


AAHAM
American Association of Healthcare
Administrative Management
Western Reserve Chapter

2013 Fall Institute OHA Update

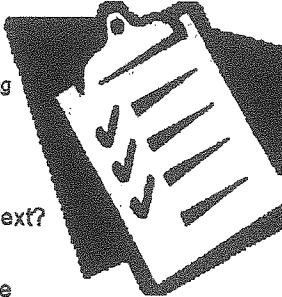
September 26, 2013


Charles Cataline
Vice President, Health Economics and Policy
Ohio Hospital Association
charlesc@ohanet.org



Agenda

- Federal Update
 - 2014 Federal Budget – What's on the Block?
 - It's Medicare PPS Rules Season!
 - FFY 2014 IPPS "Two Midnights Rule"
 - CY 2014 OPPS Enhanced Bundling and Packaging
- State Update
 - Ohio 2014/2015 Budget
 - "Medicaid Modernization II"
 - Medicaid APR-DRG Conversion – What's Next?
 - Medicaid Family Planning Benefit
 - What's Up With the Health Care Marketplace
 - BWC 2014 Hospital Payment Targets
- Other Finance / PFS Current Issues
 - HCAP Uncompensated Care Reporting Requirements
 - Is this the Last of the Big Changes to Policies & Procedures?

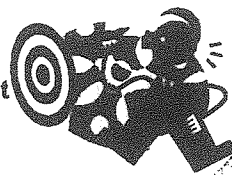



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Federal Update

It's Medicare PPS Rules Season!

- ✓ IPPS
 - Update less than 1%
 - Sequestration Continues (Effect on MA Still Disputed)
 - Coding Adjustment Continues
 - VBP & Re-admission Program Data Updated
 - DSH Payment Cuts Start – Many in Ohio Will do Okay
 - Inpatient vs. Outpatient Status Still being Debated
 - “Two Midnights” Rule
- ✓ LTCH PPS
 - ✓ Year Two of Budget Neutrality Adjustment
 - ✓ “25% Rule” Implemented
 - ✓ Bigger Changes Proposed for FFY 2015





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Federal Update

It's Medicare PPS Rules Season!

- ✓ OPPTS (Proposed)
 - Big Changes to E&M Reimbursement
 - Big Movement Toward Additional APC Packaging & “Comprehensive APCs”
 - *Is This the Start of Outpatient Encounter- Based Reimbursement?*
 - Tighter Supervision Standards at CAH's
- ✓ Also...
 - ✓ CY 2014 Physician Update
 - ✓ Psych & Rehab PPS
 - ✓ Skilled Nursing
 - ✓ Home Health



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Federal Update

Federal Budget Challenge

- ATRA 2013 Still Rolling On
 - Sequester On Until Congress Acts
- Medicare Wage Index Fight Continues
- President's 2014 Budget Includes:
 - Medicare Cuts to Medical Education, CAH, Bad Debt, Post Acute Providers, Managed Care, Additional Fraud & Abuse Effort, Additional Cost Sharing
 - Medicaid Cuts to DSH, DME and Additional Fraud & Abuse
- Expect Additional Attention Paid to Billed Charges, Charity Care & Self-Pay Bills
 - Still Waiting on IRS/Treasury Final Rule Regarding Uniform Charges to Uninsured



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State Update

Medicaid Budget 2014/2015

- "Medicaid Modernization II"
 - Additional \$67M Cut Over Biennium
 - Will ODM Recoup APR-DRG "Excess Payments?"
 - Renewed Attention to Medicaid Re-Admissions
 - Cost-Based Hospitals' Payments Reduced (July 2014?)
 - Cuts to Outpatient Hospital Payments – Effective Jan. 2014
 - ✓ Unknown (99-Level) CPT Codes Moved to Fee Schedule
 - ✓ "Paragraph L" Services Reduced to 60% of Cost
 - ✓ Secondary Procedure Payment Reduction to 50%
 - ✓ Lab Fee Schedule Reworked to Match Medicare
- Medicaid Interest on Overpayments Reduced (Jan. 2014)
- Study Medicaid Reimbursement for TeleMedicine

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Medicaid APR-DRG Conversion

Overview

- Year-Long Process to Determine Relative Weights, Base Rates & Payment Policies
- OHA Goal: Fairness and Equity Across Membership;
- Added Approx. \$84 M / Year in Inpatient Payments for In-state Hospitals
- Addressed rural hospital Inadequacies by Repurposing dollars From Out-of-state Hospitals (\$24 M / Year)
- Has Risk Corridors For Urban Hospitals to Ensure Stability & Predictability and Minimize Winners & Losers
- Preserves Most Reimbursement Policies and Payment Logic Within the Current System (For Now?!).

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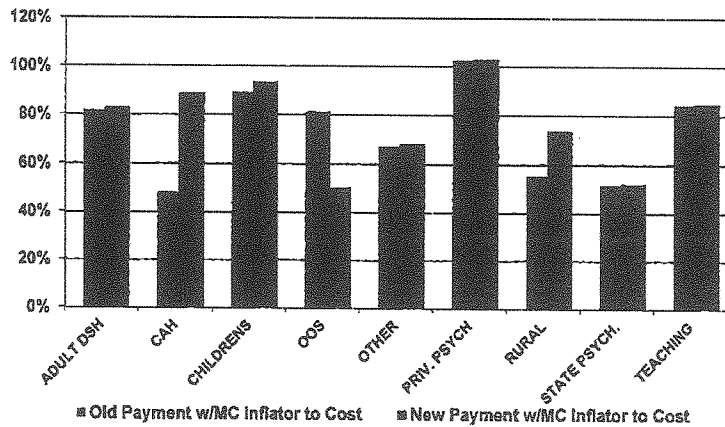
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Medicaid APR-DRG Conversion

OHA Peer Group Analysis: Current vs. APR-DRG @ Pay/Cost



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Medicaid APR-DRG Conversion

SFY 2014 Policy Shifts

- CMS Grouper 15 to 3M APR-DRG
- Outliers Policy Changed to Mirror Medicare
- New Peer Group Base Rates
- Newly Calibrated Relative Weights
- Stop Loss/Stop Gain Applications Within Peer Groups
- Med-ed Payments Held Harmless

What's Next?

- APR-DRG Version 31 Starts with Discharges Oct. 1 and After
- Stop Loss Transitions in Out Years of Three-Year Transition?
- Accuracy of Payments & Projections – Rebalance to Come?
- Additional Discussion Expected About:
 - Peer Groups, Next Scheduled DRG Re-base & Re-Calibration, Medical Education Payments, HAC, Other?

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Medicaid Cost Report Data & DSH Audits

- FFY 2011 Medicaid DSH Audits Ready to get Underway!
CMS: 2011 Audits get Serious
- Audit Focus Shifted From Uncompensated to Uninsured
- Audit Guidelines Seem to Constantly Change
- Standardized Electronic Logs Required
 - ✓ Required Electronic Logs are on ODM Cost Report Webpage:
<http://jfs.ohio.gov/ohp/bhpp/COSTRPT.stm>
 - ✓ For Most, Two Years of Logs Requested
- Requires
 - Revised Medicaid cost report version,
 - Schedules C, F, I and new J-series schedules



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Medicaid Cost Report Data & DSH Audits

Major Changes for FFY 2011 Audits

- In accordance with the Federal DSH Audit Proposed Rule (Jan. 2012) if services provided by the hospital are not covered under insurance, those services should be categorized as uninsured.
- Uninsured hospital services must reflect charges incurred during the cost report year, regardless of the patient's financial category (DA, <100%, >100%).
- Payments for uninsured hospital services must reflect payments received during the cost report year, regardless of the patient's financial category, or write off or service date.

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Medicaid Cost Report Data & DSH Audits

Other Questions

- Why is Data Duplicated on Logs?
- Timing of CPA Data Reviews & Updates After CR is Verified?
- Do "Agreed Upon Procedures" Need to be Revised?
- What Happens if Hospital Can't Meet M&S Timelines?

OHA/ODM/M&S Conference Enlightening

- OHA Memo to ODM Outlines Concerns
- OHA Task Force Organized to Assist

- ✓ **We Need More Time**
- ✓ Documented Instructions & FAQs
- ✓ Clarify Compliance Standards
- ✓ What Will On-Site Audits Entail?
- ✓ Additional Education and Training
- ✓ Clarify Divide Between HCAP & Audit Data Requirements

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Other Medicaid Issues

- Integrated Medicaid Eligibility Moving Forward
 - Simplify Eligibility Standards & Automate Process
 - Utilize MAGI Standards
 - Overhaul CRIS-E
 - Expand Presumptive Eligibility
 - DETAILS and TRAINING Expected Any Day – Watch for Notice!
- Medicaid Family Planning Benefit Still In Discussion
 - Potential Conflict With Patient Notification, Free Care, DSH Limits & 340(B) Programs
 - OHA Letter At OMA – OMA Conferring With CMS
- Medicaid RAC Roll-out Still Underway
 - Automated MITS Recovery System in Final Tests!!!
 - Interest Payments Reduced in State Budget – Rules Underway

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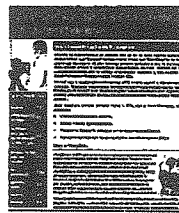


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Ohio Health Care Marketplace

- Still Waiting on List of 2014 Ohio Carriers and Plans
- August: Feds Upload into Federal Exchange
 - Initial Ohio Response Rates are Robust
 - “Correction Window” for States and Plans - Only After do Plans Sign Contract to Sell in Exchange
- October Open Enrollment (?)
January State Exchanges go Live (?)
- OHA White Paper on Consumer Support
 - To “CAC” or not to “CAC?”
 - Enroll America Can Support Hospital Efforts
- Ohio Integrated Benefits Website May Take Center Stage
- Episodic Payment Formula Under Debate

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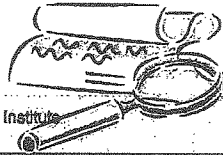
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Ohio Medicaid/Medicare Dually Eligible Integrated Delivery System (AKA "MyCare Ohio")

- Target Implementation Date is July 2014 (?).
- CMS Approved, but Implementation Still Unclear
Watch for Details soon!
- Readiness Reviews Being Done in Phases
 - Access (Provider Panel) and Coverage in Later Phase
- Utilizes a *"Payment Structure That Blends Medicare and Medicaid Funding"*
- Approx. 196,000 Medicare-Medicaid Enrollees in Ohio Currently Receiving Benefits Primarily Through FFS
 - Approx. 115,000 Included in the Demonstration Program



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Proposed Ohio Dually Eligible Integrated Delivery System

- Target Population
 - Full-Benefit Dual Eligible Enrollees Excluding:
 - Those Eligible for the Medicare Savings Program
 - Dual Eligibles with Intellectual and Developmental Disabilities Served Through an IDD 1915(c) HCBS Waiver or an ICF-IDD.
 - Those Not Under Waiver can Opt In
 - Dual Eligibles Enrolled in PACE
 - Dual Eligibles under 18
 - Duals With "Severe or Persistent Mental Illness" will be Included, Assuming the State Creates Medicaid Behavioral Health Homes
 - Individuals with SPMI in the Demonstration do not Have to Change Providers for Behavioral Health Services.

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Proposed Ohio Dually Eligible Integrated Delivery System

- Model Design
 - At Least Two Competing Health Plans in each of Seven Regions Chosen for the Demonstration (Most Rural Areas Exempt)
 - Enrollees can Choose Between the Two Health Plans in Their Region
 - All Regions Have at Least 3 Medicare Advantage Plans Currently Serving Medicare Beneficiaries
- The Demonstration will Auto-Enroll the Eligible Population With an Option to opt out for Medicare-Covered Benefits
- If They opt out for Medicare They Will Still be Enrolled in Medicaid Managed Care
 - Enrollees Will Have the Option of Switching Plans Twice a Year and can opt out of Medicare at any Time

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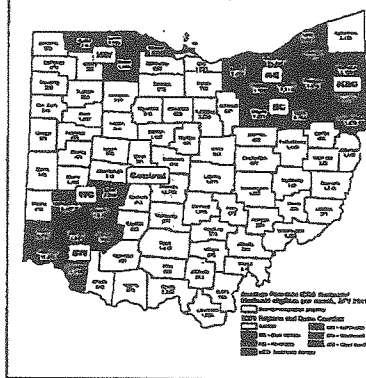
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Ohio Dually Eligible Integrated Delivery System

Appendix B
Ohio ICDS Regions



	Northwest	Southwest	West Central	Central	East Central	Northeast	Northeast
1	Aetna	Aetna	Buckeye	Aetna	CareSource	CareSource	Buckeye
2	Buckeye	Molina	Molina	Molina	United	United	CareSource
3							United

The complete RFA website is available at: <http://its.ohio.gov/rfa/612130780381CDS.htm>

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Proposed Ohio Dually Eligible Integrated Delivery System

- **Draft Payment System**
 - Medicare and Medicaid will Contribute to the Blended Payments in a Manner that Expected Aggregate Savings are Proportionately Shared Between the two Programs
 - The Blended Capitation Payment Structure is Expected to Provide Plans the Flexibility to Utilize the Most Appropriate Cost Effective Service for the Enrollee, Eliminating Incentives to Shift Costs Between Medicare and Medicaid
 - Reimbursement will Include Pay-for-Performance Incentives
- **OHA's Concerns**
 - Can MCPs Really Integrate and Manage this Array of Providers, Agencies and Services?
 - How Would This Affect Existing UPL Programs
 - Is it Right to Limit Enrollees Freedom of Choice?



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What About Medicaid Reform?

Medicaid Expansion & Health Care Marketplace Are They Compatible?

Current Status of Ohio Marketplace

- "Feds" Run, Build & Maintain IT Infrastructure
- State Retains Control Over Medicaid Eligibility and Regulation of Insurance Market
 - QHP Certification (Who Sells on Exchange)
 - Product Approval
 - Rate Approval
 - Solvency Requirements
 - Plan Compliance

Can "ARKANSAS Model" Help w/ Ohio Medicaid Reform ?!



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Medicaid and the Exchange

- The “Arkansas Model”—What is it?
 - High level: Achieves Medicaid Expansion by Using the Health Care Exchange as a Vehicle
 - Approach is Essentially a Medicaid Premium Support Model
 - Enrollees Remain on Medicaid & Are Entitled to Same Benefits and Cost-Sharing Protections
 - Out of pocket expenses, deductibles and co-pays, must be same as under Medicaid
 - States Must Have a Mechanism to “Wrap-Around” Private Coverage to the Extent Benefits are Less and Cost Sharing is Greater Than Medicaid
 - Requires Sec. 1115 Waiver & Expires at End of 2016

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What is Medicaid Premium Support ?

- Existing Law Allows States to Pay Premiums for Individuals to Buy Coverage Through Private Plans.
 - Beneficiary Receives \$ From State to Purchase, Instead of State Paying \$ Directly to MMC Plan
- Such Arrangements Must be “Cost Effective”
 - The Cost of Coverage Through Premium Assistance Must be the Same or Less than Providing “Comparable Coverage” to the Individual in the Medicaid Program.

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Medicaid Premium Support Under Arkansas Model

- “Arkansas Model” is Essentially a Premium Support Model Where the Premium Support Payments Would be Used by Beneficiaries to Purchase Private Insurance Through an Exchange
- The Premium Support Would be in Addition to Federal Subsidies Available to Those Between 100-400% FPL to Purchase Coverage on an Exchange
 - (Note: Those below 100% FPL are not eligible for federal subsidies, though would be eligible for premium support if coverage is extended.)

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OHA's Initial Concerns About Arkansas Model

- Network Adequacy
- MC Plans Controlling and Limiting Access
- Blending of Public and Private Markets
- Private Plan Reimbursement Set at Medicaid Levels
- Additional, Unreimbursed Administrative Burden on Hospitals

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Other Finance/PFS Current Issues

- **BWC 2014 PPS'**
 - Rules in Process
 - Biggest Concern is With BWC Adoption of Medicare DSH/Uninsured Formula
 - IRS Proposed Rule on Charitable Hospitals
 - Public Hearing Held in December 2012
 - Hospitals: Proposed Rule Needs to be More Flexible and Will Force Them to Leave Accounts Open for Months
 - Consumer Groups: Leave Proposed Rule as is!
 - IRS: Hospitals Within Systems Can Employ the Same Policy (What is a System?); Hospitals May Pursue Bill Collection During the Second 120-Day Period
 - STILL WAITING ON FINAL RULE



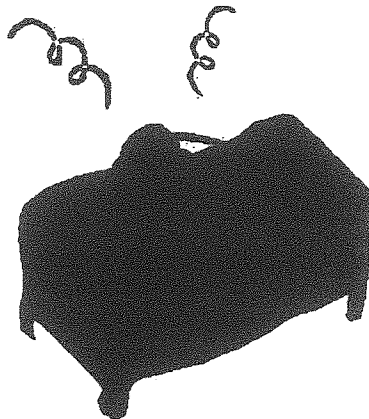
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Questions / Comments?



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