By the Numbers

A monthly compendium of OHA finance and patient financial services policy and payment alerts

June 2015

Updated Ohio HCAP and Free Care Guidance
July 1 marks the start of state fiscal year 2016 and with it comes the annual updates to the Medicaid Cost Report, the HCAP/free care data review Agreed Upon Procedures and to OHA’s web-based Frequently Asked Questions, which are designed to help clarify it all.

Details were released at the July 9 HCAP policy session during OHA’s 2015 Annual Meeting. Presentation materials from the session include a PowerPoint Presentation; the preliminary 2015 Ohio HCAP assessment and distribution Model; updated, highlighted SFY 2016 HCAP/free care Frequently Asked Questions; the SFY 2015 Medicaid Cost Report Software and Instructions; and Medicaid DSH audit Patient Log Templates, updated to July 2015. Please note that new Patient Logs 9 & 10 will be added to the set of templates on the ODM Cost Report Webpage very soon.

Medicaid Eligibility Redeterminations Legal Settlement
The Ohio Department of Medicaid (ODM) began redeterminations for Medicaid beneficiaries in January to comply with federal law. The process of redetermination was not without problems, such as undelivered mail and complicated instructions.

In March, the Legal Aid Society of Columbus sued the state’s Medicaid director on behalf of several people and two nonprofits in central Ohio. They claimed that some individuals’ Medicaid benefits were terminated or put at risk after Ohio failed to follow federal law and Medicaid regulations during the review process. Essentially, the plaintiff alleged that the state did not comply with the Affordable Care Act by using passive enrollment to re-determine beneficiaries’ coverage before ending their coverage.

The case was settled in May. It dictated that about 154,000 Ohio residents would have their Medicaid health benefits restored, but the process is not a simple flip of a switch. The beneficiaries need to have their coverage restored by their county offices of Jobs and Family Services using a manual process. The county offices received the lists of people to re-enroll on May 20 and have until August 1, per the legal settlement, to get them reinstated.

What you need to know about the settlement
Beneficiary letters
On June 1, each dis-enrolled beneficiary was mailed a letter explaining the situation. Beneficiaries are to present the letter from state to providers as proof of coverage.
Provider role
When presented with a reinstatement letter by a patient, the provider should call the Medicaid hotline and ask for verification that the person is on the list of re-enrolled beneficiaries.

- Eligibility is retroactive to the date the person was first dis-enrolled.
- State officials suggest holding claims until August 1 and checking MITS before submitting claims.

The beneficiary will be covered by fee-for-service and will not automatically be re-enrolled into their previous managed care plan. These beneficiaries will not receive an entire year of eligibility. Instead, the cases will reset for passive redetermination on the following schedule:

- September 15 for redeterminations that were due in January 2015
- October 2015 for redeterminations that were due in February 2015
- November 2015 for redeterminations that were due in March 2015

The settlement makes other changes to Ohio’s process, including creating a centralized statewide telephone number for renewals and including prepaid return envelopes in renewal packets. It directs Ohio Medicaid to make a good-faith effort to promote online and phone options for renewing Medicaid.

MACPAC and MedPAC Annual Reports are Out
Each June the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MedPAC) release annual reports to Congress with recommendations on Medicare and Medicaid service delivery and spending. Widely used by federal and state policy makers and often a bellwether for future program changes, MACPAC’s June 2015 report on Medicaid is available here and the corresponding Medicare report from MedPAC is available here.

MACPAC’s 2015 report focuses on the use of existing supplemental Medicaid payments, like Ohio’s HCAP, UPL and managed care incentive payment programs, to drive Medicaid delivery system reforms; and on recommendations to Congress on the Medicaid coverage and payment of adult dental services and behavioral health care. MedPAC’s 2015 report includes a discussion of how Medicare must align coverage and policy across payment models, like fee-for-service, managed care and ACO-based systems, and other targeted recommendations on short inpatient hospital stays and Medicare Parts B & D coverage and payment for drugs.

The Morrow County Sentinel reported that U.S. Sen. Sherrod Brown (D-OH) applauded a MedPAC recommendation that Congress should “revise the skilled nursing facility three-inpatient day hospital eligibility requirement” to ensure coverage of Medicare beneficiaries’ skilled nursing stays even if a patient was admitted under “observation status.” Currently, a Medicare beneficiary must have an “inpatient” hospital stay of at least three days in order for Medicare to pay for post-hospitalization skilled nursing care. Patients that receive hospital care on “observation status” are left to pay for skilled nursing care, even if their hospitalization lasts longer than three days.
OHA Recommending UB-04 Revenue Code 0929 for SAFE Charges on Hospitals’ Bills

OHA and its Admitting, Billing & Collection (ABC) Committee are working to standardize hospital billing procedures for services covered by the Ohio Office of the Attorney General’s (AG’s) Sexual Assault Forensic Exam (SAFE) Program and the association is recommending its members adopt one of two approaches.

OHA was approached by the AG’s Victims of Crime Compensation (VoC) Unit about reports that hospitals are billing assault victims and their third-party payers for services covered by SAFE, which is not permitted by Ohio law and rule. OHA’s responded that these inappropriate billings mostly result from confusion over what is covered and how to bill. To assist OHA is working with the VoC to improve SAFE billing instructions, and is recommending hospitals adopt revenue code 0929 (Other Diagnostic Service/Other) to report charges for SAFE-related services on UB-04-based bills. If possible, OHA recommends hospital use the narrative title “SAFE Program” in conjunction with 0929 when billing SAFE-related charges.

The ABC Committee cautioned that many hospitals already have procedures in place to handle SAFE program bills, whereby a clinical staffer examines each outpatient encounter that involves a SAFE exam and creates a specific bill, or invoice, including only the SAFE-related charges and, if appropriate, an additional, separate UB-04 with non-SAFE charges for the patient’s third-party payer. Neither OHA nor the VoC has a problem with this approach, and the VoC states it will continue to accept bills or invoices from hospitals prepared this way.

However, when charges are combined on a UB-04, the VoC want to be sure it is only paying charges related to a SAFE exam and that no SAFE-related charges are being billed to the patient or her/his third-party payer. As such, OHA is recommending that hospitals begin to associate all charges for SAFE-related services that are billed on a UB-04 with Revenue Code 0929. This approach is used in other states with similar programs. Further, OHA is recommending 0929 because it is rarely used by other payers and can be incorporated into most hospitals charge-master-based accounting systems.

The recommendation takes effect immediately. OHA will monitor its members’ ability to incorporate the use of 0929 for SAFE-related charges and continue to work with ABC and the VoC on its educational materials and provider outreach.

2016 UB-04 Manual Available for Order

The American Hospital Association’s National Uniform Billing Committee (NUBC) is processing orders for the electronic, 2016 edition of the Official UB-04 Data Specifications Manual. Information, pricing and how to place an order can be found on the NUBC website. The 2016 UB-04 Manual will be accessible on July 1, 2015. Until then current 2015 UB-04 licenses are valid. Questions or requests for technical assistance can be directed to the NUBC here.
The NUBC warns licensees that they should print a hardcopy of the 2015 manual for archival purposes, as access to it will end June 30. All users must use the LockLizard Secure PDF Web Viewer to access the 2016 UB-04 Manual. Free LockLizard Viewer Software and User Manual are available.

**CMS Releases ACO Final Rule**  
The Centers for Medicare & Medicaid Services this month released a [final rule](#) on changes to the Medicare Shared Savings Program and provisions relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations under the MSSP.

Among other provisions, CMS will allow non-risk-bearing ACOs to participate for an additional agreement period, to change the methodology for assigning beneficiaries to ACOs, create a third track for MSSP participation, and provide additional data to help ACOs better manage care. The changes generally apply to existing ACOs and approved ACO applicants participating in the program beginning Jan. 1, 2016.

**July 2015 Medicare Claims Software Release Will Cause Several "Dark" Days for the Common Working File (CWF) Hosts**  
CGS, the regional Medicare Administrative Contractor announced that the Medicare Common Working File (CWF) will have several "dark" days from Thursday, July 2 through Saturday, July 4 to install the July 2015 Fiscal Intermediary Shared System (FISS) update. CWF transactions, deductible queries, etc., will not be available, including ELGA and ELGH for Part A providers.

The CWF Dark Days will not affect a hospital’s ability to access beneficiary eligibility information through myCGS. In addition, the Interactive Voice Response (IVR) will be available. CGS reports it is customary for contractors to hold claims for several days following a quarterly release. Claims submitted prior to the release that would have been processed through the Common Working File (CWF) on July 1 and 2 will be held until the CGS nightly system cycle, Monday, July 6. CGS anticipate claims will still be processed within a normal timeframe and these slight delays will not affect the overall timeliness of providers’ payments.

**Medicare MAC Satisfaction Survey**  
CGS, the regional Medicare Administrative Contractor is asking Ohio hospitals and other Medicare Part A providers to complete the latest CMS [MAC Satisfaction Survey](#). This Medicare Fee-For-Service (FFS) Contractor Website Satisfaction Survey measures users’ satisfaction with MAC websites, with an emphasis on customer service.

Scores are measured along the American Customer Satisfactions Index (ACSI) and are based on the immediate 300 previously completed surveys for each contractor website. The average 2015 first quarter score across local, state and federal websites was 74.7. CGS had a 72.0. Other first quarter 2015 MAC scores are available [here](#).
Still no Word on Ohio Medicare or Medicaid RAC Contracts
OHA is still waiting word on who will be tapped to take over the Medicare and Medicaid Recovery Auditor Contractor (RAC) programs for Ohio. The Ohio Department of Medicaid states it released a Request for Proposals in late May and that it expects to review responses this summer. In the interim ODM released a brief set of Medicaid RAC Q&As on its efforts to clean up outstanding appeals and recoveries from the old CGI contract.

The Centers for Medicare & Medicaid Services (CMS) is still mum on the status of its next round of Medicare RAC regional contracts, and CGI Federal still occupies an extended role as Region B contractor while CMS finalizes an announcement and timeline on the next round.

At the same time CMS this month announced it has settled the appeals of outstanding Medicare inpatient status claims from more than 1,900 hospitals, representing approximately 300,000 claims, which CMS states “modestly” reduces the backlog of Medicare appeals in the system. The agency says it has paid approximately $1.3 billion to hospitals through the settlement offer it made last August, in an attempt to address the approximately 800,000 backlogged Medicare appeals awaiting a hearing before an administrative law judge.

In addition, the US Senate Finance Committee approved by voice vote a Chairman’s Mark of the Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015, a bipartisan bill to make changes to the Medicare audit and appeals process. The bill would make several changes to how Medicare contractors, including Recovery Audit Contractors, review providers’ Medicare claims, as well as changes to the appeals process intended, in part, to address the significant backlog in appeals at the administrative law judge level.

OHA Unveils the Institute for Health Innovation
This month OHA unveiled the Institute for Health Innovation, a new entity dedicated to promoting excellence in safety and quality and improving the health of our communities. OHA President and CEO Mike Abrams announced during the OHA Annual Meeting that Bricker & Eckler LLP will be a Founding Centennial Partner providing initial funding for the Institute.

The Institute combines clinical expertise with sophisticated health care data analytics to provide sound strategies and resources across the continuum of care. The work of the Institute will center on three foundational priorities: Accelerating Health Care Quality: Ohio hospitals and health systems establish and sustain a culture of safety and unrelenting quality; Integrating Transition of Patient Care: Ohio hospitals will collaborate with other care providers to deliver integrated, patient-centric care; and Advancing Community Health: Ohio hospitals lead efforts to improve community health.

The Institute is governed by a 16-person board of directors made up of Ohio hospital representatives. For additional information about The Institute, visit ohiohospitals.org/ins

AHA Testifies at Hearing on VA’s Ability to Promptly Pay non-VA Providers
The US House Committee on Veterans’ Affairs Subcommittee on Health this month held a hearing on the “VA’s ability to promptly pay non-VA providers.”
Testifying for the American Hospital Association (AHA), Vince Leist, president and CEO of North Arkansas Regional Medical Center, highlighted hospitals’ strong record of collaborating with the VA to care for veterans, but emphasized that lack of prompt payment by the VA and its contractors “hinders access to care for veterans who need non-VA services and undermines the viability of non-VA hospitals and the essential services they provide to their communities.”

Leist expressed concern about how the VA processes claims and detailed how many hospitals, including NARMC, have not been paid by the VA for claims that go back more than three years. In addition, he provided a number of recommendations that could help ensure prompt payment by the VA, including paying claims within 30 days of the receipt of a proper claim, making interest payments to hospitals when claims are not paid in 30 days and requiring the VA to develop a metric to measure effectiveness in its claims processing.

Just the Facts

- The June edition of the Ohio Bureau of Workers’ Compensation’s Provider e-News is Available here, with a lead article on BWC’s Enhanced Care Program pilot project in NE Ohio.

Hold the Dates

- OHA and the Ohio Department of Medicaid will cosponsor the first of three webinars on ODM’s new Medicaid Enhanced Ambulatory Patient Grouping (EAPG) outpatient prospective payment system Tuesday, June 30 from 10:00 to 11:30. Dial-in information and meeting materials will be forwarded to OHA finance and patient financial services members prior to the call.

  - Medicare 101 and Medicare Cost Reporting Fundamentals, an expanded Medicare two-day 101 educational seminar now includes a Cost Report session on day two. Produced in cooperation with the Florida Hospital Association and Plante Moran, the popular program is Aug. 19 & 20. Attendees will be able to register for either or both sessions. A meeting brochure and registration materials are available here.

  - Medicare & Medicaid in 2016 (aka the “Larry & Larry Show”) is scheduled Oct. 6 in Columbus. Expect registration materials in July.

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