



Quality Care Assessment (QCA) Reauthorization

State Fiscal Year (SFY)
2018/19

Agenda

- Quality Care Assessment Overview
- Reauthorization
 - Goals
 - Process
 - Results
 - Assessment
 - Payments
- Managed Care Considerations
- Next Steps
 - DHS Activities
 - Hospital Activities
- DHS Resources

Quality Care Assessment Overview

- **Legislation authorizes DHS to impose a statewide assessment**
 - Began effective July 1, 2010
 - Certain licensed Pennsylvania hospitals
 - Revenue Base – Net inpatient revenue
- **Success of the Quality Care Assessment (QCA)**
 - Nearly \$10B in MA payments for hospital services
 - \$1.3B of assessment revenue for the Commonwealth
- **Act 40 of 2018 reauthorized the QCA**
 - Effective July 1, 2018 through June 30, 2023

Reauthorization Goals

- **Support Access to Services Priority Goal**
 - Ensure access to quality hospital services for Pennsylvania MA beneficiaries
- **Goals of Reauthorization**
 - Maintain the same components that contributed to the ongoing success of the program
 - Provide new and enhanced Medical Assistance (MA) payments that are sustainable within federal limitations
 - Support quality of care through the introduction of new quality initiatives
 - Offset costs due to growth in PA's MA Program through increased state revenue

Reauthorization Process

- **DHS worked with The Hospital and Healthsystem Association of Pennsylvania (HAP) to develop an overall framework for reauthorization**
 - Hospital community's request to increase payments for outpatient hospital services
 - Hospital community's desire for financial predictability
- **Challenges**
 - Maximize the net gain for hospitals and the Commonwealth while considering the long-term sustainability of Medical Assistance payments
 - Balancing competing interests of the hospital community
 - Minimize negative impacts given the incorporation of an outpatient assessment

Reauthorization Results

- Act 40 of 2018 provides DHS with the authority to continue and modify the statewide assessment
 - All licensed Pennsylvania hospitals other than “exempt” hospitals
 - Revenue base
 - Revenue base year
 - Assessment rate(s)
 - State Revenue
 - Total Payments to Hospitals
 - Revenue Reconciliation
 - Sunset Date

Reauthorization Results

	SFY 2017/18 QCA	Act 40 of 2018
Exempt Hospitals	<ul style="list-style-type: none"> • State-owned psychiatric hospitals • Private psychiatric hospitals • Long term acute care hospitals • Federal veteran's affairs hospitals • Hospitals that do not charge for their services • Critical access hospitals • Cancer hospitals 	<ul style="list-style-type: none"> • State-owned psychiatric hospitals • Private psychiatric hospitals • Long term acute care hospitals • Federal veteran's affairs hospitals • Hospitals that do not charge for their services • Critical access hospitals • Cancer hospitals

Reauthorization Results

	SFY 2017/18 QCA	Act 40 of 2018
Revenue Base	Net Inpatient Revenue (NIR)	Net Inpatient Revenue (NIR) Net Outpatient Revenue (NOR)
Revenue Base Year	SFY 2010/11 MA-336 Cost Report	SFY 2014/15 MA-336 Cost Report
Percent of Revenue Subject to the Assessment	SFY 2017/18 <ul style="list-style-type: none"> • 3.71% of NIR 	SFY 2018/19 <ul style="list-style-type: none"> • 2.98% of NIR and • 1.55% of NOR SFY 2019/20 – SFY 2022/23 <ul style="list-style-type: none"> • 3.32% of NIR and • 1.73% of NOR

Reauthorization Results

	SFY 2017/18 QCA	Act 40 of 2018
State Savings	\$220 million	<ul style="list-style-type: none"> • \$295 million annually for SFYs 2018/19, 2019/20 & 2020/21 • \$300 million annually for SFYs 2021/22 & 2022/23
Total Payments to Hospitals	\$1.45 billion	<ul style="list-style-type: none"> • \$1.69 billion for SFY 2018/19 • \$1.91 billion (estimated) annually for SFY 2019/20 through SFY 2022/23*
Hospital Net	\$690 million	<ul style="list-style-type: none"> • \$780 million for SFY 2018/19 • \$890 million (estimated) annually for SFY 2019/20 through FY 2022/23*

* Dependent on revenue reconciliation results and Federal Medical Assistance Percentage (FMSAP) which is based on eligibility categories for MA beneficiaries

Reauthorization Results

	SFY 2017/18 QCA	Act 40 of 2018
Revenue Reconciliation	<ul style="list-style-type: none"> No revenue reconciliation reporting requirement but results provided to HAP Assessment funded payments are limited to available assessment revenue 	<ul style="list-style-type: none"> Revenue reconciliation reporting requirement Assessment funded payments are limited to available assessment revenue \$10 million trigger point for remaining balance, if any, to be used to reduce future assessment rate
Sunset Date	June 30, 2018	June 30, 2023

Reauthorization Results

SFY 2018-19 Model

- \$930M Anticipated Total Assessment Revenues
 - \$651M from inpatient hospital services
 - \$278M from outpatient hospital services
- Use of Assessment Revenues

Assessment Revenue* (State Funds)	Payment Type	Total Federalized Payment for IP & OP Hospital Services*
\$244M	FFS	\$562M
\$393M	Managed Care	\$1.13B
\$295M	FFS and/or MC	\$618M-\$776M**
\$930M	Total	\$2.3B - \$2.5B

* Rounded

**Dependent on Federal Medical Assistance Percentage (FMAP) which is based on eligibility categories for MA beneficiaries

State and Federal Sharing Overview

- Medicaid payments are funded by Federal and State dollars
- Federal Medical Assistance Percentage (FMAP) varies annually by State and eligibility category

Pennsylvania	
Beneficiary Category	FMAP
Traditional	52.25% - Federal Fiscal Year 2019
Newly Eligible*	93% - Calendar Year 2019

*FMAP for the newly eligible population will drop from 93% to 90% effective January 1, 2020

State and Federal Sharing Overview

- Slight changes in FMAP can have a significant impact
- Total funds = \$1.13 billion
 - Requires \$393 million in state funds at 65.22% FMAP
 - Requires \$404.3 million in state funds at 64.22% FMAP
 - State fund deficit = \$11.3 million
 $\$404.3 \text{ million} - \$393 \text{ million} = \$11.3 \text{ million deficit}$
- State funds = \$393 million
 - \$1.13 billion in total state and federal funds at 65.22% FMAP
 - \$1.098 billion in total state and federal funds at 64.22% FMAP
 - Decreased MA payment
 $\$1.098 \text{ billion} - \$1.13 \text{ billion} = -\32 million

Calculation of Assessment Amounts

- DHS will calculate assessment due and notify hospitals
- Example: Hospital A

	SFY 2014/15 Revenue	Rate for SFY 2018/19 Assessment Program	Assessment Due
NIR	\$55 M	2.98%	\$1,639,000
NOR	\$45 M	1.55%	\$ 697,500
Total			\$2,336,500

Assessment – Revenue Review

- Hospitals will have an opportunity to review the data used to determine both net inpatient revenue (NIR) and net outpatient revenue (NOR) amounts
 - Hospitals will receive a notice of both their NIR & NOR to be used in the calculation of the assessment amount
 - Hospitals can file a dispute during the designated review period if the hospital determines inaccurate revenue data is reflected in the notice
 - The revenue dispute period occurs prior to notice of assessment
 - *A dispute of revenue data does not delay the assessment notice or the hospital's obligation to pay the assessment amount specified in the notice*
- Changes of ownership – handled on a case-by-case basis in accordance with state legislation

Assessment – Revenue Review

- PROMISe™ Portal
 - One revenue amount reflecting combined NIR & NOR
 - Dispute must be specified as NIR and/or NOR
 - Assessment percent displayed reflects hospital-specific mix of NIR & NOR
- Examples: Hospital A and Hospital B

		Hospital A		Hospital B	
	Assessment Percent	Revenue Base	Assessment Due	Revenue Base	Assessment Due
NIR	2.98%	\$55 M	\$1,639,000	\$100 M	\$2,980,000
NOR	1.55%	\$45 M	\$697,500	\$100 M	\$1,550,000
Total		\$100 M	\$2,336,500	\$200 M	\$4,530,000
Effective Assessment Percentage		2.34%		2.27%	

Assessment – Hospital A Letter



PA Statewide Quality Care Assessment

SFY 2018-2019

On July 1, 2018, the Human Services Code (the Code) was amended by Act 40 of 2018 to continue the Statewide Quality Care Assessment (Assessment). Under the Code, certain licensed hospitals in the Commonwealth must pay an annual monetary assessment in each state fiscal year for the five-year period beginning July 1, 2018 and ending June 30, 2023. 62 P.S. §§ 801-G—816-G. Your hospital has been identified as a covered hospital subject to the Assessment.

For State Fiscal Year (SFY) 2018-2019, the monetary assessment equals 2.98% of a covered hospital's Net Inpatient Revenue (NIR) and 1.55% of a covered hospital's Net Outpatient Revenue (NOR). 62 P.S. §§ 803-G(b)(4). A covered hospital must pay its annual obligation in quarterly installments. 62 P.S. § 804-G. A quarterly installment is due on or before the first day of the second month of each quarter or thirty (30) days from the date of the notice of the quarterly assessment obligation, whichever is later. 62 P.S. § 804-G(b). Your hospital will receive quarterly billing statements as each quarterly installment obligation is due. Billing statements will specify the due date of quarterly payments and other account details specific to your hospital.

The Department established the NIR and NOR for determining your hospital's assessment. The combined NIR and NOR amount will be displayed in the PROMISE™ dispute window as "NIR", along with the hospital's specific combined assessment percentage.

Net Inpatient Revenue	\$55,000,000.00 NIR
Net Outpatient Revenue	<u>45,000,000.00 NOR</u>
Total Combined NIR/NOR (displayed as NIR in PROMISE™)	<u>\$100,000,000.00</u>
Hospital Assessment Percentage (displayed as NIR in PROMISE™)	2.34%

If your hospital submitted SFY 2014-2015 Medical Assistance 336 Cost Report (MA-336 Cost Report), the Department used the information contained on Schedule 5-6, Column 1, Line 5-NIR and Column 2 Line 5-NOR of the MA-336 Cost Report to determine your hospital's combined NIR/NOR amount.

If your hospital did not submit a SFY 2014-2015 MA-336 Cost Report, the Department used the most recent data reported and attested to by your hospital financial officer(s) in determining your combined NIR/NOR amount.

If your hospital is a new hospital which opened in SFY ending in 2016, 2017, or 2018, and your hospital has submitted an MA-336 Cost Report, the Department used the information contained on Schedule 5-6, Columns 1 and 2, Line 5 of your hospital's latest MA-336 Cost Report to determine your hospital's

Assessment – Hospital B Letter



PA Statewide Quality Care Assessment

SFY 2018-2019

On July 1, 2018, the Human Services Code (the Code) was amended by Act 40 of 2018 to continue the Statewide Quality Care Assessment (Assessment). Under the Code, certain licensed hospitals in the Commonwealth must pay an annual monetary assessment in each state fiscal year for the five-year period beginning July 1, 2018 and ending June 30, 2023. 62 P.S. §§ 801-G–816-G. Your hospital has been identified as a covered hospital subject to the Assessment.

For State Fiscal Year (SFY) 2018-2019, the monetary assessment equals 2.98% of a covered hospital's Net Inpatient Revenue (NIR) and 1.55% of a covered hospital's Net Outpatient Revenue (NOR). 62 P.S. §§ 803-G(b)(4). A covered hospital must pay its annual obligation in quarterly installments. 62 P.S. § 804-G. A quarterly installment is due on or before the first day of the second month of each quarter or thirty (30) days from the date of the notice of the quarterly assessment obligation, whichever is later. 62 P.S. § 804-G(b). Your hospital will receive quarterly billing statements as each quarterly installment obligation is due. Billing statements will specify the due date of quarterly payments and other account details specific to your hospital.

The Department established the NIR and NOR for determining your hospital's assessment. The combined NIR and NOR amount will be displayed in the PROMISE™ dispute window as "NIR", along with the hospital's specific combined assessment percentage.

Net Inpatient Revenue	\$100,000,000.00 NIR
Net Outpatient Revenue	<u>100,000,000.00 NOR</u>
Total Combined NIR/NOR <small>(displayed as NIR in PROMISE™)</small>	<u>\$200,000,000.00</u>
Hospital Assessment Percentage <small>(displayed as NIR in PROMISE™)</small>	2.27%

If your hospital submitted SFY 2014-2015 Medical Assistance 336 Cost Report (MA-336 Cost Report), the Department used the information contained on Schedule 5-6, Column 1, Line 5-NIR and Column 2 Line 5-NOR of the MA-336 Cost Report to determine your hospital's combined NIR/NOR amount.

If your hospital did not submit a SFY 2014-2015 MA-336 Cost Report, the Department used the most recent data reported and attested to by your hospital financial officer(s) in determining your combined NIR/NOR amount.

If your hospital is a new hospital which opened in SFY ending in 2016, 2017, or 2018, and your hospital has submitted an MA-336 Cost Report, the Department used the information contained on Schedule 5-6, Columns 1 and 2, Line 5 of your hospital's latest MA-336 Cost Report to determine your hospital's

Reauthorization – Current Payments

- FFS MA payments to hospitals for inpatient and outpatient services*
 - APR-DRG claim payments
 - MA Stability
 - MA Rehab Adjustment
 - Small and sole community hospital
 - Enhanced payment to certain DSH hospitals
 - Inpatient DSH, Outpatient supplemental, Medical Education & Community Access Fund (CAF) restoration payments
 - Inpatient DSH & Medical Education adjustment payments
 - OB/NICU DSH
 - Critical Access Hospital (CAH) DSH
 - Observation

*Many of these payments are fully funded by assessment revenue, while others are funded by a combination of assessment and general fund revenue.

Reauthorization – Current Payments

- Increased capitation payments to MA managed care organizations for inpatient and outpatient hospital services
 - Increased capitation for inpatient hospital services related to APR-DRG via Appendix 14
 - Increased capitation – Heritage & Expansion APR-DRG
 - Increased amount in capitation for observation services
 - Hospital Quality Incentive Program (HQIP) - Potentially Preventable Admissions

Reauthorization – New and Increased Payments

- FFS Payments
 - High-Medicaid Graduate Medical Education
 - MA Dependency Adjustment
- Designed to recognize and encourage hospitals serving a high volume or percent of MA beneficiaries
- Upcoming intent public notice
 - Eligibility criteria
 - Payment distribution methodology
- To be effective beginning SFY 2018/19

Reauthorization – New and Increased Payments

- Managed Care Payments*
 - Increased capitation for outpatient hospital services
 - HQIP
 - Addition of Opioid Use Disorder (OUD) incentive

* These payments are based on Medicaid enrollment and do not reflect enrollment for any commercial, Medicare or other payers.

Reauthorization – New and Increased Payments

- Establishing Appendix 17 to provide increased capitation for outpatient hospital services
 - Developed to address the hospital community’s request for increased outpatient hospital service payments
 - To be effective January 1, 2019
 - DHS does not set the payment distribution methodology to hospitals
 - DHS will require each MCO to demonstrate that all additional capitation funding has been expended on outpatient hospital services
 - CMS approval is required prior to increase

Managed Care Considerations - Timeline

- CY 2019 Physical HealthChoices Rate Setting



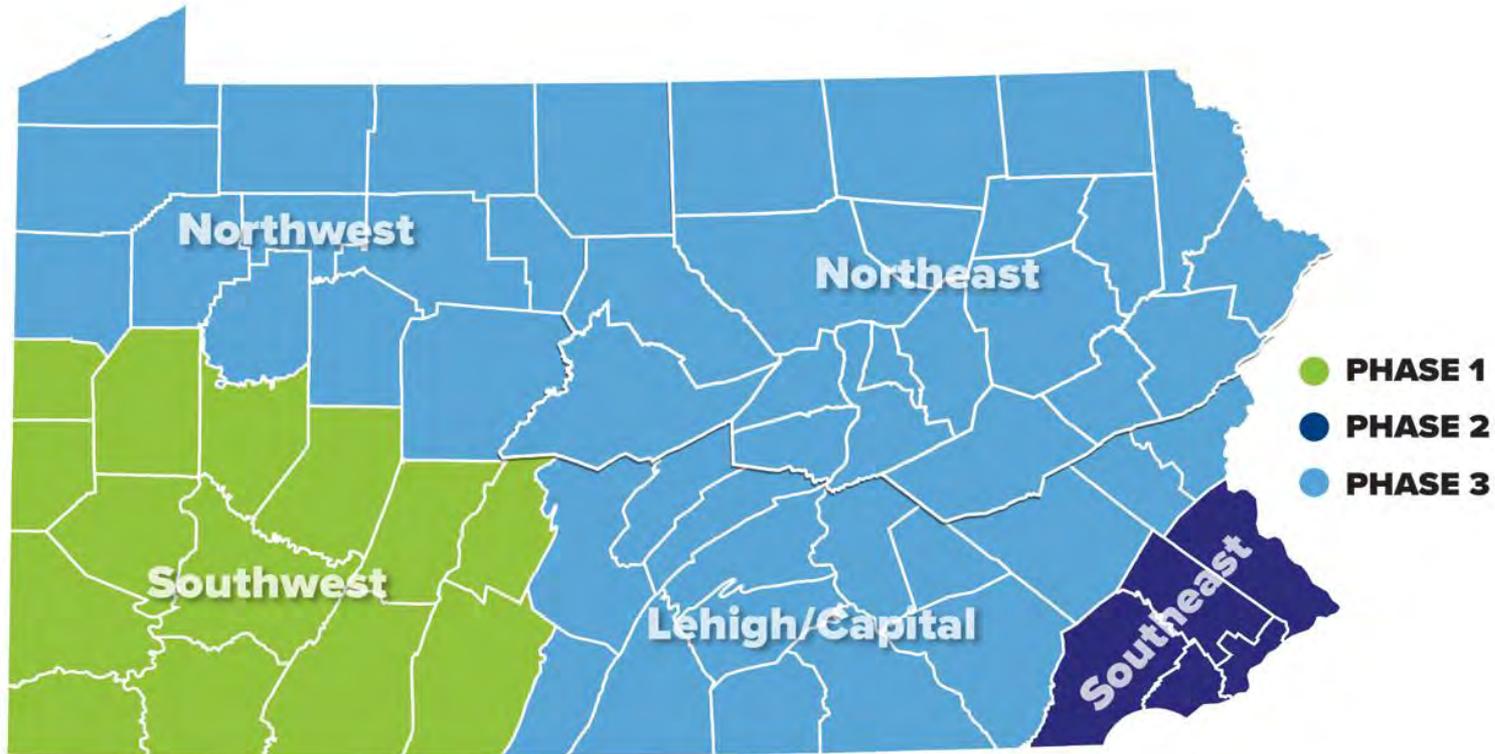
- CY 2019 Physical HealthChoices Agreement Execution



Managed Care Considerations

- Transition to Managed Care for Community Health Choices (CHC) Participants
- Who Is Impacted:
 - Dual eligible individuals in FFS and Physical Health Choices and waivers administered by the Office of Long Term Living will transition to CHC
 - This impacts the hospital claim submission and payment process for this population

Managed Care Considerations



CHC Plans:
AmeriHealth Caritas/Keystone First
PA Health & Wellness
UPMC Community HealthChoices

Phase Effective Dates:
Phase 1 was effective January 1, 2018
Phase 2 is effective January 1, 2019
Phase 3 is effective January 1, 2020



3

Managed Care Considerations

- Claims for current Physical HealthChoices dual eligible consumers will transition from Physical HealthChoices to Community HealthChoices
- Medicare cost sharing claims for all other CHC participants current dual eligible nursing facility residents, older adults receiving waiver services (Aging Waiver), and all other dual eligible who are paid through FFS will be paid by a CHC-MCO
- CHC rates consider current hospital costs paid by FFS and Physical HealthChoices including increases from implementing APR-DRG payments funded by the hospital assessment

Next Steps – DHS Activities

- DHS is pursuing required CMS Approvals
 - Broad-based waiver for assessment on outpatient hospital services
 - State Plan Amendments for several MA FFS payments
 - DHS/MCO agreements
- DHS Communication with Hospital Community
 - Dispute window
 - Annual assessment notice
 - Quarterly invoices
 - Remittance Advice (RA) statements
 - Website

Next Steps – Hospital Activities

- Review NIR & NOR via online portal
- Tentative assessment invoice and due dates

Quarter	Tentative Invoice Date	Tentative Due Date
1	November 19, 2018	December 19, 2018
2	January 28, 2019	February 27, 2019
3	April 1, 2019	May 1, 2019
4	May 6, 2019	June 6, 2019

- Review remittance advice statements for FFS claim, DSH and supplemental payments
- Collaborate with managed care plans
- Review DHS website to stay informed

DHS Resources and Contact Information

- **DHS Assessment Website**

<http://www.dhs.pa.gov/provider/hospitalassessmentinitiative/>

- **Contacts**

Hospital Assessment Questions (Database Access, Notices/Letters, Calculation of Revenue, Submitted Assessment Payments, Disputes)	ra-pwhai@pa.gov
PROMISe™ Questions (Mass Adjustments, Fee Schedules, Billing Guides)	1-800-537-8862 Hours M-F 8 a.m. – 4:30 p.m.
APR-DRG Grouper Questions (3M HIS Support)	1-800-435-7776
Disproportionate Share Payments/Supplemental Payment Questions	ra-pwdshpymt@pa.gov
Hospital Quality Incentive Program	RA-PWPQUALINCEN@pa.gov
Community HealthChoices (CHC)	RA-PWCHC@pa.gov