AGENDA

Federal
- Medicare & IRS Final Rules on Charitable Hospitals
- Federal Budget Targets Taking Shape
- Medicare RAC Contract Re-bid Still on Hold (through 2015?!)  

State
- 2014 was a Year of Transition; What’s Next in the State Budget?
- Medicaid Episodic Payment Plan Moving Forward
- BWC 2015 Hospital Payment Discussion – To PPS or not to PPS?
- Medicaid Preventable Admissions and Outpatient PPS Projects

Other Finance / PFS
- ICD.10 Test Results Looking Okay
- SAFE Program Audits Possible This Year
CMS UNINSURED DEFINITION RULE

• Few Changes From 2012 Proposed Rule (Which Guided FFY 2011 Myers and Stauffer Medicaid DSH Audits)
• Effective for DSH Audits and Reports Submitted for SPRY 2011
• Ties Hospital-Specific DSH Limit to Medicaid Payment Shortfall Plus Cost of Care to the “Uninsured”
  – Includes Non-Covered-Services (i.e. Not Part of a Patient’s Benefit Package, but **Covered by State Medicaid Plan**)
  – Includes Exhausted Benefits and Lifetime Limits, as Above
• Does NOT Include Bad Debt; Unpaid Coinsurance and Deductible, or Hospital-Based Practitioner Charges
IRS 501 HOSPITAL REGULATION (FINALLY) OUT, TOO

• 12/31/14 FR; Compliance Starts With Taxable Year AFTER 12/29/15
• Clarifies Needs Assessment & Financial Assistance Policy
• Revises Proposed Billing/Collection Standards
  – Largely Eliminates Proposed Billing Rules During 120-Notification Period
  • Substitutes Required Actions Before Collection Can Commence
  • Expands List Of Collection Actions Subject to the Waiting Period
  – Maintains 240-day Period in Which Hospital Must Accept Applications
  – Keeps Most Notification and Communication Requirements; Tightens FAP Translation Requirements
• Keeps Proposed “Amounts Generally Billed” Methodologies
  – Retro = Medicare FFS, or Medicare & Private, or Medicaid (FFS & MC)
  – Prospective = Estimated Future Medicare
• FAP Must Clearly Define AGB Standards; Prospective Changes Okay
2015 OIG WORK PLAN

Hospital Issues

• “Two Midnight” Rule
• Costs Associated with Defective Devices
• Salary Amounts on Cost Report: Are They Reasonable? Are Limits Appropriate?
• Provider-Based Status: Are Criteria Being Met? Should we Examine Payments Compared to Free-Standing Clinics?
• Swing-Beds in CAHs: Compare payments to SNFs. Are Length-of-Stay Limits Appropriate?
• “96-hour” Rule Compliance with Mechanical Ventilation
• GME Payments
• Dental Services: Are Coverage Rules Being Met?
• E&M Codes: Existing Patients Being Billed as New
2015 OIG WORK PLAN (CONT.)

Additional Hospital Issues
- Wage Data for Purposes ofCalculating Wage Index
- Pharmaceutical Compounding: Cost and Oversight
- Medical Staff Privileges (Hospitals, SNFs & HHAs): Credentialing and Checking National Practitioner Databank

Post-Acute Issues
- Adverse Events in IRFs and LTACs
- Therapy and Foot Care Billings by SNFs
- Home Health PPS Documentation

Part B Issues
- ASC Payment Rates
- Unnecessary Ambulance Transports
- Medical Necessity of Radiology & Sleep Tests
- Payments for 340(B)
WHAT ABOUT MEDPAC?! 

- **Site Neutral Payments**, Especially Non-Emergency, Ambulatory & E&M Services
- Continue Balance Overall Payment Levels Between FFS and MA
- Support Payments for Primary Care
  - Continue Incentive Payments to Primary Care Providers.
- **Expand FFS Readmission Policies to Post-Acute Providers, Especially Skilled and Home Health**
- **Expand Bundled Payments Initiatives**
  - Hospital & Physician; Hospital & Post Acute Care.
- **Modify Beneficiary Co-Payments**; Especially Guard Against High Outpatient Co-Pays, Add Catastrophic Coverage, Install Outpatient Patient-Pay Maximums
2016 FEDERAL BUDGET: FIRST TAKE FROM EXECUTIVE BRANCH

Good:

– Repeal Sequester
– Extend Medicaid CHIP Through 2019
– Reauthorize GME Shortage Area Grants & Primary Care Physician Subsidies

Bad:

– Site Neutral Payments for Services in Physician Offices
– Cut Bad Debt Payments
– Cut Indirect GME by 10%
– Cut CAH Payments to 100% Cost & Impose 10-Mile Restriction
– Bundle Payments to LTCHs, SNF, Rehab & Home Health, and Introduce Value-Based Payment Methodologies for them
– Re-Base Medicaid DSH Program
2016 FEDERAL BUDGET:
FIRST TAKE FROM EXECUTIVE BRANCH

Just Plain Ugly (to Manage Through Congress)

- Replace Physician SGR with a Permanent Fix, Require Quality Reporting & Physician Pay-for-Performance
- Require New Coding Procedures on Hospital -Acquired Conditions
- Give More Authority to Independent Payment Advisory Board (IPAB)
- Increase Medicare Bene’ Premiums and Co-pays
- Permit HHS to Negotiate Drug Prices
- Use some of the RAC Contingency Fees to Fund Appeals
• RAC Contract Rebid Still on Hold
  • **New Regions** Drawn to Re-Weigh Claims Volume
  • **Existing Region B Subdivided** – *at the Very Least Some States in Region B Must Switch Contractors*
• CMS Had “Paused” Medicare RAC Activity Until New Contracts are in Place
• **BUT…** CMS Has Now Reopened Existing Contracts to a Limited (?) Number of (Mostly) Automated Reviews.
  • Effective Through Dec. 31, 2015 (?)
  • Details and/or Issues Listed on CGI Webpage
    • DRG Payment Complex Reviews (Over/Underpayments)
    • Code and Unit Overpayments Automated Reviews
    • Drug Unit Overpayments
    • Cleaning Up Old ADRs for Records Never Submitted
MEDICARE RAC MAPS – OLD VS. NEW

Current (Old Contract)  New Contract
In the Interim, CMS Continues to “Refine” RAC Program

• Medicare RAC Program Administrative Improvements
  • Big Expansion Announced in December
• Expanded Services Eligible for Inpatient “Part B” Re-Bills
• Offer to Buy Out Outstanding Claims Under Appeal
  • @ 68% of “Net Paid Amount”
    – Be Careful About Medicaid Secondary Payments!!
• Two-Midnight Rule
• Proposals for IPPS “Short-Stay” Claims Payment

What’s in it For CMS?

• Fewer Appeals at ALJ, Settle Lawsuits, Lessen Possibility of Congressional Action
NEW MEDICARE RAC PROGRAM IMPROVEMENTS

Effective with new Contract Periods
See December Release for Details

• ADR Limits Adjusted to Provider Compliance Rates
• Limits on Look-back for Patient Status Reviews
• ADRs Must be Diversified – No Focus on Specific Types of Cases
• Faster Review Turnaround
• Expanded Discussion Periods
• Delayed Award of Contingency Fees
• Additional Program Education and Outreach – Provider Satisfaction Surveys
• Standards for RAC Accuracy and Limits on Over-Turned Denials
WHAT ABOUT THE MEDICAID RAC?!

CGI Contract Ended in July, 2014; **RFP Out for New Contractor**

ODM Assumed Responsibility for Outstanding Reviews, Recoveries and Appeals

- ODM Will Internally Correct Claims Recovered in Error
- ODM will Complete any Reviews of ADRs/Medical Records Sent to CGI Before Contract Ended
- ODM Will Manage Any Requested Appeal CGI did not Complete
  - Interest on New Recoveries Will Only Accrue to Original Overpayment Notification or Appeal Request
- No Date Released for any of the Above!
STATE ISSUES
2014: A TRANSFORMATIONAL YEAR

- Medicaid Expansion to Adults with Income up to 138% FPL
- Hospital Reimbursement Changes Connected to Expansion
  - 5% IP Cut to Non-Children’s Hospitals
  - Cut to Hospital Capital Reimbursement
- ACA Exchange implementation
  - QHP selection
  - Enrollment Issues
  - Litigation Over State V. Federal Exchange Subsidies
- Federal DSH Audits Grow Teeth
- Payment Reform Debate Continue Nationally, Especially in Ohio
  - Medicaid/ Commercial Episodic Payment Model Demo
- Year Two of APR-DRG Payment in Ohio Medicaid
- Transformational HCAP Reforms
STATE ISSUES: WHY REFORM HCAP?!

- HCAP Formula Uses Most Recent Medicaid Cost Report Data as a Proxy for Hospitals’ Current Uncompensated Care and Medicaid Loss Burden
  - CY 2014 Program Uses 2012 Data (Pre- V. Post-Expansion)
- 2013 Model Distributed over 60% of Available Funds Based on Uninsured Population that was Estimated to Most Likely Become Medicaid-Eligible (…and HCAP Ineligible!)
- DSH Auditors Review Payments Compared to Actual State and Hospital-Specific “OBRA Cap” DSH Limits for Each Federal Fiscal Year
  - Beginning with FFY 2011, Auditors can Recommend Recovery and Redistribution of Prior Payments
  - CMS Examining State Compliance with Federal Laws/Rules as Identified by Audits
Ohio Hospital Uncompensated Care Costs & Medicaid Losses vs. HCAP Federal Funding 2001-2014

Uncompensated Care Costs

HCAP Federal Funds

Millions


Uncompensated Care Costs

HCAP Federal Funds
2014 HCAP REFORM: OHA BOARD DIRECTIVE

- **Increase Fairness & Equity** Through Reforms That Narrow the Gap Between Peer-Group Net “Misery Indexes
- **Minimize the Risk of Provider Overpayments** Identified in Federal DSH Audits
- **Allow Flexibility** and Reevaluation on an annual Basis;
- Stay in Line with other OHA HCAP Principles

OHA Finance Committee Recommendation:

*To recommend the OHA Board of Trustees endorse a FFY 2014 Hospital Care Assurance Program (HCAP) based on a Distribution Model with a presumed 50% Medicaid enrollment take-up*

- Revised Preliminary 2014 Assessment and Distribution Model Available on OHA HCAP Webpage – No Date Yet for Assessments and Payments
HCAP 2015 AND BEYOND

- Finance Committee Concerns re: Budgeting for HCAP Payments Prompted an Accelerated Discussion of 2015 Model

- Staff Modeled 2015 Options Using Survey Data Based on Committee Desire to Use 2014 as a Transition Year, Updated as Additional Data Becomes Available

- Finance Committee Recommended, OHA Board Approved an Additional 37.5% Transfer from Pot 3A in 2015.
  - Q: Is This Enough?

- Continued Transformation Likely in 2016 and Beyond: HCAP Becomes a Medicaid Loss and Uninsured Program Instead of Focusing on Medicaid Cost and Uncompensated Care
STATE ISSUES: 2016/2017 STATE BUDGET DEBATE
OHA Advocacy Targets: December 2014

– Medicaid Eligibility Maintenance
– Preserve Existing Medicaid Eligibility Standards and Oppose any Movement to Foist the Cost of Enhanced Eligibility onto Hospitals
– Maintain the HCAP and State Hospital Franchise Fee Programs as They Were designed and are currently funded and managed
– Oppose any Attempt to Require Hospitals to Contract with Medicaid Managed Care Plans
– Work with ODM to Manage the Reform of the Medicaid GME and Oppose cuts to Hospital Programs that Restrict Their Ability to Train Residents
– Oppose cuts to Payments for Hospital Outpatient Care
– Oppose Additional cuts for Hospital Inpatient Care
As Released Budget Details and Hospital Targets: March 2015

• Retain Current Medicaid Eligibility, but Increase “Personal Responsibility” for Expansion Enrollees
• Eliminate 2011 5% Add-on Rate for Outpatient Services for all but Children’s Hospitals.
• Add Potentially Preventable Hospital Readmissions Program
• Repurpose GME Payments to Focus on Primary Care.
  – $25 M Cut to GME Payments in Second Year Used to Offset a Portion of the Proposed Medicaid Physician Rate Increase.
• Increase Franchise Fee from 2.7% to 3.0 % - Increase the State’s Take.
• Payment for Outpatient Detail-coded Drugs Reduced to Medicaid Physician Fee Schedule.
• Implement 3-Day Pre and Post Admission DRG Window
OHT/ODM Won $80 Million Center for Medicare and Medicaid Innovation Testing Grant

ODM/OHT have Detailed Business Requirements for Episodes Available Online

- Includes “Recipe” for Building Episodes Available to Medicaid and Commercial Plans, and Calculations for Normalization and Risk Adjustment
  - “Normalization” Disregards Hospital Add-on Payments for Capital & GME; but NOT for Variations in Base Rates

Baseline Principal Accountable Provider (PAP/Quarterback) Reports on MITS

- Hospitals can Access Asthma and COPD Reports, but Not Perinatal, PCI or Joint Replacement Directly
Retrospective episode model mechanics

1. Patients and providers continue to deliver care as they do today
   - Patients seek care and select providers as they do today

2. Providers submit claims as they do today

3. Payers reimburse for all services as they do today

4. Calculate incentive payments based on outcomes after close of 12 month performance period
   - Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode

5. Payers calculate average cost per episode for each PAP
   - Compare average costs to predetermined ‘commendable’ and ‘acceptable’ levels

6. Providers may:
   - Share savings: if average costs below commendable levels and quality targets are met
   - Pay part of excess cost: if average costs are above acceptable level
   - See no change in pay: if average costs are between commendable and acceptable levels

SOURCE: Arkansas Payment Improvement Initiative
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- **Risk sharing**: Pay portion of excess costs
- **Gain sharing**: Eligible for incentive payment

SOURCE: Arkansas Payment Improvement Initiative; each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost.
STATE ISSUES: EPISODES OF CARE

What’s Next?!

• Member Hospitals Review Initial PAP Performance Reports on Asthma and COPD Episodes from Medicaid FFS and Managed Care Organizations

• OHA Collects Hospital Reports from OHT/ODM or Hospitals, with a Focus on Hospitals at Risk of Owing Payments back to Medicaid

• OHA Considering Consultant to Validate Cost and Quality Performance Data and Coordinate Industry Response to Initial Reports
STATE ISSUES: MEDICAID PPR PROJECT

Potentially Preventable Medicaid Readmissions

• Anticipated 2016 Implementation – Still in Planning Stages
• 3M System Employs an “Open” Clinically Driven, APR-DRG Algorithm
• Identifies “Chains of Readmissions” That can be Prevented through Better Coordinated Care, Discharge Planning, and Post-Discharge Follow-up
• Still In Discussion:
  • Expected Rate-of-Readmission Benchmarks for Specific APR-DRGs,
    • Hospital Specific, Risk Adjusted Benchmark “Report Cards” In June
  • Risk Adjustments (Severity, Psych Conditions, Age, Sex, etc.),
  • Potential Penalties for Hospitals Below the Benchmarks
    o Statewide Benchmark Currently set at 9.2%, with 1 Percentage Point Reduction Proposed for Both 2016 & 2017
  • Excluded Admissions, Non-Events, Length of “Chains” and Final PPR Classifications
STATE ISSUES: MEDICAID EAPG

Enhanced Ambulatory Patient Groupings System

• Anticipated Jan. 1, 2016 Implementation
• Similar to Medicare OPPS APCs, but Developed by 3M to apply to Wider Applicability to Non-Medicare Patient Populations
• Payment Based More on Diagnoses than Procedures
• Includes EAPG Ancillary Services and Observation Packaging, Consolidated (Bundled) EAPGs, Discounting of Multiple Related EAPGs, and Inpatient-Only Services, and “Never-Pay” Services
• Separates Surgical from Medical EAPGs and Employs a Hierarchy that Identifies Significant Procedures, Ancillary Tests and Procedures, and Incidental Procedures
• Recognizes Modifiers for Distinct, Multiple, Bilateral, Discontinued & Terminated Procedures, Therapies and Never Events
• Base Rates, Weights, Payment Adjustors, and Consolidation Specifics Not Clear
• Stay Tuned!
ICD.10

• Still on for October 1, 2015 - Don’t Expect Additional Delay
• ODM 2nd Round of Code-to-Code Tests Show Improvement
  – Number of Hospitals and Coders up From First Test
  – Total Claims Matched at DRG Level up From 82% to 86%
  – Total Claims Matched at DRG SOI Level up From 61% to 77%
  – Net Financial Analysis Indicates Change in Relative Weights up From 2.74% to +1.37%

• ODM Assistance Available for Small Physician Practices
• Medicare Testing Started – See CGS Webpages
• No Word from Major Commercial and Managed Care Payers
  – Vendors Testing?
• Medicaid Enrollee Eligibility Revalidation
  – Year-long Project with Monthly Release of New Revalidations
  – Extensive (14-Page) Form
  – Opportunity to “Re-up” Quickly, but the Risk of Disenrollment is Real

• ODM/M&S Considering Downstream Effects of TX/WA DSH Data Lawsuit

• Health Care Quality & Price Transparency Still an Issue

• SAFE Program Audits Possible in 2015
OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

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