Medicare Training & Consulting, Inc.

HEALTH FINANCIAL SYSTEMS
USER MEETING
AUGUST 18, 2017
9:30 A.M. – 10:45 A.M.

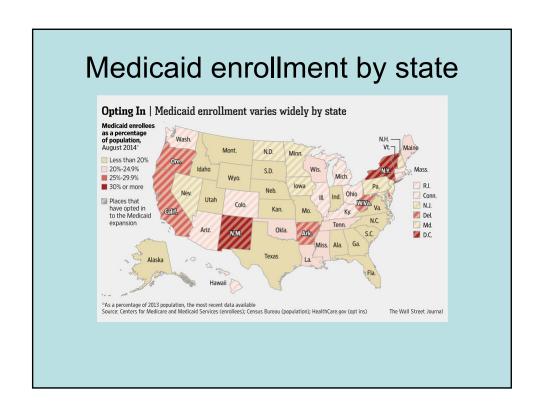
HFS USER MEETING

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PRESIDENT
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PERSONAL HISTORY

- PERSONAL BACKGROUND
- ACCOUNTANT
- TRAINED MEDICARE AUDITORS FOR BCBSA 1983-1989
- OWNED A HHA IN SALT LAKE CITY UTAH FROM 1995- 2008
- STARTED MEDICARE TRAINING & CONSULTING IN 1989 IN LANSING, IL

- GOOD NEWS FIRST
- 59 MILLION ON MEDICARE
- 10,000 RECEIVE MEDICARE CARDS EVERY DAY UNTIL 2029
- 69 MILLION ON MEDICAID



- NEW CONDITIONS OF PARTICIPATION
- PUBLISHED 1/13/2017
- EFFECTIVE 7/13/2017 DELAYED 1/13/18
- FIRST UPDATE SINCE 1995
- QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT(QAPI) EFFECTIVE 1/1/2018
 COST TO HHA \$293 M – YEAR 1
 5.6 MILLION HOURS OF TOTAL TIME

- 2018 FINAL RULE
- \$510K INCREASE in HH Payments
- Market Basket Increase 1.0%
- Case Mix Creep Adjustment (.97%) 2017 & 2018
- NET INCREASE .03%
- 3% RURAL ADD-ON EXPIRES 12/31/2017 \$80M REDUCTION
- EFFECTIVE FOR EPISODES ENDING 1/1/2018!!

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HFS USER MEETING

- 4/2/2015 MEDICARE ACCESS & CHIP REAUTHORIZATION ACT (MACRA)
- DOC FIX PERMANENTLY FIXED
- PART B CAP EXTENDED TO 1/1/2018
- NEW BENE MUST PAY FIRST \$100 BEGINNING 1/1/2020
- POST ACUTE PROVIDERS UPDATE MAX AT 1% 2018-2025
- \$50,000 SURETY BOND REQUIRED IN 2018?
- 3% RURAL ADD-ON EXTENDED TO 2018

OIG ADVISORY OPINION AUGUST 2015

- LIAISON VISITS ARE PERMISSIBLE!
- MUST HAVE A PT REFFERAL
- CAN OCCUR F-2-F, BY PHONE OR EMAIL
- MAY OCCUR IN THE HOSPITAL
- CANNOT BILL A VISIT
- CANNOT BILL PATIENT
- CANNOT GIVE PATIENT ANY ITEM OF VALUE
- HTTP://1.USA.GOV/1ML412J

New Part B Payment - NPWT

- · Criteria:
- 1. Visit is for sole purpose to furnish NWPT Bill Part B not billed as visit for the episode
- 2. Bill type 34X Revenue Codes 0559/042X/043X
- 3. Visit includes other HH Services
- 4. CANNOT BILL FOR HHA VISIT TO REMOVE EXUDATE
- a. Keep time separately for NWPT
- b. Bill NWPT time to Part B
- c. Report and Bill visit in the episode do not include NWPT time on UB-04

 2016 TOTAL AGENCIES 11,949 (-324)100.0% TEXAS 2,665(-117) 22.3% 1,149(-87) FLORIDA 9.6% CALIFORNIA 1.050(-152) 8.8% OHIO 800(+40) 6.7% ILLINOIS 784(-18) 6.6% MICHIGAN 657(- 40) 5.5% PENNSYLVANIA 418(+ 0) 3.5% OKLAHOMA 269(+ 7) 2.3% INDIANA 229(+ 5) 1.9% TOP 7 STATES 65.2%

Number of participating home health agencies increased significantly from 2004 to 2014, but declined slightly in 2015

							Percent change		
	2004	2008	2012	2014	2015	2004-2014	2014-2015		
Active agencies Number of agencies per	7,651	9,787	12,311	12,461	12,346	63%	-0.9%		
10,000 FFS beneficiaries	2.1	2.8	3.3	3.3	3.3	57	-0.7		

Note: FFS (fee-for-service). "Active agencies" includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Provider of Service file and 2016 annual report of the Boards of Trustees of the Medicare trust funds.

AGENCY BY SIZE

• < 100	3040	28%
• 100 TO 249	2478	23%
• 250 TO 499	2203	20%
• 500 TO 999	1645	15%
• 1000 OR MORE	<u>1494</u>	<u>14%</u>
• TOTAL	10,860	100%

HFS USER MEETING

• 2011 MEDICARE PAYMENTS = \$549.8B

• I/P HOSPITAL 26.2% \$144.0B

• MANAGE CARE 24.0% \$131.9B

• DRUG BENEFIT 13.0% \$ 71.5B

• PHYSICIANS 9.6% \$ 52.8B

9.070 \$ 32.0D

• HOSPITAL O/P 6.4% \$ 35.2B

• HOME HEALTH 3.7% \$ 20.3B

• HOSPICE 2.4% \$ 13.2B

- Medicare Spent \$17.7B / 6.6M Episodes / 3.4M **Beneficiaries**
- Episodes down 2.1%
- Number of HHA's dropped to 12,461 (1.2%)
- Number of Episodes per user down .8%
- Payments fell 1.6%
- · Volumes drops concentrated in Texas, Louisiana, Florida, Illinois & Tennessee
- Average Profit Margins 10.8%

							Percent change		
	1997	2000	2014	2015	1997- 2000	2000- 2014	2014- 2015		
encies	10,917	7,528	12,461	12,346	-31%	66%	-1%		
al enending (in hillions)	\$17.7	\$8.5	\$17.7	\$18.1	_52	108	2		

Changes in supply and utilization of home health care, 1997-2015

	1997	2000	2014	2015	1997- 2000	2000- 2014	2014- 2015
Agencies	10,917	7,528	12,461	12,346	-31%	66%	-1%
Total spending (in billions)	\$17.7	\$8.5	\$17.7	\$18.1	-52	108	2
Users (in millions)	3.6	2.5	3.4	3.5	-31	37	1
Number of visits (in millions)	258.2	90.6	115.1	115.1	-65	27	<0.1
Visit type (percent of total)							
Skilled nursing	41%	49%	52%	52%	20	5	-2
Home health aide	48	31	12	10	-37	-62	-10
Therapy	10	19	36	37	101	85	5
Medical social services	1	1	1	1	1	-32	<0.1
Number of visits per user	73	37	34	33	-49	-9	-1
Percent of FFS beneficiaries who							
used home health services	10.5%	7.4%	9.1%	9.1%	-30	23	1

FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: Home health standard analytical file 2015; Health Care Financing Review, Medicare and Medicaid Statistical Supplement 2002.

Medicare visits per episode before and after implementation of PPS

	Visits per episode				Percent change in:			
Type of visit	1998	2001	2014	2015	1998-2001	2001-2014	2014-2015	
Skilled nursing	14.1	10.5	9.8	9.6	-25%	-7%	-1.9%	
Therapy (physical, occupational,	0.0	5.0		7.1	20	00	5.0	
and speech-language pathology)	3.8	5.2	6.5	7.1	39	29	5.3	
Home health aide	13.4	5.5	2.2	2.0	-59	-60	-9.0	
Medical social services	0.3	0.2	0.1	0.1	-36	-32	-27.9	
Total	31.6	21.4	18.8	18.8	-32	-12	-0.2	

Note: PPS [prospective payment system]. The PPS was implemented in October 2000. Data exclude low-utilization episodes. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: Home health standard analytic file.

Fee-for-service home health care services have increased significantly since 2002

								Percent change	
	2002	2010	2011	2012	2013	2014	2015	2002- 2014	2014- 2015
Home health users (in millions)	2.5	3.4	3.4	3.4	3.4	3.4	3.5	37.3%	0.9%
Share of beneficiaries using home health care	7.2%	9.4%	9.4%	9.2%	9.2%	9.1%	9.1%	25.8	1.1
Episodes (in millions):	4.1	6.8	6.9	6.7	6.7	6.6	6.6	60.2	0.3
Per home health user	1.6	2.0	2.0	2.0	1.9	1.9	1.9	17.7	-0.6
Per FFS beneficiary	0.12	0.19	0.19	0.18	0.18	0.17	0.17	48.1	0.4
Payments (in billions)	\$9.6	\$18.4	\$18.4	\$18.0	\$17.9	\$17.7	\$18.1	84.4	2.3
Per home health user	3,803	5,679	5,347	5,247	5,156	5,156	5,225	35.6	1.3
Per home health episode	2,645	3,084	2,916	2,900	2,896	2,908	2,965	12.1	1.9
Per FFS beneficiary	274	540	504	484	476	468	478	70.5	2.4

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded; payment per episode excludes low-utilization payment adjustment cases.

Source: MedPAC analysis of home health standard analytical file.

TABLE 3: H	ome Health	Statistics, C	Y 2001 and	CY 2012 tl	rough CY	2016 ¹⁰
	2001	2012	2013	2014	2015	2016
Number of episodes	3,896,502	6,727,875	6,708,923	6,451,283	6,340,932	6,294,234
Beneficiaries receiving at least 1 episode (Home Health Users)	2,412,318	3,446,122	3,484,579	3,381,635	3,365,512	3,350,174
Part A and/or B FFS beneficiaries	34,899,167	38,224,640	38,505,609	38,506,534	38,506,534	38,555,150
Episodes per Part A and/or B FFS beneficiaries	0.11	0.18	0.17	0.17	0.17	0.16
Home health users as a percentage of Part A and/or B FFS beneficiaries	6.9%	9.0%	9.0%	8.8%	8.8%	8.7%
HHAs providing at least 1 episode	6,511	11,746	11,889	11,693	11,381	11,102
HHAs per 10,000 Part A and/or B FFS beneficiaries	1.9	3.1	3.1	3.0	3.0	2.9

Source: National claims history (NCH) data obtained from Chronic Condition Warehouse (CCW) - Accessed on May 14, 2014 and August 19, 2014 for CY 2011, CY 2012, and CY 2013 data; accessed on May 7, 2015 for CY 2001 and CY 2014 data; accessed on April 7, 2016 for CY 2015 data; and accessed on March 20, 2017 for CY 2016 data and Medicare enrollment information obtained from the CCW Master Beneficiary Summary File. Beneficiaries are the total number of beneficiaries in a given year with at least 1 month of Part A and/or Part B Fee-for-Service coverage without having any months of Medicare Advantage coverage.

Note(s): These results include all episode types (Normal, PEP, Outlier, LUPA) and also include episodes from outlying areas (outside of 50 States and District of Columbia). Only episodes with a through date in the year specified are included. Episodes with a claim frequency code equal to "0" ("Non-payment/zero claims") and "2" ("Interim - first claim") are excluded. If a beneficiary is treated by providers from multiple states within a year the beneficiary is counted within each state's unique number of beneficiaries served.

•	2015 TOTAL BENEFICIARIES	55,504,005	
•	CALIFORNIA	5,644,384	10.2%
•	FLORIDA	4,024,223	7.2%
•	TEXAS	3,633,785	6.5%
•	NEW YORK	3,343,349	6.0%
•	PENNSYLVANIA	2,533,515	4.6%
•	OHIO	2,154,337	3.9%
•	ILLINOIS	2,066,376	3.7%
•	MICHIGAN	1,895,558	3.4%
•	NORTH CAROLINA	1,769,074	3.2%
•	GEORGIA	1,519,461	2.7%
•	NEW JERSEY	1,492,066	2.7%

Clinical Documentation - Critical

- Pre-Claim Review
- 1. Illinois 8/1/16 (Paused)
- 2. Florida 4/1/17 (Paused)
- 3. Texas (Paused)
- 4. Michigan(Paused)
- 5. Massachusetts ENDED

STATE-WIDE FREEZE

7/31/2017 THRU 1/31/2018

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HFS USER MEETING

HOME HEALTH VALUE BASED PURCHASING

Nine States - 1/1/2016

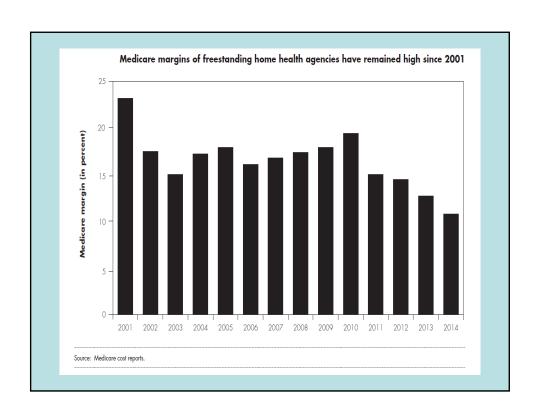
- 1. ARIZONA
- 2. FLORIDA
- 3. IOWA
- 4. MARYLAND
- 5. MASSACHUSETTS
- 6. NEBRASKA
- 7. NORTH CAROLINA
- 8. TENNESSEE
- 9. WASHINGTON

CMS PLANS TO EXPAND TO ALL STATES BY 2022!

ADJUSTED AS FOLLOWS:

• PERF	PAYMENT	REWARD
• YEAR	YEAR	<u>PENALTY</u>
• 2016	2018	+/- 3%
• 2017	2019	+/- 5%
• 2018	2020	+/-6%
• 2019	2021	+/-7%
• 2020	2022	+/-8%

- HHCAHPS
- · 34 Question survey
- Must use approved vendor
 Less than 60 exempt Must register each/yr
- Letters sent 9/16/2011 30 days to appeal
- Decision by 12/31/2011
- Can appeal to PRRB
- Failure to report data 2% decrease episodes 1/1/12!
- · Scores will posted on www.Home Health Care
- Fields Research 513-821-6266
- · Surveys increased from 20 to 40



 TOTAL HHA MEDICARE PAYMENTS & PROFITS HAVE DECLINED

		<u>PAYMENTS</u>	PROFITS
•	2011	\$18.4 B	15.2%
•	2012	\$18.0 B	14.5%
•	2013	\$17.9 B	12.7%
•	2014	\$17.7 B	10.8%
•	2015	\$17.5 B	8.8%
•	2016	\$17.3 B	????

Average # Visits Per Episode – 18.16

Average Payment Per Visit - \$166

Average Payment Per Episode - \$3,014.56

Estimated Cost Per Episode - \$2,373.87*

Equals Continued Cuts More Rebasing?

Data Comes from:

- CMS Claims Files
- •Cost Reports What & How you file MATTERS!
- * EXCLUDES NON-REIMBURSABLE COSTS!

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HFS USER MEETING

CMS 339 CHANGES ELIMINATED AND IS NOW W/S A-2-1

- The other interesting additions are to Exhibit 1 A. 2.
- The provider is involved in business transactions, including management contracts and services under arrangements, with individuals or entities (e.g., chain home offices, drug or medical supply companies, etc.) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships.
- RELATED PARTIES MUST BE DISCLOSED ON W/S A-6
- MOST COMMON IS COMMON OWNERSHIP OF A BUILDING OWNED BY THE HHA AND OCCUPPING THE BUILDING
- CMS IS EMPHASIZING COMPLIANCE!

- New Safe Harbor = free/discounted transportation
 - 42 CFR 1001.952(zz)
 - May provide <u>local</u> transportation to existing patients for medically necessary services – i.e., Drs
 - Local = 25 miles or 50 miles for rural areas
 - Existing patients = admitted
 - Can do shuttles
 - HOPE OIG favorable to HHA's

BUT:

- No advertising the transportation
- <u>Do not include on cost</u> report
- Update to Permissive Gifts to Patients
 - OIG increased amount for non-monetary gifts to beneficiaries = \$15 each/\$75 annual aggregate
 - Remove from the Cost Report



HFS USER MEETING

IMPORTANT TO GET IT RIGHT

- CMS ASSUMES ALL NUMBERS ARE CORRECT AS FILED
- THERE ARE NO AUDITS!
- NEW COST REPORT CLIENT FILED CR WITH
 - NO RENT ON LINE 1!
 - NO ADMINISTRATIVE & GENERAL COSTS ON LINE 5
 - NO A-5 OFFSETS
 - SPEECH THERAPY COSTS \$8,525.33!!
 - MEDICAL SUPPLIES RATIO 1.79
 - MEDICARE PROFIT MARGIN -\$6,975
 - PGBA HAD ISSUED A NO AUDIT NOTICE



- MTC REFILED COST REPORT CLIENT FILED CR WITH
 - RENT ON LINE 1 WAS \$33,600
 - ADMINISTRATIVE & GENERAL COSTS ON LINE 5 \$142,022
 - A-5 OFFSETS WERE \$34,332
 - SPEECH THERAPY COSTS \$309.67
 - MEDICAL SUPPLIES RATIO 1.08
 - MEDICARE PROFIT MARGIN \$104
 - PGBA ACCEPTED THE AMENDED COST REPORT



- WORSKHEET A-5 ADJSUTMENT
- MARKETING COSTS
- ADVERTISING (EXCLUDING YELLOW PAGES)
- CONTRIBUTIONS
- TAXES & PENALTIES (INCLUDING ACA HEALTH INSURANCE PENALTIES)
- NSF BANK FEES
- EXCESS OWNERS COMPENSATION
- PERSONAL EXPENSES OF OWNERS
 - CAR LEASES
 - LANDSCAPING OF PERSONAL HOMES
 - BABYSITTING
 - PERSONAL LEGAL FEES



- MARKETING COSTS ARE:
 - LEGAL
 - NON-REIMBURSABLE
 - CANNOT PAY FOR REFERRALS
 - PAID MARKETERS VS CONTRACTORS
 - TAX DEDUCTIBLE



HFS USER MEETING

HHA OWNER OWNS BUILDING

RENT EXPENSE (W/S A LINE1) \$250,000

ALLOWABLE EXPENSES

DEPRECIATION \$20,000
 PROPERTY TAX \$10,000
 INTEREST \$20,000
 INSURANCE \$2,000
 TOTAL EXPENSES \$52,000

• WORKSHEET A-6 ADJUSTMENT \$198,000



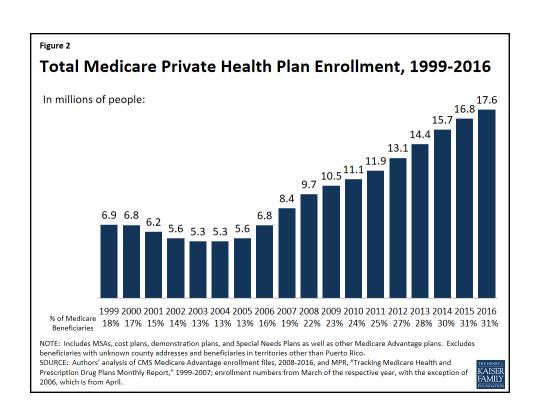
FLU SHOTS

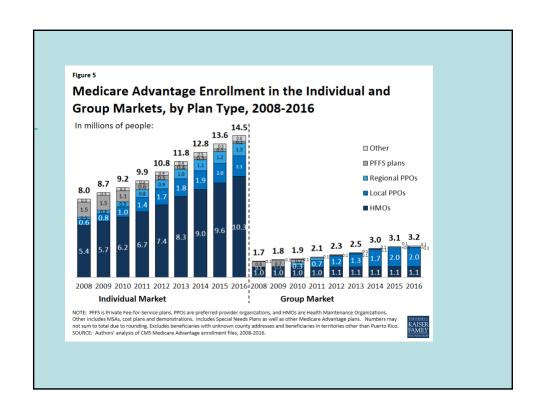


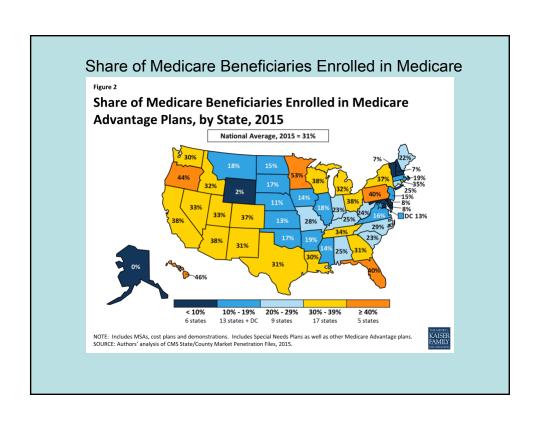
- A.FLU COST INCLUDED ON WORKSHEET LINE 13.2
 - 1. RN SALARIES 771 FEE SCREEN \$32.89
 - 2. VACCINNE LINE 13 636 COST
- B. PROVIDER MUST CHARGE ALL PTS SAME
- C. CHARGES MUST BE TRACKED IN F/S
- D. FI WILL REIMBURSE:
- 1. LOWER OF COST OF CHARGES (LCC) 636
- 2. ADMINSITRATION AT FEE SCREEN 771
- 3. CANNOT BILL ADMIN IF DONE AS SAME TIME AS VISIT
 - E. COST REPORT SETTLEMENT WILL BE REQUIRED!

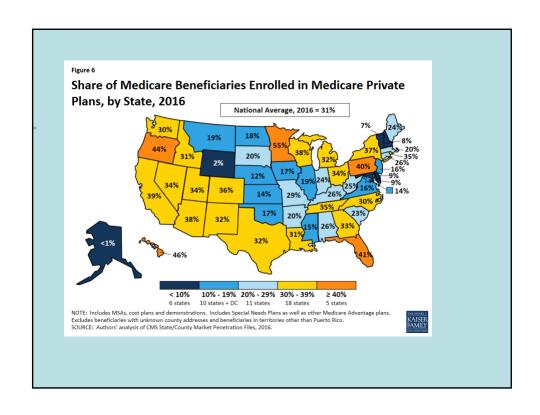
- A. MUST TRACK FLU SALARY
- B. RECLASS ON WORKSHEET A-4
- C. CHARGES FOR NON-MEDICARE CHARGES MUST BE RECORDED IN F/S
- D. NON-MEDICARE SHOTS MUST BE TRACKED
- E. OFFSET REFUNDS FOR UNUSED VACCINNE
- F. PS & R WILL BE ON REPORT 342
- G. PS & R ADMIN ON REPORT 34P

- ADVANTAGE PATIENTS
 16.8 MILLION PATIENTS UP FROM 15.7 MM
- 31% OF ALL BENEFICIARIES
- 27% OF ALL MEDICARE PAYMENTS \$4,346/BENEFICIARY \$4,100/BENEFICIARY – FFS
 \$129 B REDUCTION PAYMENTS BY 2019 REDUCTION FROM 2524 TO 2034 PLANS









	HEALTH AGENCY STATISTICAL D	DATA			Provider CCN:	Peri	od:	u of Form CMS-: Worksheet S-3	1/20-
						From	01/01/2015 12/31/2015	Parts I - IV Date/Time Prepa 8/7/2017 9:16	
			Title		Oth		Total		
	Description	County	Visits	Patients	Visits	Patients	Visits	Patients	
	PART I - STATISTICAL DATA	0	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Skilled Nursing		9,886	205	454	7	10.340	212	1.
2.00	Physical Therapy		8,043	175	241	6	8,284		
3.00	Occupational Therapy		0	0	0	0	, , ,	0	3.
4.00	Speech Pathology		0	0	0	0	C	0	4.
5.00	Medical Social Service		0	0	0	0	C		5.
6.00	Home Health Aide		305	8	249	1	554	9	6.
7.00	All Other Services				0	0	C	0	7.
8.00	Total Visits		18,234		944		19,178		8.
9.00	Home Health Aide Hours Unduplicated Census		305		249	7.00	554		9.
10.00	Count - Full Cost			221.00		7.00		228.00	10.
	Reporting Period								
	· · · · · · · · · · · · · · · · · · ·				Number of	Staff	Contract	Total	
					Hours in				
					Normal Work				
					Week	1.00	2.00	3.00	
11.00	Administrator and Assista	nt Administra	tor(s)		40.00	1.00	0.00		11.
12.00			201 (3)			0.00	0.00		
13.00						3.52	0.00		
14.00	Direct Nursing Service					5.77	0.00	5.77	14.
15.00						0.00	0.00	0.00	15.
16.00						5.02	0.00		
17.00						0.00	0.00		
18.00						0.00	0.00		18.
19.00		rvisor				0.00	0.00		
20.00						0.00	0.00		
21.00		ior.				0.00	0.00		21.
23.00						0.00	0.00		
24.00						0.00	0.00		
25.00		or				0.00	0.00		
26.00						0.00	0.00		
	OTHER (SPECIFY)					0.00	0.00	0.00	27

							1.00	1.01	
28.00	Enter the total number o				where Medicare	covered	0	2	28.00
	services were provided d	uring the cost	reporting peri	00.			MSA Codes	CBSA Codes	
							1.00	1.01	
29.00	List all MSA and CBSA co				rvices were p	rovided during			29.00
29.01	the cost reporting period	d (line 29 cont	tains the first	code):					29.01
	1		Full Episodes	LUPA Episodes	PEP Only	SCIC within a	SCIC Only	Totals	
		without	with Outliers		Episodes	PEP	Episodes		
		Outliers 1.00	2.00	3.00	4.00	5.00	6.00	7.00	
	Skilled Nursing Visits	7,042	2,499	7	14	0	0	9,562	
31.00	Skilled Nursing Visit	845,040	299,880	846	1,680	0	0	1,147,446	31.00
32.00	Charges Physical Therapy Visits	7,278	607		18	0	0	7.904	32.00
	Physical Therapy Visit	1,091,700			2,700	ō	ō	1,185,581	
	Charges								
34.00	Occupational Therapy Visits	0	٥	0	0	0	0	0	34.00
35.00	Occupational Therapy	0	0	0	o	0	o	o	35.00
	Visit Charges								
	Speech Pathology Visits Speech Pathology Visit	٥	1 9	0	0	0	0	0	36.00
57.100	Charges			, and the second	· ·	Ĭ	•	_	37.100
38.00	Medical Social Service	0	0	0	0	0	0	0	38.00
39.00	Medical Social Service	۱ ،		0	0	0	0	0	39.00
	Visit Charges	1	1		Ī			_	
	Home Health Aide Visits	152			0	0	0		40.00
41.00	Home Health Aide Visit Charges	11,400	9,900	٥	0	0	0	21,300	41.00
42.00	Total Visits (Sum of	14,472	3,238	8	32	0	0	17,750	42.00
43.00	lines 30,32,34,36,38,40)	١ .	Ι ,						43.00
	Other Charges Total Charges (Sum of	1,948,140	400,830	977	4,380	0	0	2,354,327	
	lines	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		.,			_,,	
45.00	31,33,35,37,39,41,43)			_				525	45.00
45.00	Total Number of Episodes	530		2	3	0	0	535	45.00

- JUST LIKE FAMILY
- AVERAGE REVENUE \$3,684.92
- AVERAGE VISIT / EPISODE 27.3
- AVERAGE CASE MIX 1.27

	· I	Full Episodes
		without
		Outliers
		1.00
30.00	Skilled Nursing Visits	7,042
31.00	Skilled Nursing Visit	845,040
	Charges	
	Physical Therapy Visits	7,278
33.00	Physical Therapy Visit Charges	1,091,700
34.00	Occupational Therapy	О
	Visits	
35.00	Occupational Therapy	0
	Visit Charges	
36.00	Speech Pathology Visits	0
37.00	Speech Pathology Visit	0
	Charges	
38.00	Medical Social Service	0
	Visits	
39.00	Medical Social Service	0
	Visit Charges	
	Home Health Aide Visits	152
41.00	Home Health Aide Visit	11,400
	Charges	
42.00	Total Visits (Sum of	14,472
	lines 30,32,34,36,38,40)	
	Other Charges	0
44.00	Total Charges (Sum of	1,948,140
	lines	
45.00	31.33.35.37.39.41.43)	520
45.00	Total Number of Episodes	530

- TOTAL VISITS
- W/S S-3 PT. IV LINE 42 = 14472
- TOTAL EPISODES
- W/S S-3 PT. IV LINE 45 = 530
- VISITS PER EPISODE
- 14,472/530 = 27.3 VISIT/EPISODE

TOTAL REVENUE

• WS D PART II LINE 12.01 \$1,953,006

TOTAL EPISODES

• W/S S-3 PT. IV LINE 45 530

REVENUE/EPISODES \$3,684.92

UNDUPLICATED PTS 221

EPISODES/PATIENT 2.39

	Description	Part A Services 1.00	Part B Services 2.00	
	Part II - Computation of Reimbursement Settlement	1.00	2.00	
-00	Total massamable sect (Con Instructions)	-		12.00
	Total PPS Payment - Full Episodes without Outliers Total PPS Payment - Full Episodes with outliers	0	1,953,006	
	Total PPS Payment - Full Episodes with outliers Total PPS Payment - LUPA Episodes	0		12.02
	Total PPS Payment - PEP only Episodes	0		12.03
	Total PPS Payment - SCIC within a PEP Episode	0	2,3/4	12.04
	Total PPS Payment - SCIC Only Episodes	0	0	12.06
	Total PPS Outlier Payment - Full Episodes with Outliers	0	109,650	
	Total PPS Outlier Payment - PEP Only Episodes	0	105,650	12.08
	Total PPS Outlier Payment - SCIC within a PEP Episode	0	ŏ	12.09
	Total PPS Outlier Payment - SCIC Only Episodes	o	ŏ	12.10
	Total Other Payments	0	ŏ	12.11
	DME Payments	0	ŏ	12.12
	Oxygen Payment	o	ŏ	12.13
	Prosthetics and Orthotics Payment	0	ŏ	12.14
	Part B deductibles billed to Medicare patients (exclude coinsurance)	ŭ	ŏ	13.00
	Subtotal (Sum of lines 12-12.14 minus line 13)	0	2,249,772	
	Excess reasonable cost (from line 10)	o o	2,2.5,2	15.00
	Subtotal (Line 14 minus line 15)	o o	2,249,772	
	Coinsurance billed to Medicare patients (From your records)	•	2,2.5,2	17.00
	Net cost (Line 16 minus line 17)	0	2,249,772	
	Reimbursable bad debts (From your records)	o	0	19.00
	Pneumococcal Vaccine	-	0	20.00
1.00	Total Costs - Current cost reporting period (See Instructions)	0	2,249,772	21.00
	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets	0	0	22.00
3.00	Recovery of excess depreciation resulting from agencies' termination or a decrease in Medicare	0	o	23.00
4.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit	0	o	24.00
5.00	Total Cost before sequestration and other adjustments (line 21 plus/minus line 22 minus sum of lines 23 and 24)	0	2,249,772	25.00
5.50	OTHER ADJUSTMENTS (SPECIFY)	0	0	25.50
	Sequestration Adjustment (See Instructions)	o	44,996	
	Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.50 minus line 26)	0	2,204,776	27.00
8.00	Total interim payments (From Worksheet D-1, line 4)	0	2,204,776	28.00
8.50	Tentative settlement (For contractor use only)	0	, , o	28.50
9.00	Balance due HHA/Medicare program (Line 27 minus line 28)(Indicate overpayments in brackets)	0	o	29.00
0.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pin. 15-2, section 115.2	0	0	30.00
1.00	Balance due HHA/Medicare Program (Line 29 minus line 30)(Indicate overpayments in brackets)	0	o	31.00

NAT. REVENUE/EPISODES \$3,109 CASE MIX - \$1.073 LUPA PERCENTAGE 8% OUTLIER % 3%

DAYS IN A/R MEDICARE 30 DAYS NON-MEDICARE 60 DAYS

HFS USER MEETING

PAYOR MIX

MEDICARE 56%
MEDICARE ADVANTAGE 19%
MEDICAID 3%
OTHER 12%

PRODUCTIVITY

VISITS/DAY 5-6

DAYS TO RAP 5-7 DAYS

DAYS TO FINAL CLAIM 10-14 DAYS

CY2016 ACTUAL

73% ONE EPISODE

86% TWO EPISODES

25% 30 DAYS OR LESS

HFS USER MEETING

DAYS FROM SOC

PERCENTILE TO RAP SUBMISSION

1

10 5 25 8

25 8 50 12

75 21

90 36 95 57

- NOW THE BAD NEWS
- NEW PAYMENT SYSTEM PROPOSED FOR JANUARY 1, 2019
- REDUCES PAYMENTS \$950M
- PROFIT MARGINS HAVE DECLINED
- NUMBER OF AGENCIES DECLINING
- TRADITIONAL MEDICARE PATIENTS DOWN TO 69%

HFS USER MEETING

- 2018 FINAL RULE
- NEW PAYMENT SYSTEM IN 2019
- ALL EPISODES BEGINNING 1/1/2019
- HOME HEALTH GROUPINGS MODEL (HHGM)
- 30 DAY PAYMENT PERIOD

OASIS 60 DAY EPISODE RETAINED

32 QUESTIONS ELIMINATED OR MODIFIED!!

HHGM SAME FOR SECOND 30 DAY BILLING PERIOD

- 2018 FINAL RULE
- HHGM MODEL HAS FIVE CATEGORIES
 - 1. ADMISSION SOURCE
 - 2. TIMING (EARLY VS LATE)
 - 3. CLINICAL GROUP
 - 4. FUNCTIONAL LEVEL
 - 5. COMORBIDTY

RESULTS IN 144 HHGM PAYMENT GROUPS

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HFS USER MEETING

- 2018 FINAL RULE
- ESTIMATED 30 DAY BASE IS RATE IS \$1,585.48
 LOWEST RATE IS .5034 = \$798.13
 - 1. ADMISSION SOURCE COMMUNITY \$271.12
 - 2. TIMING (EARLY VS LATE) LATE \$618.65
 - 3. CLINICAL GROUP BEHAVIORAL HEALTH
 - 4. FUNCTIONAL LEVEL LOW TO MED \$238.93 MED TO HIGH - \$195.49
 - 5. COMORBIDTY NO COMOBIDITY \$244.01

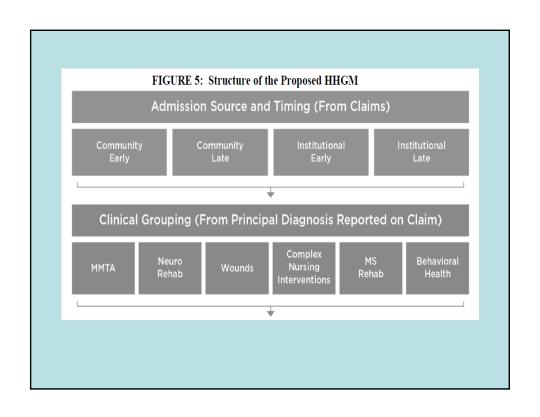
- 2018 FINAL RULE
- ESTIMATED 30 DAY BASE IS RATE IS \$1,585.48
 HIGHEST RATE IS .1.9533 = \$3100.14
 - 1. ADMISSION SOURCE HOSPITAL
 - 2. TIMING (EARLY VS LATE) LATE
 - 3. CLINICAL GROUP BEHAVIORAL HEALTH
 - 4. FUNCTIONAL LEVEL LOW
 - 5. COMORBIDTY NO CORMOBIDTY PAYMENT INCLUDES ALL SUPPLIES

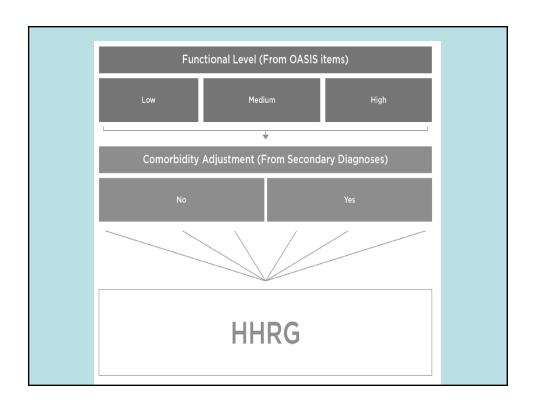
57

HFS USER MEETING

- 2018 FINAL RULE
- HHGM MODEL HAS FIVE CATEGORIES
 - 1. ADMISSION SOURCE
 - 2. TIMING (EARLY VS LATE)
 - 3. CLINICAL GROUP
 - 4. FUNCTIONAL LEVEL
 - 5. COMORBIDTY

RESULTS IN 144 HHGM PAYMENT GROUPS



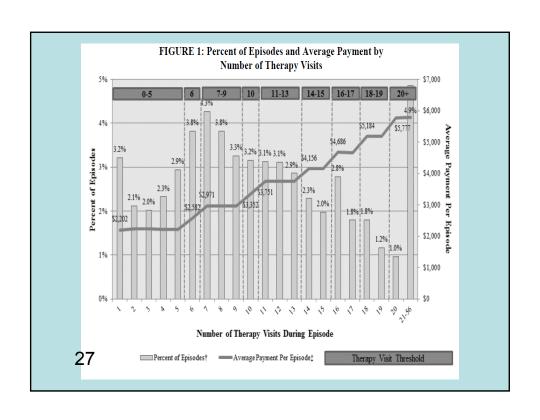


- 2018 FINAL RULE
- THERAPY VISITS ELIMINATED
- 26% INCREASE IN EPISODES WITH 6 OR MORE
- 50% INCREASE IN 20+ THERAPY
- LOW MEDIUM HIGH FORMULA
- 58% OF EPISODES INCLUDED SOME THERAPY
- 72% OF ALL MEDICARE PAYMENTS

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EARLY THERAPY SCORES

		» <u>2016</u>		2017		2009	2016
•	NO. VISITS	PAYMENT	REV/VISIT	PAYMENT	REV/VISIT	EPISODES	EPISODES
•	0			3.75%		48%	48.5%
•	1-5			3.75%		14%	9.3%
	6	\$ 593.33	\$ 98.88	\$ 593.33	\$ 96.41	3%	3.8%
•	7	\$1,056.39	\$150.91	\$1.056.39	\$147.13	9%	4.3%
•	8	\$1,056.39	\$132.05	\$1.056.39	\$128.75		3.8%
•	9	\$1,056.39	\$117.38	\$1,056.39	\$114.44		3.3%
•	10	\$1,531.14	\$153.14	\$1,531.14	\$149.31	10%	3.2%
•	11	\$1,921.27	\$174.68	\$1,921.27	\$170.29		3.1%
•	12	\$1,921.27	\$164.21	\$1,921.27	\$160.10		3.1%
•	13	\$1,921.27	\$147.79	\$1,921.27	\$144.09		2.9%
•	14	\$2,221.20	\$162.75	\$2,165.67	\$154.61	16%	2.3%
•	15	\$2,221.20	\$148.07	\$2,165.67	\$140.67		2.0%
•	16	\$2,622.72	\$163.92	\$2,622.72	\$159.82		2.8%
•	17	\$2,622.72	\$154.28	\$2,622.72	\$150.42		1.8%
•	18	\$2,926.07	\$162.60	\$2.926.07	\$158.54		1.8%
•	19	\$2,926.07	\$154.00	\$2,926.07	\$150.15		1.2%
	20	\$4,030.71	\$201.54	\$3,829.17	\$191.46	6%	1.0%
	21-56	\$4,030.71	\$201.54	\$3,829.17	\$191.46		4.9%



Year	All Episodes	Number of Early Episodes (Excluding Episodes with 20+ Therapy Visits)	% of Early Episodes (Excluding Episodes with 20+ Therapy Visits)	Number of Late Episodes (Excluding Episodes with 20+ Therapy Visits)	% of Late Episodes (Excluding Episodes with 20+ Therapy Visits)	Number of Episodes with 20+ Therapy Visits	% of Episodes with 20+ Therapy Visits
2008	5,423,037	3,571,619	65.9%	1,600,587	29.5%	250,831	4.6%
2009	6,530,200	3,701,652	56.7%	2,456,308	37.6%	372,240	5.7%
2010	6,877,598	3,872,504	56.3%	2,586,493	37.6%	418,601	6.1%
2011	6,857,885	3,912,982	57.1%	2,564,859	37.4%	380,044	5.5%
2012	6,767,576	3,955,207	58.4%	2,458,734	36.3%	353,635	5.2%
2013	6,733,146	4,023,486	59.8%	2,347,420	34.9%	362,240	5.4%
2014	6,616,875	3,980,151	60.2%	2,263,638	34.2%	373,086	5.6%
2015	6,644,922	4,008,279	60.3%	2,205,052	33.2%	431,591	6.5%
2016	6,294,232	3,802,254	60.4%	2,053,972	32.6%	438,006	7.0%

- 2018 FINAL RULE
- PAYMENT BASED ON:
- PRINCIPAL DIAGNOSIS
- FUNCTIONAL LEVEL
- COMORBID CONDITIONS
- ADMISSION SOURCE
- TIMING

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HFS USER MEETING

- 2018 FINAL RULE
- ADMISSION SOURCE WILL AFFECT PAYMENT
- PTS ADMITTED FROM HSOPITAL OR SNF WITHIN 14
 DAYS WILL RECEIVED INCREASE REIMBURSEMENT
- 33.9% FROM FACITY 66.1% FROM COMMUNITY
- NEW SOURCE CODE REQUIRED ON BILL
- ONLY PAID ON FINAL
- EARLY EPISODES FIRST 30 DAYS LATE ALL AFTER

- 2018 FINAL RULE
- NON-ROUTINE SUPPLIES PAYMENT ELIMINATED
- REPLACE WITH \$53.29 PER EPISODE
- INITIAL RAP PAYMENTS 60% RETAINED
- FINAL RAP PAYMENT IS 40%
- SECOND 30 DAYS IS 50% INITIAL RAP
- FINAL RAP 50%
- PHASE-OUT IS PROPOSED IN THE FUTURE

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2018 Urban LUPA Rates

HH Discipline	2017 Rate	2018 Rate (-2%)	Add-on Factor
ННА	\$64.23	\$62.97	
MSS	\$227.36	\$2280	
ОТ	\$156.11	\$157.75	
PT	\$155.05	\$156.68	1.6700
SN	\$141.84	\$143.33	1.8451
SLP	\$168.52	\$165.23	1.6266

2017 Urban LUPA Rates

HH Discipline	2017 Rate	2017 Rate (-2%)	Add-on Factor
ННА	\$64.23	\$64.90	
MSS	\$227.36	\$229.75	
ОТ	\$156.11	\$153.06	
PT	\$155.05	\$152.03	1.6700
SN	\$141.84	\$139.07	1.8451
SLP	\$168.52	\$165.23	1.6266

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Rural LUPA Rates

HH Discipline	2017 Rate	2017 Rate (-2%)	Add-on Factor
ННА	\$66.16	\$64.86	
MSS	\$234.18	\$229.61	
ОТ	\$160.79	\$157.65	
PT	\$159.70	\$156.59	1.6700
SN	\$146.10	\$143.24	1.8451
SLP	\$173.58	\$170.19	1.6266

Urban Non-Routine Supplies

	Points (Scoring)	Relative Weight	CY 2017 NRS Payment Amts	CY 2018 NRS Pay Amt (-2%)
1	0	0.2698	\$14.14	\$14.31
2	1-14	0.9742	\$51.05	\$51.66
3	15-27	2.6712	\$139.97	\$141.65
4	28-48	3.9686	\$207.95	\$210.45
5	49-98	6.1198	\$320.68	\$324.53
6	99+	10.5254	\$551.53	\$558.16

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HFS USER MEETING

- 2017 OUTLIER CHANGES
- FIXED DOLLAR LOSS (FDL) .56 (was .45 in 2016)
- Change from calculation based on visits to 15 minute units
- · Change would disqualify 1/3 of outliers paid in 2015
- Cost Per Unit:
- 1. HHA \$15.46
- 2. MSS \$60.34
- 3. OT \$49.61
- 4. PT \$49.80
- 5. SN \$47.50
- 6. SP \$52.44
- 8 HOURS CAP PER DAY OF CARE IN A GIVEN DAY
- **5.4 MILLION OUTLIER EPISODES**
- 15,384 EPISODES WERE HAD 8 HOURS/DAY
- 1,591 EPISODES EXCEEDED 8 HOURS

• OUTLIER	%	PPS	Ol	JTLIER
• FY2005	4.09%	\$12.9M	\$	527M
• FY2006	5.00%	\$14.0M	\$	702M
• FY2007	6.36%	\$15.7M	\$	996M
• FY2008	6.59%	\$17.1M	\$1	.127M
• FY2009	6.37%	\$18.9M	\$1	.204M
• FY2010	1.91%	\$19.3M	\$	369M
• FY2012	2.18%	\$18.6M	\$	405M
• FY2013	2.01%	\$18.4M	\$	370M
• FY2014	2.13%	\$17.9M	\$	381M
• FY2015	2.23%	\$17.7M	\$	395M
 70% OF HHA 	HADIF	SS THAN	J 19	6

HFS USER MEETING

EFFECTIVE 1/1/2011
CAP OUTLIER 10% PROVIDER SPECIFIC
CAP

- REDUCE OUTLIER 5% TO 2.5%
- REDUCE 5.5% BASE RATE CUT
- TO 3.0%
- EFFECTIVE EPISODES ENDING 1/1/10

TOTAL TOTAL TOTAL » #OUTLIER PAYM **OUTLIER OUTLIER** CLAIM PPS **CLAIMS INSULIN** METRO (MILLIONS) (MILLIONS) 44,717 \$527.8 \$396.3 MIAMI \$277.8 • CHICAGO 1,086 \$493.8 \$ 3.7 \$ 0.9 • ATLANTA 707 \$ 74.4 \$ 3.2 \$ 1.5 • HOUSTON 2,194 \$325.1 \$ 15.7 \$ 9.7 • DALLAS 13,124 \$480.6 \$ 95.3 \$ 57.4

HFS USER MEETING

2007 OUTLIER CLAIMS BY STATE

 State 	<u>Οι</u>	<u>ıtlier Claim</u>	<u>%</u>	% to Tot
• FLA	\$5	21,603,378	25.88%	52.34%
• CAL	\$1	35,157,642	10.99%	13.56%
• TEX	\$1	88,157,854	7.53%	18.87%
UTAH	\$	14,893,982	14.90%	1.49%
• LA	\$	3,624,779	.71%	.36%
• ILL	\$	1,758,722	.22%	.18%
• IN	\$	1,579,186	.65%	.16%
• MO	\$	1,001,648	.44%	.10%
• IA	\$	566,450	.86%	.06%

2014_OUTLIER CLAIMS BY STATE

• State	<u>O</u> ı	utlier Claim	% to Tot
• TEX	\$	59,356,003	15.58%
• FLA	\$	54,444,169	14.28%
• CAL	\$	41,697,090	10.94%
• NY	\$	21,316,663	5.59%
MASS	\$	6,632,154	1.74%
• OK	\$	6,424,326	1.69%
• OH	\$	5,039,449	1.32%
UTAH	\$	4,841,262	1.27%
• CO	\$	2.698,862	0.70%
• CT	\$	2,144,278	0.56%

- EFFECTIVE EPISODES ENDING JANUARY 1, 2010
- 10% OUTLIER CAP/PROVIDER
- RHHI WILL USE YTD PAYMENTS
- 1137 ARE OVER CAP
- \$340 MILLION REDUCTION TO HHA(EST) ACTUAL \$835 MILLION
- ADJUST PAYMENT TOTAL NOT PER PATIENT

2017 OUTLIER EXAMPLE

• HHRG \$1814.96

• FIXED DOLLAR LOSS _____55%

• FIXED DOLLAR \$ 998.23

• THRESHOLD \$2813.19

(\$1,814.96 + \$998.23)

HFS USER MEETING

2016 OUTLIER EXAMPLE

• 60 SN VISITS * \$134.90 = \$8094.00

• OUTLIER THRESHOLD = \$2361.69

• (\$1814.96 + 816.73)

• OUTLIER ELIGIBLE \$5732.31

• MEDICARE 80% \$4585.85

• BASE EPISODE \$1814.96

• TOTAL PAYMENT \$6400.81 INCREASE OVER 2016 \$ 340.32

REVENUE/VISIT \$106.81

PPS REFINMENT 2017

2017 OUTLIER EXAMPLE (OLD SYSTEM)

60 SN VISITS * \$141.54 = \$8492.40
 OUTLIER THRESHOLD = \$2813.19
 (\$1814.96 + 998.23)
 OUTLIER ELIGIBLE \$5,679.21
 MEDICARE 80% \$4,543.37

BASE EPISODE \$1814.96
 TOTAL PAYMENT \$6,358.33

• REVENUE/VISIT \$105.97

HFS USER MEETING

2017 OUTLIER EXAMPLE (NEW SYSTEM)

• 60 UNITS SN VISITS * \$47.50 = \$2850.00

• OUTLIER THRESHOLD = \$2831.34

• (\$1814.96 + 1016.38)

• OUTLIER ELIGIBLE \$ 18.66

• MEDICARE 80% \$ 14.93

• BASE EPISODE <u>\$1814.96</u>

• TOTAL PAYMENT \$1829.89

• REVENUE/VISIT \$30.50

2017 OUTLIER EXAMPLE (NEW SYSTEM)

• 360 UNITS SN VISITS * \$47.50 = \$17100.00

• OUTLIER THRESHOLD = \$ 2831.34

(\$1814.96 + 1016.38)

• OUTLIER ELIGIBLE \$14268.66

• MEDICARE 80% \$11414.93

• BASE EPISODE <u>\$ 1814.96</u>

• TOTAL PAYMENT \$ 9,599.97

• REVENUE/VISIT \$160.00

HFS USER MEETING

- OASIS Submission Timeliness
- Currently required to submit timely to avoid 2% Penalty
- Enforcement of this requirement is an issue
- Episodes beginning on or after July 1, 2016 and before June 30, 2017 – Must score 80%
- 2% Penalty enforced for less than 80% timely submission
- 2016 Final Rule codifies 90% timely submission threshold for July 1, 2017 – June 30, 2018.
- Impact could be significant with new enforcement in place – HHA's should keep documentable records

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- BUNDLED PAYMENT
- JULY 25, 2016 FR PROPOSED RULE
- ADD
- ACUTE MYOCARDIAL INFARCTIONS (AMI)
- CORONARY ARTERY BYPASS GRAFTING (CABG)
- SURGICAL HIP/FEMUR FRACTURE TREATMENT EXCLUDING LOWER EXTREMITY JOINT REPLACEMENT
- RUNS 2017-2021

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HFS USER MEETING

- JOINT REPLACEMENT CURERENT DEMO WAS EFF 4/1/2016
- PATIENT DISCHARGED TO HHA 5%
- PATIENTS TO SNF OR REHAB 12%
- MEDICARE TOTAL COST \$19,900 HHA
- MEDICARE TOTAL COST \$24,900 OTHER
- 25% OF KNEE REPLACMENT ARE O/P
- HHA NEED TO PARTNER WITH ASC

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- PROBE & EDUCATE
- EPISODES BEGINNING 8/1/2015
- PRE-PAYMENT REVIEW
- F-2F DENIALS
- SECOND ROUND EDS SEPT. 2017
- MAKE SURE SIGNED & DATED PROPERLY BY MD
- ASSIGN STAFF TO CHECK DATA
- CGS 92% DENIAL RATE-
- NGS = 85% DENIAL RATE
- THERE WILL BE NO THIRD ROUND!!

•

• 2017 MEDICARE PA	YMENTS =	= \$672.6B
MANAGED CARE	24.9%	\$168 B
 INPATIENT 	23.9%	\$161 B
 DRUG BENEFIT 	14.0%	\$ 94 B
• PHYSICIANS	8.9%	\$ 60 B
HOSPITAL O/P	7.0%	\$ 47 B
 HOME HEALTH 	2.7%	\$ 18 B
HOSPICE	2.5%	\$ 17 B

- HOSPITALS READMISSIONS REDUCTION 3% EFFECTIVE 10/1/2015
- CHF, MI, PNEUMONIA
- ADDING 10/1/2015
 - COPD
 - HIP/KNEE ARTHOPLASTY
 - REMOVE PLANNED RE-ADMISSION
 - DEFINES OBSERVATION LESS THAN 2 DAYS

- HOSPITALS READMISSIONS REDUCTION 3%
- EFFECTIVE 10/1/2016
- ADDING
 - CORONARY BYPASS ARTERY GRAFT (CBAG)
 - ASPIRATION PNEUMONIA
 - SEPSIS PRESENT WHEN ADMITTED FOR PNEUMO
 - 1/3 OF ALL HOSPITALS WERE PENALIZED

HHA readmission rates for diagnoses tied to hospital penalties

<u>Diagnosis</u>	Readmission rate in 2015	Readmission rate in 2014
Overall	15.9%	16.4%
Total hip and knee replacement	3.1%	3.3%
COPD	22.4%	22.4%
Congestive heart failure	22.8%	23.3%
Pneumonia	19.2%	19.9%
Acute myocardial infarction	18.9%	19.5%
Source: OCS Home	eCare, Seattle	

HFS USER MEETING

- ALJ HAS 658,307 APPEALS PENDING
- AVG WAIT TIME IS 935 DAYS!!
- AHA HAS FILED A LAWSUIT100 PROVIDERS ACCOUNT 55% OF APPEALS
- 92,000 OR 14% ARE FROM HHA & HOSPICE
- 24,500 ARE HHA
- 46% ARE DME

92

- BILLABLE MEDICAL SUPPLIES EXPENSES
- WORKSHEET A LINE 12
- PROVIDERS MUST HAVE MARK-UP POLICY
- EXAMPLE = 300% MARK-UP
- FOLEY COST \$10 \$30 CHARGE
- CANNOT BILL INSURANCE IF MEDICARE IS NOT BILLED

2	Other diagnosis = Anal Fissure, fistual and abscess	13
3	Primary diagnosis = Cellulitis and abscess	14
4	Other diagnosis = Cellulitis and abscess	8
5	Primary or other diagnosis = Diabetic ulcers	20
6	Primary diagnosis = Gangrene	11
7	Other diagnosis = Gangrene	8
8	Primary diagnosis = Malignant neoplasms of skin	15
9	Other diagnosis = Malignant neoplasms of skin	4
10	Primary or Other diagnosis = Non-pressure and non-stasis ulcers	13
11	Primary diagnosis = Other infections of skin and subcutaneous tissue	16
12	Other diagnosis = Other infoections of skin and subcutaneous tissue	7
13	Primary diagnosis = Post-operative complications	23
14	Other diagnosis = Post-operative complications	15
15	Primary diagnosis = Traumatic Wounds and Burns	19
16	Other diagnosis = Traumatic Wounds and Burns	8
17	Primary or other diagnosis = V code, Cystostomy care	16
18	Primary or other diagnosis = V code, Traceostomy care	23

19	Primary or other diagnosis = V code, Urostomy care	24
20	OASIS M01322 = 1 or 2 pressure ulcers, stage 1	4
21	OASIS M01322 = 3+ pressure ulcers, stage 1	6
22	OASIS M01308 = 1 pressure ulcer, stage 2	14
23	OASIS M01308 = 2 pressure ulcers, stage 2	22
24	OASIS M01308 = 3 pressure ulcers, stage 2	29
25	OASIS M01308 = 4+ pressure ulcers, stage 2	35
26	OASIS M01308= 1 pressure ulcer, stage 3	29
27	OASIS M01308 = 2 pressure ulcers, stage 3	4
28	OASIS M01308 = 3 pressure ulcers, stage 3	46
29	OASIS M01308 = 4+ pressure ulcers, stage 3	58
30	OASIS M01308 = 1 pressure ulcer, stage 4	48
31	OASIS M01308 = 2 pressure ulcers, stage 4	67
32	OASIS M01308 = 3+ pressure ulcers, stage 4	75
33	OASIS M01308 = 1 + Unstageable Dressing/Device	17
34	OASIS M01332 = 2 (2 stasis ulcers)	6
35	OASIS M01332 = 3 (3 stasis ulcers)	12
36	OASIS M01332 = 4 (4+ stasis ulcers)	2
37	OASIS M01332 = 1 (unobserved stasis ulcers)	9
38	OASIS M01334 = 1 (status of most problematic stasis ulcer: fully granulating)	6

39	OASIS M01334 = 2 (status of most problematic stasis ulcer: early/partial granulation)	25
40	OASIS M01334 = 3 (status of most problematic stasis ulcer: not healing)	36
41	OASIS M01342 = 2 (status of most problematic surgical wound: early/partial granulation	4
42	OASIS M01342 = 3 (status of most problematic surgical wound: not healing)	14
43	OASIS M01630 = 1 (ostomy not related to inpt stay/no regimen change)	27
44	OASIS M01630 = 2 (ostomy related to inpt stay/regimen change)	45
45	Any "Selected Skin Conditions" (rows 1-42 above) AND M01630 = 1 (ostomy not related to inpt stay/no regimen change)	14
46	Any "Selected Skin Conditions" (rows 1-42 above) AND M01630 = 2 (ostomy not related to inpt stay/no regimen change)	11
47	OASIS M01030 (Therapy at home) = 1 (IV/Infusion)	5
48	OASIS M01610 = 2 (Patient requires urinary catheter)	9
49	OASIS M01620 = 2 or 5 (bowel incontinence, daily or >daily	10

- NO SUPPLIES ON FINAL BILL
- MUST CORRECTION THE BILL IF NO
- SUPPLIES PROVIDED
- PAYMENT REDUCED IF CONVERTED TO #
- VA EXCEPTION
- FINAL CLAIM MUST CORRECTED

HFS USER MEETING

MEDICARE SECOND CYCLE BEGAN 3/1/2016

NO MORE MAIL NOTICES WILL BE SENT!!

- SCHEDULE FOR AGENCY WILL BE SENT ON THE ITS WEBSITE
- YOU WILL BE SENT AN EMAIL FROM MAC
- APPLICATION IS DUE ON LAST DAY OF THE MONTH
- ADDITIONAL 60 TO 75 TO SUBMIT APP
- AFTER THAT DATE YOUR NUMBER WILL DEACTIVATED
- CANNOT APPLY MORE THAN 6 MONTHS OR TBD

WWW.CMS.GOV/MEDICARE/PROVIDER-ENROLLMENT-AND - CERTIFICATION/MEDICAREPROVIDERSUPENROLL/REVALIDA TIONS.HTML

Exclusion of Entity Controlled by Family Member

This provision authorizes the DHHS to exclude from Medicare or any State health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following a conviction, assessment, or exclusion.

WEBSITE WWW.OIG.HHS.GOV

- ADVISORY BULLETIN 5/09/2013
 MUST CHECK VOLUNTEERS, CONTRACTOR
 - \$10,000 PENALTY PER ITEM OR SERVICE FURNISHED BY THE EXCLUDED INDIV
 - 3 TIMES THAT AMOUNT IN DAMAGES AND
 - LOSS OF MEDICARE CERTIFICATION
 - AMBULATORY HEALTH CARE SERVICES
 WAS BANNED FROM MEDICARE AGENCY
 IS NOW CLOSED 3/19/2015

- CMS BUDGETED MONEY FOR WHISTLEBLOWERS SUPPLYING TIPS
- 15% OF MONEY RECOVERED UP TO \$66M
- HHA CAN USE SELF REPORTING PROTOCOL
- CHILDREN'S HOME HEALTH CARE PAID \$318,598.43

- 5% OR MORE OWNERS ARE INCLUDED
- MAC NOW SENDING FINGERPRINT REQUEST TO HHA
- MLN MATTER SE 1417
- · CEO & CFO
- MD'S CAN BE CHECKED WITH NPI

- MEDICAID & OIG EXPECT MONTHLY OIG POSITION:
- "HAD REASON TO KNOW " THE INDIVIDUAL WAS EXCLUDED
- SEASONS HOSPICE AND PALLIATIVE CARE OF SOUTHERN FLORIDA \$73,428 SETTLEMENT
- COOPERATIVE HOME CARE IN MISSOURI \$121,010 SETTLEMENT

- HOSPITAL O/P THERAPY CAPPED EFF 10/1/2012 – 12/31/2016
- PTS SUBJECTED TO:
- 2017 Financial Limitation
 - \$1,980 PT/ST
 - -\$1,980 OT
- CWF ALLOWS TRACKING
- ONE EXCEPTION ALLOWED THRU 12/31/2017

Questions?THANK YOU