

SPRING/SUMMER 2017 EDITION

Medicare

Inside this Issue:

- Information on MACRA
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- Plus, Additional Valuable Resources!

CMS Releases APIs to Assist Physicians and Developers in Implementing MACRA Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) has released [application program interfaces \(APIs\)](#) to help physicians implement the Quality Payment Program mandated by the Medicare Access and CHIP Reauthorization Act (MACRA). Developers can use the APIs to build software applications to help physicians and their practices automatically share electronic quality measure data for the program.

This release is part of CMS' ongoing efforts to spur the development of innovative, customizable tools that reduce burden for physicians and support high-quality care for patients.

The American Hospital Association has also released an infographic to depict the two new payment pathways for clinicians under MACRA. It highlights who is eligible for the programs, payment impact and evaluation criteria. [Click here](#) to access the infographic.

CMS Website Features Updated Information on EHR Incentive Programs

The Centers for Medicare & Medicaid Services (CMS) has updated its Electronic Health Record Incentive Programs website and resources to reflect the changes outlined in the final rules concerning the Medicare Access and CHIP Reauthorization Act (MACRA), Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for calendar year 2017.

CMS encourages eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) to visit the updated website to view the official CMS resources and program information, including the following:

- 2017 Program Requirements webpage
- Medicaid 2017 Specification Sheets for EPs and hospitals
- Medicaid Stage 3 Specification Sheets for EPs and hospitals
- Medicare 2017 Specification Sheets for EHs, CAHs and Dual-Eligible Hospitals attesting to CMS

To view the updated website, [click here](#).

CGS Creates Multi-Factor Authentication Security Feature for their Providers

CGS Administrators, a Medicare Administrative Contractor (MAC) that provides numerous states including Ohio with support services for Medicare and Medicaid programs, has created a multi-factor authentication (MFA) service for their users.

This service is being instituted due to increased Centers for Medicare & Medicaid Services (CMS) security requirements, and users must sign up for the new service by **July 1, 2017**. However, they are asking providers to start using the feature now so that it becomes part of their everyday workflow before it becomes a requirement.

The myCGS MFA is an extra layer of security in the event someone manages to obtain a user's password without his or her knowledge.

To learn more about the security feature, [click here](#).

The CGS Administrators Newsletter is Available on the AMCNO Website

The winter 2017 edition of the CGS Administrators J15 newsletter has been posted on the AMCNO website for review. This newsletter is provided to the AMCNO by CGS on a regular basis. The newsletter contains a wealth of information from CGS for providers and their staff. To view the newsletter, [click here](#).



Medicaid

Through the Ohio Department of Medicaid, the Ohio Department of Mental Health and Addiction Services has issued guidance regarding the coverage of Institutions for Mental Diseases (IMD) services. As a refresher, this guidance is pursuant to federal regulations regarding managed care which allows Medicaid recipients to receive time-limited inpatient treatment for behavioral health. This policy would “go-live” July 1. To review a FAQ document, [click here](#).

Ohio's Medicaid Growth is within Targets

The Governor's Office of Health Transformation recently updated budget documents to reflect the Ohio General Assembly's Joint Medicaid Oversight Committee (JMOC) official calculation of Medicaid per member spending. For the 2018-2019 budget, JMOC recommends limiting Medicaid per member spending growth to 3.3% each year. JMOC estimates the governor's budget as introduced will limit Medicaid per member spending growth to 1.9% in 2018 and 1.5% in 2019 (1.7% on average over the biennium)—well within the legislature's 3.3% target.

[Click here to view the overall Medicaid budget impact](#) (updated)

[Click here to review the JMOC calculation of Medicaid per member growth](#)

Note from AMCNO staff: The budget bill that cleared the House included a number of changes to the Medicaid program. The debate on the budget continues in the Senate and then the Conference Committee, with the governor signing a final budget bill by the end of June. More information on the final budget will be included in future publications.

Anthem

To access the Anthem April Network Update, [click here](#).

UnitedHealthcare

To access the April UnitedHealthcare Network Bulletin, [click here](#).

Medical Mutual

To view recent Medical Mutual provider updates, [click here](#).



News You Can Use

AMCNO Submits Comments on SMBO Prescribing Rules

Governor John Kasich and the state's medical licensing boards have announced proposed rules for acute pain prescribing, with the goal of reducing the number of opiate painkillers that are distributed to patients. For short-term pain, the rules would limit the amount of prescription opioids to no more than 7 days for adults and 5 days for minors. The prescriptions cannot exceed an average of 30 morphine equivalent doses (MED) per day. Also, physicians would be required to provide a specific diagnosis and procedure code for every painkiller prescription they write, which have to be entered into the Ohio Automated Rx Reporting System (OARRS). Healthcare providers can prescribe opiates in excess of the new limits only if they provide a specific reason in the patient's medical record. The limits would not apply to care for cancer, palliative care, end-of-life or hospice care, or medication-assisted treatment for addiction.

The rules don't require new legislation, Gov. Kasich said, because they are updates to current policy and they reinforce the guidelines created by the Centers for Disease Control and Prevention for acute pain. The administration estimated that the new rules would reduce the number of opiate doses by 109 million per year.

The proposed rules were discussed by the State Medical Board of Ohio (SMBO) during their April 12 policy committee meeting and were then released for public comment. The AMCNO submitted comments to the SMBO concerning the proposed amendments to Ohio Administrative Code Rules 4731-11-01, 4731-11-02 and 4731-11-13, which outline requirements for prescribing opiates for acute pain.

In the comments sent to the SMBO, the AMCNO expressed concerns about several key points, including necessitating the inclusion of an ICD-10 code on a prescription, as it could have an impact on patient privacy. Although it is understood that the requirement is intended to have the code for every controlled substance entered into OARRS by a pharmacist, the AMCNO wants to know how the information would be used and who would be allowed to access the patient's confidential information.

Also of concern is that some electronic medical records do not readily allow diagnosis codes or a diagnosis printed on a script, and changing systems to do so would be expensive and complicated. Regardless of whether systems allow it, the requirement would take more time away from patient care.

New rule 4731-11-13 states that extended-release or long-acting opioid analgesics shall not be prescribed for the treatment of acute pain. The AMCNO stated in its comments to the SMBO that the use of these medications should be left up to the prescribing physician. The new rule provides no option for physicians when prescribing for pain.

The rule also indicates that a 3-day or less supply is usually sufficient, which does not apply to all clinical situations, and is even contrary to what is actually written into the rule. Also proposed is that if a physician believes that a prescription has to be extended for more than 5 or 7 days, the chart must show why that is necessary and why it is appropriate. It is not clear what would meet the definition of “appropriate documentation”—the SMBO would need to clearly define, through regulation or education, what needs to be included in the medical record documentation.

Another section of the new rule limits a prescription for opioid analgesics for the treatment of acute pain at 30 MED per day, without exception. There likely will be clinical situations in which this limit would have to be exceeded, so there needs to be an exception in the rule that allows for these types of situations. Also, the AMCNO questions how OARRS will be queried for this type of information as well as if and how physicians would be “investigated” if they exceed the limit.

In the AMCNO’s final comments, it was stated that data show physicians have been doing their part to curb doctor shopping and overprescribing. The AMCNO believes that focused data collection and analysis would allow the SMBO to concentrate on the physicians who need attention.

The SMBO met again in May and made some changes to the proposed rules. The AMCNO will continue to follow this issue and provide an updated report to members.

To read a copy of the letter sent to the SMBO, [click here](#).

Ohio Board of Pharmacy Report Shows Decline in Opioid Prescribing for Fourth Consecutive Year

A recent report issued by the State Board of Pharmacy’s Ohio Automated Rx Reporting System (OARRS) shows that opioid prescribing in the state has declined for the fourth consecutive year in 2016. The full 2016 OARRS Annual Report is available [here](#).

As reported, the total number of opioids dispensed to Ohio patients between 2012 and 2016 decreased by 162 million doses, or 20.4%—from a peak of 793 million doses to 631 million doses. The report also shows a 78.2% decrease in the amount of people engaged in the practice of doctor shopping since 2012. In addition, the use of OARRS continued to increase—reaching an all-time high of 24.11 million requests in 2016.

To access the OARRS website, [click here](#).

Report from Health Policy Institute of Ohio Ranks the State 46th in the Nation in Health Value

The Health Policy Institute of Ohio (HPIO) has released its latest edition of the *Health Value Dashboard*, which ranks all 50 states and Washington, DC, on a combination of population health and healthcare spending metrics. To access the full report or portions of it, [click here](#).

According to the report, Ohio ranks 46th in the nation in health value. And, data show that Ohioans live less healthy lives (43rd in population health) and spend more on health care (31st in healthcare spending) than other states. Like most states, however, Ohio’s performance is moving in the right direction, with more metrics that improved than worsened in recent years.

The 2017 *Health Value Dashboard* is the second edition of the rankings—the first edition was released in late 2014. At that time, Ohio ranked 47th in health value. The data collection and analysis for this recent dashboard was conducted in partnership with the Ohio University Voinovich School of Leadership and Public Affairs. The metrics were selected by a wide array of experts who participated in an advisory group and workgroups convened by HPIO.

Ohio Board of Pharmacy Publishes Guidance Documents for Recent Law and Rule Changes

The Ohio Board of Pharmacy has published a number of guidance documents regarding recent law and rule changes that may pertain to our AMCNO members. They include the following:

- Effective April 1, 2017, all prescribers that possess compounded drugs or engage in the compounding of dangerous drugs (ie, prescription drugs) must obtain a license as a terminal distributor of dangerous drugs (TDDD) (ORC 4729.541). More information on the provision can be found at www.pharmacy.ohio.gov/prescribercompound.
- **TDDD Requirements for Controlled Substances:** All locations that possess controlled substances are required to obtain licensure as a category III TDDD. This requirement took effect on April 6, 2017. More information on the provision can be found by visiting www.pharmacy.ohio.gov/TDDDCs.
- **Office-Based Opioid Treatment:** Effective August 4, 2017, all locations that treat more than 30 individuals for opioid dependence or addiction using a controlled substance are required to obtain a license as a TDDD with an office-based opioid treatment classification. Please be aware that there are some exemptions to this requirement. More information on the provision can be found by visiting www.pharmacy.ohio.gov/OBOT.

Nonpartisan Group Releases Profiles of All State Districts in Ohio

The Center for Community Solutions (CCS) has just released [Legislative District Profiles](#) for each of Ohio's state House and Senate Districts. This is the first time the data have been compiled at the state district level, showing that issues related to health and human services touch every district in Ohio. The profiles include basic demographic information about each district, as well as data on employment and income, poverty, education, housing, and health. These profiles are very comprehensive, and the AMCNO is providing this information to our members for their information.

AMCNO Website Features Prescription Drug Resources for Physicians

At the AMCNO, we are committed to assisting physicians in the fight to combat the opioid epidemic. Recently, we created a webpage—Prescription Drug Resources for Physicians—to house helpful information in one location about this topic from various sources, including the Centers for Disease Control and Prevention and the American Medical Association. The page is continuously updated with new information. To access the page, [click here](#).

OPCPCC Offers a Patient Engagement Toolbox

The Ohio Patient-Centered Primary Care Collaborative (OPCPCC) is a coalition of primary care providers, insurers, employers, consumer advocates, government officials, and public health professionals. They work together to create a more effective and efficient model of healthcare delivery in Ohio, known as the Patient-Centered Medical Home (PCMH). The AMCNO is part of the coalition.

The OPCPCC website now features [a toolbox](#), an informative resource center to support the PCMH. Healthcare professionals can access these materials for educational purposes and to provide additional care for their patients. Several categories are available, including Patient Safety, Self-care Goals, Tools for the Practice, and Webinars.

CliniSync Offers Webinars on Payment Reform Topics

On the CliniSync YouTube Channel, physicians can find a large array of educational online webinars and presentations on the subject of payment reform, including the Medicare Access and CHIP Reauthorization Act (MACRA). To view the complete playlist, [click here](#).

The American Health Care Act (AHCA): GOP Efforts to Repeal and Replace the Affordable Care Act—What Can Healthcare Providers Anticipate Moving Forward?

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On Monday, March 6, 2017, House Republicans released the American Health Care Act (AHCA)—the long-awaited plan to repeal and replace the Affordable Care Act (ACA). After a few weeks of intense activity, including passage of the legislation in the House Ways and Means Committee and the House Energy and Commerce Committee, the AHCA fell short of passage in the House. Republican proponents pulled the AHCA bill from consideration on Friday, March 24, 2017, due to concerns that sufficient support did not exist within the Republican Party to pass the bill. More uncertainty awaited the legislation in the Senate.

Even though the AHCA is currently tabled, the Trump administration and Republicans have not given up efforts to replace the ACA. In the past few weeks, meetings between the administration and various coalitions of Republications have taken place, showing the continued interest in replacing the ACA.

Without new draft legislation, at this point, the real question is what the recent efforts to pass the AHCA tell us about future proposals for healthcare reform. Though the authors do not pretend to have a crystal ball, the dialogue surrounding the AHCA provides some insight into future legislation. While many things may change in subsequent efforts, several foundational elements appear to emerge and are likely to stick.

Initial Efforts to Repeal and Replace—The AHCA

When the ACA was enacted in March 2010, major themes included expansion of coverage, improving the efficiency and quality of health care, and lowering the overall cost of insurance. While the goal for Republicans over the past 7 years has been to repeal the ACA, the AHCA left much of the existing ACA themes in place. Untouched were a number of the most popular aspects of the ACA, relating to the group health plan coverage requirements, including but not limited to:

- Coverage of children up to age 26;
- Prohibition on insurers denying coverage based on pre-existing conditions;
- Cap on out-of-pocket expenses;
- Guaranteed availability and renewability of coverage;
- Prohibition on maximum lifetime and annual limits; and
- No discrimination based on disability, age, or sex.

The underlying reason the AHCA did not attempt to repeal more of the ACA stems from the process invoked by Republicans to pass the bill: budget reconciliation. The advantage of passing the AHCA legislation as a reconciliation bill is that only a simple Senate majority is required for passage. This is the same mechanism that was used to enact parts of the ACA in 2010. The downside to using budget reconciliation is that it must be revenue neutral, meaning that any reduction in federal revenue (ie, tax cuts) must be offset by reduction in credits or spending. In addition, only legislation that is germane to the management of the budget is allowed to be passed using the fast-track method. This explains why the technical components of the ACA, in particular its provisions affecting the healthcare delivery system through quality initiatives and program integrity, were left unscathed in the AHCA. Overall, much of the AHCA focused on changes to the Medicaid program and the healthcare insurance market for individual consumers.

Aspects of the AHCA Likely to Reappear

Changes to the State Medicaid Programs

Included in the AHCA was a “freezing” of the ACA’s Medicaid expansion program within 3 years. In 2020, the state Medicaid programs would be able to continue serving then-current enrollees, but would not be able to accept new applicants into the programs. In addition, the Medicaid’s funding model would have shifted from an open-ended commitment by the federal government to each state, to a set annual amount provided to each state, either in the form of a block grant or capitated model related to the number of Medicaid beneficiaries. As negotiations within the Republican Party progressed, some of the accommodations intended to trigger additional Republican support included the addition of a work requirement for certain Medicaid beneficiaries and requiring Medicaid expansion beneficiaries to re-register every 6 months. Furthermore, the AHCA would have eliminated the requirement that Medicaid plans include the 10 “essential benefits” required by every plan under the ACA as follows:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Because of the interest in program savings, it is likely that many of the aspects of Medicaid reform contained in the AHCA and discussed during related negotiations will reappear in the future. In particular, the concept of the federal government providing states with a fixed amount of funding for the Medicaid program each year has been a constant of prior Republican repeal-and-replace efforts and is likely to be a feature of any future proposals. Consequently, it seems probable that future proposals to reduce Medicaid spending will result in a reduction of the total number of beneficiaries. Providers and facilities that routinely treat the uninsured and Medicaid patients are likely to be the first to feel the impact of such reduced coverage.

Individual Healthcare Insurance Market

The AHCA also proposed a number of changes to the individual healthcare insurance market. Under the AHCA, the ACA individual penalty for lack of healthcare coverage would be replaced by continuous coverage incentives that would make health insurance more expensive for individuals who lost coverage and later decided to reapply for insurance. Instead of premium subsidies based on income, the AHCA proposed tax credits based on age. The AHCA would have also permitted insurers to implement maximum risk ratios of 5 to 1 rather than 3 to 1 as required by the ACA.

During the negotiation of the AHCA, one of the issues raised by House members on the fence or against the bill was the fact that the AHCA would not cause premiums to fall for individuals purchasing insurance on the open market and that premiums would likely increase, at least in the short term. Another proposal was the elimination of the requirement that all health plans include the 10 essential health benefits in exchange for more reasonably priced coverage. Critics, however, worried that health plans would be stripped by insurers without the desired impact of significant reduction in premiums if the essential health benefits were no longer required.

Down But Not Out

Repealing and replacing the ACA remains a top priority of the new administration and the Republican Party. As recently as early April, Vice President Mike Pence met with House Speaker Paul Ryan and other House

Republicans to discuss a path forward. While the elimination of the 10 essential health benefits for all health plans was reportedly off the table, the concept of a waiver program that would permit states to eliminate the requirement that insurers comply with the ACA's community rating requirements was purportedly discussed. Such a change could negatively impact high-risk individuals and those with pre-existing conditions.

Most recently, on April 6, 2017, an amendment to the AHCA was submitted to the House Rules Committee, reintroducing the AHCA for consideration by the House, together with a new amendment that created a \$15 billion fund establishing an invisible risk-sharing program that would help states subsidize claims from high-risk individuals. Critics responded that the program would not have a meaningful impact and individuals would still feel the effects of the other contemplated changes, including the high propensity for increased premiums based on risk or age.

Efforts to repeal and replace the ACA will expectedly continue along partisan lines. Such efforts will be supported by Health and Human Services Secretary Tom Price, MD, the former Republican House Representative who issued his own repeal and replace plan in 2015 and reportedly consulted with House Speaker Ryan in assembling the AHCA. However, the lack of alignment among Republican critics of the AHCA presents unique challenges for the White House and congressional Republicans to find a way forward. In crafting and embracing more common ground with moderate critics, the White House and the Republicans already on board risk alienating the more conservative base and vice versa. These internal divisions make predicting which individual coverage elements will survive very difficult. While moderate Republicans and Democrats worry about individuals losing coverage, conservative Republicans remain concerned that the AHCA does not go far enough to curb costs. Amid the dissensions, one constant remains: Supporters of the AHCA appear ready to continue to fight and vow to repeal the ACA. In the coming days, weeks, and perhaps months, we will need to continue to monitor the progress of repeal-and-replace legislation. While some clues exist, the final shape of the next healthcare reform legislation is anyone's guess. ■

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The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

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