WESTERN RESERVE AAHAM ANNUAL FALL CONFERENCE

September 23, 2016

Agenda

- Recent 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
- 2017 BWC IPPS Proposed Rule
- Other
  - Medicare RAC Contract Re-Bid
  - Medicaid DSH Program Audits

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 Proposal

- **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.

FFY 2017 MEDICARE INPATIENT ACUTE CARE HOSPITAL
Final Rule

- Released Aug. 2; Effective Oct. 1, 2016
- Increases Overall Inpatient Payments by 0.95%
  - 2.7% Market Basket Reduced for for Productivity, Coding & Budget
  - Most of Increase Attributable to the Reversal of Four Years of 0.02 Reductions for "Two-Midnight Rule"
- Medicare DSH Payments Cut an Additional $400M
  - CBO Says 2017 Rate of Uninsured Will Drop to 10%
  - No Decision Yet to Use Cost Report S-10 for UC Data
- MOON (NOTICE Act) Compliance Delayed Until 2017
- "Bay-State Boondoggle" Still a Problem

MEDICARE OUTPATIENT OBSERVATION NOTICE

Still in Draft; Effective Aug. 6, but Compliance Delayed until 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 xx/xx/xxxx OMB approval 0938-xxxx

DRAFT

(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 xx/xx/xxxx OMB approval 0938-xxxx

DRAFT

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

FFY 2017 MEDICARE INPATIENT LTCH

Final Rule

- RELEASED AUG. 2; EFFECTIVE OCT. 1, 2016
- INCREASES LTCH PAYMENT RATES BY 1.75%
  - REDUCES 2.8% MARKET BASKET FOR PRODUCTIVITY & BUDGET
- 25% RULE TO BE FULLY IMPLEMENTED
- SECOND YEAR OF PHASE-IN TO TWO-TIERED PAYMENT SYSTEM
  - "SITE-NEUTRAL" CASES PAID A 50/50 BLEND OF OLD LTCH-PPS AND NEW SITE-NEUTRAL RATES
- COMBINATION OF 25% RULE AND SITE-NEUTRAL REDUCTIONS WILL CUT OVERALL LTCH PAYMENTS BY 7.1% ($363M) IN FFY 2017
- ADDITIONAL QUALITY REPORTING PROGRAM MEASURES FOR 2020

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

FFY & CY 2017 MEDICARE PPS RULES

Other

- Inpatient Psych Facilities
  - Final Rule Out July 28; Effective Oct. 1
  - 2.2% Overall Payment Update
  - Movement to Full Use of Inpatient PPS Wage Index
  - No Change to Rural Adjustment
- Inpatient Rehab Facilities
  - Final Rule Out July 29; Effective Oct. 1
  - 1.65% Overall Payment Update
  - No Changes to Facility-Level Adjustments
  - Quality Reporting Program Measures Finalized for 2018
  - No Change to Rural Adjustment

FFY & CY 2017 MEDICARE PPS RULES

Other

- SKILLED NURSING FACILITY PPS
  - FINAL RULE OUT JULY 29; EFFECTIVE OCT. 1
  - OVERALL 2.4 % PAYMENT RATE UPDATE
  - NEW QUALITY REPORTING PROGRAM STARTS IN 2018
  - NEW VBP PROGRAM STARTS IN 2019
- HOSPICE BENEFIT
  - FINAL RULE OUT JULY 29; TRANSITIONING TO OCT. 1 EFFECTIVE DATE
  - OVERALL 2.1% PAYMENT UPDATE
  - NEW HOSPICE CHAPS & QUALITY REPORTING MEASURES
  - REVISED PATIENT ASSESSMENT DATA FORMAT

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
- **Ohio Implementation Now Scheduled July 1, 2017**

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 SCHEDULES

- Uses ICD.9.CM or ICD.10.CM Diagnosis Codes & HCPCS/CPT Procedure Codes
- 11 Fee Schedule Groupings (Facility Fees, Surgical & Other 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.9.CM or ICD.10.CM Diagnosis 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 OPPS Policy Decisions Completed

- APPLIES TO **ALL** HOSPITALS
- MOST OF 3M OPPS ARCHITECTURE ADOPTED
- OHIO-SPECIFIC EAPG WEIGHTS DETERMINED
- 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
- EXPECT TRANSITIONAL STOP LOSS/STOP GAIN CORRIDORS TO BE APPLIED FROM FEE SCHEDULES TO EAPG OPPS UNTIL SYSTEM RE-BASED AGAIN

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

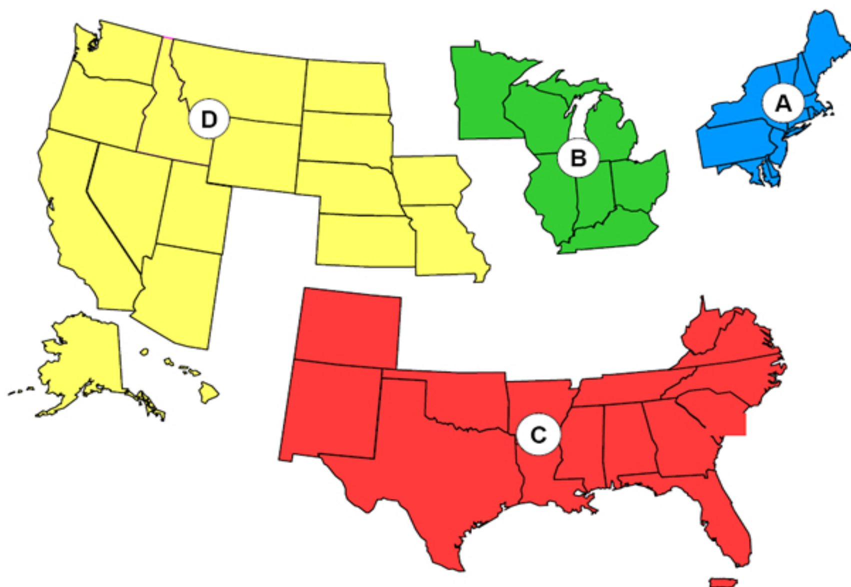
Contracts Re-bid Announcement Expected Soon

- Contract Regions drawn to Re-Weigh Claims Volume
- Old Contract Region B Will be Subdivided
    - At Least Some Region B States Will Switch Contractors
- Old CGI Contract Activity Being Closed Out
- 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

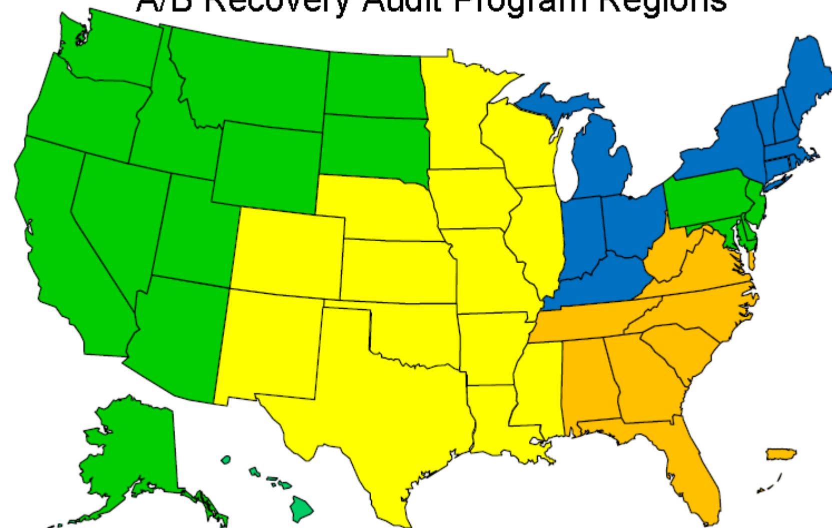
Current (Old Contracts)

RAC Regions



New Contracts

A/B Recovery Audit Program Regions



Region 1 **Region 2** **Region 3** **Region 4**

Effective Date: TBD

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 to Launch in October with Updated Patient Data Logs

OHA Webinar Scheduled for September 29

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

Charles Cataline

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