OHIO HOSPITAL ASSOCIATION

OHA UPDATE

AAHAM's Super PFS Event

February 15, 2018

Agenda

- 2018 OHA Policy/Payment Advocacy Initiatives
  - 2018 State Budget Update
  - Price Transparency Update
  - 2018 Poverty Guidelines
  - Medicare Extenders
- Medicare OPPS 2018 Highlights
- 2018 BWC OPPS
- Medicare's New Cards – April 1, 2018
- Other
  - Anthem Imaging Policies
  - Ohio Medicaid 1115 Waiver Update
  - 340B Medicaid & Medicare Update
  - Ohio Medicaid NDC Requirement Update

STATE BUDGET UPDATE

Revenues & Medicaid

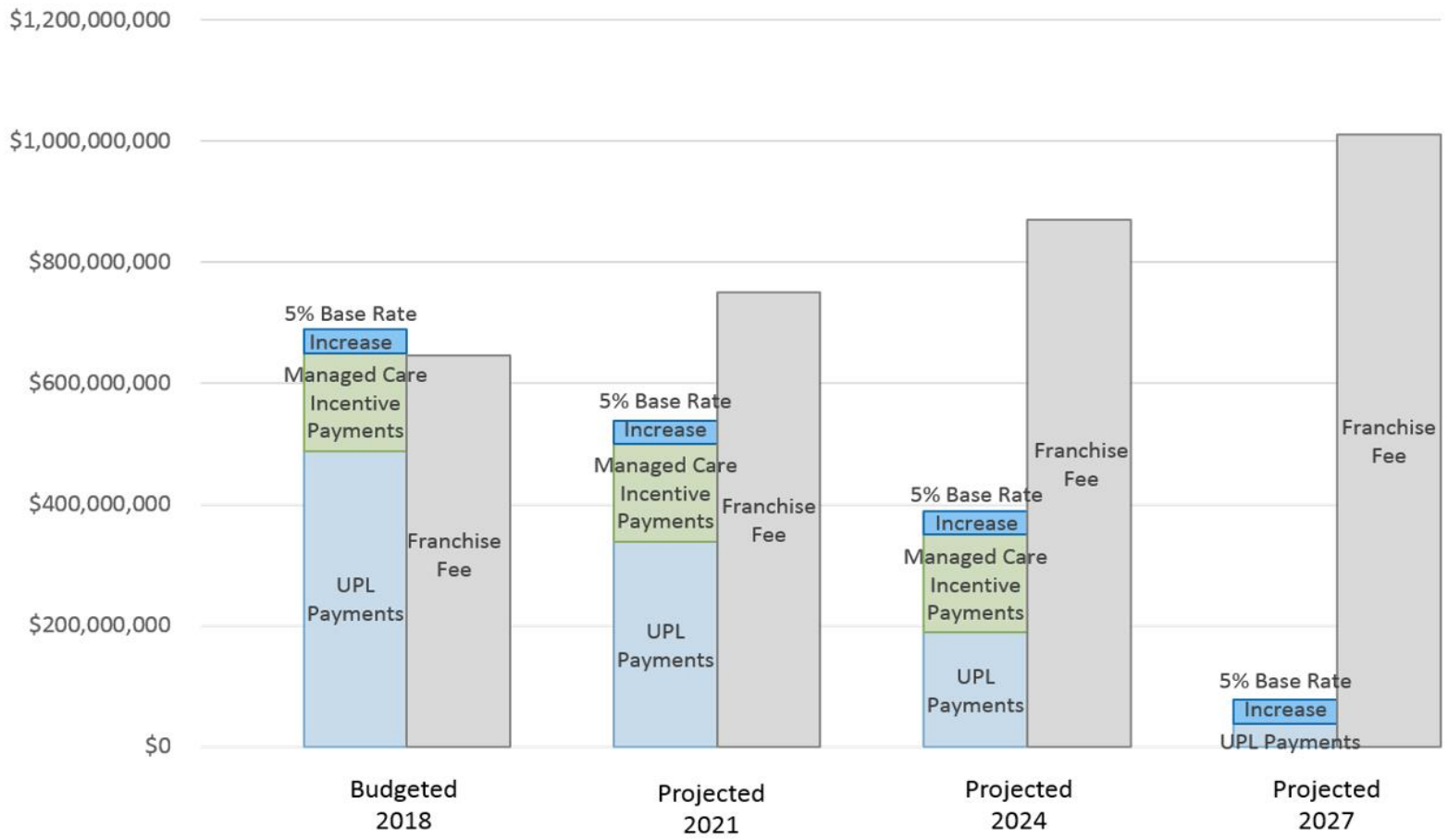
- **State tax revenues coming in as budgeted**
  - $221.5M (1.7%) above estimates through December
  - YTD tax revenues up $211M (1.6%) from prior year
- **Medicaid caseloads coming in under budget**
  - Total enrollment 108,488 (3.63%) under budget
  - 107,524 (3.63%) fewer enrollees than prior year
- **Medicaid spending coming in under budget**
  - GRF expenditures $192M (2.2%) below YTD estimate
  - All funds expenditures $173.6M (1.1%) below YTD estimate
  - OBM cites variance due to “underspending in the fee-for-service program and program administration.”
  - Latest ODM Forecast indicates year-end GRF underspend of 25M

APPROVED STATEMENT
Finance Committee on the Franchise Fee

The current franchise fee program is unsustainable for the hospitals of Ohio and needs to be reformed by July 1, 2018. Directed payments through Medicaid managed care are the most promising tools to achieve successful reform. The OHA Finance Committee hereby recommends the association pursue changes to the franchise fee that would:

- Leverage existing or new fees, as necessary, to create directed payment programs through managed care in a manner that supports quality improvement and/or state health priorities;
- Enhance the predictability of any assessment by tying the assessment to the total annual funding needs;
- Create more transparency and protections around the usage of any assessment collected;
- Adopt the 2016 net gain to hospitals as the minimum threshold for the revised franchise fee program;
- Sustain the program into the future, in accordance with OHA's franchise fee principles and goals.

FRANCHISE FEE PROJECTION – BASE "CHANGE NOTHING"



HEALTH MANAGEMENT ASSOCIATES

BOARD-ADOPTED MOTION

To direct staff to convene an ad hoc workgroup comprised of Board members, Finance Committee members and other appropriate industry leaders to identify the optimal implementation strategies for franchise fee reforms and make recommendations back to the Board by March, 2018.

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

2018 POVERTY GUIDELINES

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$12,140
2	16,460
3	20,780
4	25,100
5	29,420
6	33,740
7	38,060
8	42,380

For families/households with more than 8 persons, add $4,320 for each additional person.

MEDICARE EXTENDERS

Feb. 9, Congress passed a short-term spending deal that included a number of health care provisions:

- Extended funding for the Children's Health Insurance Program for an additional four years on top of the six years included in the last continuing resolution

- Delayed the cuts to Medicaid DSH Payments scheduled for FYs 2018 and 2019

MEDICARE EXTENDERS CON'T

- Extends funding for the Low-Volume Adjustment Program for five years.
- Repeals the Independent Payment Advisory Board
- Repeals permanently the Medicare payment caps for outpatient physical, speech language, and occupational therapy services.

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

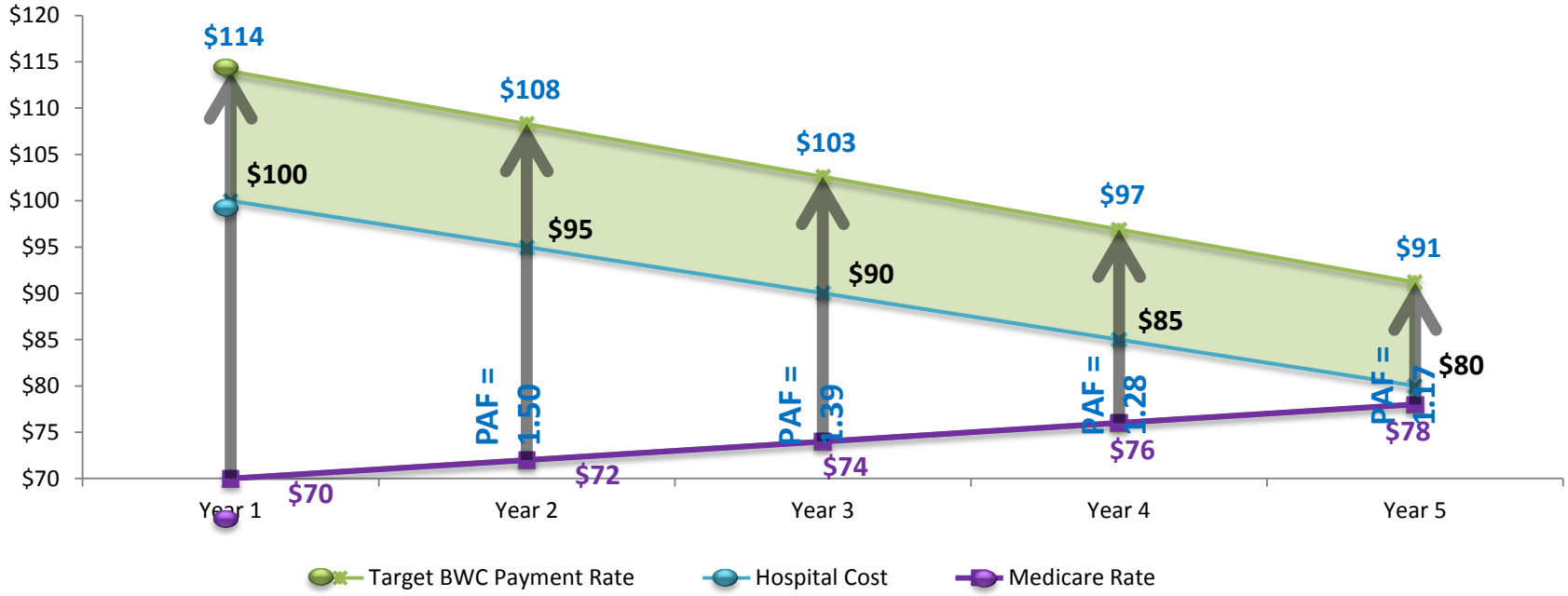
BWC 2018 OPPS BRIEF

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.

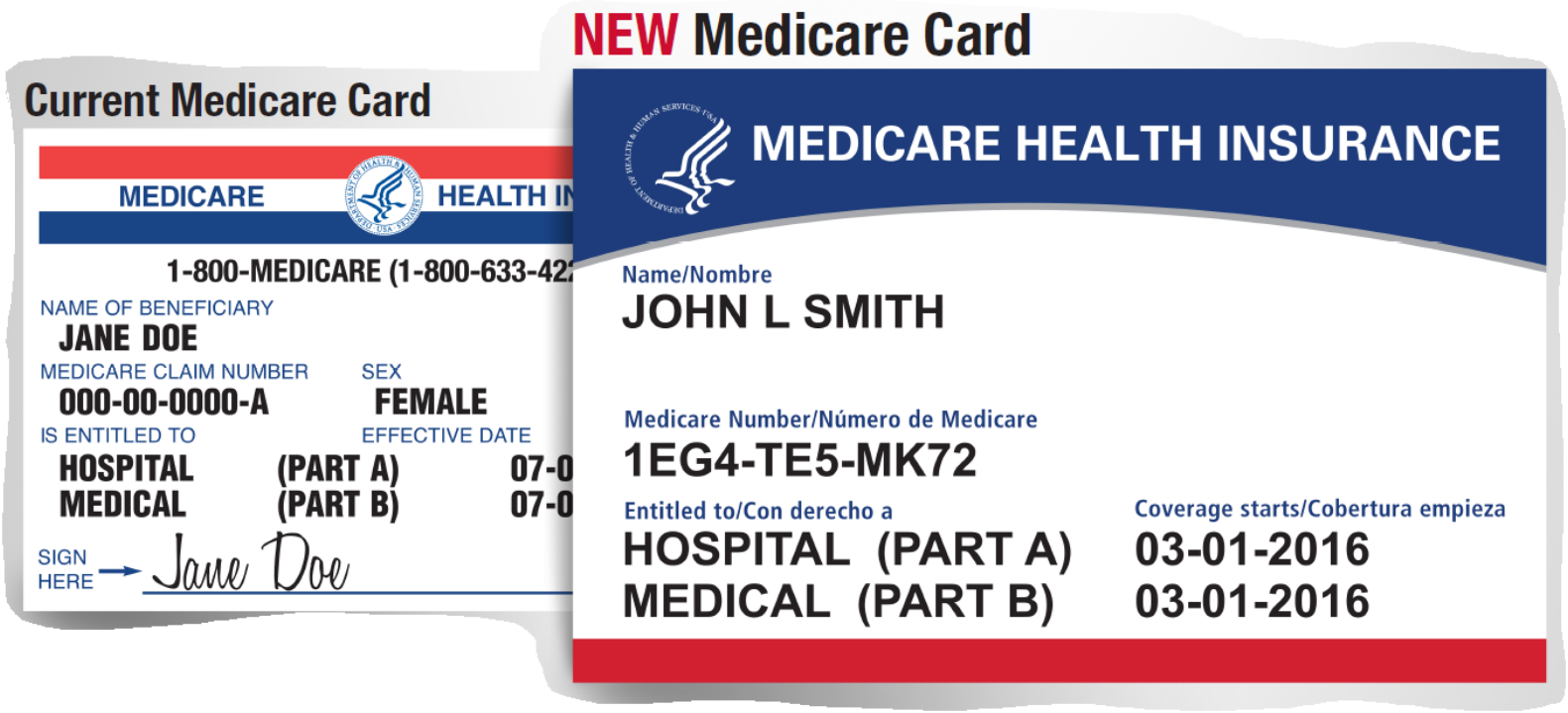
MEDICARE BENEFICIARY IDENTIFIER (MBI)

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?

- 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.

OTHER

- Anthem Imaging Policies
  - Clinical UM Guideline CG-MED-55, Level of Care: Advanced Radiologic Imaging – Sept. 1, 2017
  - ED Appropriate Site Policy – Jan. 1, 2018
  - ED Imaging Policy – ETA March 1, 2018
- Ohio Medicaid 1115 Waiver Status
- 340B Ohio Medicaid & Medicare Update
  - Medicaid's 'SE' Modifier
  - Medicare's 'JG' & 'TB' Modifiers
  - AHA Lawsuit Update
- 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

Shawn Stack

Director, Health Economics and Policy

Shawn.Stack@ohiohospitals.org

Ohio Hospital Association
155 E. Broad St., Suite 301
Columbus, OH 43215-3640

T 614-221-7614
ohiohospitals.org

HelpingOhioHospitals

@OhioHospitals

www.youtube.com/user/OHA1915