

**OHA UPDATE**

Columbus Regional  
Compliance Conference

May 4, 2018

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**AGENDA**

**OHA POLICY/PAYMENT ADVOCACY INITIATIVES**

- PRICE TRANSPARENCY UPDATE
- OHIO 1115 WAIVER

**MEDICAID**

- 2018 STATE BUDGET UPDATE
- EAPG OPSS & REBASED IPPS MONITORING
- OHIO MEDICAID – RECALIBRATION

**BWC OPSS IMPLEMENTATION MAY 1**

**MEDICARE**

- CMS MEDICARE PROPOSED FY 2019 RULES (HOSPITAL IPPS, INPATIENT PSYCHIATRIC FACILITY PPS, INPATIENT REHABILITATION FACILITY, SKILLED NURSING FACILITY, HOSPICE)
- MEDICARE BENEFICIARY IDENTIFIERS – APR. 1

**NEW HIPAA STANDARD AUTHORIZATION FORM**

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**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

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**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

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**PRICE TRANSPARENCY**

**OHA PROPOSAL CONT.**

- **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**

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**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.

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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, 2017 GRANTED UNTIL HEARING SCHEDULED FOR SOMETIME IN THE FUTURE.
- CURRENT HUFFMAN LEGISLATION IS PROGRESSING THROUGH THE COMMITTEE PROCESS.

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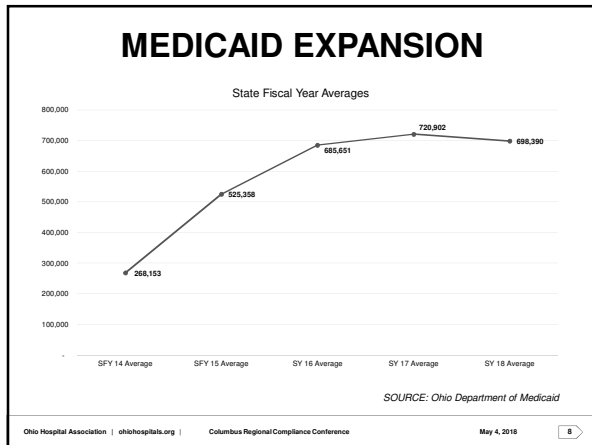
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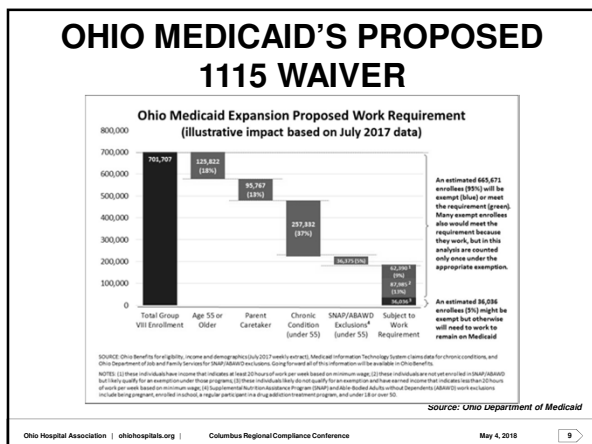
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**OHA EAPG ANALYSIS & BUDGET MONITORING**

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.

FIRST QUARTERLY REPORTS MAY 2018!



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**PROPOSED RECALIBRATION**  
Status Update

- **ODM proposal to recalibrate inpatient and outpatient relative weights effective July 1, 2018**
  - ODM granted delay until August 1, 2018
- **Hospital case-mix index increases driving desire of ODM to recalibrate**
  - ICD-10 conversion?
  - Medicaid expansion impact?
- **OHA continuing to meet with ODM**
  - Focused primarily on outpatient recalibration
  - System still very new
  - Premature to recalibrate so soon?
- **Potential impact down from \$123M**
  - New projections show recalibration will reduce hospital payments by \$84.4M per year (using 100% FFS Medicaid pricing)

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**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



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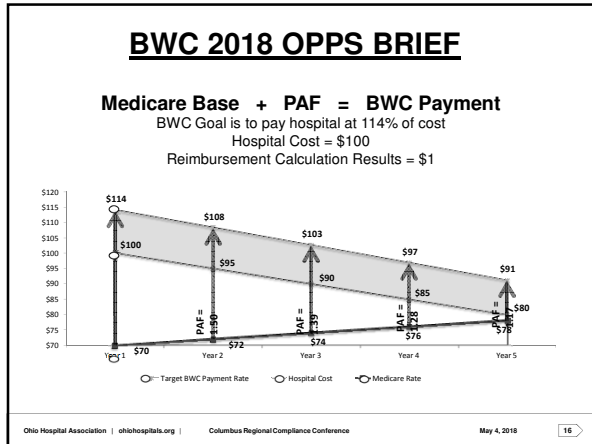
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- ### BWC 2018 OPPS BRIEF
- #### Proposed 2018 Arthroplasty Program Expansion
- Initially implemented May 1, 2016
  - ASCs have additional certification criteria
  - Adopted two procedures in 2017
    - CPT 27130 (Total Hip Replacement)
    - CPT 27447 (Total Knee Replacement)
  - Six additional codes recommended for 2018
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### 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

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**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

Appendix table of local level codes for per diem (all inclusive rates) for following 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

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**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

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**BWC 2018 OPPS BRIEF**

**Section 603 Provider-Based Departments Cont.**

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-expected service provided at an –off campus, outpatient, provider-based department of a hospital) – 60% reduction

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**BWC 2018 OPPTS BRIEF**

**340B Drugs**

For 2018, BWC is adopting Medicare's Requirements and Reimbursement Methodology

- JG and TB informational modifiers will be required as of May 1.
- Reimbursement will be provided at average sales price (ASP) minus 22.5%.



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**CMS MEDICARE PROPOSED FY 2019 HOSPITAL IPPTS RULE**

- **Increases inpatient operating rates by 1.75 percent**
- **Meaningful Use Update:**
  - CMS references changing its view on meaningful use by updating the EHR incentive program to a new 'Promoting Interoperability' program, while updating the scoring methodology and adding new measures, such as those to address e-prescribing of opioids.
  - Seeks feedback on ways to enhance interoperability.
- **Addresses price transparency:**
  - CMS acknowledges chargemaster data are 'not helpful to patients for determining what they are likely to pay for a particular service or hospital stay.
  - CMS is proposing to update its guidance to require hospitals to make available a list of their current 'standard charges' via the internet in a machine-readable format with annual updates.
  - The format for the machine-readable 'standard charges' can be the chargemaster itself or another for of the hospital's choice.

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**CMS MEDICARE PROPOSED FY 2019 HOSPITAL IPPTS RULE (CONT.)**

- **Meaningful Measures Update:**
  - Removes measures CMS deems as duplicative and excessively burdensome or those in which the providers consistently perform well in the measure. (21 duplicate measures and 19 others)
  - Adds one measure to its cancer hospital quality reporting program for 2021, which will measure claims-based 30-day unplanned readmissions.
  - Eliminates requirement for providers to record a written inpatient admission order in the medical record in order to receive Part A reimbursement.
  - Considers social risk factors in some of its quality programs.
    - Hospital Inpatient Quality Reporting Program (dual-eligible)
    - Hospital – Acquired Conditions Reduction Program (dual-eligible)

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**CMS MEDICARE PROPOSED FY 2019  
INPATIENT PSYCHIATRIC FACILITY RULE**

- **Increases inpatient overall payments 0.98 percent**
- **Removes eight measures from the Inpatient Psychiatric facilities Quality Reporting program.**
  - Seeks feedback on ways to enhance interoperability.

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**CMS MEDICARE PROPOSED FY 2019  
INPATIENT REHABILITATION FACILITIES RULE**

- **Proposes a net payment increases of 0.9 percent.**
- **Removes two measures from the IRF Quality Reporting Program:**
  - IRFs no longer have to report data for the NHSN MRSA or seasonal flu vaccination measures starting Oct. 1.
- **Removes the FIM instrument and associated function modifiers from the IRF patient assessment tool.**
- **Seeks comments on removing face-to-face requirement for rehabilitation physician visits as well as other coverage changes.**

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**CMS MEDICARE PROPOSED FY 2019  
SKILLED NURSING FACILITIES RULE**

- **Proposes a net payment increases of 2.4 percent with no forecast error correction applied in FY 2019.**
- **Outlines an overhaul of the SNF payment system, the 'RUGS', for FY 2019 and states the proposed new 'Patient-Driven Payment Model' has been changed from the version released earlier in May 2017.**
- **Proposes a change to quality reporting for SNFs by increasing the number of years of data used to calculate two measures on Nursing Home Compare from one to two years.**
  - Stated to improve validity of the results and updates to the SNF Value-based Purchasing Program.

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**CMS MEDICARE PROPOSED FY 2019  
HOSPICE RULE**

- **Proposes to increase hospice payments and the statutory annual cap by 1.8 percent.**
- **Proposes recognition of physician assistants as attending physicians for hospice beneficiaries.**

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**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, Ohio is last on the mailing list and should start receiving in June.

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.

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**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 2<sup>nd</sup>, 5<sup>th</sup>, 8<sup>th</sup>, and 9<sup>th</sup> characters will always be a letter
- Characters 1,4,7,10, and 11 will always be a number
- The 3<sup>rd</sup> and 6<sup>th</sup> characters will be a letter or a number
- Starting Jan. 1, 2020, you have to submit claims using MBIs (with few exceptions), no matter what date you performed the service.
- **Systems must have been ready by April 2018 to begin accept the new MBIs!!!**



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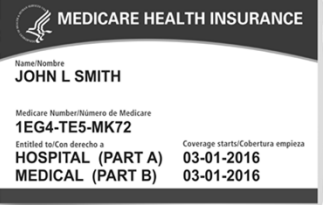
**MEDICARE BENEFICIARY IDENTIFIER (MBI)**

**How will the MBI Look On Cards?**

Current Medicare Card



NEW Medicare Card



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

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**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.

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**HIPAA STANDARD AUTHORIZATION FORM**

- New HIPAA Standard Authorization Form
  - Proposed rule and form coming out soon
  - Providers and health plans will be required to accept if properly executed
  - Broad form allows patient to identify any information they want disclosed
  - Also includes a separate form for Part 2 information disclosure

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

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