Hawaii Medicaid Provider Bulletin

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Aloha!
Don't Trash it! Pass it!
Be sure to route this to:

☐Entire Organization and Contractors

They should be up to date with the latest news!

Electronic Visit Verification (EVV)

The new mandatory statewide Electronic Visit Verification (EVV) timeline is finalized. EVV has been extended giving provider agencies additional time to ramp up given the impacts of COVID-19.

Provider Training: EVV provider training registration opens in September 2020 and training will begin early October 2020.

3rd Party EVV vendors: If your provider agency is using a 3rd Party EVV vendor, testing with Sandata begins early August. If testing is not completed by *10/16/20* your provider agency will be required to attend Sandata EVV training.

EVV Authorizations: The Health Plans will be ending existing authorizations with EVV related service codes on *9/30/20.* The Health Plans will be issuing new authorizations for EVV related service codes and modifiers to be effective on *10/1/20.* Claims submitted for EVV related visits/services MUST align to the EVV service codes and modifiers starting *10/1/20.* The Developmental Disabilities Division (DDD) authorizations are not impacted due to the service codes and modifiers not being changed.

Sandata EVV System: The Soft Launch / Parallel Testing will run from *10/5/20 - 12/29/20.* This is a ramp up time that Providers can use the live EVV system to schedule and record EVV visits. Providers using Sandata for EVV billing can have 837s generated for validation. DDD and the Health Plans can execute Visit Validation against Sandata stored visits during this time to ensure a smooth transition.

EVV Claims processing: DDD and the Health Plans are starting the "Soft Edits" for EVV related claims on *12/30/20.* The soft edits will indicate if there were any issues with the claim payment in relation to EVV that should be resolved. Claim denial *"Hard Edits" will begin on 4/1/21* if there was no EVV visit found for the claim.

EVV Mandatory usage state-wide (including 3rd Party EVV vendors) is *12/30/20.*

Med-QUEST Division's New Provider Enrollment System - HOKU

On August 3, 2020, the Med-QUEST Division (MQD) will launch a new web-based system that will allow providers to enroll, update, and make changes to their information quickly and easily online. This will reduce 'paper' processing and will save time for both the provider and our state staff. The new system is named HOKU, which stands for Hawaii's Online Kahu Utility. Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or shepherd, one who looks after their flock. Our Medicaid providers are caretakers, responsible for looking after Medicaid members. MQD will be phasing provider registration in waves and would like to encourage all Medicaid providers to register in HOKU at the appropriate time. HOKU allows providers to review their provider enrollment information, and make any revisions if needed. MQD will mail-out an updated provider memo and also update the website with information around the go-live date, registration periods for each wave (group of providers) and training opportunities. Please call MQD's Provider Hotline at 692-8099 or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions.

Med-QUEST Rescinds Managed Care Contracts

The COVID-19 pandemic has created unprecedented challenges for providers and others in the community. In response to this public health crisis, Med-QUEST is rescinding the contract awards made to managed care organizations in January, canceling the request for proposal (RFP) released in August 2019, and will issue a new RFP in the fall to address the evolving needs of the community.

Provider Relief Fund for Medicaid Providers

U.S. Department of Health and Human Services (HHS) made public announcement providing details on how they intend to disburse funding to Medicaid providers from the provider relief fund. It includes additional relief payment considerations for Medicaid providers, among other providers. If you have questions, please contact HHS directly.

Key details on the Medicaid disbursements:

- **Total Amount:** $15 billion for Medicaid providers.
- **Eligibility:** Any provider that did NOT receive a funding award from the first $50 billion in awards made to providers with some level of Medicare utilization -- AND – has directly billed a state Medicaid program or Medicaid managed care plan between January 1, 2018 and May 31, 2020.
- **Process:** Providers submit annual patient revenue information to HHS's provider relief fund portal.
- **Award Amounts:** Minimum of two percent of gross patient care revenues, with final amount determined by provider-submitted data including number of Medicaid patients served.

HHS Announces Enhanced Provider Portal, Medicaid & CHIP Providers

On June 9th, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is announcing additional distributions from the Provider Relief Fund to eligible Medicaid and Children's Health Insurance Program (CHIP) providers that participate in state Medicaid and CHIP programs. HHS expects to distribute approximately $15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Distribution.

"Healthcare providers who focus on treating the most vulnerable Americans, including low-income and minority patients, are absolutely essential to our fight against COVID-19," said HHS Secretary Alex Azar. "HHS is using funds from Congress, secured by President Trump, to provide new targeted help for America's safety-net providers and clinicians who treat millions of Medicaid beneficiaries."

HHS is providing support to healthcare providers fighting the COVID-19 pandemic through the bipartisan *CARES Act* and the *Paycheck Protection Program and Health Care Enhancement Act*, which allocated $175 billion in relief funds to hospitals and other healthcare providers, including those disproportionately impacted by this pandemic.

ENHANCED PROVIDER RELIEF FUND PORTAL

On June 10th, HHS is launching an enhanced Provider Relief Fund Payment Portal that will allow eligible Medicaid and CHIP providers to report their annual patient revenue, which will be used as a factor in determining their Provider Relief Fund payment. The payment to each provider will be at least 2 percent of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve.

The initial General Distribution provided payments to approximately 62 percent of all providers participating in state Medicaid and CHIP programs. The Medicaid and CHIP Targeted distribution will make the Provider Relief Fund available to the remaining 38 percent. HHS has already provided relief funding to over one million providers, and today's announcement is expected to reach several hundred thousand more providers, many of whom are safety net providers operating on thin margins.

Clinicians that participate in state Medicaid and CHIP programs and/or Medicaid and CHIP managed care organizations who have not yet received General Distribution funding may submit their annual patient revenue information to the enhanced Provider Relief Fund Portal to receive a distribution equal to at least 2 percent of reported gross revenues from patient care. This funding will supply relief to Medicaid and CHIP providers experiencing lost revenues or increased expenses due to COVID-19. Examples of providers serving Medicaid/CHIP beneficiaries possibly eligible for this funding, include pediatricians, obstetrician-gynecologists, dentists, opioid treatment and behavioral health providers, assisted living facilities, and other home and community-based services providers.

To be eligible for this funding, health care providers must not have received payments from the $50 billion Provider Relief Fund General Distribution and either have directly billed their state Medicaid/CHIP programs or Medicaid managed care plans for healthcare-related services between January 1, 2018, to May 31, 2020. Close to one million health care providers may be eligible for this funding.

More information about eligibility and the application process is available at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html

Conduent continues to serve our Community!

In the midst of the new corona virus pandemic, our organization will continue to stay open for our provider community. We will be open for correspondence drop offs and pick ups daily and provider payment checks will continue to be distributed on Fridays. To better serve you, please call 808-952-5570/ 1-800-235-4378 when visiting our office.

Eligibility Terminates in the Middle of Confinement

When recipient eligibility terminates with Medicaid Fee For Service during an acute **non-outlier** inpatient stay,
the claim should be billed accordingly:

- In FL04 (Type Of Bill): XX1
- In FL22 (Patient Status): 30
- In FL06 (Statement Covers Period): the through date must be the last date of the recipient's eligibility

Types of bill 112, 113, and 114 are only for use for acute inpatient outlier claims and for acute waitlisted skilled nursing facility (SNF) or acute waitlisted Intermediate Care Facility (ICF) claims.

Outlier Claims Billing Tips

The following helpful tips may help to increase faster processing time on your outlier claim.

* The first claim (interim bill type 112) should indicate in FL06 (Statement Covers Period) the date of admission through the date the covered charges equal the outlier threshold amount specified for your facility.
* All claims (bill type 112, 113, 114) must have condition code 61 (FL24-30)
* All claims (bill type 112, 113, 114) must have the same admission date (FL17)
* Bill type 112 must be approved before bill type 113 or 114 claims will approve
* In order for the claim to brand as surgical, all interim claims must indicate the surgical ICD-10 procedure code and surgical date.
* Psychiatric and out of state claims do not qualify for outlier rates.
* Please refer to Medicaid Provider Manual 11.1.4.4 (chapter 11, page 7) for additional information on outlier claims.

What is on the MQD Website?
https://medquest.hawaii.gov/en.html

Please log on your PC and surf the new website! Links of interest to Medicaid Providers are in the 'Plan and Providers' menu, such as: Medicaid Provider Bulletins, Medicaid Provider Memos, Fee schedule, and the Provider 1139 Application with instructions. Please be up to date by reviewing the quarterly Provider Bulletin which gives you up to date policy and guideline changes.

What is an EMGSVC Recipient Eligible Patient?

The Emergency Medical Treatment & Labor Act defines an emergency medical condition as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence

of immediate medical attention could reasonably be expected to result in -

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part .

If you have questions about the patient's 1149a authorization on file, please work with one of our Call Center Agents at 1-800-235-4378/1-808-952-5570. If you have questions on the patient's enrollment status, please contact the DHS Eligibility Enrollment Worker at 1-808-587-3521 and listen to the menu options carefully.

1149a Document Initiation by Conduent

Undocumented aliens who apply for the EMG SVC benefit may receive the benefit for service(s). These service(s) requires an 1149a approval. Please contact Conduent Call Center and the agents will process and initiate your medical records on your behalf. Please work with an agent today!

The provider will need to submit the following:

Emergency Room Visit
1.Date of Service(s) and name of facility
2.ER record and ER physicians written or dictated documentation

Inpatient Hospital
1.Date of Service(s) and Name of hospital
2.Admission history and physical examination
3.Discharge Summary
4.Physician and nursing progress notes for the period is requested.

To ensure your records will be processed accordingly, it is best to address the name of the Call Center agent on the cover sheet along with the CRN and all required medical records attached. We also encourage that you follow up with the Call Center on the progress of your initiated 1149a within the next couple of weeks after submission.

Medicare Advantage Plan (Med-Gap Plans)

A patient may be enrolled in a Medicare Advantage Plan. When submitting to Medicaid for secondary payment, please ensure you have the proper explanation of benefits (EOB) attached, along with the name of the supplement plan in box 9d or 11C on the 1500 or in box 50 on the UB04 claim form.

Please contact our Call Center Agents at 1-800-235-4378/1-808-952-5570 for more information about Medigap Plan listings.

Hawaii Medicaid Promoting Interoperability (PI) Program

Program Year 2020

Program Year 2020 will be opening soon. Here are some things to remember when attesting:

- The EHR reporting period for all Medicaid EPs is a minimum of any continuous 90-day period within calendar year 2020.
- All EPs must attest using a 2015 Edition CEHRT.
- All EPs are required to attest to the Stage 3 Measures and Objectives.
- All EPs must report on a 90-day CQM reporting period.
- The Security Risk Analysis must be completed within calendar year 2020. EPs are required to attach documentation of the Security Risk Analysis to their attestations. We will accept the actual Security Risk Analysis document OR the SRA Tool Summary Report from Office of National Coordinator (ONC). EPs that are part of a large group do not need to include their individual provider information, i.e. name and NPI, on the Security Risk Analysis.
- Protected Health Information (PHI) should not be included in any documentation uploaded to the SLR.

2020 EP CMS Promoting Interoperability Program Objectives and Measures

Providers are required to complete all eight MU objectives. The 2020 EP specification sheets are located here: https://www.cms.gov/files/document/medicaid-ep-2020-table-contents.pdf

2015 Edition Certified EHR Technology

All participants in the Medicaid Promoting Interoperability Program are required to use 2015 Edition CEHRT.

- The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2020.
- The functionality must be in place by the first day of the EHR reporting period.
- The product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period.
- The 2015 Edition functionality must be used for the full EHR reporting period.

Clinical Quality Measures (CQM) Policies for Program Year 2020

- All EPs must report on a 90-day CQM reporting period
- EPs are required to report on any six CQMs related to their scope of practice.
- EPs are required to report on at least one outcome measure.
    - If no outcome measures are relevant to that EP, they must report on at least one other high-priority measure.
    - If no outcome or high priority measures are relevant to an EP's scope of practice, they must report on any six relevant measures.

The CQMs can be found at https://ecqi.healthit.gov/ep-ec?year=2020.

Hawaii Outreach Coordinator

Heidi Miles is the Outreach Coordinator for the Hawaii Medicaid Promoting Interoperability Program. She is available to assist providers with their attestation questions. Contact Heidi via email or telephone at Heidi.Miles@Conduent.com or (808) 561-2197.