**OHIO HEALTH CARE ASSOCIATION**

**HOME CARE AND HOSPICE COMMITTEE**

**October 26, 2021, 1:00 p.m.**

**Conference Call**

**MINUTES**

Ms. Erin Begin opened the call and welcomed committee members. She referenced the minutes from the previous meeting as well as the conflict of interest, anti-trust compliance and confidentiality policies included in the online folder. She requested that any committee members who called in send an email for their attendance. A summary of attendance is included in a chart at the end of this document. She then informed committee members that Mr. Van Runkle would not be joining today due to a conflict with the Fall Conference.

Ms. Begin then provided an update on the Ohio Home and Community Based Services (HCBS) American Rescue Plan Act (ARPA) funds. Ohio submitted a revised and more detailed plan at the request of CMS on October 19, 2021. A copy of the plan and spreadsheet outlining fund allocations is located in the online folder. OHCA requested that eligible HCBS providers receive 20% of the fiscal year 2021 revenue in a lump sum payment. In the final plan, Ohio is providing 10% of the fiscal year 2021 revenue in a lump sum payment prior to March 31, 2022. The plan also includes technology enhancements in the amount of $50 million, other system and program enhancements, and workforce support collaborative and investments in the sum of over $200 million. The latter of these three additional items was included in the OHCA proposal in the form of a $50 million grant fund for providers. OHCA workforce committee and staff are working to develop guidance and requests for the workforce collaboration funds.

Ms. Begin then discussed the Provider relief fund phase 4 updates. The deadline to submit applications is today. The Health Resources and Services Administration (HRSA) issued a quasi-extension on the deadline. Providers who submit the tax identification number (TIN) validation by 11:59 p.m. today will have until November 3, 2021 to complete their application. The TIN validation reportedly takes 2-3 business days. This applies to both the revenue loss applications as well as the rural provider distributions. Ms. Begin also reminded members that the Period 1 reporting deadline has been moved from September 30 to November 29.

Ms. Begin then moved on to the review of financial topics outlined in the agenda for this month, starting with the Notice of Admission (NOA) updates for home health agency (HHA) providers from Palmetto GBA. During the most recent ask the contractor teleconference, representatives from Palmetto provided two important clarifications on exemptions for a late submission of the NOA. First, the NOA and RAP must be submitted timely with Medicare listed as primary payor for Medicare Secondary Payer (MSP) situations, with no exceptions. Second, CMS has instructed the Medicare Administrative Contractors (MACs) to allow for a new exception due to the incorrect Medicare advantage enrollment information in the eligibility file that later makes Medicare the primary payor. HHAs should resubmit the final claim with “CR11855 Disenroll MA [Date]” in the remarks field of the claim. No reconsideration will be necessary, as they will review the common working file for this information. Providers should still save screen shots of eligibility files for appeal purposes. Additional updates have been provided in various Medicare article communications clarifying specific situations for the NOA. For transition patients, admission date should be first period in 2022 and should follow all future periods. Ms. Begin provided an example to illustrate this clarification and pointed to the article saved in the online folder. They also provided clarifications for when a HHA provides care in a 30-day period of care and then discharges the beneficiary in the next 30-day period of care, but does not provide any billable visits in the next 30-day period, special handling of the patient status code may be needed. Normally, the patient status code for 30-day period before the discharge would be 30, since the beneficiary has not yet been discharged. However, since there will not be a claim for the period in which the discharge occurred, this would result in the HH admission period remaining open in Medicare systems and prevent billing for any later HH services. In order to close the HH admission period in these cases, the HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. This will trigger Medicare systems to close the HH admission period. If the claim has been submitted with patient status 30 before the discharge occurred, the HHA should adjust the claim to change the patient status to 01. Ms. Begin pointed out that this will be operationally challenging as it forces the provider to constantly look back to previous claims to ensure all are discharged. She also noted that in hospice, where similar billing blocks occur, the MACs require the providers to resolve discrepancies between themselves before intervening. There are additional notes for transfer situations where a HHA would not want to discharge the previous period included in the article.

Next, Ms. Begin discussed current open Medicare Claims issues impacting home health agency providers. Error 39621, which had previously listed a resolution set for the November 1 system update, has been placed back into a holding status “SMWORK” awaiting the April 2022 refresh. This error indicates a patient is enrolled in an ACO/BPCI demonstration and that the pre-claim review (PCR) Unique Tracking Number (UTN) should be removed, even when a patient doesn’t meet that description. Providers can check if their referring hospital is participating in one of these models on the CMMI innovations page. There is also an open error regarding incorrect processing for LUPA add-on payments. This is occurring for both when payments should be issued and are not; and also when the payment should not be issued but still is. Lastly, the 727D institutional payment error is still open and not scheduled for correction until the April 2022 release. This causes the payment to calculate incorrectly for an institutional add-on when a patient discharges from a Critical Access Hospital or Inpatient Rehabilitation Facility. Providers can avoid this issue by reporting the discharge date with the appropriate occurrence code.

Ms. Begin then invited Kim Tilley to discuss an issue regarding Performant RAC Audits. She stated that Performant was denying visits for non-documentation and no response letter was sent following the reconsideration. The Recoupment letter was delivered to eServices. This setting under the Administrative tab can be changed to notify of communications via email. Additionally, the takeback was for the entire episode even though only a few visits were denied. The citations also do not match the Chapter 7 manual. Three other agencies have reportedly also experienced this issue. An appeal submitted to Palmetto GBA resulted in overturning the decision made by Performant. Ms. Begin stated she would continue to follow up with NAHC on the concerns regarding the Performant RAC auditors.

Ms. Begin then discussed the HCBS rate increases, applicable to Ohio Home Care Waiver, PASSPORT and state plan Medicaid Home Health. The rates have been confirmed via a Ohio Department of Medicaid email with a start date of 11/1/2021 and a 6.1% increase. OHCA has included a rate sheet for all impacted rates located in the online folder.

Ms. Begin then moved to Electronic Visit Verification (EVV) program changes announced recently by the Ohio Department of Medicaid (ODM). Following stakeholder workgroups on the issues with EVV, which OHCA’s Debbie Jenkins participated in, ODM is making immediate changes to the program. First, ODM will not make EVV mandatory for home health therapy visits until a solution that better accommodates contracted therapists and therapy companies is implemented. ODM is also permanently removing the EVV electronic signature/voice verification requirements for all services; programs will continue to have the ability to establish documentation requirements to meet their needs. They are also changing the Alternate Vendor program, and an Alternate Vendor only has to complete the Sandata testing process and the ODM demo once. A provider who chooses a vendor who is already certified can choose to complete the testing checklist and/or a demo before requesting production credentials. Lastly, the unmatched client phone/ID exception was turned off for visits that occurred on or after October 6, 2021. However there is a known issue where the edit is still showing for HPC services. Sandata is working to resolve this issue as quickly as possible and OHCA would provide an update as soon as it becomes available. While ODM stated that many requirements will be removed, ODM is reinstating the requirement that new providers complete the required EVV training prior to obtaining their provider agreement.

Next, Ms. Begin discussed items that were specific to Hospice agency providers, starting with the hospice room and board payment rate delays and patient liability issues. OHCA submitted many examples provided by OHCA hospice members where Aetna Better Health was not applying patient liability to claims, resulting in mass adjustments and payment delays, for further research. The issue with patient liability processing is being escalated by leadership. Additionally, OHCA recently became aware that Aetna had not loaded the new SNF rates for 7/1/21 for hospice room and board code T2046. This issue should be now corrected and Aetna has initiated an automated reprocessing of impacted claims. Caresource MyCare Medicaid continues to attempt to resolve the error which resulted in claims not being paid at the correct rate for 7/1/21 as well; there is no estimated time of completion for this correction at this time. UnitedHealthcare has begun reprocessing their claims impacted by incorrect payments, and OHCA has requested an update on this process.

Ms. Begin then discussed the Hospice Value-Based Insurance Design (VBID) health plan selection and area announcement. Humana is once again concentrated in Northeast Ohio and reportedly has a full network. Aetna (CVS) will be operating in nearly every urban area of Ohio, however. The network email is in the chat for providers, and we also published in a recent News Bites article. Providers can also reach out directly to Ms. Begin for the information if they do not have access to either of these resources. Providers should weigh pros and cons before contracting with a Medicare Advantage plan. In future years, MA plans will be able to negotiate lower rates, while right now they must pay Medicare FFS rates for in and out of network providers. As it is written currently, CMS only requires the MA plans to contract with one hospice per county, which causes a great deal of concern as it relates to patient choice and resident rights in the state of Ohio. National Advocates are working to change this prior to the end of the demonstration. Providers also should keep in mind that MA plans may end up closing their networks, as Humana has done, restricting the ability to care for clients who have those health plans once the demonstration ends and the MA plan becomes a permanent benefit for the Hospice care program.

Next Ms. Begin discussed the two new claims-based measure in the Quality Measures (QMs), as it relates to the financial considerations and preparation. The two new measures, Hospice Visits in Last Days of Life (HVLDL) and Hospice Care Index (HCI), are replacing measures that previously came from the Hospice Item Set (HIS). The reporting of visits, therefore, is very important to accurately reflect agency performance and future QM outcomes. For example, HCI measures for gaps in skilled nursing visits and skilled nursing care minutes per RHC days re pulled from the claim. Telehealth visits, which are not reportable, may negatively impact hospice agency performance on these measures. The HVLDL looks at RN and Social worker visits in last 3 days of life counting the day of death. In May 2022, CMS will begin displaying this information on Care Compare, and will omit Q1Q2 of 2020 only. Check CASPER folders for your measures, as they are currently available. Ms. Begin pointed to additional information posted in the online folder relating to these two new measures.

Ms. Begin then asked if committee members had any new issues with managed care to report. Hearing none, she then moved on to the announcement from the Department of Veterans Affairs (VA) that they will not require either a No-pay RAP or a NOA for home health claims in 2022. She reminded committee members to check with their managed care contractors to see what they would require, as managed care plans do not have to follow the Medicare payment methodology.

Ms. Begin then gave a brief update on education. OHCA is in the process of developing a Medicaid training seminar for all providers with follow sessions for each provider type. OHCA was also working on scheduling targeted education on Home Health Value Based Payments (HHVBP), NOA billing preparation and the Home Health Final Rule for 2022; the latter would likely be a free member benefit.

Ms. Begin asked again if there was any other business. Hearing none, the meeting was adjourned.

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| **First Name** | **Last Name** | **Company/Facility** | **10/26/21** |
| Erin | Begin | OHCA Staff | X |
| Amy | Allen | Continuum Hospice | X |
| Kelly | Bobeczko | HW&Co | X |
| Lisa | Bracy | Legacy Hospice | X |
| Catie | Bryan | BellaCare Hospice | X |
| Gina | Covelli | Cypress Hospice | X |
| Britteny | Creel | Plante Moran | X |
| Christine | Kenney | Bricker and Eckler LLP | X |
| William | Levering | TLC Home Health Care | X |
| Lori | Revis | Hospice of Southwest Ohio | X |
| Yolanda | Riley | Richter Healthcare Consultants | X |
| Christi | Shockency | Heritage Home Care | X |
| Genevieve | Stelzer | Heritage Home Care | X |
| Kim | Tilley | Staywell Home Health | X |

Next Meeting: November 30, 2021 at 1:00 p.m. Clinical/Regulatory Focus