# What Should be on Your Medicare Radar

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Health Financial Systems User Meeting
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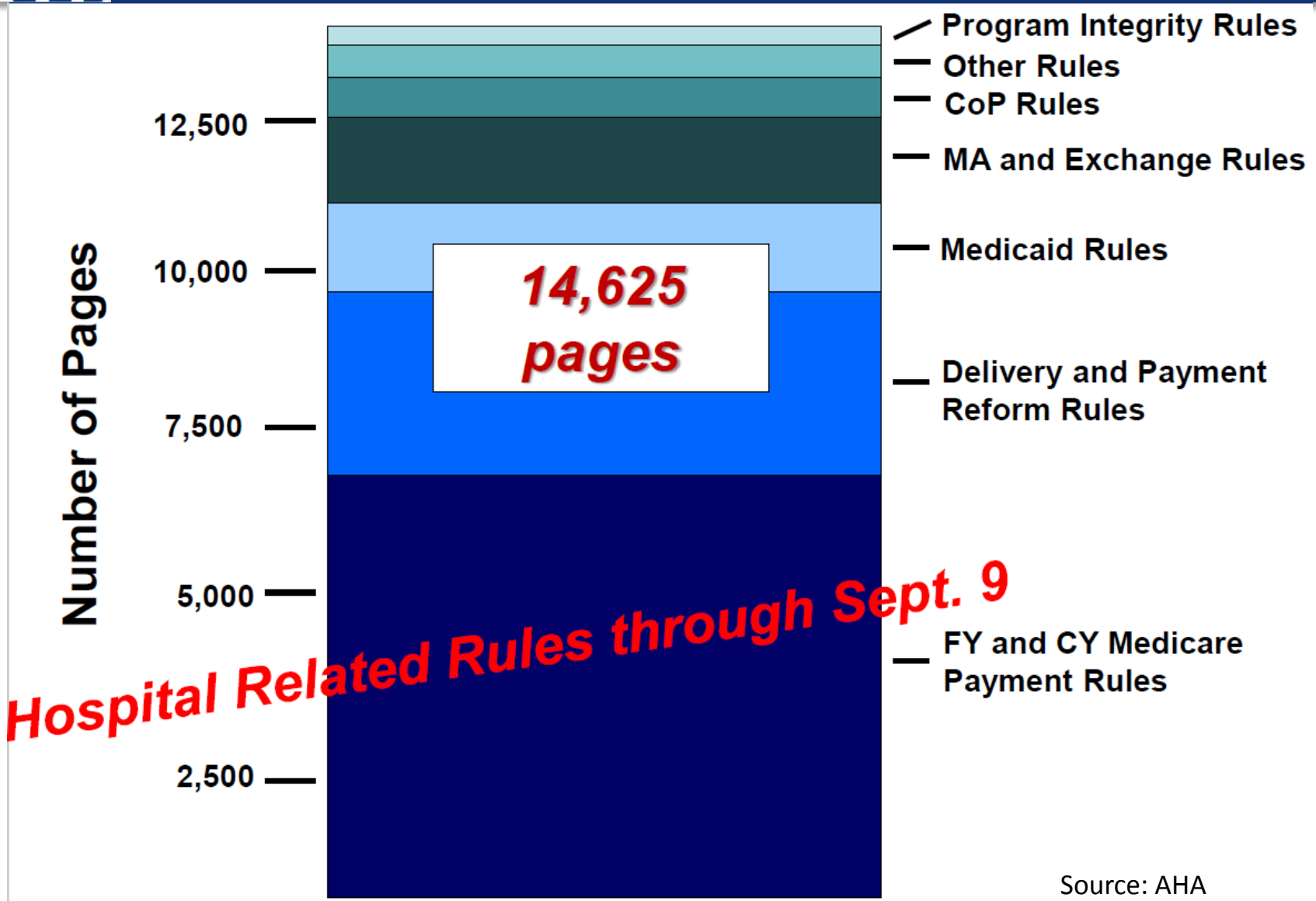
CALIFORNIA HOSPITAL ASSOCIATION

**Text your questions to 703-340-9850!**

# 2016 Regulatory Onslaught




Source: AHA

# Still to come by December 31st

- Outpatient Final Rule
- Physician Fee Schedule
- Home Health Final Rule
- MACRA Final Rule
- Cardiac Bundling Final Rule (EPMs)
- Medicare Appeals Final Rule
- 340B Guidance
- Discharge Planning CoP Final Rule
- Antibiotic/Non-discrimination Cop Final Rule
- Medicaid Supplemental Payments
- Medicaid DSH Cuts Proposed Rule – January 2017

# Overview

- Section 603 — Implementation of site-neutral payment for new provider-based hospital outpatient departments
- New Episode Payment Model for Cardiac Care and Comprehensive Joint Replacement (CJR) payment model expansion
- Proposed Medicare Part B drug payment model
- MACRA — Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
  - Implications for hospitals and physicians
- NOTICE Act — new patient notification of observation status

# Section 603 of the Balanced Budget Act of 2015

## Site Neutral Payments for New Off-Campus Provider-Based HOPDs

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# BBA of 2015

- Raises the debt ceiling through March 2017
- Raises the discretionary spending caps by $80 billion above current levels, split evenly between defense and non-defense spending
- Implements site-neutral payments for new off-campus provider-based hospital outpatient departments — those that come into being after the Nov. 2, 2015 enactment of the legislation

# Pre-Rulemaking Approach

- Ensure cuts are implemented in the most fair, favorable and flexible manner possible.
- Specifically:
  - Allow existing hospital outpatient departments (HOPDs) to relocate
  - Allow existing HOPDs to change ownership
  - Allow considerations for those “under development” as of date of enactment
- Limit administrative burden by ensuring HOPD continues to bill on UB 04, not the CMS 1500
- OPPS proposed rule outlined the provisions for implementation

# Section 603 Implementation Overview

1. Creates and defines terms including “excepted items and services” to describe those items and services that are excluded, or “excepted,” from the Section 603 site-neutral payment system policy and, therefore, would still be paid under the OPPS. “Excepted” = Grandfathered services
2. Defines “off-campus PBDs” and proposes the requirements that would allow certain off-campus PBDs to retain their “excepted” status, both in terms of the facility itself, as well as for the items and services it furnishes.
3. Establishes new payment policies for “non-excepted” items and services.

# Continued Payment under OPPS

- "Excepted items and services" would continue to be paid under OPPS if they are:
  - Furnished in a dedicated emergency department (as defined under EMTALA)
  - The PBD furnished and submitted a bill for OPPS service before Nov 2*
  - Services provided are in the same "clinical family of services" prior to Nov 2
- On-campus PBDs are excepted (grandfathered) and continue to receive OPPS payments
- Services provided within 250 yds. of remote location
- FAQ: What about PT, OT and ST? Not applicable; currently paid under PFS i.e. no change at this time

# 250 Yards

- On-campus as defined in 42 CFR 413.65
- Campus is:
  - Area “immediately adjacent” to providers main buildings
  - Areas and structures “located within 250 yards” of the main buildings
  - Other areas per regional office determination
- Preamble of the proposed rule is the first additional language outside the previously published guidance
- Consult with internal teams regarding current documentation of “your campus” and any “immediately adjacent structures”

# Relocation of Existing PBD

- Off-campus PBD services essentially frozen in time
- CMS proposes off-campus PBDs must retain the same physical address, including the suite number to retain its “excepted” status and continue to receive OPPS rates
- If a PBD changes location, it would be subject to a different applicable payment system
  - If you have an existing PBD on campus and you move to off campus, it would then be subject to new payment system
- CMS proposes a limited exception process for comment
- Most concerning for California hospitals as this impacts many plans for meeting seismic compliance

# Expansion of Services

- CMS proposes that “excepted” off-campus PBDs would continue to receive OPPS only for those items and services billed prior to November 2, 2015*
- CMS proposes that service types be defined by 19 clinical families
- Any specific service within the clinical family billed prior to November 2, that entire clinical family of services would continue to be paid under OPPS
- CMS proposes that any expansion of services beyond those furnished under the specific clinical families would be subject to site neutral rates
- *see regulatory text on page 702 of display copy

# Proposed Clinical Families of Services

| Clinical Families | APCs |
|---|---|
| Advanced Imaging | 5523-25, 5571-73, 5593-4 |
| Airway Endoscopy | 5151-55 |
| Blood Product Exchange | 5241-44 |
| Cardiac/Pulmonary Rehabilitation | 5771, 5791 |
| Clinical Oncology | 5691-94 |
| Diagnostic tests | 5721-24, 5731-35, 5741-43 |
| Ear, Nose, Throat (ENT) | 5161-66 |
| General Surgery | 5051-55, 5061, 5071-73, 5091-94, 5361-62 |
| Gastrointestinal (GI) | 5301-03, 5311-13, 5331, 5341 |
| Gynecology | 5411-16 |
| Minor Imaging | 5521-22, 5591-2 |
| Musculoskeletal Surgery | 5111-16, 5101-02 |
| Nervous System Procedures | 5431-32, 5441-43, 5461-64, 5471 |
| Ophthalmology | 5481, 5491-95, 5501-04 |
| Pathology | 5671-74 |
| Radiation Oncology | 5611-13, 5621-27, 5661 |
| Urology | 5371-77 |
| Vascular/Endovascular/Cardiovascular | 5181-83, 5191-94, 5211-13, 5221-24, 5231-32 |
| Visits and Related Services | 5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841 |

# Change of Ownership

- If a hospital experiences a change of ownership – in its entirety – and the new owner accepts the Medicare CCN, CMS proposes that the PBD may retain their “excepted” status
- If the provider agreement is terminated under a change of ownership, CMS proposes the off-campus PBD will lose its “excepted” status and be subject to site-neutral payment policies

# What happens in 2017?

- CMS proposes that for NEW PBDs, the "applicable payment system" would be the PFS for the majority of services
- **Physicians** would be able to bill on the CMS 1500 and be paid the "higher non-facility" rate under the PFS for services they are eligible to bill
- **CMS proposes no payments be made directly to hospitals during this "transition year"**
  - CMS suggests new off-campus PBDs consider re-enrolling as a group practice or an ASC and bill for services under those applicable payment schedules

# What happens in 2017?

- CMS proposes that new off-campus PBD PHP programs receive the CMHC rate for PHP services rather than OPPS rates
- Providers can bill under the CLFS as appropriate
- CMS seeks comment on how providers can direct bill for services not applicable under other fee schedules
- CMS expects new relationships to form under such a proposal and seeks input on the impact of Stark and Anti-kickback
- Limitations of the reassignment of billing rights rules, anti-markup prohibition, application of physician self-referral laws etc.

# CHA Comments

- The statue must be interpreted to infer that services were furnished not necessarily billed before November 2.
- CHA provided legal arguments for the statue to be read in its broadest sense to get additional California facilities under the exception process
- Support CMS not making any revisions to current provider-based regulations; leaving definition of campus to discretion of CMS regional offices.

# CHA Comments

- **Urge CMS to delay implementation of Section 603 until FY 2018 at the earliest, <u>non-payment to hospitals is unacceptable and unreasonable</u>**
  - History of delay, and more time needed to update systems
  - Impact on beneficiaries access to care
  - Impact on relationships with physicians – no time to revisit all contracts
  - Need to provide CMS with the list of all the billing issues they need to address when implementing this rule
    - 3 day payment window, different services at different sites on same day, different payment systems

# CHA Comments

- **Relocation and rebuild must be allowed under the regulatory framework**
- Reconsider exception process; **perhaps an attestation process for common reasons for relocation**
- Lease renewal, renovation needed, more convenient location for patients, natural disaster, state law requirements (seismic)
- Consideration of services billed for that were on campus, and need to move off campus for same reasons.
- Intent was to discourage acquisition of physician practices, not to freeze health care services in time

# CHA Comments

- Law is silent when it comes to expansion of services
- CHA will  argue that CMS defines the provider-based department as a department, regardless of services provided and **that any limitation on services provided would be unacceptable**
  - Focus must be on patients and community needs without the threat of the loss of reimbursement
  - Need specific stories of services that are needed in communities and hospitals commitment to provide service

# CHA Comments

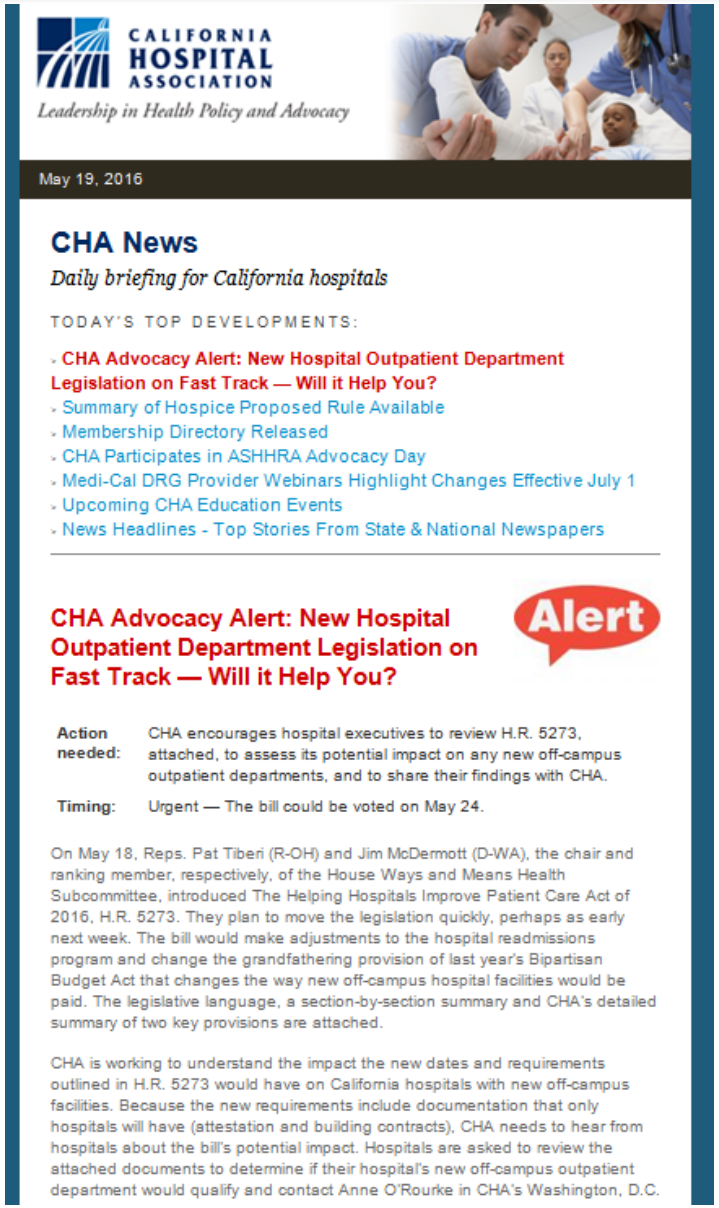
- **Urge CMS to allow individual PBDs to be transferred from one hospital to another and maintain excepted status**
  - Need to preserve access to services in community and some hospitals may not be able to financially sustain certain services
- CHA will not support CHMC rates for PHP for new off-campus PHP providers; argue for PHP rates
- CMS should consider self-reported data from hospitals prior to implementing site neutral payment system
  - Data collection will take time (not feasible by Jan 1)
  - Clear guidance for reporting from CMS needed
  - Hospitals should review CMS 855, attestation forms etc. before responding to CMS; consistent reporting

# Our Legislative Approach

- Provide exception for those already in development on date of enactment (Nov. 2, 2015)
- Look for legislative vehicle
- Challenges:
  - Cost
  - Calendar
    - Few legislative days in 2016
    - Other priorities
- “Dear Colleague” letters  to CMS pre-rulemaking and post-rulemaking

# HR 5273

- Introduced May 18, passed June 7
- Several provisions important to hospitals
  - HOPD
  - Readmissions and socioeconomic status (SES) adjustment



CALIFORNIA HOSPITAL ASSOCIATION
*Leadership in Health Policy and Advocacy*

May 19, 2016

**CHA News**

*Daily briefing for California hospitals*

TODAY'S TOP DEVELOPMENTS:

- **CHA Advocacy Alert: New Hospital Outpatient Department Legislation on Fast Track — Will it Help You?**
- Summary of Hospice Proposed Rule Available
- Membership Directory Released
- CHA Participates in ASHHRA Advocacy Day
- Medi-Cal DRG Provider Webinars Highlight Changes Effective July 1
- Upcoming CHA Education Events
- News Headlines - Top Stories From State & National Newspapers

**CHA Advocacy Alert: New Hospital Outpatient Department Legislation on Fast Track — Will it Help You?**

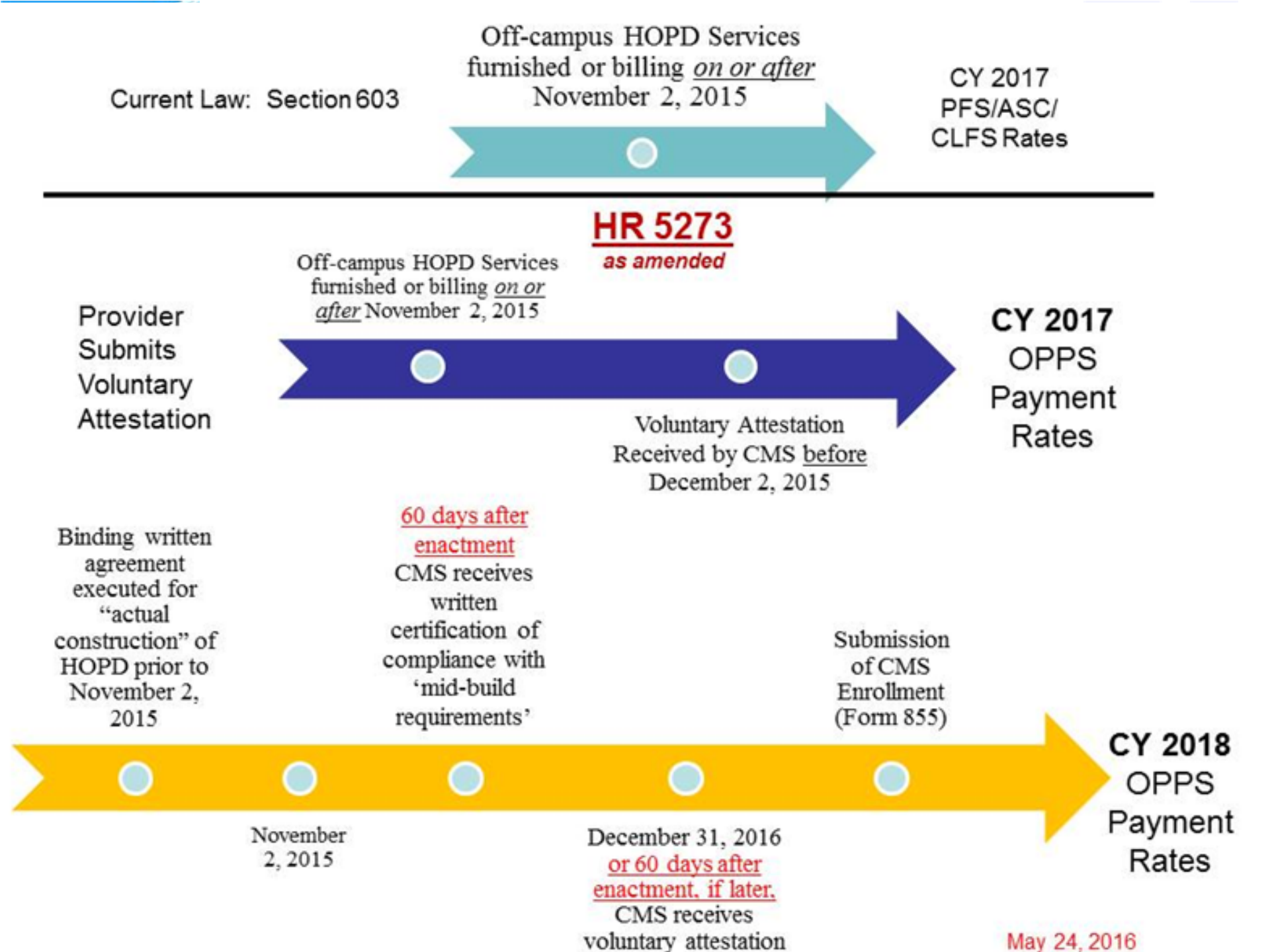
Alert

**Action needed:** CHA encourages hospital executives to review H.R. 5273, attached, to assess its potential impact on any new off-campus outpatient departments, and to share their findings with CHA.

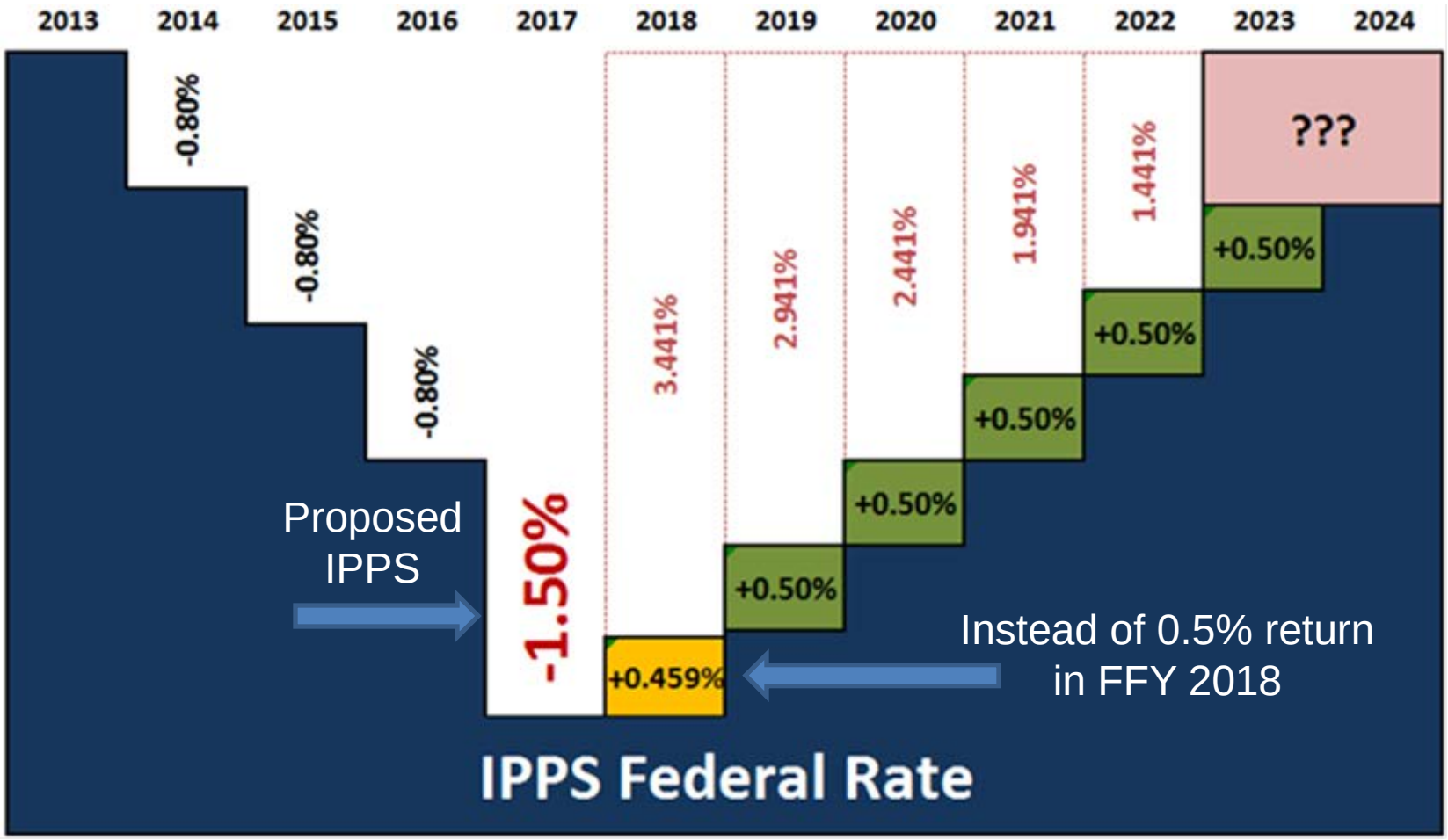
**Timing:** Urgent — The bill could be voted on May 24.

On May 18, Reps. Pat Tiberi (R-OH) and Jim McDermott (D-WA), the chair and ranking member, respectively, of the House Ways and Means Health Subcommittee, introduced The Helping Hospitals Improve Patient Care Act of 2016, H.R. 5273. They plan to move the legislation quickly, perhaps as early next week. The bill would make adjustments to the hospital readmissions program and change the grandfathering provision of last year's Bipartisan Budget Act that changes the way new off-campus hospital facilities would be paid. The legislative language, a section-by-section summary and CHA's detailed summary of two key provisions are attached.

CHA is working to understand the impact the new dates and requirements outlined in H.R. 5273 would have on California hospitals with new off-campus facilities. Because the new requirements include documentation that only hospitals will have (attestation and building contracts), CHA needs to hear from hospitals about the bill's potential impact. Hospitals are asked to review the attached documents to determine if their hospital's new off-campus outpatient department would qualify and contact Anne O'Rourke in CHA's Washington, D.C.


Current Law: Section 603
Off-campus HOPD Services furnished or billing on or after November 2, 2015
CY 2017 PFS/ASC/ CLFS Rates
HR 5273
as amended
Off-campus HOPD Services furnished or billing on or after November 2, 2015
Provider Submits Voluntary Attestation
CY 2017 OPPS Payment Rates
Voluntary Attestation Received by CMS before December 2, 2015
Binding written agreement executed for "actual construction" of HOPD prior to November 2, 2015
60 days after enactment
CMS receives written certification of compliance with 'mid-build requirements'
Submission of CMS Enrollment (Form 855)
CY 2018 OPPS Payment Rates
November 2, 2015
December 31, 2016 or 60 days after enactment, if later,
CMS receives voluntary attestation
May 24, 2016

# HR 5273 – 0.041 offset



# Next Steps

- Assess the next steps; depending on OPPS final rule provisions and future sub regulatory guidance
  - OPPS final rule expected November 1
- Hospitals should reexamine their long-term plans and impacts this may have on future service lines

# Episode Payment Models
# Cardiac Care and CJR Expansion

## Proposed Rule Highlights

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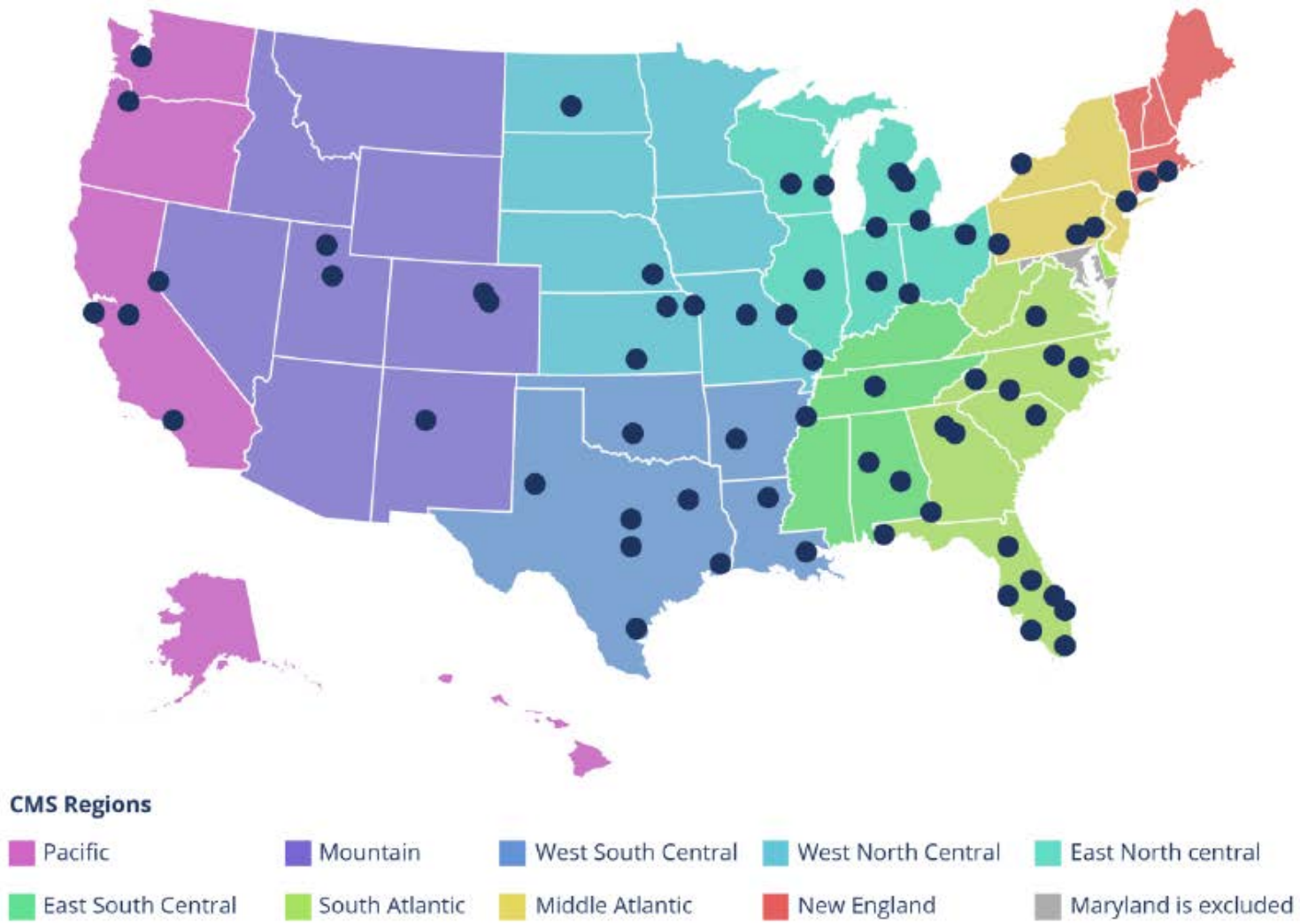
# CJR Payment Program Implementation Began April 1



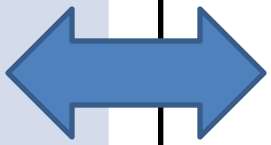
# Overview

- CMS Proposed Rule issued July 26, published in the August 2nd Federal Register
- **Comments were due October 3**
- Anticipated final rule December (TBD)
- Proposed Effective Date July 1, 2017

# EPM Overview

- Establishes additional clinical areas for episode payment models for Medicare FFS patients

| AMI | CABG | SHFFT | CJR |
|---|---|---|---|
| • MS DRG 208-282<br>• PCI with AMI MS DRGs 246-251 | • MS DRG 231-236 | • MS DRG 480-482 | • MS DRG 469-470 |



AMI : Acute Myocardial Infraction, PCI: Percutaneous Coronary Intervention, CABG: Coronary Artery Bypass Graft, SHFFT: Surgical hip/femur treatment fracture (excluding lower extremity joint replacements); CJR (formerly CCJR) Comprehensive Care for Joint Replacement payment model

# EPM Overview

- Program Duration: 4.5 Years
  - July 1, 2017 – December 31, 2021
- **Required participation** of most short-term acute care hospitals in randomly selected MSAs
  - 294 identified MSA's identified; 98 will be randomly selected for the AMI/PCI and CABG episodes and finalized in a final rule later this year
  - SHFFT episodes will remain mandatory for the same 67 CJR MSA's

# EPM Overview

- California CJR Mandatory MSAs include: Los Angeles-Long Beach-Anaheim, Modesto, and San Francisco-Oakland-Hayward
  - 135 California hospitals currently subject to CJR
  - +/- 3 percent of all cases subject to CJR program
- 294 identified MSA's, 16 MSA's in CA; 98 will be selected
  - All three CJR MSA's overlap with the 16
  - 255 eligible CA hospitals for new EPMs
  - 135 CJR hospitals could be subject to SHFFT and CABG, AMI/PCI at the same time.

# EPM Overview

- Excluded Hospitals*
  - Critical Access Hospitals (payments made to a CAH's may still be included in the 90 day episode calculation, e.g. swing bed payments for PAC)
  - BPCI Model 2&4 participants


- **Unlike BPCI, short term acute care hospitals are the episode initiator and are accountable for risk associated with the 90 day episode**
  - Physicians and conveners can not be episode initiators EPM rule

# EPM Applicable Beneficiaries

- Applicable to Medicare FFS Beneficiaries only
- Episode includes the anchor hospitalization and ALL Part A & B services related to the MS-DRG including 90 days post discharge.  EPMs account for hospital transfers or “chaining”
- Episode is cancelled if beneficiary dies during an anchor stay (CJR episode is canceled if they die at any point during the 90 day episode)

# EPM Episode Inclusions and Exclusions - Services

## Included services

- Physicians' services
- Inpatient hospitalization
- Inpatient hospital readmission
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs and biologicals
- Hospice
- **PBPM payments under models tested under section 1115A of the Social Security Act**

## Excluded services

- Hemophilia clotting factors
- New technology add-on payments
- OPPS transitional pass-through payments for medical devices
- Unrelated hospital admissions for MS-DRGs that map to the diagnostic categories of Oncology; Trauma, medical; Chronic disease, surgical; and Acute disease, surgical.
- Chronic conditions rarely affected by the EPM diagnosis, procedure, or post-acute care
- Acute conditions not arising from existing EPM-related chronic conditions or from EPM episode complications.

- **The list of excluded MS-DRGs and ICD-CM diagnosis codes, including both ICD-9-CM and ICD-10-CM, is posted on the CMS Web site**

# EPM Payment Methodology

- A “Bundled Payment” ≠ A Prospective Capitated Payment
- EPMs are Mandatory, Retrospective Two-Sided Risk Payment Models
  - Hospitals bear all the risk
  - All providers continue to receive FFS payments as they do today throughout the duration of this program

# EPM Target Price

- After each performance year, the actual episode spending would be compared to the historical spending episode target price

**Historical Spending (3 Years of Data)**

- Physician Services
- Inpatient hospital, including readmissions
- IPF
- LTCH
- IRF
- SNF
- Home Health
- Hospice
- Outpatient Therapy
- Clinical Lab
- DME
- Part B Drugs
- Hospice

- Discount Factor
= Target Price

**Actual Episode Spending (in Performance Year)**

- Physician Services
- Inpatient hospital, including readmissions
- IPF
- LTCH
- IRF
- SNF
- Home Health
- Hospice
- Outpatient Therapy
- Clinical Lab
- DME
- Part B Drugs
- Hospice

Actual Performance

# EPM Target Price

Hospital Specific
Target Price

Pacific Region
Target Price
(AK, WA, OR, CA, HI)

| Target Price Components | Performance Year | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Hospital-specific Data | 2/3 | | 1/3 | 0% | |
| Regional Data | 1/3 | | 2/3 | 100% | |
| Discount Factor | (Variable, Adjusted for Quality Performance) | | | | |
| Baseline Period | CY2013-2015 | | CY 2015-2017 | | CY 2017-2019 |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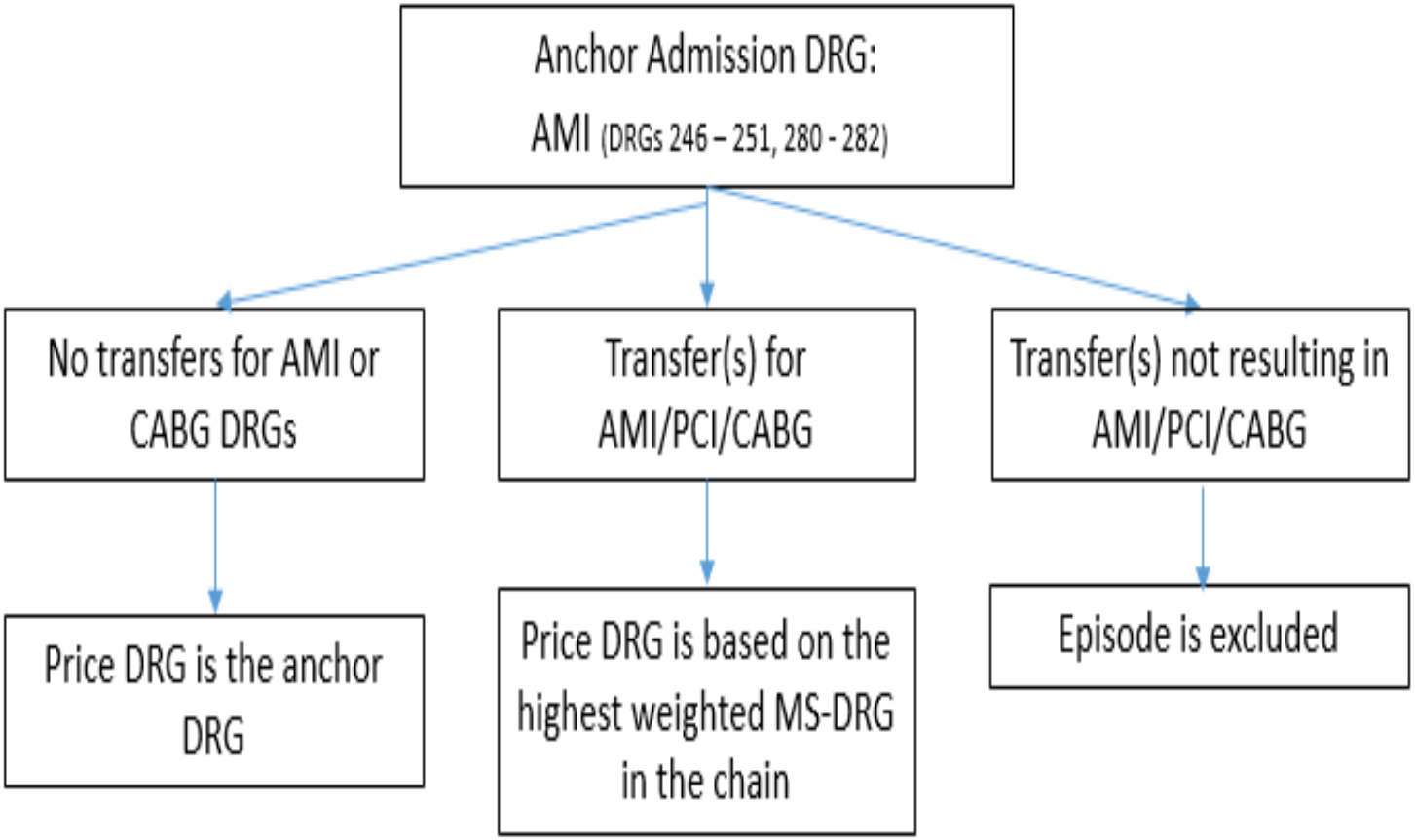
# How are the EPM episode targets different than CJR episodes?




Anchor Admission, Price DRG, Chaining

# Hospital Attribution in Chained Admissions

**Hospital A is an EPM Participant**

| | Included in Episode | | | | |
|---|---|---|---|---|---|
| **Start of Episode** | | **End of Episode** | | | |
| **Anchor DRG (Hospital A)** | **Price DRG (Hospital B)** | **Post Discharge Period** | **Performance Period Hospital Attribution** | **Performance Period Episode Assignment for Reconciliation** | **Baseline Period Episode Assignment for Benchmark/Target Calculation** |
| **MS-DRG 281 AMI Discharged Alive w/CC** | **MS-DRG 246 PCI w/Drug-eluting Stent w/MCC** | **90 Days** | **Hospital A** | **MS-DRG 246** | **MS-DRG 246** |

**Hospital A is NOT an EPM Participant; Hospital B is an EPM Participant**

| | Included in Episode | | | | |
|---|---|---|---|---|---|
| | **Start of Episode** | **End of Episode** | | | |
| Hospital A | **Anchor DRG = Price DRG Hospital B** | **Post Discharge Period** | **Performance Period Hospital Attribution** | **Performance Period Episode Assignment for Reconciliation** | **Baseline Period Episode Assignment for Benchmark/Target Calculation** |
| MS-DRG 281 | **MS-DRG 246** | **90 Days** | **Hospital B** | **MS-DRG 246** | **MS-DRG 246** |

# Chaining – Hospitals without PCI services disadvantaged

PCI Episode Pathways

| Anchor DRG | Transfer DRG | Readmission for CABG |
|---|---|---|
| AMI | PCI | No |
| PCI | No | No |

**Example**

**Average Medicare Spend for PCI Episodes**

| | Anchor DRG | Price DRG | Anchor | Transfer | Post-Discharge | Total |
|---|---|---|---|---|---|---|
| *Hospital A* | 281 | 246 | $6,300 | $21,000 | $12,000 | $39,300 |
| *Hospital B* | 246 | 246 | $21,000 | | $12,000 | $33,000 |
| | | | | | Average=Target | **$36,150** |

Expected post-discharge spend would be equal; total spend for ***Hospital A*** higher by $6,300 = loss compared to “target”

# Regional Medical Center

**Analysis of Episode Payment Model (EPM) Proposal for Cardiac (AMI, CABG, PCI) and SHFFT Episodes**

**Estimated Performance Using Data from Federal Fiscal Years (FFYs) 2012, 2013, and 2014**

**St. Elsewhere Regional Medical Center**

**Located in a Potentially Mandatory Cardiac EPM Metropolitan Statistical Area (MSA)**

| | | | | Hospital | | | | | Middle Atlantic Region | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Episode Type | Price Stratifier | Price MS-DRG | MS-DRG Description | Episode Volume | Average Spend (Total) | Average Spend (Anchor Stay) | Average Spend (Post-Discharge) | Chained Episodes (%) | Episode Volume | Average Spend (Total) | Average Spend (Anchor Stay) | Average Spend (Post-Discharge) | Chained Episodes (%) |
| Percutaneous Coronary Intervention (PCI) | Without CABG Readmission | 246 | PERC CARDIOVASC PROC W DRG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS | 162 | $42,842 ▲ | $25,335 ▲ | $17,507 ▲ | 0.62% ▼ | 5,303 | $39,153 | $24,845 | $14,308 | 11.37% |
| | | 247 | PERC CARDIOVASC PROC W DRG-ELUTING STENT W/O MCC | 341 | $22,086 ▲ | $14,734 ▼ | $7,352 ▲ | 0.00% ▼ | 15,383 | $21,610 | $15,275 | $6,335 | 10.88% |
| | | 248 | PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS | 60 | $46,812 ▲ | $25,502 ▲ | $21,310 ▲ | 0.00% ▼ | 2,205 | $40,757 | $23,218 | $17,540 | 10.57% |
| | | 249 | PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC | 84 | $22,482 ▲ | $13,466 ▼ | $9,016 ▲ | 0.00% ▼ | 4,556 | $22,299 | $13,873 | $8,425 | 10.00% |
| | | 250 | PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC | 38 | $52,221 ▲ | $23,206 ▼ | $29,015 ▲ | 0.00% ▼ | 771 | $41,834 | $23,658 | $18,176 | 9.19% |
| | | 251 | PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC | 30 | $30,139 ▲ | $14,129 ▼ | $16,010 ▲ | 0.00% ▼ | 1,082 | $24,301 | $14,469 | $9,832 | 7.96% |

- Licensed for PCI and CABG
- No chained episodes
- No “penalty” for initial AMI discharge

# Comparison to CJR Final Rule – Targets

| | CJR FR | EPMs PR |
|---|---|---|
| Discount Factor | 1.5% - 3.0% dependent upon quality performance | Same |
| Hospital Specific vs. Regional | PY 1,2 – 1/3 Region; 2/3 Hospital<br>PY 3 – 2/3 Region; 1/3 Hospital<br>PY 4,5 – 100% Region | Same |
| Baseline | 3 Year Baseline CY **2012-2014**; updated every other year | 3 Year Baseline CY **2013-2015;** updated every other year |
| Low Volume Thresholds 100% Regional Data | MS DRG 469-470<br>Fewer than 20 cases | SHFFT – 50 cases<br>AMI – 75 cases PCI – 125 cases<br>CABG 50 cases |

***CMS changing CJR rules to align with EPM**

# Comparison to CJR Final Rule – Targets (con't)

| | CJR FR | EPMs PR |
|---|---|---|
| VBP, HAC, Readmissions | Adjusted out of both targets and performance | Same |
| Wage Adjustment | Adjusted out of individual claims at provider specific level; added back at attributed hospital, 70% labor share | Same |
| Operating vs. Capital | Operating and capital payments | Same |
| Prospective target prices | Announced prior to start of each quarter; changing Oct.1 and Jan.1 or each CY | Same |
| Treatment of reconciliation payments and repayments | Not included in update of baseline | Included in update of baseline* |

- CMS has not outlined a timeframe for release of target prices and unlike CJR, they have not yet posted any preliminary data for review.

***CMS changing CJR rules to align with EPM**

# EPM Reconciliation

| Price DRG and Stratified44 | Performance Period Episode Count (a) | Performance Period Episode Target $ (b) | Total Performance Target $ (a*b) | Total Actual Performance $ (c) | Reconciliation Amount $ ([a*b]-c) |
|---|---|---|---|---|---|
| AMI 281 w/o CABG Readmission | 100 | $24,000 | $2,400,000 | $2,200,000 | $200,000 |
| AMI 280 w/o CABG Readmission | 10 | $40,000 | $400,000 | $550,000 | -$150,000 |
| Hospital A Total | 110 | $24,455 | $2,800,000 | $2,750,000 | $50,000 |

- First reconciliation will take place 3 months after the end of the first performance year. (April 1, 2018)
- Final reconciliation will take place 12 months later to ensure all claims run-out is captured (April 1, 2019) (Budgeting implications)
- Same process for years 2 through 5
- Notably the EPMs (Cardiac, AMI/PCI ) create 30 different target prices (revised twice a year, making a total of potentially 60 target prices )
- Combine CJR and SHFFT – total 74 potential targets!

# Refresh of Baseline Every Other Year

| | CY 2013 | CY 2014 | CY 2015 | 3-Year Average= Baseline for 2016-2017 Targets |
|---|---|---|---|---|
| A) Hospital Average | $21,500 | $21,500 | $21,000 | $21,333 |

| | CY 2015 | CY 2016 | CY 2017 | 3-Year Average= Baseline for 2018-2019 Targets |
|---|---|---|---|---|
| A) Hospital Average | $21,000 | $21,333 | $20,500 | $20,944 |

| | CY 2017 | CY 2018 | CY 2019 | 3-Year Average= Baseline for 2020 |
|---|---|---|---|---|
| A) Hospital Average | $20,500 | $20,000 | $19,500 | $20,000 |

Each refresh will likely produce lower average

# Proposed Change: Inclusion of Reconciliation Payments

| | CY 2017 | CY 2018 | CY 2019 | 3-Year Average= Baseline for 2020 Targets |
|---|---|---|---|---|
| A) Hospital Average | $20,500 | $20,000 | $19,500 | $20,000 |

| | CY 2017 | CY 2018 | CY 2019 | 3-Year Average= Baseline for 2020 Targets |
|---|---|---|---|---|
| A) Hospital Average | $20,500 | $20,000 | $19,500 | $20,000 |
| B) Target | $21,333 | $20,500 | $20,000 | $20,611 |
| C) Reconciliation Payments made to hospital = B-A | $833 | $500 | $500 | |
| Actual Medicare Spend = **A** + **C** | **$21,333** | **$20,500** | **$20,000** | **$20,611** |

- Decrease in targets over time is slowed
- Set equal to ACTUAL Medicare spend
- Simplified to ignore impact of region
- Regional component will be impacted by EPM *and* BPCI participants

# Comparison to CJR Final Rule

| | CJR FR | EPMs PR |
|---|---|---|
| Stop-Loss Limits | Year 2: 5%<br>Year 3: 10%<br>Years 4-5: 20%<br>Additional protections for Rural, SCH, MDH, RRC | Same |
| Stop-Gain Limits | Year 1-2: 5%<br>Year 3: 10%<br>Years 4-5: 20% | Same |
| Episode level stop-loss | 2 standard deviations above regional mean by DRG; stratified by Fracture status | Further stratified by anchor vs post-discharge period for CABG; presence of CABG readmission for AMI episodes |

# EPM Quality Measures

| AMI/PCI | CABG | SHFFT (Same as CJR) |
|---|---|---|
| 1. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction<br>2. Excess Days in Acute Care after Hospitalization for AMI (NQF submitted)<br>3. HCAHPS Survey<br>4. Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization. | 1. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery<br>2. HCAHPS Survey | 1. Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary THA and/or TKA<br>2. HCAHPS Survey<br>3. Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) voluntary patient-reported outcome (PRO) and limited risk variable data submission |

# EPM Pay-for-Performance

- **Composite score methodology**
  - Based on each hospital's performance compared with the nation's
  - Hospitals earn between 0 and 20 points for each measure
  - Measure scores are weighted
- **Transparency**
  - Data is reported on Hospital Compare
  - 30-day preview period

| Quality Category | AMI Composite Quality Score | CABG Composite Quality Score | SHFFT Composite Quality Score | Eligible for Reconciliation Payments | Eligible for Quality Incentive Payment * | Discount for Calculating Reconciliation (All Program Years) | Discount for Calculating Repayment (Years 2(DR)** and 3) | Discount for Calculating Repayment (Years 4 and 5) |
|---|---|---|---|---|---|---|---|---|
| Below Acceptable | < 3.6 | < 2.8 | < 5.0 | No | No | 3.0% | 2.0% | 3.0% |
| Acceptable | ≥ 3.6 and < 6.9 | ≥ 2.8 and < 4.8 | ≥ 5.0 and < 6.9 | Yes | No | 3.0% | 2.0% | 3.0% |
| Good | ≥ 6.9 and ≤ 14.8 | ≥ 4.8 and ≤ 17.5 | ≥ 6.9 and ≤ 15.0 | Yes | Yes | 2.0% | 1.0% | 2.0% |
| Excellent | > 14.8 | > 17.5 | > 15.0 | Yes | Yes | 1.5% | 0.5% | 1.5% |

# EPM Medicare Policy Waivers

- **SNF three-day rule**
  - SNF Waiver on or after April 1, 2018 if SNF is 3 stars or higher; waiver not available for CABG or SHFFT episodes
- **Home health visits**
  - Does NOT waive the homebound requirements
  - Waives the “incident to” direct supervision rule
  - AMI: 13 home visits, CABG: 9 home visits and SHFFT: 9 home visits
- **Telehealth services**
  - Waives the geographic site and originating site requirements

# Other Provisions

**Financial arrangements/Gainsharing**

- Hospitals can enter into financial arrangements with EPM collaborators:
- SNFs, HHAs, LTCHs, IRFs, Physician Group Practices, Physicians, non-physician practitioners, and outpatient therapy providers
- **EPMs Allows the ability to collaborate with CAHs and ACOs***
- Physicians' payments capped at 50% of the total Medicare amount approved under the Physician Fee Schedule
- EPM collaborators can share in downside risk repayments
- Individual EPM collaborator payments cannot exceed 25% of the amount owed to CMS

**Beneficiary incentives/protections**

- Hospitals can provide in-kind incentives to beneficiaries, if certain criteria are met
- Beneficiaries cannot opt out
- Beneficiaries cannot opt out of data sharing with providers
- Beneficiary deductibles and coinsurance will not change

# Advanced APM Considerations

- To meet the QPP Advanced APM requirement, at least one outcome measure must be included if an appropriate measure is available on the QPP MIPS list of measures. CMS proposes the following three outcome measures in the EPMs:
  - AMI Model- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #0230);
  - CABG Model- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG (NQF #2558); and
  - SHFFT- Hospital-level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550)
- Those EPM participants that meet the CEHRT use requirement must attest to meeting the definition as specified by CMS. In addition, each EPM participant would be required to submit a clinician financial arrangement list no more often than quarterly. This list must include information on each EPM collaborator, collaboration agent, and downstream collaboration agent.

# CHA Comments

- Too much too soon; it's a marathon not a sprint
- Opposes expansion of CJR at this time
- Exclude CJR hospitals from Cardiac EPM Models
- Phase in Cardiac model at a later date, following evaluation of voluntary efforts; start with elective CABG
- Learn from experience, lead from the front, build on success

# CMS Part B Drug Payment Model

CALIFORNIA HOSPITAL ASSOCIATION

# Background

- CMS proposed a new payment model, Part B Drug Payment Model, under the authority of the Center for Medicare and Medicaid Innovation (CMMI)
- Published in the March 11, 2016 issue of the Federal Register (81 FR 13230-13261)
- Comments were due to CMS by May 9, 2016
- Expected final rule, TBD

# Background (cont.)

- Medicare Part B includes a limited drug benefit that encompasses drugs and biologicals that fall into three general categories:
  - Drugs furnished incident to a physician's service (and generally not self-administered)
  - Drugs administered via covered item of durable medical equipment (DME)
  - Other drugs specified by statute

# Background (cont.)

- Medicare pays for drugs that are administered in a physician's office or the hospital outpatient department
  - Average sales price (ASP) plus a statutorily mandated six percent add-on
- CMS expresses concern that ASP methodology encourages the use of more expensive drugs

# Participation: Selected Geographic Areas and Sampling

- CMS requires the participation of all **providers** and suppliers furnishing covered and separately paid Part B Drugs
- 5 year demonstration beginning as soon as this fall
- CMS chose Primary Care Service Areas (PCSAs) as the geographic unit for this model
  - PCSAs were developed by HRSA and based upon patterns of Medicare Part B primary care services

# Summary of CMS Proposal for Medicare Part B Drug Payment Model

| Phase 1 – ASP+X (no earlier than 60 days after display of final rule, Fall 2016) | Phase 2 – VBP (no earlier than Jan. 2017) |
|---|---|
| ASP+6% (control) | ASP+6% (control) |
| | ASP+6% with VBP Tools |
| ASP+2.5% and Flat Fee Drug Payment | ASP+2.5% and Flat Fee Drug Payment |
| | ASP+2.5% + Flat Fee Drug Payment with VBP Tools |

Note: Primary Care Service Areas (PCSAs), which are clusters of ZIP codes that reflect primary care service delivery, would be randomly assigned to each model test arm and the control group. The assigned PCSAs would not include ZIP codes in the state of Maryland where hospital outpatient departments operate under an all-payer model.

# Phase II: Applying Value-Based Purchasing Tools

- Proposes to implement VBP tools for Part B drugs using tools that are often used by commercial health plans (e.g., Medicare Part D plan sponsors, Pharmacy Benefit Managers (PBMs), and hospitals)
- CMS does not propose specific tools at this time, but offers example of what VBP strategies could include:
  - Reference pricing
  - Indications-based pricing
  - Outcomes-based risk sharing agreements
  - Discounting or eliminating patient coinsurance amount

| Value-Based Purchasing Strategy | CMS definition and proposals |
| --- | --- |
| Reference Pricing (Providing equal payment for therapeutically similar drug products). | Reference pricing is setting “a benchmark rate based on the current payment rate for a drug or drugs in a class that may be used as the basis of payment for all other therapeutically similar drug products in a group.”<br><br>CMS proposes to prohibit Medicare providers and suppliers from billing the beneficiary; may not be held responsible for paying the difference between their prescribed drug and the benchmark (common practice in commercial plans). |
| Indication-based pricing | CMS proposes using value-based pricing to vary prices for a given drug based on its varying clinical effectiveness for different indications covered under existing Medicare authority. |
| Outcomes-based Risk Sharing Agreement | CMS proposes it have the ability to establish a voluntary outcome based agreement with manufacturers that would tie the final price of a drug to results achieved by specific patients rather than using a predetermined price based on historical population data. |
| Discounting or eliminating patient coinsurance amounts | Beneficiary cost-sharing could be reduced for Part B drugs “deemed to be high in value.” Reductions in cost sharing would not change the overall payment amount that providers receive for the drug. |

# Phase II: Applying Value-Based Purchasing Tools (cont.)

- CMS describes the process it would use to finalize implementation of specific tools
- CMS would solicit public input on each proposal by posting on the CMS website
  - **Thirty days** would be provided for public comment;
  - A minimum of **45** days public notice would be provided before implementation

# CHA Comments

**Phase 1**

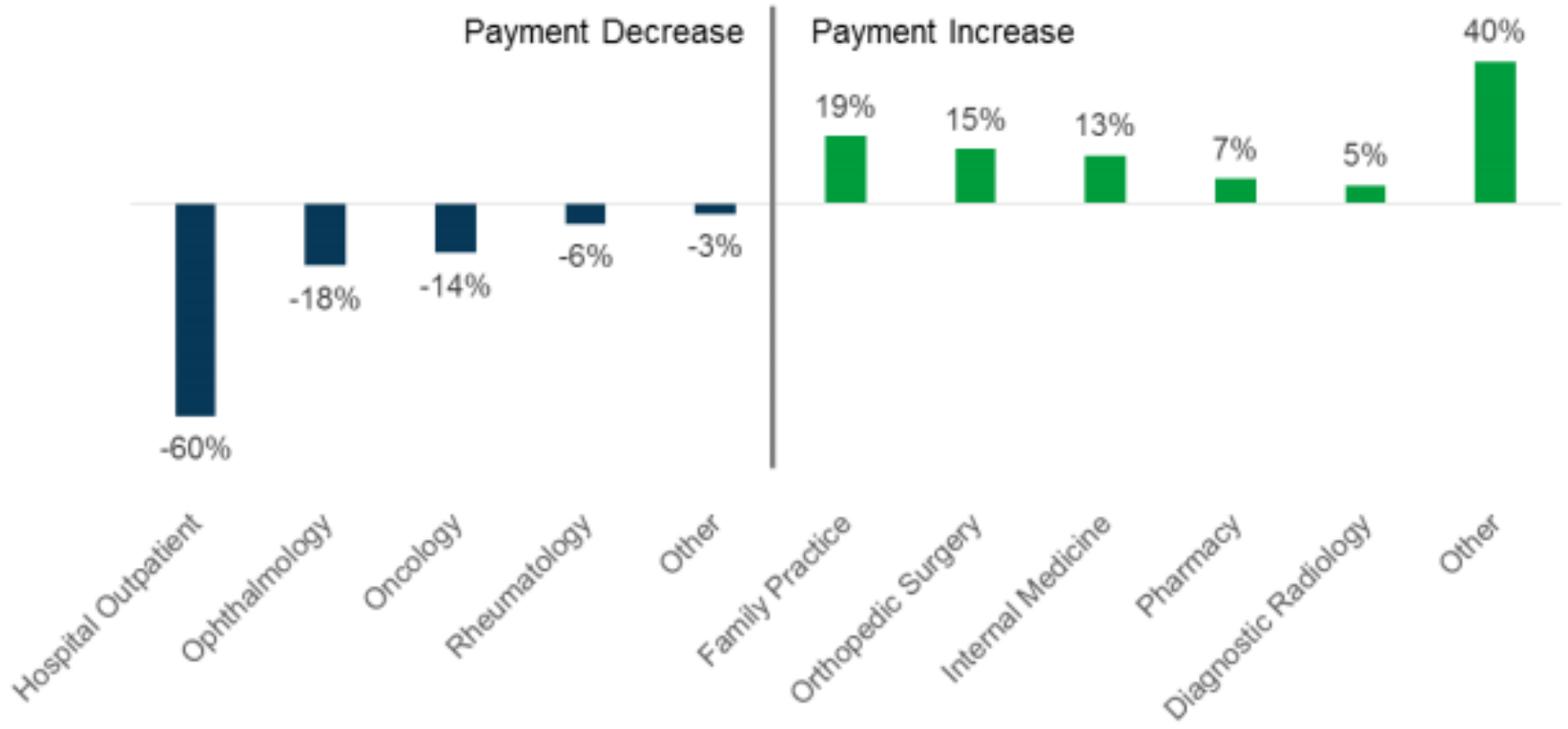
- Nothing more than a payment cut to OPPS
- Budget neutrality adjustment across all Part B disproportionately harms hospitals — already operating with negative 12% outpatient margins
- Hospitals lose because of current OPPS drug packing policies (OPPS) < $100 (no flat fee)
- Urge CMS to exclude hospitals from Phase I
  - Hospitals do not prescribe drugs – physicians do
  - Lack of lower cost drug substitutes in hospital setting as opposed to physician setting

# Drugs That Cost More Than $480 Per Day Would Result in Greater Reduction in Reimbursement


Source: Avalere Analysis, April 6, 2016
http://avalere.com/expertise/managed-care/insights/proposed-medicare-part-b-rule-would-reduce-payments-to-hospitals-and-some-s

# Hospitals Disproportionately Harmed by this Policy

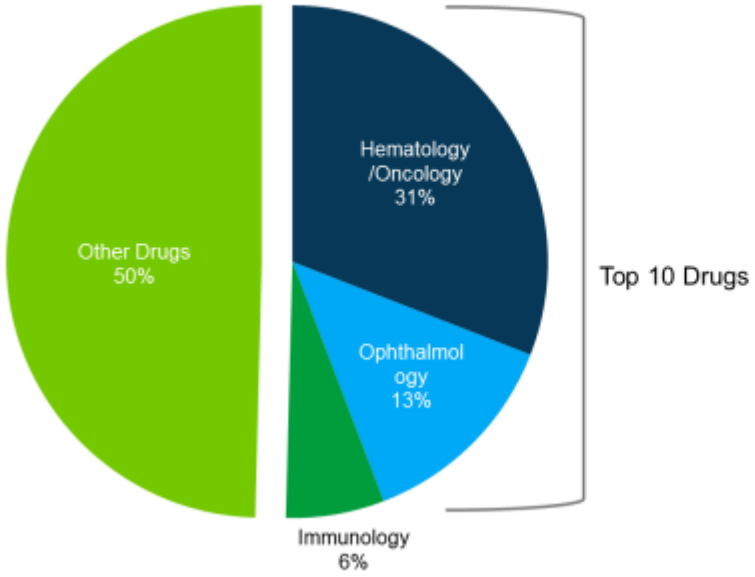
**Share of Increase / Reduction in Payment Under Proposed Part B Rule, by Provider Specialty**




Source: Avalere Analysis, April 6, 2016
http://avalere.com/expertise/managed-care/insights/proposed-medicare-part-b-rule-would-reduce-payments-to-hospitals-and-some-s

# Cancer Drugs Significantly Impacted

**Total Medicare Part B Payment Reduction Under Proposed Rule Including Sequester Impact for Top 10 Drugs**




Source: Avalere Analysis, April 6, 2016
http://avalere.com/expertise/managed-care/insights/proposed-medicare-part-b-rule-would-reduce-payments-to-hospitals-and-some-s

# CHA Comments

- If CMS includes hospitals in Phase 1, they should
  - Scale back number of hospital participants
  - Exclude cancer drugs
  - Consider applicability to only certain specialties
- Implementation of G codes (for purpose of paying flat fee) is burdensome to hospitals
  - CMS should change their systems not make us change ours
- Delay implementation until July 1, 2016

**Phase II**

- Implementation of Phase II is too soon, and proposed regulation makes no specific proposals for comment
- Move forward only through notice and comment

# Next Steps

- CMS has until 2019 to finalize a rule
- Likely to be finalized by the end of this year
- Scope of rule is uncertain
- Field is divided — but Pharma and hospital industry in agreement to scale back, purchasers and consumers and some health plans encouraging CMS to proceed
- Congress has expressed significant concerns

# MACRA

CALIFORNIA HOSPITAL ASSOCIATION

# What's Different About MACRA

- MACRA stands for "Medicare Access and CHIP Reauthorization Act"
- Repealed the infamous "Sustainable Growth Rate" legislation
- Bipartisan?!?!
- Changes how Medicare will pay physicians

# MACRA

MACRA is more evolutionary than revolutionary, because the transition to value-based payments (VBPs) is not new. However, MACRA accelerates these changes:

- Prospective solicitation of stakeholder input
- Extensive retrospective review and reporting
- Exceptional amount of authority delegated to the Secretary of Health and Human Services
- Closer alignment of incentives under Parts A and B
- Expect an impact elsewhere –
  - Medicare Advantage
  - Commercial Payers

# New MACRA Legislation

MACRA provides a new payment structure for physicians with quality metrics and two distinct tracks for physician's compensation

## KEY LAW CHANGES: PAYMENT CHANGES AND PERFORMANCE METRICS

| | |
|---|---|
| RATE INCREASES ARE MORE CONSISTENT | • Rate increases have been standardized for the next few years<br>• Rate increases change depending on track |
| PAY-FOR-PERFORMANCE METRICS ARE INTEGRATED | • The Physician Quality Reporting System (PQRS), meaningful use (MU), and the value-based payment modifier (VBPM) have been combined into the first track<br>• The second track is for physicians using risk-based models that already incorporate VBP |

# New MACRA Legislation
# MACRA Tracks 1 and 2

## TRACK 1:
## "MIPS" — MODIFIED FEE-FOR-SERVICE TRACK

*Rate Changes Are Scheduled Under MIPS Over Time*

- **2015–2019**: 0.50% annual increase
- **2020–2025:** No annual fee change
- **2026–?:** 0.25% annual increase

### ADDITIONAL INFORMATION

- The Merit-Based Incentive Payment System (MIPS) incorporates upside and downside risk through four performance measures
- Downside penalties will pay for upside bonuses, making MIPS budget-neutral
- There is an additional $500 million that will be distributed annually to top performers from 2019 through 2024

## TRACK 2:
## Alternative Payment Models — (RISK-BASED)

*Rate Changes Are Scheduled Under APM Over Time*

- **2015–2019**: 0.50% annual increase
- **2020–2025:** No annual fee change
- **2026–?:** 0.75% annual increase

### ADDITIONAL INFORMATION

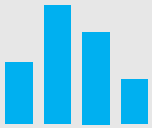
- Alternative Payment Models (APMs) means value-based, non-traditional (FFS) payment mechanisms, such as ACOs. To be eligible, physicians must use an EHR, be paid for quality metrics similar to those under MIPS, and bear "more than nominal" financial downside risk
- Physicians must receive a large percentage of revenue through APMs to be eligible for this track
- The APM track frees physicians from participating in the MIPS performance metrics
- Plus: 5% bonus from 2019 - 2024

# MIPS: Performance Evaluation

MIPS incentivizes performance across four key measures, utilizing a single composite score in a budget-neutral fashion

CLINICAL QUALITY (30%)

RESOURCE UTILIZATION (30%)



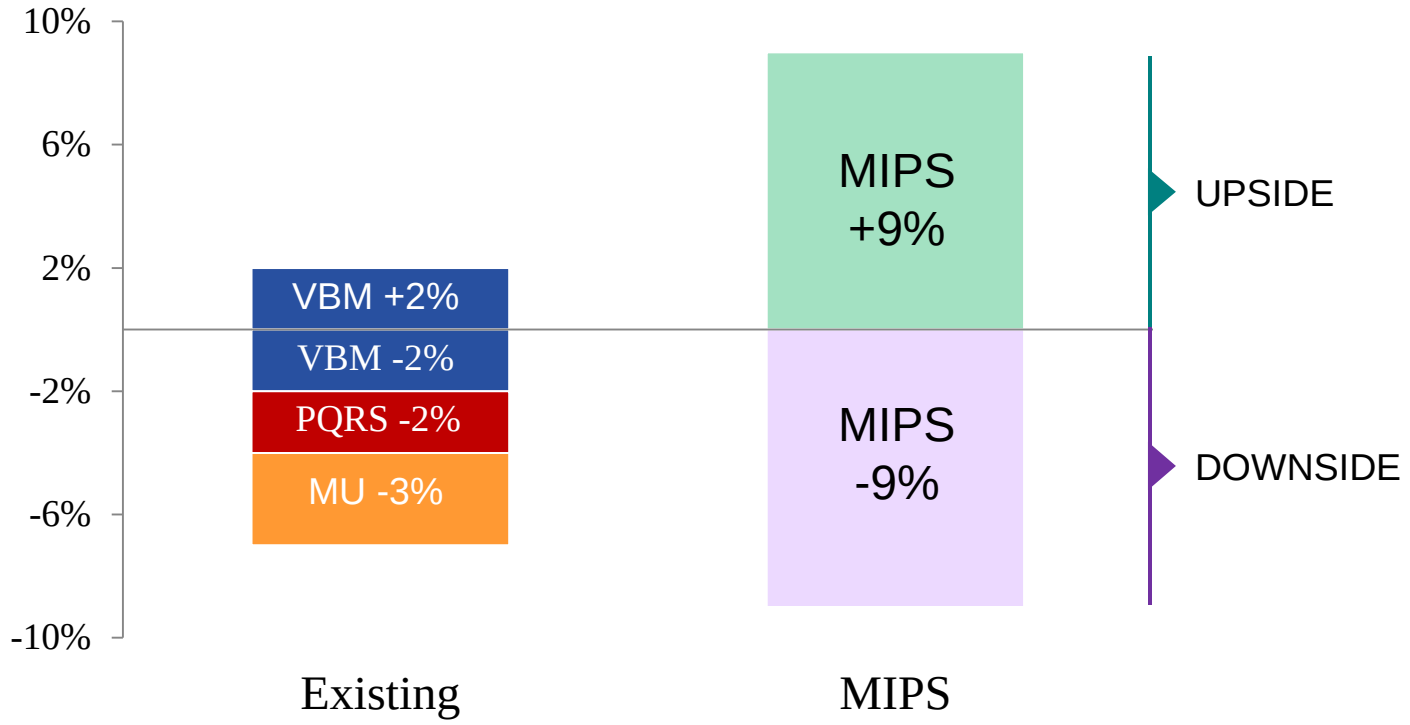
PRACTICE IMPROVEMENT (15%)

MU (25%)

- Physicians receive a score ranging from 0 to 100 based on their performance across the four metrics and the relative weight assigned to each metric
- This score, which is compared to scores of other physicians, then determines whether physicians pay a penalty, earn a bonus, or simply receive payment according to the fee schedule
- The downside and upside risks are capped at a certain level that changes over time

# MIPS by the Numbers
# Comparison to Existing Incentives

Under MIPS, the range of upside/downside potential is substantially greater than the existing programs it replaces



# Allowable APM Examples

The APM track gives physicians who care for larger Medicare patient populations an opportunity to pursue alternative models and rewards them financially for doing so

## APM MODELS

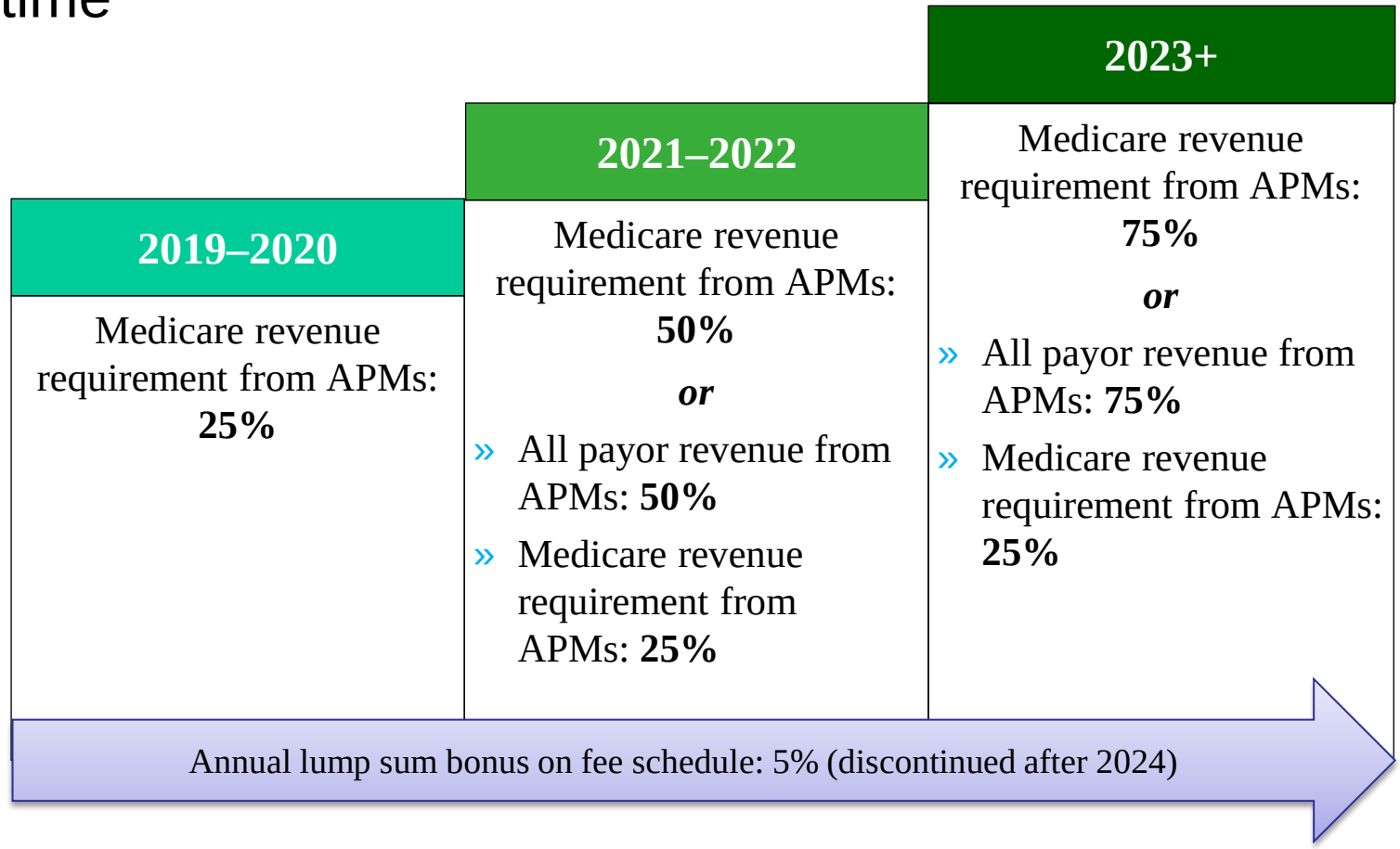
- Models from Center for Medicare and Medicaid Innovation
- The Medicare shared savings program (ACOs)
- A demonstration under Health Care Quality Demonstration Program
- Demonstrations required by Federal law

## CRITERIA FOR ELIGIBILITY

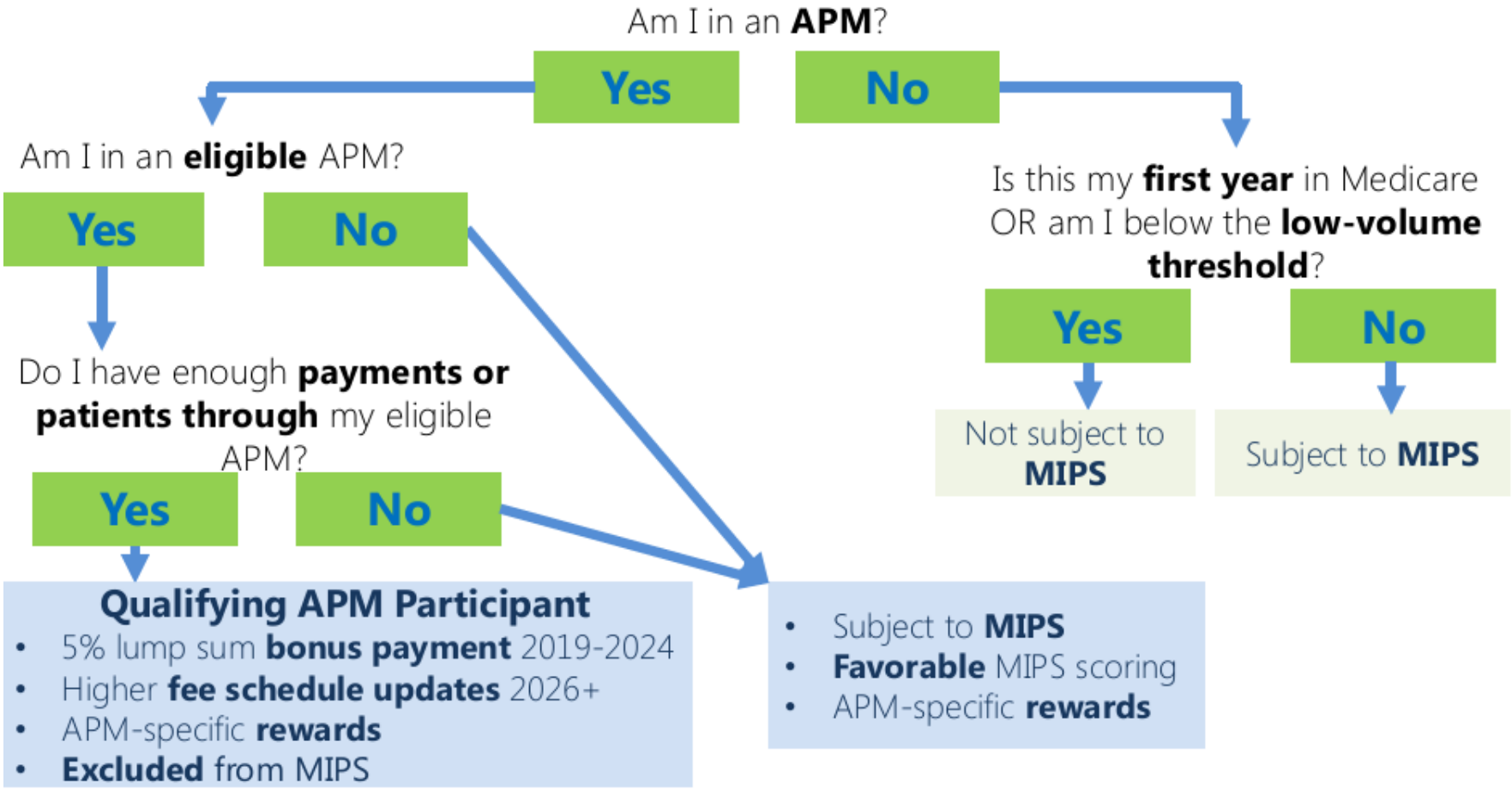
- Certified EHR
- Comparable quality measures to MIPS
- Risk above a “nominal amount” or a medical home that meets expansion criteria

# APMs: Medicare Requirements and Lump Sum Bonuses

Requirements for participation in APMs will increase over time



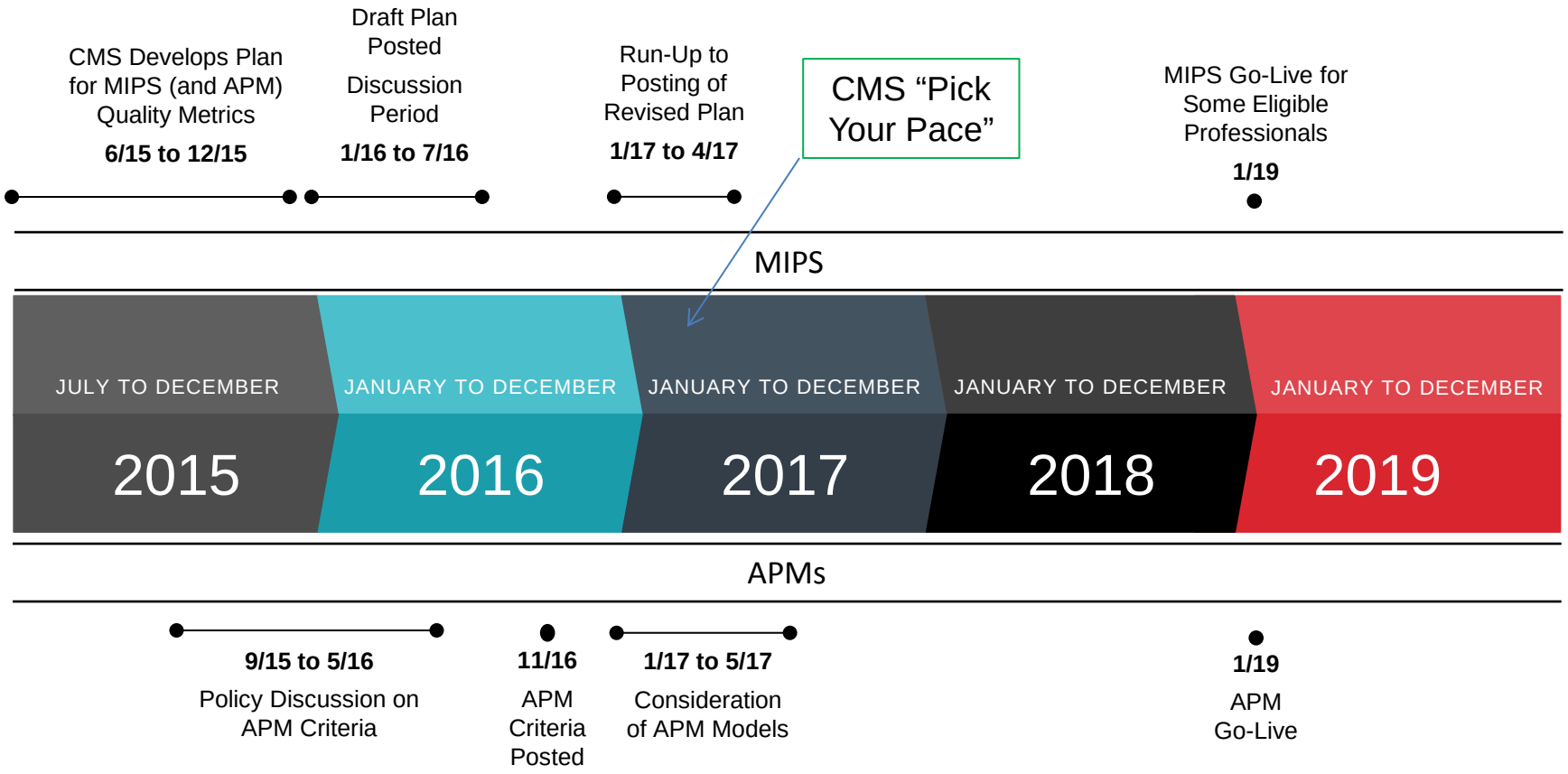
# How will MACRA affect me?




*Bottom line: There are opportunities for* ***financial incentives for participating in an APM****, even if you don't become a* ***QP****.*

# Timing of Rollout

The rollout of MIPS and APMs will take place in a very compressed time frame by government standards. Stakeholders will want to keep abreast of developments and provide input to the process as needed



# Implications

- The ability to understand and manage the cost of care, and to demonstrate value to payers, will become even more important
- CMS payment methodologies for non-physician services may change as well
- The relationship between Parts A and B will become more complicated

# Implications (cont.)

- Physician practice consolidation and acquisitions will continue
- Physician compensation and service agreements will need to evolve
- Commercial managed care contracts will need to be amended
- Interested parties have a voice in shaping the final product

# Implications (cont.)

- Hospitals with physician vehicles will have to quickly decide whether to stay in MIPS or move to an APM
- Hospitals offering physicians a MIPs or APM solution may be more competitive
- Hospitals may be able to take advantage of physician needs for capital and expertise required to participate effectively in the new payment structures
- Alignment strategies particularly with respect to APMs

# Comment Themes — MIPS

- CHA appreciates that CMS streamlined and reduced the required number of quality measures for physicians
  - Adjust for Socio-demographic factors (SDS) where appropriate
- Consideration of a method for allowing hospital-based physicians to use their facilities' quality reporting and pay-for-performance program measure performance in the MIPS
- Considerations for alignment between hospitals' EHR Incentive Program requirements with the Advancing Care Information requirements for physicians

# Comment Themes — APMs

- Allow for current EPM models to qualify as APMs to further align hospitals and physician payments and incentives
- CMS should recognize risk associated with initial investment in establishing APMs
- Consider changes to fraud and abuse laws that are barriers to clinical integration and alignment
- Consideration of capturing risk-sharing agreements in Medicare Advantage

# Medicare's New Outpatient Observation Notice (MOON)

# NOTICE Act Requirements

- NOTICE Act requires Medicare patient notification when observation services last more than 24 hours for ALL individuals entitled to Medicare benefits under Title XVIII
  - Enacted Aug. 6, 2015
  - Effective Aug. 6, 2016
- CMS requires a **standard** notice, the MOON, and it must be provided:
  - Within 36 hours of start of observation or sooner if patient is discharged, transferred or admitted before 36 hours
  - Written and verbal notification
- Requires: reason for observation and that it could affect cost-sharing and post-acute coverage (e.g. SNF stay)

# Medicare Outpatient Observation Notice (MOON)

- First MOON draft released in April as part of the FFY 2017 IPPS proposed rule
- Second notice released by OMB on August 8 for an additional 30 day comment period
- Current Notice available at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=descending

# Advocacy on the MOON

CHA successfully advocated for CMS changes including:

- **Timing**: CMS now allows the notice to be provided anytime before the patient has been on observation 36 hours, or sooner, if discharged, transferred or becomes inpatient.
- **Length and Complexity**: CMS shortened the notice and simplified the language (CMS has only agreed to English and Spanish versions).
- **Implementation timeline**: CMS moved the implementation date from Aug 6, 2016 to 90 days after the MOON is released as final by OMB (likely in the next few months).
- **Which staff can provide MOON**: CMS allows hospitals to determine appropriate staff.

# MOON – Round 2
# OMB Review

- The Office of Management and Budget (OMB) conducted a 30-day comment period on the MOON form pursuant to the Paperwork Reduction Act. OMB solicits comment on the following issues:
  - The need for the information collection and its usefulness in carrying out the proper functions of our agency.
  - The accuracy of the estimate of the information collection burden.
  - The quality, utility and clarity of the information to be collected.
  - Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

# MOON Notice: Receiving Observation Services

(Hospitals may include contact information or logo here)

**Medicare Outpatient Observation Notice**

**Patient name:** **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

# MOON Medicare Coverage Discussion

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

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Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

**NOTE:** Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

DRAFT

# Questions/ Complaints about Observation Services

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

CMS explains:

The MOON notification of observation status does not constitute a determination and the NOTICE Act does not provide for appeal rights for the notice itself.

Medicare beneficiaries can always call 1-800-MEDICARE.

# MOON Cost for Medications and Other Financial Information

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

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**If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C),** your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

**If you're a Qualified Medicare Beneficiary through your state Medicaid program,** you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

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http://www.calhospital.org/cha-news-article/oig-issues-policy-discounts-waivers-self-administered-drugs

# CMS Site: Beneficiary Notice Initiative Page (www.cms.gov/bni)

Home | About CMS | Newsroom | FAQs | Archive | Share Help

CMS.gov
Centers for Medicare & Medicaid Services

Learn about your health care options

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach Educatio

Home > Medicare > Beneficiary Notices Initiative (BNI) > Beneficiary Notices Initiative (BNI)

**Beneficiary Notices Initiative (BNI)**

- FFS ABN
- FFS HHCCN
- FFS SNFABN and SNF Denial Letters
- FFS HINNs
- FFS ED Notices
- MA Denial Notices
- MA ED Notices

## Beneficiary Notices Initiative (BNI)

**Please Note: For Medicare Prescription Drug Coverage Notices -- see below under "Related Links."**

### Beneficiary Notices Initiative

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to b

**Use the navigation tool on the le instructions:**

- FFS Advance Beneficiary N

**Medicare Outpatient Observation Notice (MOON)**

The Medicare Outpatient Observation Notice (MOON) is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH).

The MOON is mandated by the federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

CMS held a listening session on December 21, 2015 to solicit the input of the hospital industry, beneficiary advocates, and other stakeholders regarding CMS's implementation of the MOON. See the link to the written transcript in "Downloads" below. The link to the audio file of this listening session can be found in "Related Links" below.

**CMS Proposals**

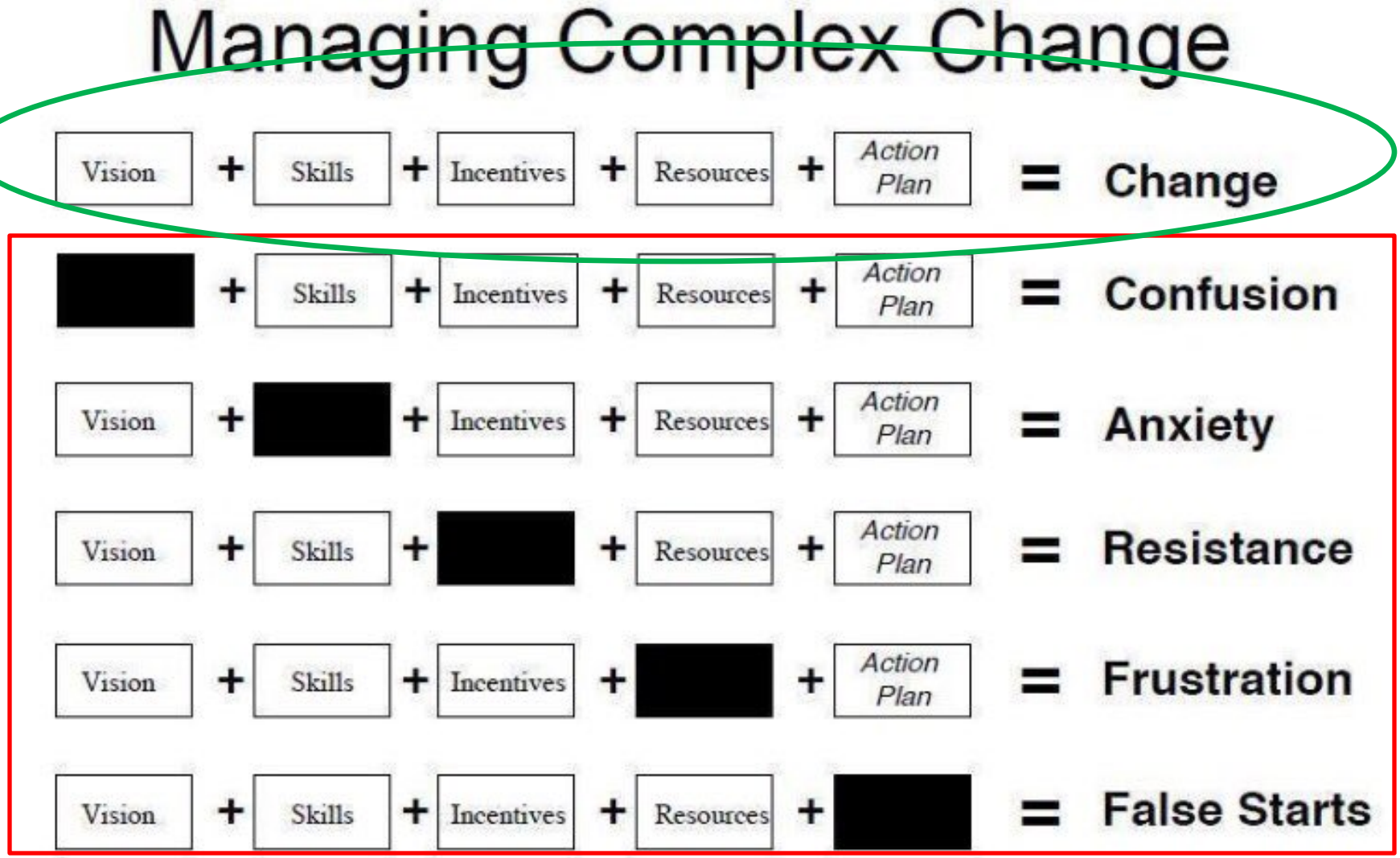
Updated versions of the MOON, its instructions, and implementing regulations were posted on August 2, 2016, in conjunction with the FY 2017 Medicare hospital inpatient prospective payment systems (IPPS) final rule.

See "Federal Register - IPPS - NOTICE Act Final Rule" and "CMS-10611" in "Related Links" below to view the proposed NOTICE Act regulation (Section L and 42 CFR 489.20), the updated draft MOON, and accompanying materials. For instructions on how to comment on the MOON and related material, please see "CMS-10611" in "Related Links".

# Still to come by December 31st

- Outpatient Final Rule
- Physician Fee Schedule
- Home Health Final Rule
- MACRA Final Rule
- Cardiac Bundling Final Rule (EPMs)
- Medicare Appeals Final Rule
- 340B Guidance
- Discharge Planning CoP Final Rule
- Antibiotic/Non-discrimination Cop Final Rule
- Medicaid Supplemental Payments
- Medicaid DSH Cuts Proposed Rule – January 2017

# Conclusion




*Adapted from Knoster, T., Villa R., & Thousand, J. (2000). A framework for thinking about systems change. In R. villa & J. Thousand (Eds.), Restructuring for caring and effective education: Piecing the puzzle together (pp. 93-128). Baltimore: Paul H. Brookes Publishing Co.*

# Thank You/Questions

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