Meeting Summary for OHCA NF Member Call

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Quick recap

pete provided updates on the application process for private rooms in Ohio long-term care facilities and the process of getting approved by CMS, which could take up to six months. He also discussed the uncertainly of the exact number of category 2 private rooms and the $30 daily rate for Medicaid residents in approved private rooms. Finally, he addressed new rules regarding vent rate and billing for non-invasive events, and emphasized the importance of administrators checking and renewing their licenses.

Summary

Zoom Instructions and Ohio Long Term Care Updates

Mandy and pete initiated the first call of the New Year, with Mandy providing instructions on how to use the Zoom platform for those who were joining via phone. pete then shared updates, noting that the application period for Category One private rooms in Ohio long term care had begun. They emphasized that receiving a confirmation email does not guarantee approval and that there will be a preliminary vetting process. pete also mentioned that providers have 10 business days to respond if additional information is needed. The process is expected to remain quiet for anywhere from 6 to 9 months.

CMS Approval Process and Medicaid Funds Inquiry

pete discussed the ongoing process of getting approved by CMS, noting that the state has not yet applied or requested a review of preliminary information. They estimated that the review process could take up to 6 months, and there could be a change in ownership during this period. pete also mentioned a request to Medicaid to inquire about the number of applicants for the program due to a limit on available funds. They advised those planning to apply for private rooms that there should be no problem, but suggested not delaying the application process. They also highlighted the potential for issues with the application process and encouraged members to report any problems.

Private Room Project Progress Discussed

pete discussed the progress of the private room project, mentioning that they were moving into the second phase in March. They explained that the exact number of category 2 private rooms was unknown, but they had room for approximately 29,000. They also addressed a question about the $30 daily rate for Medicaid residents in approved private rooms, clarifying that it only applied to those on a Medicaid stay. pete also mentioned that the implementation of the project would be 6 months after CMS approval, but the exact timeline was uncertain.

Vent Rate Rule Discussion and Feedback

There was a discussion about the new rule regarding vent rate, which is linked to retroactive approval. pete clarified that there won't be any retroactive approval and the decision will be made on a case-by-case basis. They also mentioned that the rule isn't yet effective, but a draft has been provided for feedback. The draft clarifies some aspects and prohibits billing for noninvasive vents. The discussion also indicated that the Department has not given clear guidance on the implementation of this rule.

Billing, Reporting, and Quality Criteria Discussion

pete discussed the implications of a rule regarding billing for non-invasive events. They noted that while the rule doesn't address this issue, there's a policy statement from the Department of Medicaid that suggests providers shouldn't bill for non-invasive events. They questioned the enforceability of this, given it wasn't in the rule or law. pete also mentioned that approved vent programs will no longer have to report associated pneumonia or VAP rates due to the introduction of a new quality criterion. They speculated that the Department might not strictly enforce the reporting of VAP rates even before the official rule change. Finally, pete mentioned they had more to cover specifically related to the one-star and special focus aspects.

Billing, Admission, and Notification Procedures

The meeting primarily focused on clarifying the billing and admission procedures for facilities with patients. pete explained that if a patient returns to the same facility after a hospital visit, it's not considered an admission but a readmission. Conversely, if a patient goes to another facility or home and then returns, it would be considered a new admission and the facility wouldn't be able to bill for it. They also mentioned that the department has yet to propose a notification system for facilities when they transition from one star or special focus status. Erin’s raised a concern about the timing issue regarding notification of the Cms Star rating, which they felt was still unresolved. pete also highlighted a proposal in the rule to inactivate a provider's status if they have an approved event program but aren't using it.

License Renewal and Draft Rule Changes

pete began by referencing a rule linked in the news bytes and mentioned that questions about it would be addressed. They then passed the discussion to Mandy, who emphasized the importance of administrators checking and renewing their licenses, particularly those with last names starting with A through L, to ensure they met the updated requirements. Mandy also discussed the draft skilled nursing facility rules, highlighting new reporting requirements, changes in administrator roles, and modifications to other areas. They encouraged feedback on these proposed changes. pete then brought up a point about administrator licenses, noting a new exception for temporary absences.

Policy, Address Verification, Incident Reporting, Billing Codes, Rate Changes

Mandy clarified that an acting administrator in a nursing home cannot delegate their role to an unlicensed staff member. They introduced a new policy that requires annual verification of each employee's home address, linked to the third quarter of the 2023 Ij Bulletin. Mandy also discussed the results of surveys conducted at various facilities, highlighting an increase in incidents related to elopement and abuse, and emphasized the importance of promptly reporting such occurrences. Erin’s highlighted the release of billing codes for the assisted living waiver program, stressing the importance of using the correct modifier. Debbie added that providers need to ensure their usual and customary rate on their claim is above the Medicare maximum. Finally, pete discussed the January rate changes and reminded everyone of the 30-day window to file a rate reconsideration request.

2023 Funding Uncertainty and Point Value Adjustment

pete discussed the uncertainty surrounding the 25th percentile funding measure, noting that it would depend on data from the four quarters of 2023, which won't be available until the end of April 2024. They also mentioned the influence of cost reports on the calculations, which won't be filed until the end of March with a 14-day extension, potentially not being available until mid-April. pete estimated that if the 25th percentile maintained the same relationship to the total maximum points as it did in January, it would be approximately 34.5 points. pete concluded by suggesting that the value of each point might be reduced to around $1.20 per point, a decrease from the current value of $1.88 per point.

Next steps

Members who haven't applied for Category 1 private rooms should do so as soon as possible.

Mandy will send out the updated draft of the skilled nursing facility rules for review and collect comments by the end of the day.

Mandy will find and post the link to the belt's write-up on license requirements.