annually (SO)
  o Passwords change every 60 days – new format
  o (upper/lower case, numbers and characters)
  o Highly recommend a Backup Security Official – what happens when the SO is gone?

Worksheet S – Certification Page

PART II – CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/or IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/or IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by , (Provider Name(s) and Provider NPI(s)) for the cost reporting period beginning and ending and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I signed my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

OFFICER OR ADMINISTRATOR OF PROVIDER

Signed: ____________________________

Printed Name: ____________________________

Printed: ____________________________

Date: ____________________________

Title: ____________________________
Worksheet S – E-Signed Certification Page

E-signature checkbox checked and typed First and Last Name

[Image of E-Signed Certification Page]

Source: CMS Medicare Learning Network webcast – March 28, 2019

MCReF

[Image of Medicare Cost Report e-Filing System (MCReF)]

Source: CMS Medicare Learning Network webcast – March 28, 2019
**MCReF Usage**

- Since 5/1/2018
  - Over 6,250 successful submissions from over 1,475 distinct users
  - Median Submission time: 3.4 seconds
  - Over 700 providers were able to correct errors with their MCR prior to submission and without the need for correspondence with their MAC, and potentially avoiding the rejection of the MCR
  - Last 3 months: 1/3 of all MCR submissions were e-filed via MCReF (including ½ of all Hospital MCR submissions)
- Source: CMS Medicare Learning Network Webinar – March 28, 2019

**Proposed Cost Report Changes**

- Link to cost report forms and instructions (Chapter 32)
Proposed Changes to the Home Health Medicare Cost Report Forms: CMS Form 1728-19

objectives

• Review proposed changes in Medicare Cost Report form for home health agencies
• Identify changes needed in recordkeeping and data requirements
• Discuss differences in HHA-based Hospice and freestanding Hospice reporting requirements
proposed cost report changes

• Proposed rule issued April 16, 2019
• 60 day comment period – ended June 17, 2019
• After review of comments by CMS and OMB, another 30 day comment period
• Effective for cost reporting periods beginning on / after January 1, 2019 and ending on / after December 31, 2019 – this could be problematic
• Significant more detail reporting of cost and statistics

proposed cost report changes

• Worksheet S, Part I – Cost Report Status
  o Line 3  Amended cost report
  o Line 4  Low or no utilization cost report (prior WS S-2, line 9)
• Worksheet S-2, Part I
  o Eliminated HHA-based CORF, CHMC, RHC and FQHC
  o Can only be HHA-based Hospice
  o Eliminated other questions regarding depreciation expense, lower of cost
    or charge, fragmented admin & general cost allocation method
proposed cost report changes

- Does HHA receive an allocation of costs from more than one home office?
- What is a home office?
  - Chain organization of two or more health care facilities owned or controlled (PRM 15-1, section 2150)
  - May include non health care organizations

proposed cost report changes

- Home Office cost reports are required to be submitted
  - CMS Form 287-05
- If home office cost report not filed, home office costs disallowed
- What if home office does not have a home office provider #?
- Federal Register – August 17, 2018, page 41684-41686
- Worksheet S-2, II, Line 3 – related party
proposed cost report changes

- Worksheet S-3, Part I – Census Statistics
- Medicaid visit / patient statistics separately identified – previously included with “Other”
- Segregation of visits statistics by discipline – does billing system do this?
  - Skilled Nursing Care – Separate RN and LPN
  - Physical Therapy – Separate Therapists and Therapy Assistants
  - Occupational Therapy - Separate Therapists and Therapy Assistants
- Visits are reported based on date of service – PPS Episodes in Part IV
- Medicare Advantage and Medicaid Managed Care?

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proposed cost report changes

- What are like kind services? (line 10) PM 97-11.60 (August 1997)
  - Confined to home
  - Under the care of physician
  - Need intermittent skilled nursing, PT, ST or continuing need for OT
  - Under a plan of care
  - Furnished by participating HHA
    - If homebound status not met, can still be like kind
  - If these conditions are not met, then non like kind
proposed cost report changes

- Financial impact of non like kind services?
  - Visit statistics are excluded from like kind (line 10, col 5 and 6)
  - Cost is separately reported in a non reimbursable cost center on Worksheet A
  - The cost per visit for Medicare services excludes cost and services for non like kind
proposed cost report changes

• Worksheet S-3, Part II – FTE’s – no change
• Detail of FTE counts does not match cost
• FTE’s are based on Total Paid Hours divided by 2,080
• New Occupational Wage Data worksheet – S-3, Part V
• Worksheet S-3, Part III – CBSA Areas
  o Still identify number of CBSA’s and list specific codes
  o PS&R does accommodate breakout of Nursing and Therapy visits but not charges
  o Separate “G Codes” for LPN and Therapy Assistants
  o No separate UB04 revenue codes

proposed cost report changes

• Worksheet S-3, Part IV – PPS Episodic Data
  o No instructions on conversion to PDGM
  o Visit statistics detail does not match Part I breakout
    o Nursing, PT & OT
  o PS&R does accommodate breakout of Nursing and Therapy visits but not charges
  o Separate “G Codes” for LPN and Therapy Assistants
  o No separate UB04 revenue codes
proposed cost report changes

Worksheet S-3, Part V – Occupational Wage Data

- Appears to be CMS attempt at Home Health wage index survey
- Wages and fringe benefits costs separately reported for all disciplines to match visit statistics (benefits may be allocated)
  - RN, LPN, PT, PTA, OT, OTA, ST, Aides, Other
- MSW is not listed
- Contract Labor – same reporting of level of detail as wages
- Total Paid Hours related to wage employees and contract labor
  - This includes all paid hours – i.e. PTO, Admin, travel.....
proposed cost report changes

• Worksheet S-3, Part V – Occupational Wage Data – Concerns
  o FTE’s still reported on Worksheet S-3, II – data is not reliable
  o What to do if you don’t have total paid hours?
  o Compensation method – pay per visit
  o Old AHSEA guidelines used 1.0 hour per visit for contractor with no hours
  o Does not address employees
  o Length of time per visit is probably less
proposed cost report changes

• Worksheet S-4, HHA Based Hospice Census Data (Prior WS S-5)
• No real changes
  o Unduplicated days by level of care and payor
  o Payor Medicare, Medicaid and Other
  o Medicare / Medicaid Dual eligible – Medicare
  o Contracted Inpatient Days (Part II) – subset of Part I

proposed cost report changes

• Worksheet A – Trial Balance of Expenses - by type (no change)
  o Column 1 – Salaries
  o Column 2 – Employee Benefits
  o Column 3 – Transportation
  o Column 4 – Contracted Purchased Services
  o Column 5 – Other Costs
  o Column 6 – Total Costs (agree to financial statements)
proposed cost report changes

• Worksheet A – Trial Balance of Expenses – more detail
  o Line 4 – Transportation (line 4 vs. column 3)
  o Line 5 – Remote Patient Monitoring
  o Line 16 – Skilled Nursing Care – RN
  o Line 17 – Skilled Nursing Care – LPN
  o Line 18 – Physical Therapy
  o Line 18 – Physical Therapy Assistant
  o Line 20 – Occupational Therapy
  o Line 21 – Occupational Therapy Assistant

proposed cost report changes

• Worksheet A – Trial Balance of Expenses
  o Line 25 – Medical Supplies – Billable / non routine medical supplies only
    o Non billable routine supplies (Admin & General)
  o Line 26 – Drugs – vaccine supply cost (#636)
  o Line 27 – Cost of administering vaccines – OPPS fee schedule (#771)
  o Line 29 – Disposable Devices
  o Line 30 – Telehealth – Remote patient monitoring is not telehealth (line 5)
    o This should really be in the non reimbursable section (below line 31)
**proposed cost report changes**

### Worksheet A

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEPARTMENT COST CENTER</strong></td>
<td><strong>SALARIES</strong></td>
<td><strong>SALARY DISCOUNTS</strong></td>
<td><strong>TRANSPORTATION</strong></td>
<td><strong>TOTAL PURCHASED SERVICES</strong></td>
<td><strong>OTHER COSTS</strong></td>
</tr>
<tr>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

- **Worksheet A-6 – Reclassifications**
  - Prior Worksheet A-4
  - Now separately report “salary” and “other” amounts
- **Worksheet A-8 – Adjustments**
  - Prior Worksheet A-5
- **Worksheet A-8-1 – Related Party**
  - Prior Worksheet A-6
- **Worksheet A-7 – Capital Asset Balances – no change**
proposed cost report changes

• Worksheet A-8
  o Home Office now flows from WS A-8-1, rather than line 4
  o Advertising Costs – non allowable portion
    ▪ Separate line for offset on WS A-8, line 11
    ▪ Hospice CR – WS O, line 67 – NRCC
    ▪ HHA based Hospice – offset or NRCC?
    ▪ Dilutes cost for HHA based Hospice

proposed cost report changes

• Worksheet B-1 Statistics
  o CRC – Bldg Square footage
  o CRC – MME Square footage / $ Value
  o Plant Operation & Maint Square footage
  o Transportation Mileage
  o Remote Patient Monitoring Time Spent
  o Administration & General Accumulated costs
    ▪ Do not have to allocate A&G to inpatient / contracted costs
proposed cost report changes

• Worksheet B-1 – Remote Patient Monitoring
  o Allocation statistics – time spent (cost report instructions)
  o What does this mean?
  o Alternative basis?

proposed cost report changes

• Worksheet C
  o Medicare visits are broken down as follows:
    o RN / LPN, Therapists and Therapy Assistants
  o Medicare visits no longer identified by CBSA code
  o Medical Supplies
  o Vaccines supply cost
  o Disposable devices
• Outpatient Therapy visits – Part III
proposed cost report changes

- Worksheet D
  - Part I – vaccines only
    - No separate columns for Part A and Part B
    - Subject to deductible & coinsurance – Osteoporosis drugs
  - Part II – Reimbursement Settlement
    - PPS Payments by episode type
    - Allowable bad debts (Osteoporosis drugs) – future?
- Worksheet D-1 – Total Medicare Payments – no change

proposed cost report changes

- Worksheet F – Balance Sheet – eliminated “Fund” columns
- Worksheet F-1 – Statement of Revenue and Expenses
  - Line 1 - Gross patient revenue now separately identified
    - Medicare – Title XVIII
    - Medicaid – Title XIX
    - Other
  - Line 2 – Allowances and discounts - aggregate
- Worksheet F-2 – Statement of changes in fund balance / equity
  - Worksheet eliminated – this is a helpful worksheet
proposed cost report changes

• HHA Based Hospice – Worksheet “O” Series
  o Appears that the existing “O” forms have been inserted – no real change
  o Does not take into account changes to the Freestanding CMS Form – 1984-14
  o Inconsistencies from Worksheet A to Worksheet O
    ▪ Medical Records
    ▪ Nursing Administration
    ▪ Volunteer Service Coordination
    ▪ Fundraising
    ▪ Thrift Store

• HHA Based Hospice – Worksheet O Series
  o Worksheet A – direct cost (HHA – WS A, line 57)
    ▪ Combine overhead with HHA
  o Worksheet B and B-1 – HHA overhead allocation to Hospice
  o Worksheet A flows to Worksheets O, O-1, O-2, O-3, and O-4 in detail
  o Cost must be reported by level of care
    ▪ Continuous Home Care (O-1)
    ▪ Routine Home Care (O-2)
    ▪ Inpatient Respite Care (O-3)
    ▪ General Inpatient Care (O-4)
proposed cost report changes

• HHA Based Hospice – Worksheet O Series
  o General Service Cost Centers (Overhead) – lines 1 to 16
  o Direct Patient Care Service Cost Centers – lines 25 to 46
    ▪ Worksheets O-1, O-2, O-3 and O-4 (flows to WS O)
  o Non Reimbursable Cost Centers – lines 60 to 71
  o All cost centers are reported as Salary (column 1) and Other (column 2) – segregated on trial balance

• HHA Based Hospice – Worksheet O Series
  o Worksheet O-5 – HHA overhead cost allocation to Hospice – flows to Worksheet O-6
  o Worksheet O-6 – Hospice overhead cost allocation
  o Part II stats must agree to WS B-1 – many new Hospice overhead cost centers
  o Worksheet O-8 – cost per day by level of care
    ▪ Be careful with Continuous Home Care
    ▪ Compare to payment rates
proposed cost report changes

• HHA Based Hospice – Worksheet O Series
  o DME / Oxygen (line 38) still shaded on IRC and GIP
    ▪ This was opened up on the Form 1984-14
  o No separate cost center for Drugs Charged to Patients (42.50)
  o Advertising costs (line 67) – NRCC or cost offset?

proposed cost report changes

• HHA Based Hospice versus Freestanding Hospice
• Cost Report forms are not consistent
• Level I edits implemented last year to require a balance in certain cost centers in the freestanding hospice form to have cost (T-3)
• These edits do not apply to home health based hospice cost report
• Following edits apply only to freestanding Hospice forms
• Recommend that you review in home health based hospice setting
proposed cost report changes

• Edit 1050A Level I - if expenses are not reported on Worksheet A, column 7 for the following cost centers:
  o Line 1 Capital Related Costs – Building & Fixtures
  o Line 2 Capital Related Costs – Movable Equipment
  o Line 3 Employee Benefits
  o Line 4 Administration & General
  o Line 13 Volunteer Service Coordination

proposed cost report changes

• Edit 1050A Level I - if expenses are not reported on Worksheet A, column 7 for the following cost centers:
  o Line 28 Registered Nurse
  o Line 33 Medical Social Service
  o Line 37 Hospice Aide & Homemaker Services
  o Line 38 Durable Medical Equipment / Oxygen – now inpatient LOC
  o Line 14 Pharmacy
  o Line 42.50 Drugs Sold to Patients (new cost center)
    ▪ Sum of 14 and 42.50 combined
proposed cost report changes

Error rate of Level I edits (CMS Form 1984-14)

TABLE 11—NUMBER AND PERCENTAGE OF FREESTANDING HOSPICE COST REPORTS WITH MISSING INFORMATION IN WORKSHEET A—COLUMN 7—“LEVEL 1 EDITS”

<table>
<thead>
<tr>
<th>Part of the cost report</th>
<th>Line</th>
<th>% missing</th>
<th>N that are missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits</td>
<td>3</td>
<td>13.90</td>
<td>395</td>
</tr>
<tr>
<td>Administrative &amp; General</td>
<td>4</td>
<td>0.29</td>
<td>8</td>
</tr>
<tr>
<td>Plant Operations and Maintenance</td>
<td>5</td>
<td>45.16</td>
<td>1,260</td>
</tr>
<tr>
<td>Volunteer Services Coordination</td>
<td>13</td>
<td>37.71</td>
<td>1,052</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>14</td>
<td>12.47</td>
<td>346</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>28</td>
<td>1.22</td>
<td>34</td>
</tr>
<tr>
<td>Hospice Aids and Homemaker Services</td>
<td>37</td>
<td>2.69</td>
<td>75</td>
</tr>
<tr>
<td>Durable Medical Equipment/Oxygen</td>
<td>38</td>
<td>11.65</td>
<td>325</td>
</tr>
<tr>
<td>Labs Diagnostics</td>
<td>41</td>
<td>22.83</td>
<td>637</td>
</tr>
<tr>
<td>Capital Related Costs—Building and Fixtures</td>
<td>1</td>
<td>17.13</td>
<td>478</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>33</td>
<td>4.37</td>
<td>122</td>
</tr>
<tr>
<td>Missing Any of the Above</td>
<td></td>
<td>65.59</td>
<td>1,830</td>
</tr>
</tbody>
</table>


proposed cost report changes

• What to do Now?
  o Review payroll system for proper tracking and recording of hours and dollars
    ▪ Nursing and therapy assistants
    ▪ Non like kind services
  o Contract services (accounts payable)
    ▪ Make sure outside contractors provide required information on invoices
  o Billing system for breakdown of visit statistics
  o Review and modify financial statement chart of accounts for detailed tracking
proposed cost report changes

- Link to Federal Register Notice

- Link to draft forms and instructions

Questions?

CONTACT
Dave Macke, Shareholder
Director of Reimbursement Services
MBA, CHFP, FHFMA

T  800.887.0437   E  dmacke@vlcpa.com
Data Driven Home Health Management: *Essential Benchmarks for Success*

Tammy Ross, Axxess

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Data Analytics: Road Map to Success

1. **Outcomes**
   - Quality Metrics that Count

2. **Business Development**
   - Know Your Markets

3. **Compliance**
   - Keep Your Revenue

4. **Financial**
   - Key Metrics to monitor on the road to PDGM Success
Learning Objectives

The audience will have an understanding of **Key Quality Metrics** and how to benchmark

The audience will understand how **Operational Key Performance Indicators** relate to business development.

The audience will understand **Key Compliance Metrics** and how to benchmark their agency.

Utilizing **Key Operational Indicators**, the audience will understand success strategies for PPS and PDGM revenue models.

Quality

- **Home Health Compare**
  - [https://www.medicare.gov/homehealthcompare/search.html](https://www.medicare.gov/homehealthcompare/search.html)

We built the **Home Health Compare (HHC)** website on Medicare.gov to help consumers choose a home health care provider. It’s an easy-to-access, convenient, official source of information about provider quality.

Sometimes the information on HHC can seem like “too much of a good thing” to consumers who must make an urgent choice and there’s too much information and too many measures to consider—**STAR Ratings**
Home Health Compare
Quality Measures

- Compare up to 3 agencies at a time
- Compare agencies to National and State
- Graphing
# Star Rating

## Quality
- Timely Initiation of Care (process measure)
- Improvement in Ambulation (outcome measure)
- Improvement in Bed Transferring (outcome measure)
- Improvement in Bathing (outcome measure)
- Improvement in Pain Interfering With Activity (outcome measure)
- Improvement in Shortness of Breath (outcome measure)
- Improvement in Management of Oral Medications (outcome measure)
- Acute Care Hospitalization (claims-based) (outcome measure)

## Patient Satisfaction
- Recommend this agency to friends/ family
- Overall Rating of agency - must be 9 or 10
- Communication among providers
- Specific Care Issues
- Care of Patients

---

## STAR Ratings
- All Medicare-certified HHAs may potentially receive a Quality of Patient Care Star Rating.
- HHAs must have data for at least 20 complete quality episodes for each measure to be reported on HHC.
- Completed episodes are paired start or resumption of care and end of care OASIS assessments.
- Episodes must have an end-of-care date within the 12-month reporting period regardless of start date.
- To have a Quality of Patient Care Star Rating computed, HHAs must have reported data for 5 of the 8 measures used in the Quality of Patient Care Star Ratings calculation.
### Benchmarks For Quality

*Home Health Compare data was last updated on May 17, 2019*

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>National Average</th>
<th>Quality Indicator</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Initiation of Care</td>
<td>94.6%</td>
<td>Wounds improved or healed after an operation</td>
<td>91.2%</td>
</tr>
<tr>
<td>Taught Patients About Their Meds</td>
<td>98.3%</td>
<td>Pts got better at taking their meds.</td>
<td>67.6%</td>
</tr>
<tr>
<td>Checked patients for depression</td>
<td>97.5%</td>
<td>Admitted to the hospital</td>
<td>15.8%</td>
</tr>
<tr>
<td>Determined if patients received a flu shot</td>
<td>78.6%</td>
<td>ER without being admitted</td>
<td>13%</td>
</tr>
<tr>
<td>Ensure pts. have received a pneumococcal vaccine</td>
<td>81.6%</td>
<td>Developed new or worsened pressure ulcers</td>
<td>.4%</td>
</tr>
<tr>
<td>For diabetics gave foot care/ taught foot care</td>
<td>97.8%</td>
<td>Remained in the community after discharge</td>
<td>Not Available</td>
</tr>
<tr>
<td>Patients got better at walking</td>
<td>76.3%</td>
<td>Timely physician recommended actions to address med issues.</td>
<td>92.6%</td>
</tr>
<tr>
<td>Patients got better at getting in and out of bed</td>
<td>75.8%</td>
<td>Improved Breathing</td>
<td>78.4%</td>
</tr>
<tr>
<td>Patients got better at bathing</td>
<td>78.5%</td>
<td>How much Medicare spends on an episode</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Benchmark For Patient Satisfaction HHCAHPS

*Home Health Compare data was last updated on May 17, 2019*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend this agency to friends and family</td>
<td>77%</td>
</tr>
<tr>
<td>Overall Rating of agency 9 or 10 on scale of 1-10</td>
<td>83%</td>
</tr>
<tr>
<td>Communication among providers</td>
<td>85%</td>
</tr>
<tr>
<td>Specific Care Issues/discussed medicines, pain, and home safety with them</td>
<td>83%</td>
</tr>
<tr>
<td>Care of Patients in a professional way</td>
<td>88%</td>
</tr>
<tr>
<td>Star Rating</td>
<td>3.5</td>
</tr>
</tbody>
</table>
CASPER Reports /OBQI


CASPER Reporting Quality Metrics

- OASIS Data Driven
- National Data Bank for all certified agencies
- Data is Risk-Adjusted
- Delays in Reporting
CASPER Reporting Potentially Avoidable Events

- Prioritize the potentially avoidable event outcomes to investigate first
- Identify the care provided to patients in tabular Potentially Avoidable Events Report
- Select instance of problematic care provision
- Review clinical records for the selected cases
- Develop and implement Improvement Plan

States Currently Participating in VBP

- Massachusetts
- Maryland
- North Carolina
- Florida
- Washington
- Arizona
- Iowa
- Nebraska
- Tennessee

<table>
<thead>
<tr>
<th>Year</th>
<th>Reward/Penalty Imposed</th>
<th>Max Reward/Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2018</td>
<td>3%</td>
</tr>
<tr>
<td>2017</td>
<td>2019</td>
<td>5%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>6%</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
<td>7%</td>
</tr>
<tr>
<td>2020</td>
<td>2022</td>
<td>8%</td>
</tr>
</tbody>
</table>
Compliance Monitoring / PEPPER Reports

• The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a Microsoft Excel file summarizing provider-specific Medicare data statistics for target areas often associated with Medicare improper payments due to billing, HHRG, coding and/or admission necessity issues. Target areas are determined by CMS
• 2015 Developed for Home Health Agencies

Use PEPPER to:
• Identify areas of potential overpayments and underpayments
• Compare length of stay data
• Assess Medicare reimbursement for target areas, track and trend over time

Percent of Agencies that Access Report
PEPPER Report Target Areas

<table>
<thead>
<tr>
<th>TARGET AREA</th>
<th>SUGGESTED INTERVENTIONS FOR HHA AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Case Mix (Case Mix)</td>
<td>This could indicate a risk of potential overcoding of beneficiaries’ clinical and functional status. The HHA should determine whether beneficiaries’ clinical and functional status as reported on the OASIS is supported and consistent with medical record documentation.</td>
</tr>
<tr>
<td>Average Number of Episodes (Nbr Episodes)</td>
<td>This could indicate that the HHA is continuing treatment beyond the point where services are necessary. The HHA should review documentation for beneficiaries with a high number of episodes to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, such services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries’ condition.</td>
</tr>
</tbody>
</table>

PEPPER Report Target Areas

<table>
<thead>
<tr>
<th>TARGET AREA</th>
<th>SUGGESTED INTERVENTIONS FOR HHA AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80TH PERCENTILE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with 5 or 6 Visits (5 or 6 visits)</td>
<td>This could indicate that the HHA is considering the minimum number of visits (5) to obtain an HHRS payment instead of a LUPA payment when there are less than 5 visits. The HHA should review documentation for episodes with 5 or 6 visits to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, such services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries’ condition.</td>
</tr>
<tr>
<td>Non-LUPA Payments (Non-LUPA)</td>
<td>This could indicate that the HHA is considering the minimum number of visits (5) to obtain an HHRS payment instead of a LUPA payment where there are less than 5 visits. The HHA should review documentation to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. If the individualized assessment of the patient does not demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, such services are not covered under the home health benefit. The HHA should review plans of care to ensure they are individualized and appropriate for the beneficiaries’ condition.</td>
</tr>
</tbody>
</table>
PEPPER Report Target Areas

How to Access the PEPPER Report
https://pepper.cbrpepper.org/About-PEPPER/Distribution-Schedule-Get-Your-PEPPER
Key Performance Metrics for Business Development

- Census
- Referrals
- Census by Payor Source
- Referrals by Source
- Referrals by Specialty
- Pendings
- Non-Admits

96% of Non-Admits Potentially Avoidable
Financial Benchmarks

Key Performance Indicators

- Census
- Gross Margin
- Productivity
- Staffing Optimization
- Visit Utilization
- Patient to Clinician Ratio
- Supply Cost
- Mileage
- Salary/Staffing Models
- Case Mix/Payment
- Length of Stays
- LUPA
- Days to RAPs
- Days to Finals

Run Rate To Budget

Budget
Productivity and Staffing

Visits Per Day

Case Management

Number of Patients in Typical Caseload
Staff Manages at a Given Time

<table>
<thead>
<tr>
<th>Caseload</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 or less</td>
<td>25.1%</td>
</tr>
<tr>
<td>20-25</td>
<td>36.0%</td>
</tr>
<tr>
<td>26-30</td>
<td>18.3%</td>
</tr>
<tr>
<td>More than 30</td>
<td>20.7%</td>
</tr>
</tbody>
</table>
Increased Productivity

- Non-Visit Time
- Geo-Mapping
- Incentive Bonus
- In-home Documentation
- Streamline Operations
- One Source Documentation
- Integrations

Agencies That Plan to Change Productivity Standards

- 305
- 95

Source: Agencies’ plans to change/adapt roles to achieve productivity under PDGM

Turnover Cost

The average cost of turnover for a nurse ranges from $37,700 to $58,400*

*2016 National Healthcare Retention & RN Staffing Report
Average Payment Rates

Home Health Prospective Payment System (HHPPS)
- $3,154: National standard 60-day episode payment rate
- $15 – $570: Non-routine supply (NRS) payment add-on per 60-day episode based on OASIS responses
- Average Case Mix: 1.0384 (Fazzi data 2016)

Patient-Driven Groupings Model (PDGM)
- $1,753.68 estimated proposed national 30-day period payment rate
- NRS is built into payment rate
- Actual rate will be set in 2020 payment final rule

FMC 19 Operations Dashboard
Average Revenue per Episode

Average PPS Revenue Per Episode $3154
Visit Utilization

Mean Visits & Resource Use in each 15 Day Segment of a (Full) and First 60-Day Episode among CY 2016 Episodes; n=856,014

<table>
<thead>
<tr>
<th>Days 1-15</th>
<th>Days 16-30</th>
<th>Days 31-45</th>
<th>Days 46-60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Visits</td>
<td>8.1</td>
<td>6.4</td>
<td>5.1</td>
</tr>
<tr>
<td>SN Visits</td>
<td>3.9</td>
<td>2.5</td>
<td>2.2</td>
</tr>
<tr>
<td>PT Visits</td>
<td>2.6</td>
<td>2.4</td>
<td>1.7</td>
</tr>
<tr>
<td>OT Visits</td>
<td>0.8</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>SLP Visits</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Aide Visits</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>MSS Visits</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Resource Use: $328.99 $233.01 $184.52 $171.60

LUPA Threshold: 8.0 National Average %

<table>
<thead>
<tr>
<th>LUPA Threshold</th>
<th>HHRGs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Visits</td>
<td>94</td>
<td>22%</td>
</tr>
<tr>
<td>3 Visits</td>
<td>128</td>
<td>30%</td>
</tr>
<tr>
<td>4 Visits</td>
<td>137</td>
<td>32%</td>
</tr>
<tr>
<td>5 Visits</td>
<td>63</td>
<td>15%</td>
</tr>
<tr>
<td>6 Visits</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>432</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LUPA Threshold</th>
<th>Early</th>
<th>%</th>
<th>Late</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Visits</td>
<td>6</td>
<td>6%</td>
<td>88</td>
<td>94%</td>
</tr>
<tr>
<td>3 Visits</td>
<td>33</td>
<td>26%</td>
<td>95</td>
<td>74%</td>
</tr>
<tr>
<td>4 Visits</td>
<td>105</td>
<td>77%</td>
<td>32</td>
<td>23%</td>
</tr>
<tr>
<td>5 Visits</td>
<td>62</td>
<td>98%</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>6 Visits</td>
<td>10</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

2019 LUPA Rates
- Home health aide: $66.34
- Medical social worker: $234.82
- Occupational therapy: $161.24
- Physical therapy: $160.14
- Skilled nursing: $146.50
- Speech therapy: $174.06

$1,753.68 30-day visit rate without LUPA

Four nurse visits in first 30 days

$586.00

TOTAL REVENUE LOSS

$1,167.68
Benchmark for RAP: 7-10 days

Benchmark for Final: 10-15 days
Summary: Benchmarks For Success

Quality

Financial

Success

Compliance

Sales

?
Grow Your Agency Organically & Maintaining Compliance
Liz Zink-Pearson, Esq.
Pearson & Bernard PSC.

Growing Your Agency: Introduction

• It’s Critical!
  • Consensus that more & more health care moving to home
    • Cost difference is huge!
    • Patients preference
  • Need to be able to service more patients’ health care needs
  • Becoming a bigger player – the Go-To Agency
  • Expand by service line and/or geography

• How?
  • New clinical programs
  • Increased service area
  • Innovative technology
  • Enlarge service area
Growing Your Agency – Planning for Growth

• Organic growth vs. Acquisition (inorganic)
  • Expansion of your services builds on your quality & compliance vs. acquiring someone else’s;
  • Acquisition by asset purchase can place you on Enhanced Scrutiny per CMS because it’s a new provider agreement; and
    • Enhanced Scrutiny – intended to address fraud, waste & abuse and is not well-defined by CMS but new HHA’s will have RAP payments suppressed & likely could face pre-pay audits.
  • Become known as an innovator

• Strategic planning for growth
  • Internal planning with staff on unmet needs and enhanced services;
  • Build on what you do best; and
  • Assure you have qualified employees to staff the new program/service area

Growing Your Agency- Planning

• Strategic Planning – Where to start
  • Educate yourself on areas (clinically & geographically) of unmet needs and where possible innovative services can enhance patient care;
  • Stay on top of industry trends & new technology that shows promise to enhance patient care;
  • Emphasis on cost-savings, efficiency & outcomes for payers;
  • Review holes in the care continuum; and
  • Discussions with referral sources.

• Importance of Staff Input
  • You staff are eyes & ears in the community;
    • See needs in the home
  • Identify staff with specific strengths; and
  • Get their buy-in
Growing your Agency - Geographically

• Geographic Expansion
  • Medicare rule: HHA can reasonably oversee/supervise service in expanded service area
  • State licensing rules vary:
    • Some give specific distances – CA. sets at 4 hr drive time.
    • Others: rule is unstated but generally applied.
    • No licensing: some have a benchmark like Ohio = 3 counties in any direction from main office
    • Statewide service area not likely but has happened.

Growing your Agency – Geographically

• Service area should include full expanse permitted by State licensing laws
  • CMS & States don’t police & gives you opportunity if referral comes your way
• Don’t avoid rural areas
  • Many rural hospital closings around country & people are forced to go to city hospitals
  • Few if any specialists in rural areas
• Consider unique issues in a specific area.
  • High crime areas
  • Travel costs
• Market your expansion so referral sources know.
Growing your Agency –
When to Branch

- Considerations for Opening a Branch
  - Must be in your identified service area;
  - Established patient census to support cost;
  - Competition in area;
  - Must be able to access staff both clerical & clinical;
  - Provides a community footprint;
  - Grows your brand;
  - Must be evidence of supervision from parent/Surveyors can survey;
    - DON/Clinical Manager supervision
  - Branch vs. dropsite/workstation
    - No signage at workstations
    - No records stored at workstations

Growing Your Agency:
Branch Requirements

- States Survey Agencies—license or not – require a branch application
  - CMS requirement
  - Generally quite detailed including estimates of staffing
- CMS 855A must be filed with MAC
- CMS Approval
- Gets its own PTAN
  - To be used in billing
Growing your Agency: Clinical Programs

• Plug holes in care continuum
  • Your clinicians can offer insight
  • Review and evaluate reasons for hospital readmission
  • Programs to coordinate with referral sources

• Establish programs/services that improve patient access
  • Outpatient services in the home – OPT & more
  • More federal money going to States to increase home & community-based care
  • Target specific patient populations with chronic diseases

• Utilize new technology to enhance outcomes
  • Telemonitoring – it’s time for certain patients!
  • Smart technology

Growing your Agency – Clinical Programs

• Holes in Care Continuum
  • Your clinicians have experienced patients who need more/different care than normal home health skilled care provides
    • Usually involve social determinates of health
    • Many with behavioral health issues and/or lack of caregiver network
  • Patients with complex care needs – multiple chronic conditions
    • Medication management huge!
    • Higher risk for readmissions
  • Pain management – palliative care
Growing Your Agency-Clinical Programs

• Plugging Holes in Care Continuum
  • Must meet or overcome homebound requirement for Medicare
    • Private pay or insurance coverage
  • Understand Social Determinants of Health (SDoH)
    • [https://www.cdc.gov/socialdeterminants/index.htm](https://www.cdc.gov/socialdeterminants/index.htm)
  • Many State Medicaid programs adopting palliative care programs – no homebound requirement for Medicaid
    • 27 states
    • Saving them as much as $7,000 per patient
  • Wound care program & train or get wound care specialists
  • Learn about new programs for referral sources
    • Primary Care Initiative

Growing your Agency-Clinical Programs

• Primary Care Initiative
  • Risk based payment program to begin in January 2020
  • Both target chronic disease patients
  • Home health for disease management
• Cardiac Rehab
  • Studies show that <20% cardiac patients receive rehab following hospitalization due to lack of referral or access
  • Improves recovery/reduces readmissions
  • Can be done in home or as OPT in home vs hospital cardiac rehab
  • [https://journals.lww.com/jcrjournal/Fulltext/2017/11000/Developing_an_Adapted_Cardiac_Rehabilitation.4.aspx](https://journals.lww.com/jcrjournal/Fulltext/2017/11000/Developing_an_Adapted_Cardiac_Rehabilitation.4.aspx)
• Other science/evidence-based programs
  • Educate yourself as much as possible
Growing your Agency

• Programs to Increase Patient Access – Outpatient services in home
  • Cardiac Rehab
    • Most patients homebound following discharge
  • Outpatient physical therapy
    • Permitted under home health COP’s – 42 CFR 484.105(g)
    • Bill under different bill type using CPT codes for therapy services
    • Extends home health services beyond homebound requirement
  • Wellness Services at ALF’S or CCRC’s
    • Provide education and wellness checks for residents
    • Facility staff education
    • Paid by ALF or resident
    • Activities too!
    • See: Attachment

Growing your Agency: Clinical Programs

• Home & Community Based Care Programs
  • ACA funded states additional monies to establish or grow HCBS
  • Available to persons who otherwise would need SNF level care
  • Medicaid waiver program – so not as strict income requirements
  • Patients/consumers with illnesses, many chronic, that diminish their ability to perform ADL’s
  • Usually dual eligibles
Growing your Agency: Clinical Programs

- Programs Using New Technology – Improve Outcomes/Reduce Costs/Visits
  - Telemonitoring in home for variety of patients
    - CHF & other patients who need vitals monitored
    - Reduce # of visits needed
    - Catch symptoms/issues quicker
  - Improved Wound Care outcomes- AccentCare – used telemonitoring that allowed aides to consult with wound care specialists
- Smart technology
  - New options everyday to assist with monitoring patients’ conditions

Growing your Agency – Process & Marketing your New Programs

- Process:
  - Strategize roll-out: start slow to identify utilization;
  - Train staff;
  - Monitor – gather data on acceptance & outcomes;
  - Watch costs vs. referrals;
  - Alter program as necessary to improve efficiencies & outcomes

- Marketing
  - Train marketers on program specifics
  - Prepare a script/brochure explaining program and update with results/outcomes
  - Monitor marketers sale of program
    - Make sure they are not promising more that you can provide
Growing your Agency – Staying Compliant

• However your plan to grow – must stay compliant with all laws & regulations

• For geographic growth:
  • Assure compliance with license service area rules
  • Assure supervision of services

• For Clinical programs:
  • Compliance with Anti-kickback Act: forbids providing anything of value (money or services) to anyone for a referral
  • Compliance with Stark II – Forbids a physician with a financial relationship with HHA to refer patients unless protected by safe harbor contract
  • Compliance with HIPAA Anti-inducement – forbids offering items of value (> $15 per item/$75 over a year) to induce a patient to obtain HHA services.

Growing your Agency- Staying Compliant

• New Program Services
  • Make sure all services are either reimbursed by payer or by referral source or patient
  • Safe Harbor contract for services provided directly to referral source
    • Must be for legitimate services
    • Payment rates cannot be based on volume or value of referrals
    • Payment rates FMV
Growing your Agency – Conclusion

• Summary:
  • You must grow to remain competitive and active in your community;
  • Organic growth most important;
  • Take advantage of your State’s permitted service area; don’t leave money on the table because you didn’t claim your full-service area when a referral comes in;
  • You must advance/grow clinically to remain impactful for your patients and referral sources
    • Take it slow at first
  • Utilize technology in most cost & outcome effective ways
  • Let your community know of your successes

Growing your Agency – Thank you! And Your Questions

• Thank you for your attention!
• Now: questions?
• Later: liz@pblaw.org

• Please Note: This presentation was intended to provide education and was not intended to provide specific legal opinions on the matters discussed. In all cases, counsel should be consulted on individual legal questions
PDGM Introduction
Compliance Risks
Melinda A. Gaboury, Healthcare Provider Solutions, Inc.

Patient Driven Groupings Model (PDGM)

- Proposed originally 2017 - Proposed under new title 2018
- Budget Neutral transition
- Behavioral Adjustments (6.42%)
  - Diagnosis coding, Comorbidities, LUPA avoidance
- $1753.68 “unit of payment” ($1607 w/HHGM)
- LUPA: 2-6 visits @ 10th percentile value of total visits in payment group
- Outlier based on 30 day unit of payment
- PEP adjustments will be based on 30 day periods
- Therapy Thresholds are NO MORE
Patient Driven Groupings Model (PDGM)

- **432 payment groups** – increased from 216 groups
- Episode timing: “early” or “late”
- Admission source: Community or Institutional
- Clinical grouping: **12 sub-groups** (primary diagnosis)
- Functional level: 3 groups – Low, Medium or High
- Comorbidity adjustment: None, Low or High (secondary diagnoses)

Patient Driven Groupings Model (PDGM)

- PDGM makes no changes to the 60-day clinical episode certification
  - SOC/Recert (Follow-Up)
  - 60-day Plan of Care
  - Recertification visit within the last 5 days prior to the beginning of the Recertification Episode
  - Face to Face Requirements remain
Patient Driven Groupings Model (PDGM)

• Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)
  • Only the first 30-day period will be considered Early and all others late. Similar to the current PPS model, the payment period could only be considered Early if greater than 60 days has passed since the end of a previous period of care.
  • IMPORTANT: However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall; a follow-up assessment would be submitted at the start of a second 30-day period to reflect any changes in the patient’s condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly.

Patient Driven Groupings Model (PDGM)

Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)

• Admission Source will be Community or Institutional – depending on the healthcare setting utilized in the 14 days prior to home health (inpatient acute care hospitalization, skilled nursing facilities, inpatient rehabilitation facility, psychiatric or long term care hospital)

• IMPORTANT: A post-acute stay (SNF, Rehab, LTCH, or Psych) in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay
Patient Driven Groupings Model (PDGM)

Clinical Grouping (Primary Diagnosis) –

NEW - - Medication Management, Teaching and Assessment (MMTA)
• MMTA – Surgical Aftercare
• MMTA – Cardiac/Circulatory
• MMTA – Endocrine
• MMTA – GI/GU
• MMTA – Infectious & Blood-forming Diseases/Neoplasms
• MMTA – Respiratory
• MMTA – Other

Patient Driven Groupings Model (PDGM)

Clinical Grouping (Primary Diagnosis) –

• Neuro Rehab,
• Wounds,
• Complex Nursing Interventions,
• Musculoskeletal (MS) Rehab,
• Behavioral Health
Patient Driven Groupings Model (PDGM)

• Functional Level (OASIS Items) – (Low, Medium, High)
  • Anticipates roughly 33% of periods of care will fall into each of the categories.
  • M1800-M1860 and M1033 are OASIS-D (D1) Items proposed for use in determining Functional Level under HHGM.

Patient Driven Groupings Model (PDGM)

• No comorbidity adjustment
• Low comorbidity adjustment: There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups associated with higher resource use, or;
• High comorbidity adjustment: There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.
CMS Targeted Probe & Educate

- CMS expansion on Probe & Educate is for Home Health and Hospice and will be effective 10/1/2017. This is referred to as Targeted Probe & Educate (TPE). This review will include targeted medical review and education along with an option for potential elevated action, up to and including referral to other Medicare contractors including the Zone Program Integrity Contractor (ZPIC), Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC), etc.
- The goal of TPE is to reduce/prevent improper payments. The purpose of this expansion is to reduce appeals, decrease provider burden, and improve the medical review and education process.

CMS Targeted Probe & Educate

- All MAC medical record reviews are replaced with three rounds of pre-payment or post-payment TPE. If the provider's error rate remains high upon completion of the first round, then the provider is retained for the second and, potentially, a third round of review.
- Providers with a continued high error rate after three rounds of TPE will be referred to CMS for additional action.
- **MAC will select the topics for review based upon existing data analysis procedures.**
- The claim sample size for each round of probe review is limited to a minimum of 20 and a maximum of 40 claims.
- TPE processes include provider specific education that will focus on improving specific issues without allowing other problems to develop along with an opportunity for the provider to ask questions. Education will be offered after each round of 20 to 40 claims reviewed.
**CMS Targeted Probe & Educate**

- **RECEIPT OF DOCUMENTATION** – When your documentation has been received the claim is moved from status/location S B6001 to S M50MR for review. Providers can monitor the S M50MR status/location in FISS, to verify that their documentation has been received. Confirmation of receipt is also provided when using to submit your documentation.

- **REVIEW OF DOCUMENTATION** – A nurse reviewer will examine the medical records submitted to ensure the technical components (OASIS, certifications, election statement, etc.) are met, and that medical necessity is supported. MAC has 30 days from the date the documentation is received to review the documentation, and make a payment determination. For demand denials (condition code 20), MAC has 60 days from the date the documentation is received to review the documentation.
Results from CGS – completed thru 03/31/18

Home Health Review Decisions by State

Home Health Risk Category
Risk Category is defined based on end of round provider error rate. The categories are defined as:

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>0-25%</td>
</tr>
<tr>
<td>Moderate</td>
<td>26-50%</td>
</tr>
<tr>
<td>Significant</td>
<td>51-100%</td>
</tr>
</tbody>
</table>

Home Health Risk Category

- Minor: 47%
- Moderate: 33%
- Significant: 20%
Top Denial Reasons

1. Face-to-Face missing/incomplete/untimely
2. Therapy visits not medically necessary
3. Initial certification invalid
4. Skilled nursing not medically necessary
5. Plan of care missing/invalid

- **FTF Documentation Denials** accounted for approximately 30% of the total Targeted Probe and Educate denials.
  - Actual FTF encounter document not submitted
  - Certifying physician did not document the date of the FTF encounter
  - CGS Home Health Physician Certification Web page
  - Community physician was not identified when a physician who would not be following the patient after discharge signed the certification
  - Required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification

Refer to the CGS Home Health Coverage Guidelines Web page for a variety of resources on the home health FTF encounter.

- **Documentation did not support medical necessity of therapy services** accounted for approximately 18% of the total Targeted Probe and Educate denials.

Refer to the CGS Physical Therapy Web page for documentation tips, access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7) therapy information and the Local Coverage Determination for physical therapy services.

---

Top Denial Reasons

- **Initial certification invalid** accounted for approximately 6% of the total Targeted Probe and Educate denials.

Refer to the CGS Home Health Physician Certification Web page for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).

- **Skilled nursing not medically necessary** accounted for approximately 6% of the total Targeted Probe and Educate denials.

Refer to the CGS Skilled Nursing in Homecare Web page for documentation tips, access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).

- **Plan of care missing/invalid** accounted for approximately 5% of the total Targeted Probe and Educate denials.

Refer to the CGS Physician Orders, Plan of Care and Certification and Home Health Missing/Incomplete/Untimely Plan of Care or Certification (PDF) Web pages for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).
Questions & Contact Information

Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc.
810 Royal Parkway, Suite 200
Nashville, TN 37214
615-399-7499 Phone
info@healthcareprovidersolutions.com
www.targetedprobeandeducate.com

Current Home Health Issues:
Medicare Advantage & Medicaid
Thomas Boyd, Simione Consultants
What are Medicare Advantage Plans?

A Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you’ll still have Medicare but you’ll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. In most cases, you’ll need to use health care providers who participate in the plan’s network coverage. Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your Medicare card in a safe place because you’ll need it if you ever switch back to Original Medicare.
What are the different types of Medicare advantage Plans?

<table>
<thead>
<tr>
<th>Health Maintenance Organization (HMO) Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider Organization (PPO) Plans</td>
</tr>
<tr>
<td>Private Fee-for Service (PFFS) Plans</td>
</tr>
<tr>
<td>Special Needs Plans (SNPs)</td>
</tr>
<tr>
<td><strong>HMO Point-of-Service (HMOPOS) Plans:</strong> These are HMO plans that may allow you to get some service out-of-network for a higher copayment or coinsurance.</td>
</tr>
<tr>
<td><strong>Medical Savings Account (MSA) Plans:</strong> These plans combine high-deductible health plan with a bank account that the plan selects. The plan deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. MSA Plans don’t offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug Plan. For more information on MSA Plans, visit Medicare.gov. To find out if an MSA Plan is available in your area, visit Medicare.gov/find-a-plan</td>
</tr>
</tbody>
</table>

MA Plan Enrollment Continued to Grow Faster Than Total Medicare Beneficiary Growth in 2018 (MedPAC March 2019)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>2018 MA Enrollment As A Share of Total Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>18.9</td>
</tr>
<tr>
<td>Plan Type</td>
<td>18.7</td>
</tr>
<tr>
<td>CCP</td>
<td>12.2</td>
</tr>
<tr>
<td>HMO</td>
<td>5.1</td>
</tr>
<tr>
<td>Local PPO</td>
<td>1.4</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>0.2</td>
</tr>
<tr>
<td>PFFS</td>
<td>2.5</td>
</tr>
<tr>
<td>SNPs*</td>
<td>3.7</td>
</tr>
<tr>
<td>Employer group*</td>
<td>2.5</td>
</tr>
<tr>
<td>Urban/Rural</td>
<td>16.3</td>
</tr>
<tr>
<td>Urban</td>
<td>2.5</td>
</tr>
<tr>
<td>Rural</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Restricted availability plans included in totals above
## Projected Benchmarks, Bids, and Payments as a Share of Fee-For-Service Expenditures for 2019, by Plan Type

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Share of FFS Spending in 2019</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benchmarks</td>
<td>Bids</td>
<td>Payments</td>
</tr>
<tr>
<td>All MA Plans</td>
<td>107%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>HMO</td>
<td>107</td>
<td>88</td>
<td>100</td>
</tr>
<tr>
<td>Local PPO</td>
<td>109</td>
<td>96</td>
<td>104</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>105</td>
<td>91</td>
<td>97</td>
</tr>
<tr>
<td>PFFS</td>
<td>107</td>
<td>104</td>
<td>106</td>
</tr>
</tbody>
</table>

Restricted availability plans included in totals above

SNP

106 91 100

MedPAC March 2019

## Share of Medicare Advantage Enrollment by Parent Organization, October 2018 (MedPAC March 2019)

### Metropolitan Areas

<table>
<thead>
<tr>
<th>Parent Organization</th>
<th>Share of Total MA Enrollment in Metropolitan Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealth Group, Inc.</td>
<td>26%</td>
</tr>
<tr>
<td>Humana, Inc.</td>
<td>16</td>
</tr>
<tr>
<td>Aetna, Inc.</td>
<td>9</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc.</td>
<td>8</td>
</tr>
<tr>
<td>Anthem, Inc.</td>
<td>4</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
<td>3</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of Michigan</td>
<td>2</td>
</tr>
<tr>
<td>CIGNA</td>
<td>2</td>
</tr>
<tr>
<td>Centene Corporation</td>
<td>1</td>
</tr>
<tr>
<td>Highmark Health</td>
<td>1</td>
</tr>
<tr>
<td>Total, Top 10 Organizations</td>
<td>73</td>
</tr>
</tbody>
</table>

### Non-Metropolitan Areas

<table>
<thead>
<tr>
<th>Parent Organization</th>
<th>Share of Total MA Enrollment in Non-Metropolitan Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealth Group, Inc.</td>
<td>29%</td>
</tr>
<tr>
<td>Humana, Inc.</td>
<td>26</td>
</tr>
<tr>
<td>Aetna, Inc.</td>
<td>8</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of Michigan</td>
<td>4</td>
</tr>
<tr>
<td>Anthem, Inc.</td>
<td>3</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
<td>2</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>2</td>
</tr>
<tr>
<td>Highmark Health</td>
<td>2</td>
</tr>
<tr>
<td>UPMC Health System</td>
<td>2</td>
</tr>
<tr>
<td>Spectrum Health System</td>
<td>1</td>
</tr>
<tr>
<td>Total, Top 10 Organizations</td>
<td>80</td>
</tr>
</tbody>
</table>
In 2017, FFS and MA Consumer Assessment of Health providers and Systems Performance Rates Were Similar

<table>
<thead>
<tr>
<th>CAHPS Measure</th>
<th>FFS</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting needed care and seeing specialists</td>
<td>84%</td>
<td>84%</td>
</tr>
<tr>
<td>Getting appointments and care quickly</td>
<td>77</td>
<td>78</td>
</tr>
<tr>
<td>Care coordination</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Rating of health plan</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>Rating of health care quality</td>
<td>85</td>
<td>86</td>
</tr>
<tr>
<td>Annual influenza vaccine</td>
<td>74</td>
<td>73</td>
</tr>
</tbody>
</table>

MedPAC March 2019

Provider Interest in Medicare Advantage Plans Surges

February 27 - Medicare beneficiaries may now choose from about 3,700 plans for 2019, or 600 more than in 2018, and the Centers for Medicare & Medicaid Services (CMS) expects MA enrollment to jump to nearly 23 million people this year, a 12 percent increase.

John Gorman, founder of the Gorman Health Group, estimated that there will be 40 to 50 new MA insurers (which could each offer multiple plans) over the next two years and said “the overwhelming majority” of those will be provider-sponsored plans.

Gorman’s assessment echoed the findings of a 2018 survey by Lumeris that found 27 percent of major health system executives intended to launch MA plans within the next four years.

The plans also have seen a surge of enrollments that is expected to continue in the coming years. Half of all new enrollees select an MA plan over FFS Medicare within their first two years of joining the program, as of last year. That could result in half of all Medicare enrollees being in an MA plan by as soon as 2023, he said.

In 2020, MA plans can offer additional evidence-based benefits that help enrollees’ health, including home modifications, home and palliative care, transportation, food security, housing, and programs to address loneliness.

Rich Daly, HFMA Senior Writer/Editor
Home Care Providers in These States May Be Best Positioned for Medicare Advantage - 6/9/19 Home Health Care

Medicare Advantage (MA) enrollment is expected to skyrocket in coming years, with more than one-third of Medicare beneficiaries currently signed up. But the pace of the great MA migration may be slower than originally anticipated — and vastly different across state lines. For home care providers, this means there could be fewer older adults with access to expanded benefits. [https://homehealthcarenews.com/2019/06/home-care-providers-in-these-states-may-be-best-positioned-for-medicare-advantage/](https://homehealthcarenews.com/2019/06/home-care-providers-in-these-states-may-be-best-positioned-for-medicare-advantage/)

What Percentage of NEW Medicare Beneficiaries Are Enrolling in Medicare Advantage?

Less than one-third of the new Medicare beneficiaries are enrolled in Medicare Advantage plans during their first year on Medicare.

![Pie chart showing 71% in Traditional Medicare and 29% in Medicare Advantage.](image)

3.7 million new Medicare beneficiaries in 2016
What Percentage of NEW Medicare Beneficiaries Are Enrolling in Medicare Advantage?

The share of new Medicare beneficiaries enrolling in Medicare Advantage during their first year on Medicare has been similar to the national Medicare Advantage penetration rate, 2010 – 2016.

The share of new Medicare beneficiaries enrolling in Medicare Advantage plans ranges across states, from 0% to more than 40% in 2016.
What Percentage of NEW Medicare Beneficiaries Are Enrolling in Medicare Advantage?

In counties with relatively high Medicare Advantage penetration rates, a relatively large share of new Medicare beneficiaries enrolled in Medicare Advantage plans.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>0-10%</th>
<th>11-20%</th>
<th>21-30%</th>
<th>31-40%</th>
<th>41-50%</th>
<th>More than 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counts</td>
<td>618 Counties</td>
<td>760 Counties</td>
<td>812 Counties</td>
<td>488 Counties</td>
<td>273 Counties</td>
<td>253 Counties</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>0.2 million</td>
<td>0.6 million</td>
<td>0.7 million</td>
<td>0.8 million</td>
<td>0.9 million</td>
<td>0.5 million</td>
</tr>
</tbody>
</table>

What Percentage of NEW Medicare Beneficiaries Are Enrolling in Medicare Advantage?

In counties with relatively high Medicare Advantage penetration rates, a relatively large share of new Medicare beneficiaries enrolled in Medicare Advantage plans.

<table>
<thead>
<tr>
<th>Number of Medicare Beneficiaries Per County 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5,000</td>
</tr>
<tr>
<td>19%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1578 Counties</td>
</tr>
<tr>
<td>677 Counties</td>
</tr>
<tr>
<td>516 Counties</td>
</tr>
<tr>
<td>213 Counties</td>
</tr>
<tr>
<td>80 Counties</td>
</tr>
<tr>
<td>45 counties</td>
</tr>
<tr>
<td>95 Counties</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2 million</td>
</tr>
<tr>
<td>0.3 million</td>
</tr>
<tr>
<td>0.6 million</td>
</tr>
<tr>
<td>0.5 million</td>
</tr>
<tr>
<td>0.4 million</td>
</tr>
<tr>
<td>0.3 million</td>
</tr>
<tr>
<td>1.4 million</td>
</tr>
</tbody>
</table>
What Percentage of NEW Medicare Beneficiaries Are Enrolling in Medicare Advantage?

New Medicare beneficiaries under age 65 with disabilities enrolled in Medicare Advantage plans at a lower rate than those age 65 and older.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of New Beneficiaries (in millions 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2.9 m</td>
</tr>
<tr>
<td>2011</td>
<td>0.8 m</td>
</tr>
</tbody>
</table>

### New Beneficiaries Who Are Full Dual Eligibles

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of New Beneficiaries (in millions 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>3.0 m</td>
</tr>
<tr>
<td>2011</td>
<td>0.2 m</td>
</tr>
<tr>
<td>2012</td>
<td>0.5 m</td>
</tr>
</tbody>
</table>

### New Beneficiaries Who Are Partial Dual Eligibles

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of New Beneficiaries (in millions 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1.5 m</td>
</tr>
<tr>
<td>2011</td>
<td>0.1 m</td>
</tr>
<tr>
<td>2012</td>
<td>0.3 m</td>
</tr>
</tbody>
</table>

### New Beneficiaries Who Are Not Dually Eligible

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of New Beneficiaries (in millions 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1.5 m</td>
</tr>
<tr>
<td>2011</td>
<td>0.1 m</td>
</tr>
<tr>
<td>2012</td>
<td>0.3 m</td>
</tr>
</tbody>
</table>
Private MA enrollment could grow to over 37M by 2025, report says
The number of seniors enrolled in private Medicare Advantage plans is expected to grow to more than 37 million in 2025, accounting for 47% of total Medicare beneficiaries, and this share could further increase to up to 70% by 2040, according to a report from L.E.K. Consulting. The growth can be attributed to the rising number of baby boomers becoming eligible for Medicare and regulatory changes that permit MA plans to cover more supplemental benefits, the report says.
Forbes (6/18)

Less Than One-Third of New Medicare Beneficiaries Enrolled in Medicare Advantage During Their First Year on Medicare

Twenty-nine percent of new beneficiaries chose to enroll in Medicare Advantage their first year in Medicare in 2016, finds a new KFF analysis.

The shear choosing Medicare Advantage in their first year varies considerably across states and counties, however. Less than 11 percent of new beneficiaries picked Medicare Advantage in Delaware, Maryland, Nebraska, New Hampshire, Vermont and the District of Columbia, to cite a few examples, while more than 40 percent selected such plans in Oregon and Minnesota.
CMS Adds More In-Home Care Services as Medicare Advantage benefits for 2020

For the second year in a row, the Centers for Medicare and Medicaid Services (CMS) has widened the scope of supplemental benefits Medicare Advantage (MA) plans can offer, creating even more opportunities for home care providers to become partners in MA contracts. CMS is also giving the MA program a pay raise to help drive:

Home Health Care News – 4/2/2019

Health insurers add MA benefits amid single-payer model debate

Health insurers are taking advantage of revised federal rules to add new benefits to their Medicare Advantage plans, even as the single-payer "Medicare for All" model drives debate among candidates seeking the Democratic party's nomination for president. "With new flexibility introduced for 2019, Medicare Advantage plans were given even more runway to introduce innovative solutions that improve seniors' health while reducing costs," said Keith Fontenot, AHIP's executive vice president, policy and strategy.
Forbes (4/28)
Medicare Advantage Evolving

Reimbursement limitations on home healthcare are being loosened 10/27/18 Modern Healthcare

https://www.modernhealthcare.com/article/20181027/NEWS/181029949?ite=40681&ito=1156&itq=b4a7f501-7614-47bd-b808-7af69f812175&itx%5Bidio%5D=1624167

Medicare Advantage Evolving

Medicare Advantage Plans 2019: Testing New Payment Models and Care Delivery Remington 10/31/18

Medicare Advantage Evolving

Proposed rule would expand Medicare Advantage telehealth benefits 10/26/18 Modern Healthcare


With a Dig At Single Payer, Humana’s Medicare Advantage Business Booms

“Each day, more and more seniors are choosing Medicare Advantage, a program that today has over 22 million members, demonstrating the compelling value of a program that delivers affordable, quality care for seniors and improved clinical outcomes as payers and providers work together to understand each member’s whole health and help them navigate the complex healthcare system,” Humana president and chief executive officer Bruce Broussard said.

Broussard said Medicare Advantage allows for the insurer and doctors to take a “holistic view” of the health plan member and their “complex and chronic conditions.” Humana’s Medicare Advantage plans include primary care, home health and are increasingly addressing social determinants of health, Broussard said.

Humana’s individual Medicare Advantage membership jumped 14% to 3.4 million as of March 31. That was an increase of 414,800 from 3 million as of the end of the first quarter of last year and the Medicare Advantage enrollment was up 369,300, or 12 percent, from 3,064,000 as of December 31, 2018, the company said.
How 24 Hour Home Care Won SCAN, CareMore Medicare Advantage Contracts

With SCAN Health Plan and CareMore contracts, 24 Hour Home Care has been among the most active non-medical home care providers when it comes to 2019’s expanded Medicare Advantage (MA) benefits. Its early success working with MA players serves as a case study for industry peers looking to do the same in 2020 and beyond.

https://homehealthcarenews.com/2019/06/how-24-hour-home-care-won-scan-caremore-medicare-advantage-contracts%ef%bb%bf/

Home Health Care News – 6/2/2019

Lyft to Partner with “Majority of Largest Medicare Advantage Plans’ by 2020

Seniors; specifically those who are Medicare Advantage (MA) beneficiaries; will be a driving force in Lyft’s (Nasdaq: LYFT) health care business in 2020 and beyond, according to vice president of health care Megan Callahan.

“We expect to be working with the majority of the largest MA plans by 2020, as an increasing number


Home Health Care News – 5/30/2019
Uber Health Exec: ‘There’s So Much We Can Do When It Comes to Home Care’ (6/9/19 Home Health Care)

As Medicare Advantage (MA) plans prepare to expand their supplemental benefits in 2020 to cover even more non-medical services, players from a growing number of industries are hopping on board. That includes ride-hailing companies such as Lyft (Nasdaq: LYFT) and Uber (NYSE: UBER), which say seniors are a driving force in their health care businesses.

Dual-eligible MA recipients have lower costs than those under FFS

An Avalere Health study found dual-eligible Medicare Advantage beneficiaries have lower health care costs, hospitalization rates and emergency department utilization than their fee-for-service counterparts. Average health care costs for dual-eligible MA recipients were $11,159 compared with $13,398 for dual-eligible FFS populations, and co-author Christie Teigland said care coordination, preventive care and efforts to address social determinants of health could explain the difference.
HealthLeaders Media (5/21)
Upcoding May Have Led to Higher Medicare Advantage Payments

Dive Insight: Healthcare Dive 5/28/19

Medicare Advantage plans have been a boon for private insurers. That success has drawn the attention of watchdog agencies and researchers in the past. Previous studies have found risk scores of those who switched to MA grew faster than those who stayed in FFS, with MA enrollment growth intensifying those scores.

In 2016, Risk Adjustment Data Validation audits on MA plans found nearly all audited plans overcharged the federal government for most of their members.

Greater coding intensity could be an indication of upcoding, according to authors of this most recent study. Their results suggest MA plans may be using greater code intensity to drive higher risk scores. In order for upcoding to be ruled out, risk scores between MA and FFS populations would have to be closely parallel.

“This was not the case,” they write.

CMS’ 2014 overpayment rule attempted to tackle fraud and upcoding by requiring MA plans to report and reimburse overpayments within 60 days of identifying them. That rule allowed CMS to treat failures to return overpayments as violations of the False Claim Act. That led UnitedHealthcare, which had been sued under the new rule, to file a lawsuit against CMS in January 2016.

Much of the original lawsuit against UnitedHealthcare was tossed by the DOJ in 2018.

Upcoding May Have Led to Higher Medicare Advantage Payments

Dive Brief: Healthcare Dive 5/28/19

- Medicare advantage plans may have received higher payments as a result of upcoding from 2010 to 2014, according to new research published by Health Management, Policy & Innovation. The study’s authors, both from the University of Minnesota, point to overstated risk differences between Medicare Advantage and traditional fee-for-service populations they say are the result of upcoding within the risk adjustment system.

- Diagnostic intensity was more severe for patients with Medicare Advantage plans over that period of time. For example, patients with Medicare Advantage plans were diagnosed with diabetes at almost twice the rate of their peers in traditional fee-for-service plans.

- The authors argue that risk scores based on ICD-10 codes, a practice adopted in 2015, may have addressed this issue, but recommend CMS repeat their analysis. “Hopefully, ICD-10 is less susceptible to differences in coding intensity designed to take undue advantage of the government payment incentives,” they write.
Your Medicare Options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

**Original Medicare**
- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage

**Medicare Advantage** (also known as Part C)
- Medicare Advantage is an “all in one” alternative to Original Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
- Some plans may have lower out-of-pocket costs than Original Medicare.
- Some plans offer extra benefits that Original Medicare doesn’t cover – like vision, hearing, or dental.

---

### Original Medicare vs. Medicare Advantage

**DOCTOR AND HOSPITAL CHOICE**

<table>
<thead>
<tr>
<th>Original Medicare</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can go to any doctor that accepts Medicare</td>
<td>In most cases, you’ll need to use doctors who are in the plan’s network (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans</td>
</tr>
<tr>
<td>In most cases you don’t need a referral to see a specialist.</td>
<td>You may need to get a referral to see a specialist.</td>
</tr>
</tbody>
</table>
### Original Medicare vs. Medicare Advantage

#### COST

<table>
<thead>
<tr>
<th>Original Medicare</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Part B-covered services, you <strong>usually pay 20% of the Medicare-approved amount</strong> after you meet your deductible.</td>
<td>Out-of-pocket costs <strong>vary</strong> – some plans have low or no out-of-pocket costs.</td>
</tr>
<tr>
<td>You <strong>pay a premium (monthly payment)</strong> for Part B. If you choose to buy prescription drug coverage, you’ll pay that premium separately.</td>
<td>You may <strong>pay a premium for the plan</strong> (most include a prescription drug coverage) and a premium for Part B. Some plans have a $0 premium or will help pay all of part of your Part B premium.</td>
</tr>
<tr>
<td>There’s <strong>no yearly limit</strong> on what you pay out-of-pocket.</td>
<td>Plans have a <strong>yearly limit</strong> on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plans limit, you’ll pay nothing for Part A and Part B covered services for the rest of the year.</td>
</tr>
<tr>
<td>You <strong>can buy</strong> supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).</td>
<td>You <strong>can’t buy or use</strong> separate supplemental coverage – but some plans have lower out-of-pocket costs that Original Medicare.</td>
</tr>
</tbody>
</table>

#### ORIGINAL MEDICARE VS. MEDICARE ADVANTAGE

<table>
<thead>
<tr>
<th>Original Medicare</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Medicare covers medical services and supplies in hospitals, doctors’ offices, and other health care settings.</td>
<td>Plans must cover all of the services that Original Medicare covers. Some plans offer <strong>extra benefits that Original Medicare doesn’t cover</strong> – like vision, hearing or dental.</td>
</tr>
<tr>
<td>You can join a separate Medicare Prescription Drug Plan to get drug coverage.</td>
<td>Prescription drug coverage <strong>IS INCLUDED</strong> in most plans.</td>
</tr>
<tr>
<td>In most cases, you don’t have to get a service or supply approved ahead of time for it to be covered.</td>
<td>In some cases, you have to get a service or supply approved ahead of time for it to be covered.</td>
</tr>
</tbody>
</table>
Original Medicare vs. Medicare Advantage

| TRAVEL |
|------------------|------------------|
| **Original Medicare** | **Medicare Advantage** |
| Original Medicare generally **doesn’t cover care outside of the U.S.** You may be able to buy supplemental coverage that covers care outside of the U.S. | Plans usually **don’t cover care outside the U.S.** Also, plans usually don’t cover non-emergency care you get outside of your plan’s network. |

How do I Compare Medigap Plans?

<table>
<thead>
<tr>
<th>Benefits</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F*</th>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medicare part B coinsurance or copayment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%*</td>
<td>**</td>
</tr>
<tr>
<td>Blood (first 3 pints)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Part A hospice care coinsurance or copayment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility care coinsurance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Medicare Supplement Insurance (Medigap) Plans

<table>
<thead>
<tr>
<th>Benefits</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F*</th>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A deductible</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Part B deductible</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B excess charges</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign travel emergency (up to plan limits)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Plan F offers a high deductible plan in some states. If you chose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,300 in 2019 before your policy pays anything.

** For plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($185 for 2019), the Medigap plan pays 100% of covered services for the rest of the calendar year. Out-of-pocket limit in 2019 **

| ** | 5,560 | 2,780 |

** Plan N pays 100% of the part B coinsurance, except for a copayment up to $20 for some office visits and up to a $50 copayment for emergency room visits that don’t result in an inpatient admission.

How do I Compare Medigap Plans?

Medicare Resources

Medicare Rights Center
https://www.medicarerights.org

Center for Medicare Advocacy
https://www.medicareadvocacy.org/

Medicare.gov
https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans
Managed Care And Delivery System Reforms
Managed care is the predominant delivery system for Medicaid in most states. Among the 39 states with comprehensive risk-based managed care organizations (MCOs), 29 states reported that 75 percent or more of their Medicaid beneficiaries were enrolled in MCOs as of July 1, 2017. More states continue to carve complex populations as well as behavioral health services into MCO contracts. Twenty-six of the 39 MCO states reported that they plan to use authority to receive federal matching funds for adults receiving inpatient psychiatric or substance use disorder (SUD) treatment in an institution for mental disease (IMD) for no more than 15 days a month included in the 2016 managed care regulations. Close to half of MCO states reported that the day limit is insufficient to meet acute inpatient or residential treatment needs for those with serious mental illness (SMI) or SUD. Nearly all states have managed care quality initiatives in place such as pay for performance or capitation withholds. Working in conjunction with or outside of MCO contracts, the majority of states (40) had one or more delivery system or payment reform initiative in place in FY 2017 (e.g., patient-centered medical home, ACA Health Home, accountable care organization, episode of care payment, or delivery system reform incentive program (DSRIP).

What to watch:
States are using MCO arrangements to increase attention to the social determinants of health and to promote value-based payment. States are increasingly requiring MCOs to: screen beneficiaries for social needs (19 states in FY 2017 and two additional states in FY 2018); provide care coordination pre-release to incarcerated individuals (six states in FY 2017 and one additional state in FY 2018); and use alternative payment models (APMs) to reimburse providers (13 states in FY 2017 set a target percentage of MCO provider payments that must be in APM and nine additional states plan to set a target in FY 2018). More than one in three states also have initiatives to expand dental access or improve oral health outcomes (for children and/or adults) and to expand the use of telehealth.

Henry J Kaiser Family Foundation 10/19/2017
Contact Information

Thomas Boyd, MBA, CFE, CHFP
Vice President of Reimbursable Services
Simione Healthcare Consultants, LLC

tboyd@Simione.com
800-949-0388, Ext 206

www.Simione.com
## Thank You for Coming!

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Company</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>David C. Macke, MBA, CHFP, FHFMA</td>
<td>VonLehman CPA &amp; Advisory Firm</td>
<td><a href="mailto:dmacke@vlcpa.com">dmacke@vlcpa.com</a></td>
<td></td>
</tr>
<tr>
<td>Tammy Ross, SVP</td>
<td>Axxess Technology Solutions</td>
<td><a href="mailto:tross@axxess.com">tross@axxess.com</a></td>
<td></td>
</tr>
<tr>
<td>Elizabeth Pearson, Esq.</td>
<td>Pearson &amp; Bernard PSC</td>
<td><a href="mailto:liz@pblaw.org">liz@pblaw.org</a></td>
<td></td>
</tr>
<tr>
<td>Thomas Boyd, MBA, CFE, CHFP</td>
<td>Simione Healthcare Consultants, LLC</td>
<td><a href="mailto:tboyd@simione.com">tboyd@simione.com</a></td>
<td></td>
</tr>
<tr>
<td>Melinda A. Gaboury, CEO</td>
<td>Healthcare Provider Solutions, Inc.</td>
<td><a href="mailto:info@healthcareprovidersolutions.com">info@healthcareprovidersolutions.com</a></td>
<td></td>
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