




OHA UPDATE


Healthcare Compliance Assoc. Event:
State Budget, Medicaid & Medicare

May 5, 2017

AGENDA

- **2016/2017 OHA POLICY/PAYMENT ADVOCACY INITIATIVES**
 - STATE BUDGET AS-INTRODUCED
 - PRIOR AUTH LAW
 - HEALTHY OHIO PROGRAM – REMEMBERING 2016!
 - HEALTH CARE PRICE TRANSPARENCY
- **MEDICARE RAC CONTRACT ROLLOUT FOR OHIO REGION ONE**
- **MEDICARE IPPS PROPOSED RULE**
- **MEDICAID EAPG IMPLEMENTATION & IPPS REBASE**
- **OTHER**
 - 340B MEDICAID BILLING & ENTITY REPORTING REQUIREMENTS
 - SOCIAL SECURITY NUMBER REMOVAL INITIATIVE (SSNRI)

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BUDGET AS-INTRODUCED

Key Hospital Issues:

- Replaces MCO sales tax with sustainable tax on all HMOs
- Maintains current Medicaid eligibility levels ***Waiver TBA*
- Assesses premium payments for adults over 100% FPL
- Eliminates price transparency law... but it is coming back!
- **Creates a new High-Medicaid peer group and imposes new cuts to hospitals outside peer group**
- **Imposes ICD-10 coding “inflation” cut**
- **Implements “non-contracting” language**
 - Cuts in the budget for hospitals just slightly less than \$600 Million

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HOSPITAL PAYMENT ASSUMPTIONS

- Hospital payments increased from FY'13 to FY'14 due to UPL changes, MetroHealth pilot program, APR-DRGs being in place for full FY
- Hospital payments increase from FY'14 to FY'15 because of increased caseloads due to Medicaid Expansion
- Payments were relatively flat from FY'16 to FY'17
- No explanation for a projected 7.6% increase for FY'18
 - Increased Per Member Per Month (PMPM) costs are not reflected in increased hospital costs
 - Hospitals get paid the same no matter what category a beneficiary is in (e.g. Group 8 v ABD)



PRIOR AUTHORIZATION LAW



- GOVERNOR SIGNED SUB. S.B. 129 IN JUNE 2016
- VARIOUS EFFECTIVE DATES; MOST START WITH POLICIES ISSUED AFTER JANUARY 2018
- PERMITS PROVIDERS AND PATIENTS TO OBTAIN PAs THROUGH 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

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; TO BE 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

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PRICE TRANSPARENCY

OHA'S RESPONSE

- **RECOMMENDED PARAMETERS**
 - LIMIT TO "UPON REQUEST"
 - LIMIT TO HOSPITAL SERVICES
 - LIMIT TO "SHOPPABLE" SERVICES
 - ELIMINATE ESTIMATE OF "CHARGES"
 - NON-GOVERNMENT PAYERS
 - REQUIRE RESPONSE W/IN 48 HOURS FROM PAYER
 - HOSPITAL CAN'T BE FOUND IN VIOLATION IF PAYER DOESN'T COOPERATE
 - PILOT PROJECT CONDUCTED IN 6 HOSPITALS
 - 2 – CRITICAL ACCESS HOSPITALS
 - 2 – MEDIUM SIZE HOSPITALS (80-200 BEDS)
 - 2 – LARGE SYSTEM BASED HOSPITALS (OVER 200 BEDS)

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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

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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.

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PRICE TRANSPARENCY

HEARING DATE EXTENDED


- LAWSUIT FILED ON DEC. 22, 2016
- TEMPORARY RESTRAINING ORDER PREVENTING THE LAW FROM BECOMING EFFECTIVE ON JAN. 1 GRANTED UNTIL HEARING SCHEDULED FOR JAN. 20, HEARING RESCHEDULED FOR AUG. 14
- TEMPORARY RESTRAINING ORDER EXTENDED UNTIL NEW AUG. 14 HEARING DATE
- THE EXECUTIVE BUDGET STRUCK THE TRANSPARENCY LAW FROM THE BUDGET ON FEB. 6, SO THAT LEGISLATURE CAN REVISIT THE ISSUE THROUGH REGULAR ORDER OF PUBLIC COMMITTEE HEARINGS.

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MEDICARE RECOVERY AUDIT CONTRACTOR

PERFORMANT RECOVERY HEALTH SERVICES

- **REGION 1 & 5 AWARD WENT TO PERFORMANT RECOVERY**
- OHA IS COORDINATING TWO FACE-TO-FACE MEETINGS BETWEEN PERFORMANT AND HOSPITAL PROVIDERS COMING UP IN MAY. THE MEETINGS WILL BE HELD IN CENTRAL OHIO (COLUMBUS AREA) AND IN NORTHERN OHIO (CLEVELAND AREA). THE MEETINGS WILL COVER:
 - LOOK-BACK PERIODS FOR PATIENT STATUS REVIEWS
 - ADR DIVERSIFICATION
 - ADR LIMITS ADJUSTED TO PROVIDER COMPLIANCE RATES
 - ADR ACTIVITY: WHICH BEGAN IN MARCH
 - RAC PERFORMANCE
 - PROVIDER SATISFACTION SURVEYS



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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

THE CENTER FOR MEDICARE & MEDICAID SERVICES PAYMENT PROPOSAL

- OVERALL PROPOSED INCREASE OF **1.6 PERCENT** IN OPERATING PAYMENT RATES FOR GENERAL ACUTE CARE HOSPITALS PAID UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) THAT PARTICIPATE SUCCESSFULLY IN THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM AND ARE MEANINGFUL ELECTRONIC HEALTH RECORD USERS.



- **BREAKING IT DOWN:**
 - MARKET-BASKET = +2.9%
 - **CODING OFFSET ADJUSTMENT = +0.4588%**
 - ACA PRODUCTIVITY CUT = -0.4%
 - ACA MANDATED CUT = -0.75%
 - TWO – MIDNIGHT POLICY ADJUSTMENT = -0.6%
 - ANNUAL BUDGET NEUTRALITY ADJUSTMENT = -0.16%
 - OVERALL PROPOSED FEDERAL RATE = +1.45%
 - HOSPITAL SPECIFIC INCREASE = +0.98%**

**MEDICARE FY '18 HOSPITAL INPATIENT PPS
PROPOSED RULE**

THE CENTER FOR MEDICARE & MEDICAID SERVICES PAYMENT PROPOSAL (CON'T)

INPATIENT QUALITY REPORTING (IQR) AND EHR INCENTIVE PROGRAMS
IMPACTS TO PAYMENTS

BEGINNING IN FFY '15, THE IQR MB PENALTY CHANGE FROM -2.0 PERCENTAGE POINTS TO A 25% REDUCTION TO THE FULL MARKET BASKET (MB), AND THE HER MEANINGFUL USE (MU) PENALTY BEGAN ITS PHASE-IN OVER THREE YEARS, STARTING AT 25% OF THE FULL MB. BEGINNING FFY 2017, THE EHR MU PENALTY IS CAPPED AT 75% OF THE MB; HENCE THE FULL MB UPDATE WILL BE AT RISK BETWEEN THESE TWO PENALTY PROGRAMS.

**MEDICARE FY '18 HOSPITAL INPATIENT PPS
PROPOSED RULE**

THE CENTER FOR MEDICARE & MEDICAID SERVICES DSH PAYMENTS

- CMS launches its three-year transition to begin using the Medicare Cost Report Worksheet S-10 to calculate Medicare DSH payment amounts and distribution schedules as a required change to DSH payments instituted as a part of the ACA. In 2018, CMS will use S-10 data on uncompensated care costs from FY'14 cost reports in combination with Medicaid inpatient days plus Medicare SSI inpatient days from FY'12 and FY'13. CMS also proposes to use cost of charity care and non-Medicare bad debt as defined on line 30 of the S-10.
- Under the new DSH payment formula, by law, hospitals get 25 percent of the Medicare DSH funds they would have received under the prior statutory formula. The remaining 75 percent of the funds (Uncompensated Care Funds) are placed into a pool for DSH-eligible hospitals. The new pool will be distributed based on the proportion of total uncompensated care Medicare DSH hospitals provide, with the pool receiving reductions as the percentage of uninsured declines.

**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

THE CENTER FOR MEDICARE & MEDICAID SERVICES DSH PAYMENTS (CON'T)

- CMS states they have developed an audit process for the S-10 data and will be sending instructions to Medicare Administrative Contractors (MACs) soon. CMS estimates that S-10 Worksheets on FY'17 cost reports will be the first to be subject to the desk reviews. Based on the audits, CMS will then consider revisions to the S-10 instructions.

WAGE INDEX

- CMS proposes for FFY '18 to transition to the use of the Federal Information Processing Standard (FIPS) county codes for cross walking CBSAs.
- The imputed rural floor will no longer be considered a factor in the national budget neutrality adjustment.
- New proposed deadlines for SCh and RCC Classification Status to the MGCRB.
- Changes to the 45-Day Notification Rule
- Labor Related Share is proposed to be updated to be budget neutral.
- Changes to the Inclusion of Other Wage-Related Costs
- CMS will use the CY '16 Occupational Mix Survey to calculate the FFY '19 wage index.
- CMS spells out the Wage Index Development Timetable for FFY '19

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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

GME/IME PAYMENTS

CMS did not propose any major changes to the direct GME payment policies for FFY 2018 and Indirect Medical Education (IME) adjustment factor is proposed to remain at 1.35 for FFY 2018.

OUTLIER PAYMENTS


To maintain outlier payments at 5.1% of total IPPS payments, CMS is proposing an outlier threshold of \$26,713 for FFY 2018. The adopted threshold is 13.33% higher than the current.



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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

THE CAH 96-HOUR CERTIFICATION REQUIREMENT



- History:* Status requires a physician certify that an individual may reasonably expect to be discharged or transferred to a hospital within 96 hours after admission to a CAH, as a condition for payment for inpatient services provided by a CAH.
- Update in rule:* In an effort to reduce burden on providers, CMS provided notice to Quality Improvement Organizations (QIOs), the Supplemental Medical Review Contractor (SMRC) MACS and Recovery Audit Contractors (RACS) to make the CAH 96-hour physician certification requirement a low priority for medical record reviews on or after Oct. 1, 2017.

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MEDICARE FY 2018 HOSPITAL INPATIENT PPS PROPOSED RULE

INPATIENT QUALITY REPORTING (IQR) PROGRAM

- *FY 2019:* CMS proposes to reduce the number of electronic clinical quality measures (eCQMs) hospitals report, as well as shorten the data reporting period. CMS proposes that hospitals report on at least six eCQMs, instead of on eight eCQMs. The proposal also allows hospitals to self-select two quarters of data from CY'17, instead of reporting the entire CY.
- *FY 2020:* CMS proposes that hospitals report on at least six eCQMs, instead of on eight eCQMs. The proposal also requests that hospitals submit data for the first three quarters (Q1, Q2, Q3) of CY'18 reporting period, instead of the one calendar year of data. Additionally, the agency plans to modify the electronic eCQM reporting requirements of the Medicare HER Incentive Program for eligible hospitals and CAHs to align with the proposed Hospital IQR electronic eCQM requirements for the CY'17 and CY'18 to self-select two quarters of data from CY'17, instead of reporting the entire CY.

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MEDICARE FY 2018 HOSPITAL INPATIENT PPS PROPOSED RULE

INPATIENT QUALITY REPORTING (IQR) PROGRAM (CON'T)

- *IQR Program Measures:* The proposal is to adopt four new measures (three clinical episode-based payment measures, one claims-based outcome measure) and will remove 15 measures (two of which are topped-out and 13 that have been suspended) to the hospital IQR program beginning in FFY2020. CMS is proposing refinements to two previously adopted measures for the Hospital IQR program beginning in FFY 2020 and one measure refinement beginning in FFY 2023.
- The rule includes proposed changes to the PPS-exempt Cancer Hospital Quality Reporting Program; specifically addressing the importance of end-of-life treatment. Several changes are also proposed to the Inpatient Psychiatric Facility Quality Reporting Program.
- The agency is also considering potential options to adjust for social factors in the IQR program.

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MEDICARE FY 2018 HOSPITAL INPATIENT PPS PROPOSED RULE

VALUE-BASED PURCHASING (VBP) PROGRAM


- *FY 2018 impacts:* CMS proposes to reduce base operating diagnosis related group payments to participating hospitals -2.0 percent to fund the program. Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0 percent reduction.
- *FY 2019 impacts:* CMS proposes to remove the claims-based patient safety indicator (PSI) composite due to compatibility issues with ICD-10.
- *FY 2022 impacts:* CMS proposes to introduce an episode-based payment measure for pneumonia.
- *FY 2023 impacts:* CMS will reintroduce a revised PSI composite based on ICD-10.

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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

- For FY 2019 CMS proposes to implement a socioeconomic adjustment approach that has been mandated by the 21st Century Cures Act. The adjustment assesses readmission penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who receive full benefits and are dually eligible for Medicare and Medicaid. The approach places hospitals into one of five peer groups based on the proportion of their Medicare fee-for-service and Medicare Advantage patients and assignment must be implemented in a budget neutral fashion.



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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

- History:* The ACA mandates that the HAC Reduction Program impose a 1 percent reduction in total Medicare payments for hospitals who perform in the worst quartile of national HAC rates. CMS expects to release a list of hospitals subject to the HAC penalty for FY '18 in Oct. 2017.
- Update in the rule:* CMS does not propose changes to the HAC Reduction Program's measure set or scoring. The agency is soliciting feedback on several policy issues and measures for future adoption including:
 - How to account for patient complexity in the healthcare associated infection (HAI) measures
 - How to account for social risk factors in assessing penalties

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**MEDICARE FY 2018 HOSPITAL INPATIENT PPS
PROPOSED RULE**

MEDICARE AND MEDICAID EHR INCENTIVE PROGRAM CY '18 REPORTING PERIOD

- CMS proposes a modification to report a minimum of any continuous 90-day period within CY'18 from the original full year reporting requirement. CMS believes that some eligible hospitals, critical access hospitals and eligible professionals will not be ready and will require an extended timeframe to implement the 2015 edition certified EHR. The agency goes on to state that others would benefit from additional time to implement new processes and workflows to support the new features of the EHR.
- Furthermore, CMS acknowledges that if a change is identified in trends in the certification and deployment of the 2015 edition, they will consider flexibility in 2018 for eligible hospitals and professionals not able to implement the 2015 edition. Two of these flexible options may be:
 - Use either the 2014 edition or 2015 edition for 2018
 - Allow a combination of the 2014 and 2015 edition EHR technologies to be used for reporting in 2018

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MEDICARE FY 2018 HOSPITAL INPATIENT PPS PROPOSED RULE

MEDICARE AND MEDICAID EHR INCENTIVE PROGRAM CY '18 REPORTING PERIOD

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MEDICARE FY 2018 HOSPITAL INPATIENT PPS PROPOSED RULE

SURVEY AND CERTIFICATION REQUIREMENTS

- CMS proposes to require CMS-approved accreditation to accrediting organizations (AOs) in order to make hospital survey reports and acceptable plans of correction (PoCs) public. Under the new requirements, AOs that apply or reapply for CMS-approval of its Medicare provider or supplier accreditation program must agree to make all Medicare provider or supplier survey reports and PoCs within the last three years publicly available on its website.

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MEDICARE FY 2018 HOSPITAL LTCH PROPOSED RULE

THE CENTER FOR MEDICARE & MEDICAID SERVICES PAYMENT PROPOSAL

- FY 18 IS THE FIRST YEAR OF THE STATUTORY-MANDATED, TWO-TIERED PAYMENT SYSTEM FOR LTCHS.
- **STANDARD RATE:** THE OVERALL PROPOSED NET INCREASE OF 0.4% (\$15 MILLION), COMPARED TO FY 2017. INCLUDED IN THE FINAL INCREASE IS THE 1.0% MARKET BASKET UPDATE MANDATED BY MACRA. THE NET RATE ALSO INCLUDES TWO PROPOSED DECREASES IN OVERALL HIGH-COST OUTLIER PAYMENTS:
 - SETTING A HIGH-COST OUTLIER (HCO) THRESHOLD OF \$30,081 FOR STANDARD RATE CASES (A \$8,138 INCREASE OVER 2017).
 - IMPLEMENTING A 7.975 PERCENT HIGH-COST OUTLIER POOL, A .025 PERCENT CUT FROM THE 8% POOL IN THE 21ST CENTURY CURES ACT.
- **SITE-NEUTRAL RATE:** THE OVERALL PROPOSED NET DECREASE OF 22 PERCENT (\$253 MILLION), COMPARED TO FY 2017.
 - SITE-NEUTRAL CASES WILL BE PAID AT THE INPATIENT PPS RATE OF \$26,713. CMS BELIEVES THAT THE COSTS AND RESOURCE INTENSITY THAT THE LTCH SITE-NEUTRAL CASES REQUIRE, ARE SIMILAR AS THOSE OF INPATIENT CASES.

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MEDICARE FY 2018 HOSPITAL LTCH PROPOSED RULE

MORATORIUM OF THE LTCH 25% RULE

- THE 21ST CENTURY CURES ACT IMPLEMENTS A ONE-YEAR STATUTORY MORATORIUM ON THE LTCH 25% RULE, WHICH GOES INTO EFFECT FOR 2017. THE RULE IS PROPOSED TO EXTEND THE MORATORIUM THROUGH FY'18 AFTER THE EXPIRATION WAS SET TO EXPIRE ON SEPT. 30, 2017. THE PLAN IS TO USE THIS TIME TO EXAMINE THE IMPACT OF LTCH SITE-NEUTRAL PAYMENT AND DETERMINE WHETHER THE 25% RULE CONTINUES TO BE SUPPORTIVE. SITE-NEUTRAL CASES ARE SADDLED WITH ARE THE SAME AS THOSE OF INPATIENT CASES.

MEDICARE FY 2018 HOSPITAL LTCH PROPOSED RULE

SHORT-STAY OUTLIER (SSO) METHODOLOGY

- CMS PROPOSES REMOVING THE INCENTIVE TO DELAY THE DISCHARGE OF A SHORT-STAY UNTIL JUST BEYOND THE THRESHOLD. THIS REMOVAL WILL MAKE THE CASE ELIGIBLE FOR A FULL LTCH PPS PAYMENT, INSTEAD OF REIMBURSING AT THE REDUCED SHORT-STAY PAYMENT. THE FOCUS OF THE PROPOSAL WILL ALLOW SSO CASES TO BE REIMBURSED AT A COMBINATION OF IPPS PER DIEM AMOUNTS AND 120 PERCENT OF THE MEDICARE-SEVERITY LONG-TERM CARE DIAGNOSIS RELATED GROUP (MS-LTC-DRG) PER DIEM AMOUNT WITH THE ALLOWANCE THAT THE RATE WILL INCREASE WITH THE LENGTH OF STAY.



MEDICARE FY 2018 HOSPITAL LTCH PROPOSED RULE

IMPLEMENTATION OF 21ST CENTURY CURES PROVISIONS:

- THE 21ST CENTURY CURES ACT PROPOSES THE FOLLOWING PROVISIONS TO LTCC PPS:
 - SITE-NEUTRAL PAYMENT RATE EXEMPTIONS FOR COST REPORTS BEGINNING IN FY'18 FOR SEVERE WOUND CASES TREATED BY GRANDFATHERED LTCHS
 - SITE-NEUTRAL PAYMENT RATE EXEMPTIONS FOR COST REPORTING PERIODS BEGINNING FY'18 AND FY'19 FOR NON-PROFIT LTCHS UNLESS THEY HAVE:
 - EXISTED SINCE JUNE 1, 2014 AND HAVE SIGNIFICANT OUT-OF-STATE ADMISSIONS.
 - PRIMARILY PROVIDE TREATMENT FOR CATASTROPHIC SPINAL CORD OR
 - ACQUIRED BRAIN INJURIES OR
 - OTHER PARALYZING NEUROMUSCULAR CONDITIONS.
 - THE ALLOWANCE TO EXISTING LTCHS AND SATELLITES TO INCREASE THEIR NUMBER OF BEDS IF THEY MEET CERTAIN QUALIFYING CRITERIA, RETROACTIVE TO APRIL 1, 2014
 - CHANGES TO THE AVERAGE LENGTH-OF-STAY CRITERIA TO LTCHS THAT BEGAN OPERATIONS AFTER DEC. 26, 2013 WOULD MIRROR THE CRITERIA FOR LTCHS EST. THROUGH DEC. 26, 2013. THE CRITERIA DEFINED AS THE 25-DAY AVERAGE LENGTH OF STAY IS CALCULATED WITHOUT MEDICAID ADVANTAGE AND LTCH SITE-NEUTRAL CASES.

MEDICARE FY 2018 HOSPITAL INPATIENT PPS AND LTCH PROPOSED RULE

MOVING FORWARD WITH THE PROPOSED RULES

- CMS is accepting comments on the proposed rule through June 13
- The final rule will be published Aug. 1
- Policies and payment rates will take effect on Oct. 1

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MEDICAID IPPS / OPPTS REBASING

HIGHLIGHTS

- **IMPLEMENTATION ON SCHEDULE FOR JULY 1, 2017**
- **NEW RULEMAKING REQUIRED**
 - MEDICAID RULES SUBMITTED TO JCARR ON APR. 17
- **NEW PEER GROUPS, CONSISTENT ACROSS OPPTS & IPPS**
 - CHILDREN'S HOSPITALS
 - MAJOR TEACHING HOSPITALS
 - URBAN REGIONAL: CENTRAL, SE, SW, NE & NW
 - CRITICAL ACCESS HOSPITALS
 - OTHER RURAL HOSPITALS
 - PRIVATE PSYCHIATRIC HOSPITALS
 - OUT OF STATE HOSPITALS

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MEDICAID EAPG OPPTS / IPPS REBASING

Final EAPG Model #12 was released and approved by OHA's Finance Committee and Board in Dec. 2016

Stop-loss/Stop-gain specifics:

Medical Education: Rebased GME payments, with stop loss/stop gain of -0% / +10%

Psych DRGs: Not rebased (avoids payment reductions for inpatient psychiatric services)

Rural and CAH Challenges: Inpatient cost coverage floor of 70%

Across-the-Board Risk Mitigation:

- Inpatient overall stop loss/stop gain of +/- 5% applied to current payments
- Outpatient overall stop loss/stop gain of -0% / +5%

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MEDICAID EAPG OPPS

BACKGROUND

- **ENHANCED AMBULATORY PATIENT GROUPS**
 - CREATED BY 3M
 - IN USE AT 13 STATE MEDICAID OR BLUE CROSS PLANS
 - APPLIES TO ALL HOSPITALS BILLING OHIO MEDICAID
 - OHIO-SPECIFIC EAPG WEIGHTS CALCULATED
 - 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

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MEDICAID EAPG OPPS

EAPGs vs. DRGs

<u>DRG</u>	<u>EAPG</u>
– Inpatient Admission	– Ambulatory Visit
– Discharge Date Defines Code Sets	– Claim "FROM" Date Defines Code Sets
– Uses ICD-9-CM or ICD-10-CM Diagnosis & Procedure Codes	– Uses ICD-10-CM Diagnosis Codes & HCPCS/CPT, Procedure Codes
– Only One DRG per Admission	– Multiple EAPGs May be Assigned per Visit
– Employs Some Charge Bundling	– Employs Significant Charge "Packaging," Consolidation & Discounting

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MEDICAID EAPG OPPS

EAPG Definitions

- **Packaging:**
The inclusion of payment for certain services within payment for significant procedure or medical services
- **Discounting:**
A reduction in the standard EAPG payment rate when multiple significant procedures are performed
- **Consolidation:**
When a patient has multiple related significant procedures performed on the same date

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MEDICAID EAPG OPPS

Ohio Medicaid payment formula

A = Hospital specific base rate adjusted for risk corridors
 B = EAPG relative weight
 C = Applicable discounting factor(s)
 \$ = Payment (rounded to the nearest penny)

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MEDICAID EAPG OPPS

FINAL TRANSITION PREPARATION

OHA HOSTED AN INTRODUCTION TO 3M'S EAPG GROUPER ON JAN. 24 WITH 3M CONSULTANT DAVE FEE AND 'PREPARING FOR A SUCCESSFUL EAPG IMPLEMENTATION' WITH BKD, LLC ON APRIL 25TH. A RECORDING AND COPIES OF BOTH PRESENTATIONS CAN BE FOUND AT:

WWW.OHIOHOSPITALS.ORG

ADVOCACY & POLICY
 FINANCE & POLICY
 BY-THE-NUMBERS
 JAN. & APR. 'JUST THE FACTS'

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OTHER

'340B Covered Entity Requirements' 5160-1-17.11 (Proposed)

- A 340B covered entity shall notify The Ohio Department of Medicaid (ODM) of their 340B status annually.
- Hospital 340B entities seeking reimbursement on an outpatient claim will be required to include an NDC and modifier (TBA) signifying they are billing for the reimbursement of a 340B drug on the claim charge line.
- Contract Pharmacy drugs acquired through the 340B drug program and dispensed by an entity under contract with the 340B covered entity will not be covered by Ohio Medicaid.
- 5160-1-17.11 was pulled from JCARR on March 6 and April 17 due to legislative push-back.

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OTHER

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

Ohio Hospital Association | ohiohospitals.org | HCCA Event May 5, 2017 40

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

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