Meeting summary for OHCA Home Care and Hospice Member Call (09/11/2024)

Quick recap

Heidi announced the merger between NAC and NHPCO, introducing the new Hope assessment tool and the new CEO, Steve Landers. Josh discussed the home health proposed payment rule and the Alliance's comments on the detrimental effects of payment cuts on access to care. Erin addressed ongoing issues related to the Provider Network Management System (Pnm), the implementation of the access role, and the introduction of quality measures reporting in 2026.

Next steps

• Providers to prepare for reporting cost data and quality measures for the new Access Rule starting in 2026.
• Providers to monitor and report any ongoing issues with PNM eligibility verification to Medicaid through the integrated help desk email.
• Providers experiencing TPL denial issues with managed Medicaid plans to report examples to Erin for follow-up.
• Jennifer to keep Erin updated on any further denials of routine hospice care claims from Buckeye, Molina, and Anthem Medicaid.

Summary

NAC-NHPCO Merger and Hope Assessment Tool

Heidi announced the finalization of the merger between NAC and NHPCO, with Steve Landers as the new CEO and the new organization to be called the National Alliance for Care at Home. She also introduced the new Hope assessment tool, set to replace the HIS from October 1, 2025. The Hope assessment will be used on admission, discharge, and at 6 and 15 days of a patient's stay, with additional updates on living arrangements, comorbidities, skin conditions, and symptom impact. Josh was expected to discuss the home health proposed payment rule.

Payment Rule Discussion and Alliance's Comments

Josh discussed the recent comments submitted by the Alliance in response to the payment rule. He explained that the rule, which aims to ensure budget neutrality, has been following a methodology that the industry considers faulty, resulting in negative adjustments to payment rates. The proposed rule for this year would reduce rates by about 4%, offset by a 2.5% market basket increase, leading to a 1.5% payment cut. The Alliance's comments this year focused more on the detrimental effects of these cuts on access to care and the insufficient inflationary adjustments in the past couple of years.

Payment, Access, Overtime Rule, and EVV Updates
Josh discussed the adequacy of payment and access to care, mentioning that the Office of Civilian Health, Employment, and Rehabilitation (OCHRE) had signed off on certain comments. He also talked about the overtime rule, which increased the salary threshold for overtime exemption to $43,008.88, with a further increase to $58,656 per year set for January 2025. Josh also mentioned a preliminary injunction issued in a lawsuit in Texas, which applied only to that state. He advised providers to prepare for potential changes in employee policies. Lastly, he shared that the implementation of electronic visit verification (EVV) for Medicaid claims had been delayed to January 1st, providing a reprieve for home health services.

Provider Network Management System Issues
Erin discussed several ongoing issues related to the Provider Network Management System (Pnm). She addressed a recent notice from Medicaid about mass reports of fee-for-service claims not appearing in Pnm, and provided instructions for providers to contact their listed contacts in the Pnm module. Erin also discussed the issue of duplicate overpayments, which were being processed by Medicaid, and the problem of mass recruitments from an Odm initiated error that occurred in December 2023. She noted that these overpayments were isolated from the current overpayments being recouped. Lastly, Erin highlighted issues with the eligibility function in Pnm, such as delays in beneficiary approval and incorrect information in the system. She encouraged members to report any problems they encounter with these issues. Erin also discussed ongoing issues with the 8, 34 file that affects managed care plan eligibility and the struggle with the TPL denial issue with managed Medicaid plans. She advised that evidence of coverage documents should be requested for claims prior to June 2024, and that the issue is being worked on with the plans. jennifer from Continuum Care raised a specific issue with Buckeye, which Erin confirmed was one of the example cases being worked on.

Upcoming CMS Policy Changes and System Developments
Erin discussed upcoming policy changes from CMS regarding the implementation of the access role, which requires providers to use 80% of the Medicaid rate for healthcare worker compensation. She noted that this requirement would apply to Ohio home care, waiver, and passport services, but would not take effect until 2020 with reporting starting in 2028. Erin also mentioned a rate transparency provision that would require providers to detail how much of the rate is allocated to the worker, travel, and administrative overhead. She expressed concern about the potential administrative burden on providers and the need to start discussions with the Department of Medicaid on data collection. Erin also mentioned the introduction of quality measures reporting in 2026, which would require providers to submit 25% of the quality measures. She concluded by stating that they would follow up with the relevant person at Medicaid to discuss these changes and how to reduce the administrative burden on providers. Erin

also discussed the ongoing developments and potential changes in the healthcare system, the need for a streamlined critical incident reporting system, and the importance of rate transparency and quality measure reporting. She cautioned that the access rule is politically sensitive and could be affected by a change in administration. Lastly, Erin mentioned the implementation of the new system, "My Care," which will replace the current system on January 1, 2026, and the need for rate floors for Medicaid services.

Addressing Denials and Systemic Issues in Care
Erin and jennifer discussed issues with the new generation of care and denials for routine care claims. jennifer, from Continuum Care Hospice, reported multiple denials for patients with no Medicaid involvement, and issues with Buckeye, Molina, and Anthem Medicaid. Erin suggested that these denials might be due to a systemic issue and advised jennifer to go through the reconsideration process. Erin also requested jennifer to send any similar issues her way to monitor the situation. The team agreed to meet again in October to discuss further.