CMS Manual System

Pub. 100-19 Demonstrations

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

Transmittal 17 **Date: JANUARY 28, 2005**

CHANGE REQUEST 3660

SUBJECT: Demonstration Project for Medical Adult Day-Care Services

I. SUMMARY OF CHANGES: This CR describes the changes necessary to implement the Demonstration Project for Medical Adult Day Care Services. The changes include: (1) implementation of logic to allow for the identification of demonstration patients from the text "HHDAYC" in the claim remarks field. (2) For these claims, make payment to home health providers at 95% of the regular PPS rate in accordance with Section 703 of the MMA.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2005
***IMPLEMENTATION DATE: July 5, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-19	Transmittal: 17	Date: January, 28, 2005	Change Request 3660

SUBJECT: Demonstration Project for Medical Adult Day-Care Services

I. GENERAL INFORMATION

A. Background:

Section 703 of the MMA states that the Secretary shall conduct a 3 year demonstration in not more than 5 sites to provide, as part of the episode of care for home health services, medical adult day-care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries homes. Participation of Medicare beneficiaries in the demonstration is voluntary but limited to 15,000 beneficiaries at any one time.

Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home. Payment will be provided directly to the HHA for all services delivered during the home health episode of care whether at home or in the adult day care facility. In addition, participating home health agencies and medical adult day-care facilities may not separately charge a beneficiary for medical adult day-care services furnished under the home health plan of care.

The business requirements specified in this change request apply only to the Medicare home health benefit and only affect those RHHIs serving sites in States covered under the demonstration.

B. Policy:

Implementation of this demonstration will require changes in payments or payment processing under the home health prospective payment system.

The demonstration design as it pertains to the identification of demonstration patients and the processing of claims and associated information about the home health episode of care is as follows:

At implementation of the demonstration, Medicare beneficiaries receiving home health services at participating HHAs will be able to voluntarily enroll in the demonstration.

After a Medicare beneficiary is referred for home care, the participating HHA, in consultation with the referring physician, conducts an initial patient assessment to determine whether the patient is eligible to receive home health services under the Medicare fee-for-service program. At the initial assessment, the HHA will provide information to the Medicare beneficiary about the demonstration and ask the beneficiary if he/she wishes to participate. The beneficiary will be advised that participation is voluntary and that refusal to participate will not affect his or her home care services or other Medicare benefits. Considering that for some home health patients, treatment outside the home under the demonstration may be contraindicated, the HHA and/or beneficiary should also seek the advice of the referring physician.

The term Medicare beneficiary is defined in section 703(i)(4) as an individual entitled to benefits under part A of title XVIII of the Act, enrolled under part B of this title, or both. However, the RHHIs will not be able to obtain claims information for home health patients enrolled in Medicare Advantage Plans nor would we be able to obtain patient medical record information. Therefore, for the purposes of this demonstration, we will stipulate that the demonstration will not count Medicare beneficiaries who are enrolled in Medicare Advantage Plans or a Medicare managed care demonstration (e.g., Preferred Provider Organizations). The demonstration will apply to all Medicare Part A or Part B beneficiaries participating in the Medicare fee-for-service program.

The demonstration is limited to 5 sites. A site is defined as an HHA selected by CMS from proposals submitted in response to a formal solicitation. The processing of claims for the demonstration will be limited to the 5 HHA demonstration sites. The provider numbers of the selected HHA demonstration sites will be submitted to the RHHIs.

For each identified demonstration patient, the HHA will submit to the RHHI a request for anticipated payment (RAP) entering a special code (the string "HHDAYC") in the remarks section (FL84) of the claim identifying the patient as part of the demonstration. The HHA will place the same code on the end of their episode claim as well.

The RHHI will receive and process the RAP and subsequent (e.g., end-of-episode) claims for payment in accordance with standard Medicare rules. The claim is processed through the Fiscal Intermediary Standard System (FISS), which outputs the claim to the Common Working File (CWF) adding a Special Processing Number 4X for all demonstration claims (those with the string "HHDAYC" anywhere in FL84). The HHA will process claims in accordance with standard Medicare claims processing rules. The RHHI will receive and process the claims for payment in accordance with standard Medicare rules except that final payment to the HHA for that Medicare beneficiary for each episode of care will be adjusted to 95% of the amount that would otherwise be paid out under the Home Health Prospective Payment System. The payment reduction only applies to the HHA PPS payment amount. Any fee schedule items (e.g., DME, P&O, oxygen) provided during the episode are not affected in terms of payment.

On a weekly basis, the FISS will create a file containing the paid claim history in FSSCPDCP/FSSCPDCR record format for each demonstration claim processed and paid during the week, and write it to a designated file address at the CMS data center. Each new file update will be submitted by each RHHI to a GDG (generational data group) established at the CMS Data Center by the support contractor in order to create a cumulative data set of information about all beneficiaries served under the demonstration. The process shall be designed such that, in any week where no demonstration claims are received by a RHHI, an empty data file shall be transmitted to the data center to confirm that the process was executed. The FISS will also create an accompanying report listing selected variables identifying the claims included in each transmission.

Using information from the claim, the support contractor will send the demonstration participant information about the demonstration and also provide a toll-free number and Web site address for further information or questions.

Under the demonstration, all Medicare beneficiaries actively enrolled will be accounted for through the claims identification process. The support contractor will maintain a listing of enrollees. New enrollees will be added to the listing along with their admission date and other pertinent identifiable information and a notation will be made when a home health claim is received that indicates that the enrollee was discharged from home health care at the participating site.

When the number of enrollees reaches 14,500, all demonstration sites will be informed that they must first check with the support contractor before enrolling a new patient under the demonstration. Such requests will be denied after the 15,000-enrollee number has been reached and continue to be denied unless a discharge claim is received for an existing enrollee. In this way, demonstration sites will be prevented from having more than 15,000 Medicare beneficiaries enrolled at any one time.

The support contractor may contact the HHA to request a copy of the plan of care and medical record for each patient after 6 months of treatment or at discharge, whichever occurs first.

C. Provider Education:

Primarily, the Support Contractor will provide provider education. However, the RHHIs will be required to be familiar with the demonstration and issue instructional notices about and/or be able to answer questions posed by the provider with regard to the appropriate use of the special claim code and the need for the collection by the Support Contractor of information about demonstration patients (i.e., the plan of care and medical record).

A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Website and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin."

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3660.1.0	The RHHI shall be informed of all of the provider numbers held by the 5 HHAs selected to participate in the demonstration. The RHHI shall instruct the participating HHAs that for each identified demonstration patient, the HHA shall prepare the Request for Anticipated Payment (RAP) claim, and the end of episode claim in the usual manner, except that the provider submits each claim (DDE, EMC, HCOPY) with the text " 'HHDAYC' in the remarks field (FL84).		X							CMS HHA
3660.1.1	The RHHI shall instruct the HHAs to process the RAP and all subsequent (e.g., end-of-episode) claim(s) in accordance with standard Medicare claims processing rules.		X							HHA
3660.1.2	The RHHI upon receiving a RAP or any other claim with the text "HHDAYC" in the remarks field shall process the claim for payment in accordance with standard Medicare rules, except as noted below.		X							
3660.2.0	The FISS shall develop and implement logic in the beginning of processing to interrogate the remarks field. If the text 'HHDAYC' is present, then FISS shall place a demonstration indicator of 'D' in the DEMO IND field on claim Page 12.					X				
3660.2.1	If the demonstration indicator is present, then the FISS shall transmit a special processing number (SPN) of "48" to the CWF.					X			X	

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3660.2.2	FISS shall reduce the payment amount returned from the HH Pricer by 5 percent (i.e., multiply the payment by .95) for claims with the new SPN.					X				
3660.2.3	If a claim is subsequently adjusted, all related adjustment claims shall have a special processing number (SPN) of "48" attached to that claim.					X			X	
3660.3.0	The FISS shall design and create a process for creating a file of all demonstration claims paid each week, and transmit it in SSCPDCP/FSSCPDCR record format weekly to a generational data group (GDG) at a file address (to be designated) at the CMS data center. The process shall be designed such that, in any week where no demonstration claims are received by a RHHI, an empty data file shall be transmitted to the data center.					X				
3660.3.1	The FISS shall make available a printable version of the report to the RHHI containing the following items for each demonstration claim included in the weekly claims file: a. home health agency provider number b. beneficiary Medicare health insurance identification number with alphanumeric suffix c. beneficiary name d. date of service e. bill type f. claim from date & claim through date g. document control number (DCN) i. original claim DCN (for adjustment claims)		X			X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3660.3.2	The RHHI shall obtain and install a copy of the Connect: Direct software product from CMS.		X							
3660.3.3	The RHHI shall complete a CMS/Data Center user agreement and become a CMS/DC registered user.		X							
3660.3.4	The RHHI contractor shall make a connection to the CMS/DC through the Connect Direct software product and queue a file to be transferred to the CMS/DC. (note: The facility utilized at the CMS Data Center for transferring files in/out of the CMS/DC is the Sterling Commerce, Inc.)		X							
3660.3.5	The RHHI contractor shall submit FISS generated files of newly processed claims on a weekly basis to a generational data group (GDG) at the CMS data center. New files shall be appended to the existing file so that cumulative data is retained.		X							
3660.3.6	Once transferred to the CMS/DC, the file shall be stored on the CMS/DC mainframe platform and protected by the RACF data security protection facility.									CMS, DC
3660.3.7	Other CMS/DC registered users that were granted RACF access authority to the RHHI files stored at the CMS/DC shall have access to manipulate those files.		X							CMS, DC, Support Contractor
3660.3.8	The RHHI files shall be deleted from the CMS/DC mainframe platform 400-days after last use. (note: At that time, those files would become unrecoverable unless an independent magnetic tape copy was taken for an extended period of time by "our" contractor.)									CMS, DC

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3660.4.0	The RHHI shall provide notification to HHA demonstration sites of the: (1) Suspension of the demonstration when notified by CMS that a total of 15,000 current enrollees has been reached, or (2) Cessation of the demonstration at the end of the demonstration treatment period. This shall be the earlier of: (a) Three years after the start of the demonstration; or (b) Such other date as provided by CMS. Upon notification, RHHIs shall no longer identify patients and tag claims based on the presence of "HHDAYC" in the remarks field as described above.		X			X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Armen Thoumaian 410-786-6672 **Post-Implementation Contact(s):** Armen Thoumaian 410-786-6672	**Medicare Contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**