OHA UPDATE

HFMA North West Event

January 19, 2017

Agenda

- 2016/2017 OHA Policy/Payment Advocacy Initiatives
  - Prior Auth Law
  - Community Health Needs Assessments
  - Healthy Ohio Program
  - Health Care Price Transparency
- FFY/CY 2017 Medicare PPS Rules
  - Site Neutral Payment Policies
  - MOON
- 2017 Medicaid EAPG OPPS & Rebased IPPS
- Medicare RAC Contract awarded
- 2017 BWC IPPS/OPPS
- Other
  - Medicaid DSH Program Audits
  - Ect., ect

PRIOR AUTHORIZATION LAW

- Governor Signed Sub. S.B. 129 in June
- Various Effective Dates; Most Start with Policies Issued After January 2018
- Still Waiting on Public Rules and Additional Direction from ODI and ODM
- Permits Providers and Patients to Obtain PAs Through a Web-based Systems
- Requires Payers to Respond within 48 hours for urgent care and 10 days for other services
- Requires Retroactive PA Requests & Limits Retroactive Denials
- Requires Appeals Process for PA Denials

COMMUNITY HEALTH NEEDS ASSESSMENTS

Align Local Health Assessments and Planning

- Every three years, beginning in 2020

Submission of Local Planning Assessments

- Existing assessments and plans submitted to a state repository, effective July 1, 2017
- Plans and assessments covering years 2020-2022 submitted by October 1, 2020
- ODH will provide guidance regarding submission

Hospital Community Benefit Reporting

- Requires tax-exempt hospital submission of IRS Schedule H (Form 990) to ODH to better account for community benefits, effective July 1, 2017

HEALTHY OHIO PROGRAM

- In the SFY 2016/2017 state budget Medicaid expansion was a key issue
- Legislators required Healthy Ohio Program in exchange for expansion funding

- Includes CFC and expansion populations
- Establishes health savings account (Buckeye Account) for each participant
- Requires "contributions" of lesser of 2% of participant's annual family income or $99
- Requires each county JFS office to refer unemployed or underemployed participants to a workforce development agency

HEALTHY OHIO PROGRAM

- Terminates a non-pregnant participant if monthly payment is 60 days late, or for failure to submit documentation for redetermination
- Reinstates participant when participant pays the full monthly installment, or submits documentation
- Requires participant who exhausts the annual or lifetime payout limits to be transferred to fee-for-service Medicaid or the care management system
- Requires participants to enroll in an MCP
- Requires co-payments for covered services. Co-payments waived whenever the amount of the core portion of the participant's Buckeye Account is $0

HEALTHY OHIO PROGRAM

KEY IMPLEMENTATION QUESTIONS FOR HOSPITALS

- PROGRAM COSTS
- ADMINISTRATIVE COMPLEXITY
- PATIENT EDUCATION
- COLLECTION OF CO-PAYS
- EXPECTED ENROLLMENT DECLINE
- HOSPITALS AS NON-PROFITS
- TRANSITIONS
- RETROACTIVE ELIGIBILITY ELIMINATION

HEALTHY OHIO PROGRAM

CMS Denied "Round One" Waiver Application in September

Ohio application Does Not

"support the objectives of the Medicaid program"

- Would not Increase Efficiency or Quality of Care
- Premium Structure is Concerning, Especially given Predictions that 100,000+ Could Lose Coverage
- High Potential for reduced access to Care, Especially if Enrollees are Indefinitely Eliminated due to Inability to Pay Overdue Premiums

Anticipate Revised Proposals and New Waiver Request to be Introduced as Part of 2018/2019 State Biennial Budget Debate

PRICE TRANSPARENCY

The Legislative Language

- Part of Am. Sub. HB 52; Effective 1/1/17
- Passed in the 11th hour state budget discussions without stakeholder input
- Requires providers to provide, prior to delivery of non-emergency services, a written "good faith estimate" of
  - Amount provider will charge patient or plan
  - Amount health plan intends to pay
  - The difference or consumer out-of-pocket
- Health plans are required to respond to a provider's inquiry regarding a patient's insurance coverage within a "reasonable time"
- Requires Ohio Department of Medicaid rules

PRICE TRANSPARENCY

OHA's Response

- **Recommended Parameters**
  - Limit to Hospital Services
  - Limit to "Shoppable" Services
  - Eliminate estimate of "charges"
  - Limit to "upon request"
  - Require Payer Cooperation
  - Response w/in clearly defined time
  - Hospital can't be found in violation if payer doesn't cooperate
  - **More time to comply**
- **Frequent, ongoing conversations with legislative leaders over the last 12 months**

PRICE TRANSPARENCY

OHA PROPOSALS

- **SCOPE OF SERVICES**
  - AFFIRMATIVELY PROVIDE AN ESTIMATE FOR A LIST OF NON-EMERGENCY SCHEDULED SERVICES
  - PROVIDE AN ESTIMATE UPON REQUEST FOR OTHER SERVICES
  - CONVENE A COMMITTEE TO UPDATE THE LIST AS NECESSARY
- **SCHEDULED SERVICES**
  - ESTIMATES FOR NON-EMERGENCY SERVICES PROVIDED WITHIN 7 DAYS, CONTINGENT ON PAYER COOPERATION
- **PAYER COOPERATION**
  - RESPONSE TO PROVIDER INQUIRY REQUIRED WITHIN 48 HOURS

PRICE TRANSPARENCY

OHA PROPOSAL (CONTINUED)

- **NON-GOVERNMENTAL PAYERS** – NO ESTIMATE FOR MEDICAID ENROLLEES, WHO HAVE ZERO OOP OBLIGATIONS
- **OUT-OF-POCKET COSTS** – ESTIMATE TO INCLUDE OOP OBLIGATIONS, NOT "CHARGES"
- **MORE TIME TO COMPLY**
- **PENALTIES/LIABILITY PROTECTION** – NO PUNITIVE APPROACH / NO PENALTY FOR HOSPITALS MAKING GOOD FAITH EFFORT
- **"GOOD FAITH"** – PROVIDERS CAN'T BE HELD RESPONSIBLE FOR PATIENTS WHO ARE DIFFICULT TO CONTACT
- NO **DELAY IN CARE** AND **INSURER PAYMENT NOT CONTINGENT ON RECEIPT OF ESTIMATE**

PRICE TRANSPARENCY

OHA Vendor Discussions

- OHA explored vendor relationships to assist hospitals in their Transparency performance
- Several tools in marketplace to allow hospitals to provide the information required in the law
- OHA entered exclusive arrangement with TransUnion for member discount to purchase TU tool
- Hosted informational webinar for members in March 2016

PRICE TRANSPARENCY

LEGISLATORS' END GAME

- IN THE END, THOSE LEGISLATORS WE ARE WORKING WITH WANT PROVIDERS TO HAVE SYSTEMS IN PLACE TO PROVIDE A WRITTEN ESTIMATE FOR ALL PATIENTS AND ESSENTIALLY EVERY SERVICE BEFORE THE SERVICE IS DELIVERED
- OHA'S CHALLENGE IS TO SCALE THIS PERSPECTIVE BACK TO SOMETHING WITH WHICH HOSPITALS CAN COMPLY AND THAT WILL PROVIDE MEANINGFUL INFORMATION TO PATIENTS.

MEDICARE OUTPATIENT OBSERVATION NOTICE

Effective Aug. 6, 2016, but Compliance Delayed until March 2017

(Hospitals may include contact information or logo here)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON Expiration 12/31/2019. OMB approval 0938-1308

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email:AltFormatRequest@cms.hhs.gov.

Form CMS 10611-MOON Expiration 12/31/2019. OMB approval 0938-1308

FFY 2017 MEDICARE INPATIENT ACUTE CARE HOSPITAL

- Hospital-Acquired Conditions Reduction at 1% of Payments for all MS-DRGs for Top Quartile of Hospitals
  - New Scoring Mechanisms Finalized for 2018
- "Excessive" Readmissions Penalty at 3% of Base Payments
  - Covered Conditions & Measures Expanded
- VBP Program Funding Set at 2% of Base Payments
  - $1.8B at Risk in 2017
- Several Changes to Quality Reporting Program and Measures Finalized for 2019 & 2020
- 2% Payment Sequestration Still in Effect
- Detailed OHA Analysis Available Online

CY 2017 MEDICARE OUTPATIENT HOSPITAL

Proposed Rule

- Released July 6; Effective Jan. 1, 2017
- Increases Overall Payments by 1.55%
  - Reduces 2.8% Market Basket for Productivity & Budget
- Strict Interpretation of BBA Sec. 603
  - No Recognition of Provider-Based Status to Facilities Started, Moved or Expanded After Nov. 2, 2015
  - Payment Policies Unclear: Physician Fee Schedule or Other Facility Rates
  - Administrative Costs Will Rise

CY 2017 Medicare Outpatient Hospital & ASC

Proposed Rule (cont.)

- Comprehensive APCs Expanded
- Inpatient-Only List Reduced
- Payments for XC-Ray Films Reduced
- Several Changes to Quality Reporting Programs

Ambulatory Surgical Facility Proposals

- Payments Updated by 1.7%
- New Covered Surgical Procedures and Additional "Office-Based" (Lower Reimbursement) Procedures
- ASC Quality Reporting Program Expanded

MEDICAID IPPS / OPPS REBASING

In General

- Implementation Delayed Until July 1, 2017
- New Rulemaking Required
  - Six-Month Process
  - MCPs Require Six Months to Ramp up New Systems
- New Peer Groups, Consistent Across OPPS & IPPS
  - Children's
  - Major Teaching
  - Urban Regional: Central, SE, SW, NE & NW
  - CAH
  - Other Rural
  - Private Psych
  - Out of State

MEDICAID EAPG OPPS

Background

- Enhanced Ambulatory Patient Groups
  - Created by 3M
  - In Use at 13 State Medicaid or Blue Cross Plans
  - Designed for Outpatient Encounters and Services
  - Replaces Ohio Medicaid Outpatient Fee Schedules
  - Groups Services with Similar Cost & Resource Use
  - Applicable to All Ambulatory Settings
    - Same-Day Surgery
    - Outpatient Hospital ED & Clinic Visits
    - Freestanding Outpatient Diagnostic & Treatment Facilities

MEDICAID EAPG OPPS

EAPGs vs. DRGs

DRG

- Inpatient Admission
- Discharge Date Defines Code Sets
- Uses ICD-9-CM or ICD-10-CM Diagnosis & Procedure Codes
- Only One DRG per Admission
- Employs Some Charge Bundling

EAPG

- Ambulatory Visit
- Claim "FROM" Date Defines Code Sets
- Uses ICD-9-CM or ICD-10-CM Diagnosis Codes & HCPCS/CPT, Procedure Codes
- Multiple EAPGs May be Assigned per Visit
- Employs Significant Charge "Packaging," Consolidation & Discounting

MEDICAID EAPG OPPS

EAPGs vs. ODM Fee Schedules

FEE SCHEDULE

- Uses ICD.10.CM Diagnosis Codes & HCPCS/CPT Procedure Codes
- 11 Fee Schedule Groupings (Facility ED & Clinic Fees, Surgical & Ancillary Procedures, and Diagnostic Tests)
- Multiple Fee Schedule Payments Likely Per Visit
- Employs CCI Edits, but Little Charge Bundling/Packaging
- Permits Exception Payments for High Cost Pharmacy, Medical Supply & Device Costs, and for Outpatient Observation

EAPG

- Uses ICD.10.CM Diagnosis & Procedure Codes & HCPCS/CPT Procedure Codes
- 564 EAPGs in Five Major Categories (Significant, Ancillary & Incidental Procedures, Medical Visit and Drugs)
- Multiple EAPGs Possible per Visit
- No CCI Edits in 3M Model, but Employs Significant Charge Packaging, Consolidation & Discounting
- No Exception Payments*

MEDICAID EAPG OPPS

ODM EAPG OPPS Policy Decisions

- Applies to **ALL** Hospitals
- Most of 3M OPPS Architecture Adopted
- Ohio-Specific EAPG Weights Calculated
- Full Packaging, Consolidation & Discounting Applied
  - *Six Month Transition to Full Packaging for "Paragraph L" Fee Schedule Exceptions, and to Payments for Outpatient Observation and Dental Services

MEDICAID EAPG OPPS / IPPS REBASING

Most Recent Generally Released Model (# 12) Includes:

- The Addition of More Than $27.8M to outpatient payments, principally by increasing overall outpatient cost coverage and applying a 0% OPPS stop-loss
- A stop loss for Graduate Medical Education at zero and a cap on GME payment increases at 10%
- A 5% stop-loss/stop-gain for rebased IPPS payments, based on the rates in place in year three of the initial APR-DRG conversion, and employed after the application of the med-ed hold-harmless
- A 0% stop-loss and a 5% stop-gain for the new OPPS
- An IPPS cost coverage floor for rural and Critical Access Hospitals at 70%

MEDICAID IPPS / OPPS REBASING

Remaining issues

- Some hospitals dissatisfied with proposed peer groups
- Education on underlying changes to EAPG system
- Final Decisions on transition
  - Stop loss/stop gain Benchmarks
  - Cost coverage floors
  - Schedule for Next Rebase & stop loss/stop gain Maintenance
  - Long-term impact on EAPG Payments for Expansion Population
- Lack of Final pricing input data for hospitals to test
  - Finance Committee reviewed historical claims data, but has limited ability to modeled future payments
- Future of GME Payment formula
  - $25M cut to DGME avoided in budget
  - how formula will be modified to is still unknown

BWC CY 2017 PPS PROPOSED RULE

Follows Medicare IPPS' Lead

- Budget Target Set at 114% of Medicare Cost
- Employs Patient Adjustment Factor (PAF) to Inflate Medicare Payments to BWC Budget Target
  - 115.6% for MS-DRG Payments
  - 177.4 for PPS Outliers
  - 1.156 for GME
- Adopts Medicare VBP and Unnecessary Readmissions Programs via Medicare Pricer
- OHA Concerned About Wholesale Application of Medicare PforP Programs to BWC Patient Population
- BWC Also Considering Joint Replacement Payment Strategies
  - OHA Will From Task Force to Negotiate Terms

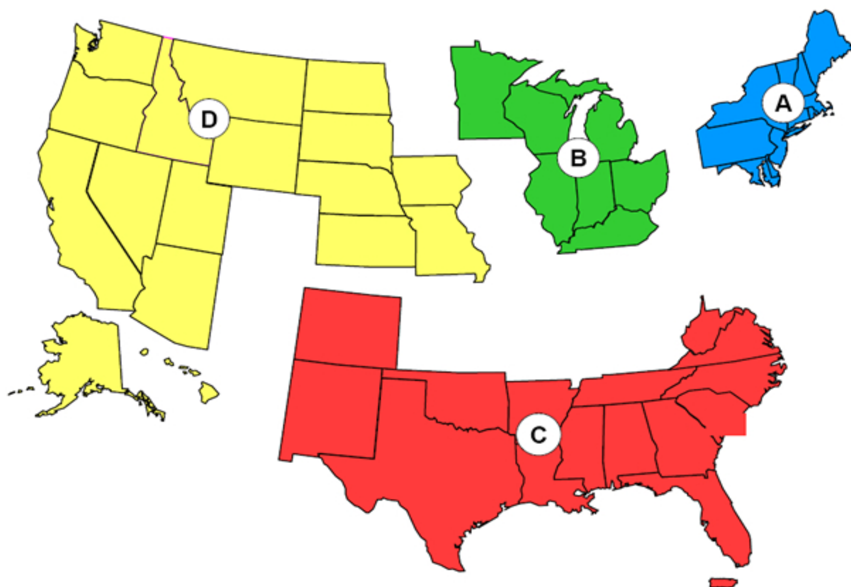
MEDICARE RECOVERY AUDIT CONTRACTOR

Contracts Re-bid Announced

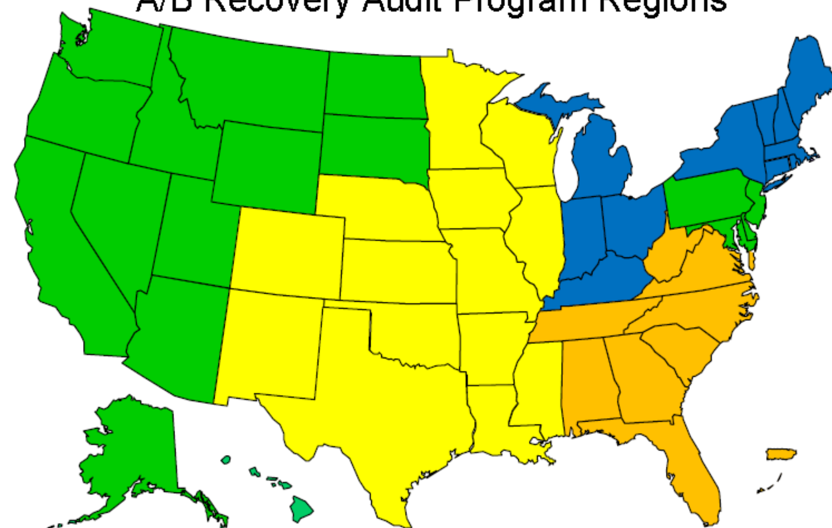
- **Region 1 & 5 Award Went to Performant Recovery Healthcare Services**
- Contract Regions drawn to Re-Weigh Claims Volume
- OHA already in communication with Performant on Transition New Contracts Will Bring Program Enhancements
  - Limits on Look-back for Patient Status Reviews
  - ADRs Must be Diversified
  - ADR Limits Adjusted to Provider Compliance Rates (Benchmarks Still Under Discussion)
  - RAC Performance Standards Tightened
  - Provider Satisfaction Surveys

MEDICARE RAC MAPS – OLD VS. NEW

Current (Old Contracts)



New Contracts



MEDICAID DSH PROGRAM AUDITS

FFY 2011 - 2014

- ODM Delivered 2011 & 2012 Final Reports to CMS
  - **No response Yet**
  - 11 Hospitals with Adjusted DSH Limits Below 2011 Payments; 14 Hospitals Below 2012 Payments
- Common Issues Cited by Myers & Stauffer
  - Patient Logs Submitted, but no Corresponding Data on Cost Report
  - Reverse of Above: Cost Report Data, but No Log
  - Logs Not in the Required Format
- 2013 Audit Report Due to CMS in December 2016
- 2014 Audit Launched in October with New Patient Data Logs
  - **OHA September 29 Webinar Replay Available Online**
- 2015 Audit is where Things Get Really Interesting!!!

OTHER

- BWC 2017 OPPS Payment Proposals Out
  - BWC Also Looking to Allow Some Joint Replacement Procedures on an Outpatient Basis
- OHA Meeting with Anthem on its Site-Neutral Policies
  - Anthem also wants to discuss Application of Episodes of Care and ED Diversion
- Medicare Expanding Cardiac and Hip Bundled Payment Demos
  - Watch Out Central Ohio!
- 2017 Will be a Big Federal and State Budget Year
  - OHA Finalizing Advocacy Targets and Outreach
  - CMS on a 2016 Rules Tear! Will Things Slow Down in 2017?

OTHER

- MACRA
  - Reporting begins 1/1/2017
  - 'Pick Your Pace'
- Social Security Number Removal Initiative (SSNRI)
  - Replacing active, deceased and archived HICN with Medicare Beneficiary Identifiers (MBI)
  - Consist of the same 11 characters as the HICN. Randomly assigned: Upper Case, Alpha, Numeric… excludes S, L, O, I, D, Z… key positions 2, 5, 8 and 9 will always be alpha… no special characters
  - Transition period to replace will go from Apr, 2018 – Dec. 2019
  - HICN will no longer be used Jan. 1. 2020
  - Eligibility Inquiry Challenges!

    SSNRemoval@cms.hhs.gov

Key	Example
SSA HICN	123-45-6789-A1
MBI	1EG4-TE5-MK73

OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

Shawn Stack

Director, Health Economics and Policy

Shawn.Stack@ohiohospitals.org

Ohio Hospital Association
155 E. Broad St., Suite 301
Columbus, OH 43215-3640

T 614-221-7614
ohiohospitals.org

HelpingOhioHospitals

@OhioHospitals

www.youtube.com/user/OHA1915