OHA UPDATE

Northwest Ohio HFMA

January 18, 2018

Agenda

- 2018 OHA Policy/Payment Advocacy Initiatives
  - 2018 State Budget Update
  - Price Transparency Update
  - Medicare Extenders
- Medicare OPPS 2018 Brief
- 2018 BWC OPPS
- Medicare's New Cards – April 1, 2018
- Medicaid EAPG OPPS & Rebased IPPS Monitoring Project
- Other
  - Anthem Imaging Policies
  - 340B Medicaid & Medicare Billing & Entity Reporting Requirements
  - Medicaid NDC Requirements Update

WHO KNEW HEALTHCARE WAS SO COMPLICATED???

MBI
HOPD CUTS
Performant
340B
Wage Index
Inpatient Only List

Repeal/Replace
Price Transparency
Waivers
Block Grants

Peer Groups
IP Rebase
EAPG Implementation
BH Redesign
HE Modifier
SE Modifier
NDC Requirements
Franchise Fee
KEPRO
ICD9/ICD10 CREEP

ED HIGH TECH IMAGING
OUTPATIENT CT/MRI
MANAGED CARE CONTRACTS
NCD/LCD FIASCO
INFUSION CLAIMS

BIENNIUM OHIO MEDICAID BUDGET UPDATE

Proposed cut: 5% rate cut ($690 million)

- Hospital rate cut was withdrawn on Nov. 13 by ODM for SFY ‘18
- Managed Care non-contracting language was pulled from legislation in final budget
- Additional monitoring will be done through meetings between OHA and ODM quarterly throughout SFY ‘18 and SFY ‘19 to track spending and budget allowances

PRICE TRANSPARENCY

THE LEGISLATIVE LANGUAGE

- PART OF AM. SUB. HB 52; EFFECTIVE 1/1/17
- REQUIRES PROVIDERS TO PROVIDE, PRIOR TO DELIVERY OF NON-EMERGENCY SERVICES, A WRITTEN "GOOD FAITH ESTIMATE" OF
  - AMOUNT PROVIDER WILL CHARGE PATIENT/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 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

Transparency legislation introduced Nov. '17 by State Rep. Huffman

- Require health care providers to provide good faith estimate within 7 days, upon the patient's request, for services that are scheduled at least seven days in advance. Plan must respond within 48 hours.
- For services that require prior auth, plan would be required to provide good faith estimate directly to patient.

PRICE TRANSPARENCY

HEARING DATE EXTENDED

- LAWSUIT FILED ON DEC. 22, 2016
- TEMPORARY RESTRAINING ORDER PREVENTING THE LAW FROM BECOMING EFFECTIVE ON JAN. 1, 2016 GRANTED UNTIL HEARING SCHEDULED FOR MAR. 15-16, 2018
- TEMPORARY RESTRAINING ORDER EXTENDED UNTIL NEW MAR. 16, 2018 HEARING DATE

MEDICARE EXTENDERS

The current proposal is a 2-year extension of Medicare-Dependent Hospital and Low-Volume Adjustment programs

- OHA strongly supports the extension of these programs

In the House, one proposal is to modify payments to CAH 'swing beds'

- Proposal to pay SNF PPS instead of current cost-base reimbursement methodology. Payment would be based on resident classification within the SNF resource utilization grouper (RUG).

- OHA has communicated our concerns to our congressional delegation.

MEDICARE EXTENDERS

Proposed change to low-volume adjustment eligibility methodology

- Currently: Hospitals with fewer than 200 Medicare discharges annually = 25% increase in payment (adjusting down to 0% at 1,600 Medicare discharges)

- Proposal: tether payment increases to total discharges rather than Medicare discharges from 500 to 2,500 discharges annually.

MEDICARE EXTENDERS

Next Steps:

- A bipartisan agreement has been reached on tax reform… we expect to see a bill sent to the President this week, leadership's focus is primarily on the tax bill right now.

- OHA's expectation for the year-end package:
  - A five-week continuing resolution to keep the government funded until Jan.
  - CHIP and/or extenders may make it in to this bill or whether they will be held until the full-year appropriations bill

MEDICARE 2018 OPPS FINAL RULE

2018 OPPS Payment Rate Breakdown

	Final CY 2017	Final CY 2018	Percent Change
OPPS Conversion Factor	$75.001	$78.636	+4.85%

Final CY 2018 Update Factor Component	Value
Marketbasket (MB) Update	+2.70%
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.6 percentage points (PPT)
ACA-Mandated Pre-Determined MB Reduction	-0.75 PPT
340B Drug Payment Reduction BN Adjustment	+3.19%
Wage Index BN Adjustment	-0.03%
Pass-through Spending / Outlier BN Adjustment	+0.20%
Cancer Hospital BN Adjustment	+0.08%
Overall Final Rate Update	**+4.85%**

MEDICARE 2018 OPPS FINAL RULE

- Reinstate the nonenforcement of direct supervision for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds
- Change the rate for nonpass-through drugs purchased by hospitals through the 340B program = From ASP +6 to ASP – 22.5
- Payment changes for packaging of low-cost drug administration services

MEDICARE 2018 OPPS FINAL RULE

- Change the inpatient only list

✓ CPT code 27447— Total knee arthroplasty
✓ CPT code 55866 — Laparoscopy, surgical prostatectomy, retropubic radical, including nerve paring, includes robotic assistance
✓ CPT code 43282 — Laparoscopy, surgical, repair of paraoesophageal hernia with implantation of mesh
✓ CPT code 43772 — Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
✓ CPT code 43773 — Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
✓ CPT code 43774 — Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components

MEDICARE 2018 OPPS FINAL RULE

- Change the laboratory date of service policy
- Payment change for non-excepted services furnished in off-campus provider-based departments = 40% of OPPS
- Change exceptions to the list of services to be packaged into APCs as opposed to separately paid
- Update payment rates and policies for Ambulatory Surgical Centers (ASCs)

BWC 2018 OPPS BRIEF

- Adopt Medicare 2018 final rule including, but not limited to, update the previously adopted joint replacement procedures
- Modify BWC payment adjustment factor (PAF) to reflect the statewide reimbursement to cost benchmark of 114%
  Children's Hospital Factor 266.4% / Non-Children's Factor 144.7%
- Recommend addition of six procedures from the inpatient only list to be performed in the outpatient setting
- Adopt Section 603 of the Bipartisan Budget Act of 2015 for reimbursement of off-campus hospital departments
- Adopt reimbursement methodology for outpatient detoxification services

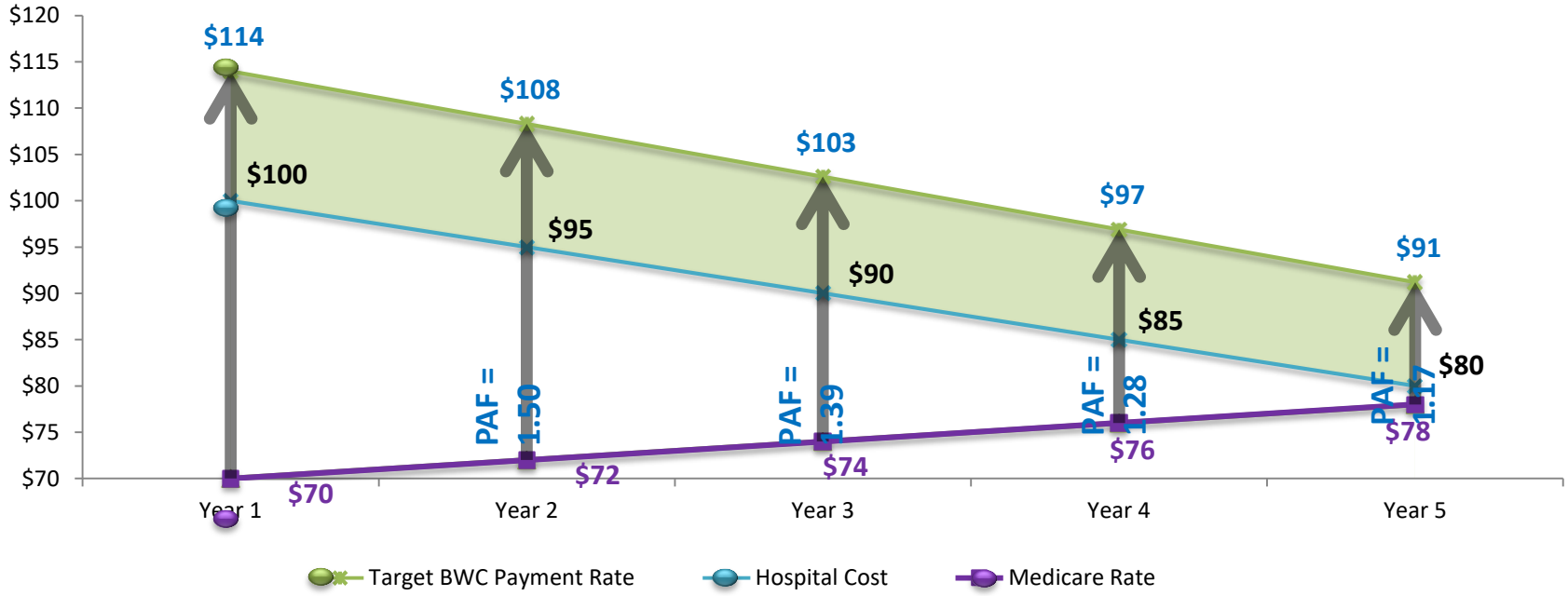
BWC 2018 OPPS BRIEF

Medicare Base + PAF = BWC Payment

BWC Goal is to pay hospital at 114% of cost

Hospital Cost = $100

Reimbursement Calculation Results = $1



BWC 2018 OPPS BRIEF

Proposed 2018 Arthroplasty Program Expansion

- Initially implemented May 1, 2016
- ASCs have additional certification criteria
- Adopted two procedures in 2017
  - CPT 27130 (Total Hip Replacement)
  - CPT 27447 (Total Knee Replacement)
- Six additional codes recommended for 2018

BWC 2018 OPPS BRIEF

CPT	Description	2018 Medicare Base Rate
23472	Total shoulder replacement	$10,122.22
27125	Partial hip replacement	$10,122.22
27132	Previous hip surgery converted to total hip replacement	$10,122.22
27445	Total knee replacement	$10,122.22
27702	Total ankle replacement	$10,122.22
27703	Revision of total ankle replacement	$10,122.22

BWC 2018 OPPS BRIEF

Section 603 Provider-Based Departments

- Provision goal - equalize payments between:
  - Free-standing physician office setting, and
  - Off-campus provider based departments
- No longer pay hospitals OPPS rates for non-grandfathered outpatient departments
  - Beginning January 1, 2017
  - For 2018, non-grandfathered departments paid at 40% of OPPS rates

BWC 2018 OPPS BRIEF

Section 603 Provider-Based Departments Con't

- For 2018, BWC is to adopt this provision
  - Projected 2018 impact is a .01% payment variance to Ohio hospitals
  - BWC to require mandatory submission of modifiers
    - PO (excepted service provided at an –off campus, outpatient, provider-based department of a hospital) and
    - PN (non-excepted service provided at an –off campus, outpatient, provider-based department of a hospital) – 60% reduction

BWC 2018 OPPS BRIEF

Outpatient detoxification services (OAC 4123-6-21.7)

- Allows payment of inpatient and outpatient detoxification services without a claim allowance over an 18 month period
- Per diem = all inclusive rate
- Appendix table to outpatient rule establishes local level codes for per diem structured programs and services

BWC Local Code	Description	2018 BWC Rate
Z0430	Detox program assessment	$192.48
Z0450	Partial hospitalization detox all inclusive per diem	$427.40
Z0460	Intensive outpt detox all inclusive per diem	$273.80

BWC 2018 OPPS BRIEF

Outpatient detoxification services Con't

- Projected financial impact
  - 2018 payments of $119 million
- Continue to meet 114% reimbursement to cost goal for Ohio hospitals
- Maintain injured worker access to quality care

MEDICARE BENEFICIARY IDENTIFIER (MBI)

- The MACRA legislation requires that CMS mail out new Medicare cards with a new MBI by April 2019.
- The new Medicare numbers won't change Medicare benefits. People with Medicare may start using their new Medicare cards as soon as they receive them.
- CMS will begin mailing new cards in April 2018
- The gender and signature line will be removed from the new Medicare cards.
- The Railroad Retirement Board will issue their new cards to RRB beneficiaries.

MEDICARE BENEFICIARY IDENTIFIER (MBI)

How will the MBI Look?

- 11 Characters in length
- Made up only of numbers and uppercase letters (no special characters
- Each MBI is unique, randomly generated, and “non-intelligent”
- The MBI’s 2nd, 5th, 8th, and 9th characters will always be a letter
- Characters 1,4,7,10, and 11 will always be a number
- The 3rd and 6th characters will be a letter or a number
- The dashes aren’t used as part of the MBI. They won’t be entered into computer systems or used in file formats.
- **Systems must be ready by April 2018 to accept the new MBIs!!!**

MEDICARE BENEFICIARY IDENTIFIER (MBI)

How will the MBI Look?

https://www.cms.gov/Medicare/New-Medicare-Card

MEDICARE BENEFICIARY IDENTIFIER (MBI)

How will providers receive the MBI information?

- From patients. The new cards that NOW FITS IN THEIR WALLETS!!!
- In June 2018, providers can query the Medicare look-up tool which allows providers to search eligibility by:
  - First & Last Name
  - Date of Birth
  - Social Security Number
- Beginning Oct. ’18, through the transition period, when providers submit a claim using a patient’s valid HICN, Medicare will return both the HICN and the MBI on every remittance advice. The MBI will be in the same place providers currently receive the ‘changed HICN”:
  - **835 Loop 2100, Segment NM1 (Corrected Patient/Insured Name), Field NM109 (Identification Code)**
- MACs will be mailing letters to providers with instructions on how to use the MAC’s secure portal so that in June 2018, providers will be able to look up Medicare patients who don’t have their MBIs.

OHA EAPG ANALYSIS & BUDGET MONITORING

- OHA and corporate partner BKD engaged in our EAPG & Biennium Budget Monitoring Project for state fiscal years 2018 and 2019.

- Offered through OHA, the base package includes EAPG level analysis on hospital stop loss/stop gain corridors and budget spend for the biennium.

- BKD is offering an optional package of services which includes a deeper dive into your hospital's billed and paid Ohio Medicaid Claims, analyzed by payer. Reports will also focus on potential high impact areas such as high cost drugs and supplies billed with UB modifier, claims with "Lesser of EAPG or charges" and Observation claims.

OTHER

- Anthem Imaging Policies
  - Clinical UM Guideline CG-MED-55, Level of Care: Advanced Radiologic Imaging – Sept. 1, 2017
  - ED Imaging Policy – Jan. 1, 2018
- 340B Ohio Medicaid & Medicare Requirements
  - Medicaid's 'SE' Modifier
  - Medicare's 'JG' & 'TB' Informational Modifiers
- Ohio Medicaid NDC Requirements Update
  - Jan. 1, 2018 ODM will begin to deny claim lines without NDCs
  - Guidelines for billing NDCs to Ohio Medicaid can be found in the Ohio Medicaid Hospital Billing Guidelines: Section 3.6, 3rd Paragraph NOTE: COMPOUND DRUGS!

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

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