By the Numbers

A monthly compendium of OHA finance and patient financial services policy and payment alerts

July 2015

OHA Overview of CY 2016 Medicare OPPS Proposed Rule Available
OHA has an overview of the CY 2016 Medicare outpatient prospective payment system (OPPS) proposed rule available [here](#). CMS’ 2016 OPPS proposals include the usual mix of updates to Ambulatory Payment Classification (APC) groups and weights, inpatient-only procedures and quality reporting requirements. However, the proposed rule also includes new revisions to CMS’ “two-midnight” inpatient admission standards, and, in what is expected to be a highly controversial move, CMS is proposing to reduce the net annual inflationary OPPS update by an additional two percentage points to recoup alleged increased outpatient payments related to the 2015 lab packaging exceptions. OHA is working with the American Hospital Association on comments, due Aug. 31, and will have detailed, hospital-specific analyses of the 2016 OPPS proposed rule available within the next two weeks.

OHA Comments to CMS Proposed Rule on Medicaid and the Children’s Health Insurance Programs
This month OHA submitted comments to CMS on its proposed rule on Medicaid and Children’s Health Insurance Programs (CHIP). Released June 1, 2015, the massive rule puts forth several strategies to modernize Medicaid and CHIP and is the first major update to Medicaid and CHIP managed care regulations in more than a decade. The intent is to better align the programs with existing commercial, Marketplace, and Medicare Advantage regulations.

In general, OHA supports the direction of the proposed rule. In its comments, OHA suggests that the agency remain mindful of the need to strike the appropriate balance between federal standards and state flexibility so that enrollees have timely access to quality health services. The comments primarily focus on transparency and adequacy of capitation rate development, uniform standards for medical loss ratio computation, special contracting provisions related to provider payment and delivery system reform, provider network adequacy standards, support for the inclusion of institution for mental diseases (IMD) related capitation payments for short term inpatient psychiatric stays, and program integrity.

CareSource Compromises on NCCI Code-Pair Medical Reviews
At a meeting with OHA this month, CareSource, Ohio’s largest Medicaid managed care plan, announced it will immediately revise its policy requiring a medical documentation review of every outpatient bill with HCPCS Modifier 59 and/or 25. To this point, CareSource’s National Correct Coding Initiative (NCCI) edit logic required medical records to be submitted with any claim containing Modifier 25 and/or 59, or the service line(s) would be denied.
OHA members expressed concerns that the policy was causing an unnecessary claims processing delay and a huge increase in cost to produce and manage required medical records on what are often routine, low-cost outpatient encounters. **After study, CareSource announced a policy change, whereby they will only require medical records on outpatient bills with Modifier 59 and/or 25 when the billed charges on a claim exceed $3,000.**

The policy shift goes into effect immediately, but the software update to modify the NCCI edit from denying bills with Modifier 59 and/or 25 that have no attached medical records will take another 45 to 60 days to complete. In the interim, CareSource states it will expedite the processing of any bill containing Modifier 59 and/or 25 that can bypass the edit with an attachment of any sort, even a blank page. That is, until its software is updated, CareSource’s system will continue to deny any outpatient bill with Modifier 25 or 59 that has no attachment, but it can bypass the edit on those with an attachment, even if the attachment is a blank page. As an alternative, hospitals can also simply hold claims with these modifiers until the edit is changed. CareSource states it will act as fast as possible and that the edit will be updated by Oct. 1 at the latest.

**New Ohio Medicaid Hospital OPPS Moving Forward**
The Ohio Department of Medicaid (ODM) is making steady progress on its new outpatient hospital prospective payment system (OPPS), currently scheduled to launch Jan. 1, 2016. Created by 3M and modeled on Medicare’s OPPS, ODM’s Enhanced Ambulatory Patient Classification system includes “EAPGs” for non-Medicare aged patients, and takes into account both the diagnoses and procedures performed during an outpatient encounter. ODM used data from three years of paid hospital claims to create Ohio-specific EAPG weights and now, in consultation with the OHA Finance Committee and others, it is considering new hospital peer groups, from which it can begin to model OPPS base rates.

ODM has also finalized several outstanding policies on the packaging and payment of outpatient observation, dental and, so-called, “Paragraph L” services, which will require a transitional approach to payment for them while ODM continues to gather data on HCPCS codes and costs for future EAPG refinement, ODM’s instructions are outlined below and will go into effect with the adoption of the new Medicaid EAPG-based OPPS next year.

- **Observation Services**
  Hospitals should code observation services with HCPCS code G0378, and units of one hour, which will map to EAPG 500, 501 or 502, based upon the submitted claim information. ODM will pay for EAPGs 500-502 during the transitional period at the statewide average rate paid in CY 2014 for observation services billed under 992xx CPT codes.

- **Paragraph L Services**
  Hospitals can still elect to bill expensive drug/device/medical supplies at 60% of hospital-specific cost by reporting the CPT/HCPCS code for the drug or item with UB-04 Revenue Codes 25X, 636, and 27X and adding a HCPCS modifier — yet to be determined — to the line(s) they wish to be paid 60% of cost. Hospitals also must code
and bill for all other services performed on the same date of service on the claim, so ODM can collect data about the other services performed during the encounter. The inclusion of the modifier will trigger MITS to pay the claim as it does now at 60% of cost for the 25X, 636, and 27X lines, rather than invoking EAPG pricing. Any claims received without the Paragraph L modifier on lines RCC 25X, 636, and 27X will be assigned to the appropriate EAPGs and paid in accordance with normal EAPG pricing policy.

- **Dental Services**
  Hospitals must bill dental services using an appropriate Current Dental Terminology (CDT) codes, and the services will map to the appropriate dental EAPG. All dental claims will be paid a set fee during the transitional period that is based upon the current fee schedule amount for CPT 41899.

OHA will continue to meet with ODM on its new OPPS and will report again as decisions on hospital peer groups, base rates and a conversion schedule are finalized. OHA will also schedule another membership webinar once payment and conversion details are available.

**2016/2017 State Budget Summary**
OHA’s advocacy efforts for the first six months of 2015 have been dominated by state budget negotiations. On June 30, Gov. John Kasich signed into law the state’s biennial budget (Am Sub HB 64), effective July 1. With the help of our member hospitals, advocacy efforts were successful for a number of important health care provisions. See OHA’s budget summary for a discussion of key hospital issues in the budget.

**CMS Withdraws Request for Quotes for Medicare RAC Contracts**
The Centers for Medicare & Medicaid Services has withdrawn its request for quotes for the next round of Recovery Audit Contractor contracts, the agency announced July 10. The agency plans to update its Statement of Work for the RAC program and release requests for proposals soon. In the meantime, CMS says current RACs will continue auditing through at least Dec. 31. In March, the U.S Court of Appeals for the Federal Circuit ruled CMS’s proposed new contracts for Medicare RACs violate contracting requirements under the Federal Acquisition Regulations. In May, the U.S. Court of Federal Claims issued an injunction that prohibits CMS from proceeding with contracts under its original requests for quotation.

**Pre-Admission Review and Residency Review (PASRR) Contractor Change**
Effective Aug. 1, the vendor completing Level II assessments for discharging patients hospitalized for serious mental illness to nursing homes for convalescent stays has changed. Per scheduled contract renewal guidelines, the Keystone Peer Review Organization (KEPRO, Inc.) has been awarded the contract for statewide Pre-Admission Screening and Residency Review – Serious Mental Illness assessments. Ascend Management will stop receiving faxes for PASRR-SMI assessments at 6:00 p.m., EST on July 31; KEPRO, Inc., will begin accepting faxes and completing PASRR-SMI assessments at 6:01 p.m. EST. Details on the transition may be found here and on the Ohio Department of Mental Health and Addiction Services’ website.
IRS Clarifies Provider List Rule for Hospital Financial Assistance Policies

Hospitals may use the names of practice groups or departments, instead of individual providers (e.g., physicians), to establish a list of providers delivering care in the hospital, according to a notice issued this month by the Internal Revenue Service. In a final rule issued last Dec. 31, the IRS required hospital financial assistance policies to list the providers delivering emergency or other medically necessary care and whether each is covered by the policy.

The American Hospital Association last month urged the IRS to withdraw the requirement, because it was confusing, extraordinarily burdensome and did not provide proper notice and an opportunity for public comment. “We’re disappointed that IRS again failed to seek comment before issuing final guidance,” said Melinda Hatton, AHA senior vice president and general counsel. “While this relieves some of the unnecessary burden – issues still remain about the administrative requirements and feasibility of assuring compliance.”

CMS Launches ‘Dry Run’ Test of Overall Hospital Quality Star Ratings

The Centers for Medicare & Medicaid Services this month launched a “dry run” of its proposed star rating system for overall hospital-level quality. The test, which runs through Aug. 17, allows hospitals to ask questions and provide feedback, which may contribute to refinements of the methodology before overall star ratings are posted on the Hospital Compare website next year.

Each hospital will receive a Hospital-Specific Report, which includes its star rating results and the measures used to calculate them. CMS encourages hospitals to review their results and email their questions and comments to cmsstarratings@lantanagroup.com. For more on the dry run, including links to a mock report and HSR User Guide, visit www.qualitynet.org. In initial comments on the proposal, the American Hospital Association urged CMS to exercise considerable care in developing its overall approach to star ratings. In April, CMS posted star ratings for hospital performance on patient experience of care measures.

2015 Preliminary HCAP Update

An update to the 2015 preliminary HCAP model has been posted on OHA’s Finance News website. It can be found here. Points of interest in regards to this model include:

- The numbers in the model have been developed in parallel with ODM, so OHA does not expect significant changes to this model before assessments and payments are made. However, the model is still preliminary and numbers still subject to change.
- ODM has initiated the CMS review process with regard to the 2015 model in the hopes of avoiding delays similar to those that occurred in the 2014 HCAP process.
- ODM is moving forward with OHA’s recommended changes to the model, which include further reforms to reward hospitals for total uncompensated care costs (including Medicaid shortfall) rather than just free care provided to HCAP-eligible patients.
- OHA will keep members up to date with any news regarding CMS approval and ODM assessment/payment dates. At this point, OHA is hopeful HCAP 2015 will be administered on or about January, 2016.
Just the Facts

- CMS published clarifying questions and answers on its announcement that it will give some ICD.10 billing flexibility to physicians and other practitioners who are paid under the Medicare Physician Fee Schedule. The ruling does not apply to hospitals paid under Medicare Part A.
- The Ohio Department of Medicaid is promoting an ICD-10 Vendor Readiness Issue Brief from the Workgroup for Electronic Data Interchange (WEDI). The WEDI brief provides a list of items that system vendors should address regarding the ICD-10 remediation, testing, and implementation of their products. Communicating the items identified in this issue brief will help to provide greater transparency and insight into a Vendor system's ICD-10 readiness.

Hold the Dates

- **Internal Revenue Service Code Section 501(r) Webinar**
  This OHA members-only webinar is being co-sponsored by Plante Moran and is scheduled **Thursday, Aug. 6 from 10 to 11:30**. It will cover Plante Moran’s recommended best practices for covered charitable hospitals’ community needs assessments, implementation strategy, financial assistance and billing and collection policies, emergency medical care policies and billing limitations on patient charges. **OHA members can expect an agenda and materials Aug. 3.**
- **10 Steps to a Successful ICD.10 Implementation Webinar**
  Another OHA members-only program scheduled **Tuesday, Aug. 11, from 10 to 11:30** is being presented by McGladrey and 3M in a web-based session that will cover the October 2015 ICD.10 conversion from a perspective of protecting providers’ revenue streams, including patient and physician impact, denials management and post-ICD.10 conversion planning. **OHA members can expect an agenda and materials the week before the session.**
- **Medicare 101 and Medicare Cost Reporting Fundamentals**, an expanded Medicare two-day 101 educational seminar now includes a Cost Report session on day two. Produced in cooperation with the Florida Hospital Association and Plante Moran, the popular program is **Aug. 19 & 20**. Attendees will be able to register for either or both sessions. **A meeting brochure and registration materials are available here.**
- **Medicare & Medicaid in 2016** (aka the “Larry & Larry Show”) is scheduled **Oct. 6** in Columbus. Expect registration materials in August.

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