MHA
Michigan Health & Hospital Association

Leading Healthcare

Great Lakes HFMA Chapter
Sept. 28, 2018

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FY 2019 Medicare IPPS Final Rule

- When all policy changes are considered, Michigan IPPS payments are estimated to increase by $114m, or 2.6%
- Post-acute care transfer policy applies to patients transferred to hospice; will reduce Michigan IPPS payments by $18m
- Includes a net 1.4% operating and 1.3% capital rate increase
- 3% decrease in cost outlier threshold from $26,537 to $25,769
- Number of MS-DRGs increasing from 754 to 761
  - Relative weight changes for many, generally less than 5% up or down
- CMS continuing its transition to use S-10 data to allocate uncompensated care DSH pool payments
- MHA distributed hospital-specific impacts reports Aug. 21

Continued, FY 2019 Medicare IPPS Final Rule

- 39 measures removed from inpatient quality reporting program
- No major changes finalized for Medicare quality-based programs (VBP, RRP, HAC)
- Changes include:
  - Continuation of four domains for VBP program weighted at 25% each
  - Implementation of the socio demographic status (SDS) adjustment for the RRP (previously finalized)
  - Elimination of program domains with the 6 measures in the HAC reduction program weighted equally

Low-volume Adjustment Criteria

- Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments
- Budget Act of 2018 extended the less stringent criteria until Sept. 30, 2022, and modified criteria for FY 2019 - FY 2022
  - FY 2011 - FY 2018 Criteria: 15 miles/<1,600 **Medicare** discharges
  - FY 2019 - FY 2022 Criteria: 15 miles/<3,800 **total** discharges
- Sept. 1 was deadline for FY 2019 payment adjustment
  - For requests received after Sept. 1, the payment adjustment will be applied prospectively within 30 days of the determination

Medicare Dependent Hospitals (MDH)

- Bipartisan Budget Act of 2018 also extended program to Sept. 30, 2022

Medicare Part A Hospital I/P Admission Orders Documentation

- Existing policy requires that the medical record include a written hospital inpatient admission order as a condition for Medicare Part A payment
- Effective for admissions on and after Oct. 1, 2018, CMS does not require written inpatient admission orders in the medical record as a condition of payment
  - Does not change the requirement that a patient must meet inpatient admission criteria
    - Goal is to reduce technical denials due to missing admission order

Online Posting of Hospital Charges

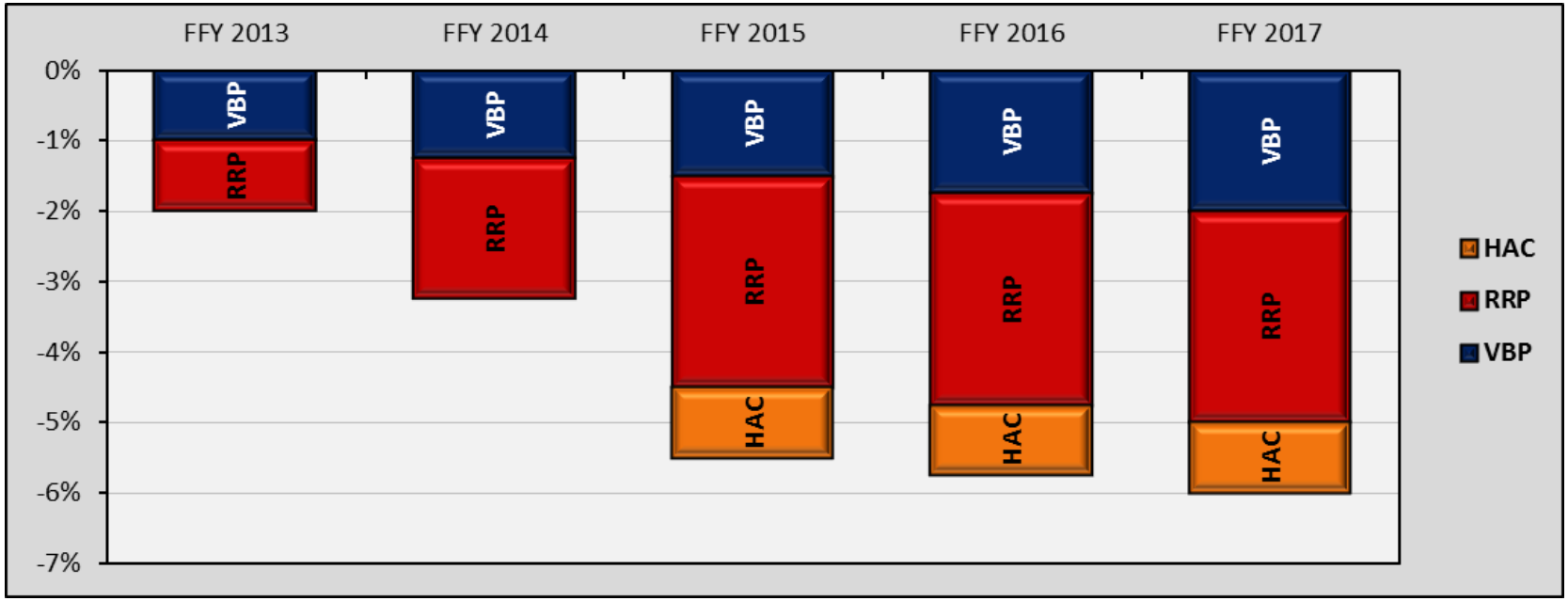
- Effective Jan. 1, 2019, the CMS will require hospitals to make a list of their current standard charges available via the internet in a machine-readable format
- Requires annual updates, or more often as appropriate
- Hospital could release its charge master or another form of the hospital's choice in a machine-readable format
- Applies to all hospitals, including critical access hospitals

Preservation of GME Resident Caps

- In IPPS final rule, CMS notified hospitals of the closure of Memorial Hospital of Rhode Island
  - IME Resident Cap – 73.66
  - GME Resident Cap – 72.62
- Hospitals can apply for and receive slots from the closed hospital
- **Hospitals must submit applications directly to the CMS Central Office no later than Oct. 31, 2018**
- Section 5506 Application Form is available at:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html.

Quality Program - General Themes

- Increased financial exposure each year (max exposure shown below)



HAC = Hospital Acquired Condition (HAC) Reduction Program; RRP = Readmission Reduction Program; VBP = Value-based Purchasing Program

Continuation of 2% Sequestration Cut

- Mandated by Budget Control Act of 2011
- Bipartisan Budget Act of 2018 extended two additional years, through 2027
- Not applied to the Medicare payment rate
  - Reduces IPPS FFS payments to Michigan hospitals by approximately $90M annually
- 2% cut is applied to Medicare claims **after** determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments
- Also applies to other Medicare payments, including GME, bad debts, EHR incentive payments

2019 Medicare OPPS Proposed Rule

- Proposal includes a 1.16% OPPS rate update
- Payment for **all clinic visits** (G0463) provided at off-campus hospital outpatient departments at 40% of OPPS rate regardless of grandfathered status
- CMS proposes to extend the 340B drug payment adjustment to non-grandfathered HOPDs
- Changes to the inpatient only list
  - Removal of CPT code 31231 Nasal/sinus endoscopy and CPT code 01402 – Anesthesia for open or surgical arthroscopic procedures on knee joint
  - Addition of HCPCS code C9606 – Percutaneous transluminal revascularization

Cont., 2019 Medicare OPPS Proposed Rule

- An 11% increase in the cost outlier threshold from $4,150 to $4,600
- Comments due to CMS Sept. 24
- MHA will provide an updated hospital-specific impact analysis following release of final rule expected by Nov. 1 for the Jan. 1, 2019 effective date

2019 Physician Fee Schedule Proposed Rule

- Proposes to increase PFS payments by 0.13% resulting in a conversion factor of $36.0463, up from $35.9996.
- Proposal to collapse payment rates for level two through five Evaluation/Management (E/M) visits into a single rate for new patients and another for established patients
- Proposes to recognize the use of communication technology for remote provider-patient check-ins and remote evaluation of “store and forward” videos or images

Continued, 2019 PFS Proposed Rule

- Would continue to pay for non-grandfathered services in certain off-campus hospital outpatient departments at 40% of the OPPS amount
- Would reduce payment for new Part B drugs from 106% of wholesale acquisition cost (WAC) to 103% until new average sales price data are available
- Final rule expected by Nov. 1, for Jan.1 effective date

340B Cuts Implemented in 2018

- 2018 OPPS final rule cut payments for non pass-through drugs provided through the 340B program
- These drugs now paid at average sales price (ASP) less 22.5 percent instead of ASP plus 6 percent
- Nationally, this change cut OPPS payments by $1.6 billion with Michigan impact estimated $73 million cut
- Rule included a 3.2 percent positive budget neutrality adjustment to OPPS rate for non-drug services

Continued, 340B Cuts

- Sept 5, the AHA, AAMC, America's Essential Hospitals and three hospital plaintiffs refiled a lawsuit in federal district court seeking expedited relief from the 340B cuts
- Lawsuit argues that the 340B provisions of the CMS 2018 OPPS final rule violate the Administrative Procedure Act and exceed the CMS' statutory authority

Skilled Nursing Facility Final Rule

- Oct. 1, 2018 – value based purchasing (VBP) program takes effect – estimated to reduce payments to Michigan hospital-based SNFs by $185k
- FY 2019 final rule expected to increase payments to Michigan hospital-based SNFs by $390k
- Oct. 1, 2019, CMS implementing a new patient classification system to replace the current Resource Utilization Group (RUG-IV) system with the Patient Driven Payment Model (PDPM)
  - Estimated to increase payments to Michigan hospital-based SNFs by $4M

Continued, Other Post Acute Care Final Rules

- IPF & IRF – no major changes adopted
  - Michigan IPF payments est. to increase $1.2m
  - Michigan IRF payments estimated to increase $2.1m
- LTCH – FY 2019 final rule permanently removed the "25% threshold"; site-neutral blended rate continues in FY 2019
  - Michigan LTCH payment estimated to increase $891k
- CMS finalized the removal of some measures from quality reporting program for all settings

2019 Home Health Proposed Rule

- CMS proposes to change the HH unit of payment from 60 days to 30 days effective Jan. 1, 2020
- CMS also proposed a new case-mix adjustment methodology, the Patient-Driven Grouping Model (PDGM) to replace the current Home Health Resource Groups (HHRGs)
  - Estimated to increase Michigan hospital-based HH payments by $2.1m
- No major changes proposed for 2019; estimated to increase payments to Michigan hospital-based HHs by $2.6m
- Final rule by Nov. 1, for Jan. 1, 2018 effective date

Medicare Advantage Plans

- As of July 2018, 33 plans operating in Michigan, with 810,000 or approximately 40% of Michigan's 2 million Medicare beneficiaries enrolled
  - Enrollment up 4,000 since March
  - Up to 20 plans in some counties
- Review MA payment rate for all plans
- CAH entitled to Medicare cost reimbursement
- Each MA plan may determine own utilization model and is not required to maintain electronic transactions
- Many MA plans have instituted "RAC-like" utilization programs
- Matrix of MA plans by county available at MHA website – updated quarterly, with MHA Monday Report article

Healthy Michigan Plan Enrollment

- As of September, 2018
  - 670,000 Enrolled
  - 83 counties
  - Breakdown of Beneficiaries
    - 49% Female 51% Male
    - 25-34 Age Range has the most (181,000)
    - 19-24, 35-44, 45-54, 55-64 all between 112,000 and 129,000

2018 Election

- Governor – Open
- Attorney General – Open
- Secretary of State – Open
- Michigan Supreme Court - 2 seats (Clement, Wilder)
- US Senate – Debbie Stabenow up for reelection
- US House of Representatives – 14 MI seats (9 R, 5 D)
  - Three open seats: Conyers (13th), Levin (9th), Trott (11th)
- MI House of Representatives – 110 seats (63 R, 47D)
- MI Senate – 38 seats (27 R, 11 D)

2018 Election – State Legislature

- House of Representatives – 110 seats
  - 43 open seats
  - Democrats need to flip 9 seats for majority
  - New leadership on both sides of the aisle
- Senate – 38 seats
  - 27 open seats
  - Democrats need to flip 8 seats for majority
  - New Senate Majority Leader will be elected

FY 2018 Rural & OB Stabilization Pool Payments

- MSA distributed $5m in fee-for-service rural access pool payments quarterly
- MSA distributed $10.8m in GF-only RAP payments on Feb. 22, 2018
- As a result of MHA advocacy efforts, FY 2018 supplemental budget included $7m in additional funding for these pools
  - MSA distributed $4.2m in RAP payments and $2.8m in OB payments on Aug. 24

FY 2019 Rural & OB Stabilization Pool Payments

- Budget includes an additional $10m which MSA intends to distribute in late Q1 or early Q2
- Total payments:
  - Rural Access Pool $18 m
  - OB Stabilization Pool $ 8 m
- MSA will update data source for these payment allocations to use FY 2017 data

FY 2018 HRA Payments

- FY 2018 HRA payments are based on managed care encounter data accepted by MSA each quarter and provide:
  - 70% add-on for inpatient services
  - 87.3% add-on for outpatient services
- Q1 payments $408m
- Q2 payments $418m
- Q3 payments $411m
- FY 2019 will provide same percentage add-on
- Hospital payments will vary based on Medicaid managed care services provided

FY 2019 Psych HRA Payments

- 2016 CMS managed care final rule requires changes to Psych HRA program or phase-out over 10 years
- MDHHS recently submitted their proposed plan to CMS for approval
- Proposed plan would provide a $308 per-diem add-on for each Medicaid and Healthy Michigan Plan inpatient psych day based on accepted encounters from the PIHP for each quarter
  - $308 per-diem add-on subject to change in final plan
- Hospitals encouraged to confirm that the national provider identifier (NPI) used to bill inpatient psych services is enrolled in CHAMPS

FY 2019 Updates

- MSA will use data from hospital cost reports ending during state FY 2017 to update the hospital quality assurance assessment program (QAAP) tax base
- MSA will determine FY 2019 Medicaid Access to Care Initiative (MACI) pool payments amounts using FY 2017 fee-for-service paid claims data
- MSA will update hospital-specific inpatient operating and capital rates effective Oct. 1, 2018
- MSA will also update APR-DRG relative weights effective Oct. 1, 2018

MSA Final Policy - LARCs

- MSA released final policy 18-22 to provide hospital payment for long acting reversible contraception (LARC) implants and IUDs provided in the I/P setting immediately postpartum effective Oct. 1, 2018
  - Payment separate from maternity DRG payment
- Hospital must submit a separate professional claim with place of service 21 – Inpatient Hospital including the hospital as the billing provider and the practitioner performing the related procedure as the rendering provider

Continued, MSA Final Policy - LARCs

- Provider must use the appropriate Healthcare Common Procedure Coding System (HCPCS) Level II procedure code and National Drug Code (NDC)
- Payment rates will be made in accordance with the Practitioner Medicaid fee schedule in effect on the date of service for the procedure code billed
  - Current rates range from $723 to $910
- 340B hospitals are required to continue to bill 340B actual acquisition cost for the LARCs
  - Drugs/devices obtained through the 340B program must be indicated on the claim using the U6 modifier

MSA Final Policy – 340B Final Settlement Process

- Policy establishes a hospital final settlement adjustment process to uniformly quantify hospital outpatient drug costs
- Existing MSA policy requires that 340B hospitals bill Medicaid its actual acquisition cost
- Hospitals that participate in the Medicaid fee-for-service 340B program will have the option to have their 340 drug costs adjusted from actual acquisition cost to charges for purposes of the upper payment limit calculation
  - Policy does not impact or require additional action for providers that do not participate in the Medicaid FFS program

MSA Data Request – FY 2017 HRA Payments

- MSA request posted via file transfer site requesting that hospitals provide the following data by Oct.1:
  - HRA payments
  - Healthy Michigan Plan HRA payments
  - Psych HRA payments
- To assist hospitals in providing this data, MHA distributed FY 2017 payment summary on Sept. 7

MHA Board CAH Medicaid Funding Task Force

- Core issue: critical access hospital Medicaid payments approximate 75% of cost while the remaining hospitals receive payments totaling approximately 95% of cost
- A key component to achieve a Medicaid payment increase is to identify a funding source through one of two mechanisms:
  - state general funds or
  - an increase in the hospital QAAP tax that would provide additional state retention

Cont., Board CAH Medicaid Funding Task Force

- After consideration, the Board passed a motion to support advocating for an increase in general funds in the FY 2020 budget, in conjunction with a longer-term plan, to support Medicaid payments for critical access hospitals commensurate with payment levels for other rural and urban hospitals.
- While this will not provide additional funding immediately, it is a plan to increase state general funds for CAHs.

DSH Payments

- Aug. 21 - MSA released FY 2018 Step 1 DSH data for hospital review with hospitals having until Aug. 31 to notify MSA if they opt to reduce their DSH limit
- MSA will distribute $45 m in regular DSH and $145 m in QAAP tax-funded DSH payments by Sept. 30
  - QAAP tax invoices also distributed
- FY 2015 preliminary audit report due to MSA Sept. 30, with final report due to CMS Dec. 31, 2018
- FY 2019 DSH eligibility forms due to MSA Oct. 1
  - Failure to return completed form will result in forfeiture of FY 2019 DSH payments

Medicaid Work Requirements

- Senate Bill 897 (Sen. Shirkey)
- After quick Senate passage, Governor signals major concerns with the bill
  - House states intent to wait for Governor to sign-off on bill prior to additional movement
- Ultimately Governor signed legislation much different from the original in June

Continued, Medicaid Work Requirements

- Apparent fairly early on that the only two elected officials who were concerned about the details of the bill were Gov. Snyder & Sen. Shirkey
- Four MHA Board members met directly w/Gov. Snyder Apr. 26
- MHA & Gov. have very similar concerns regarding the policy
  - Gov. believes if he didn't come to some agreement while still in office, future of HMP in jeopardy
  - Agreed to continue to work together to find solutions to mitigate the unnecessary loss in coverage to Medicaid recipients
  - Gov. took our concerns into his negotiations on SB 897 with Shirkey

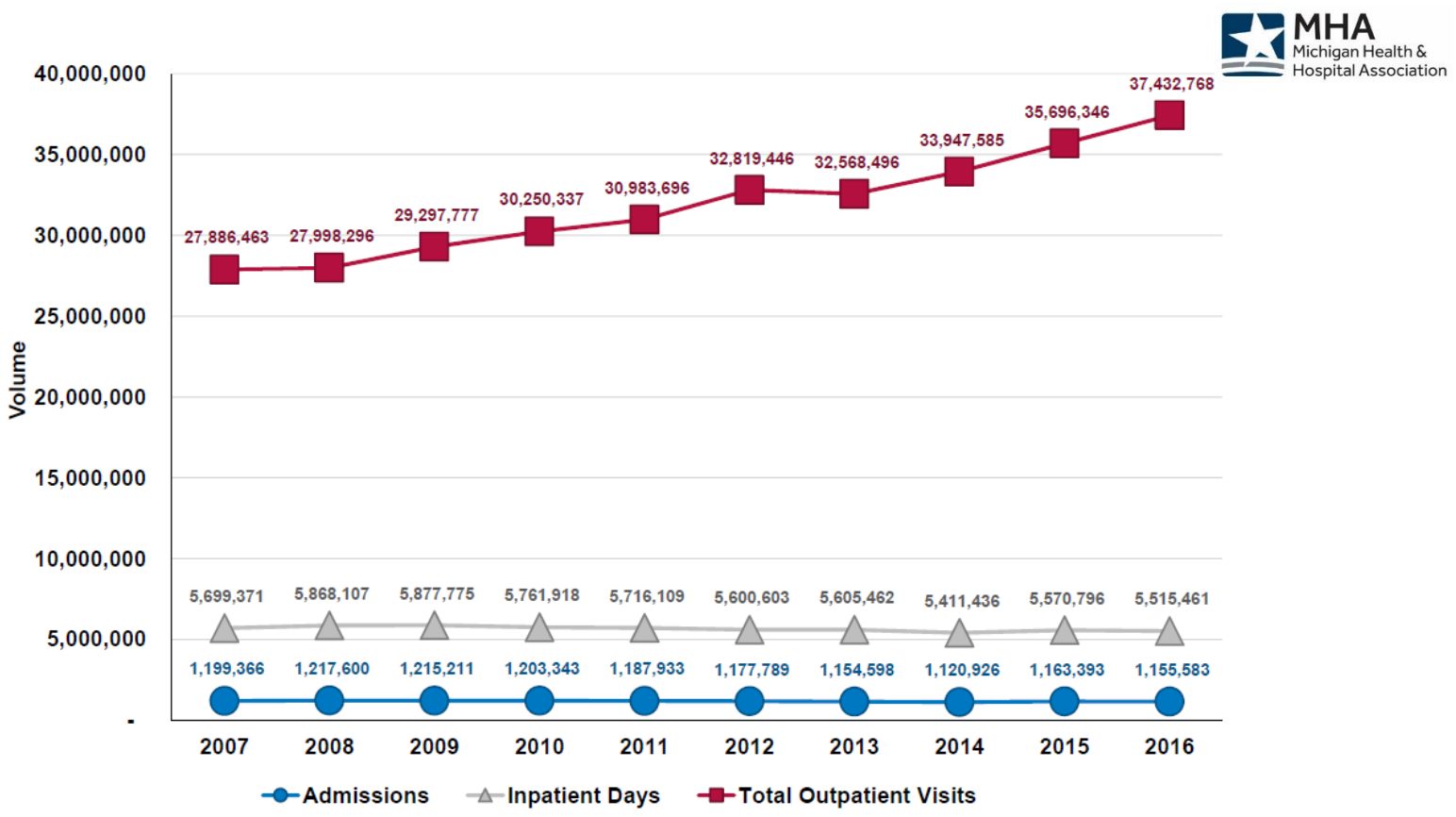
Medicaid Work Requirements – Key Changes

- Medicaid population subject to work requirement reduced to only HMP enrollees
- Hours required to comply was reduced from 29 to 20 per week
- Penalty for simple noncompliance reduced to 1 month
- Key exemptions added:
  - 3 months per year grace period
  - 3 months can be satisfied by volunteer work
- No lifetime limits on HMP enrollees, but have to contribute 5% of annual income after 48 mos to continue to receive benefit

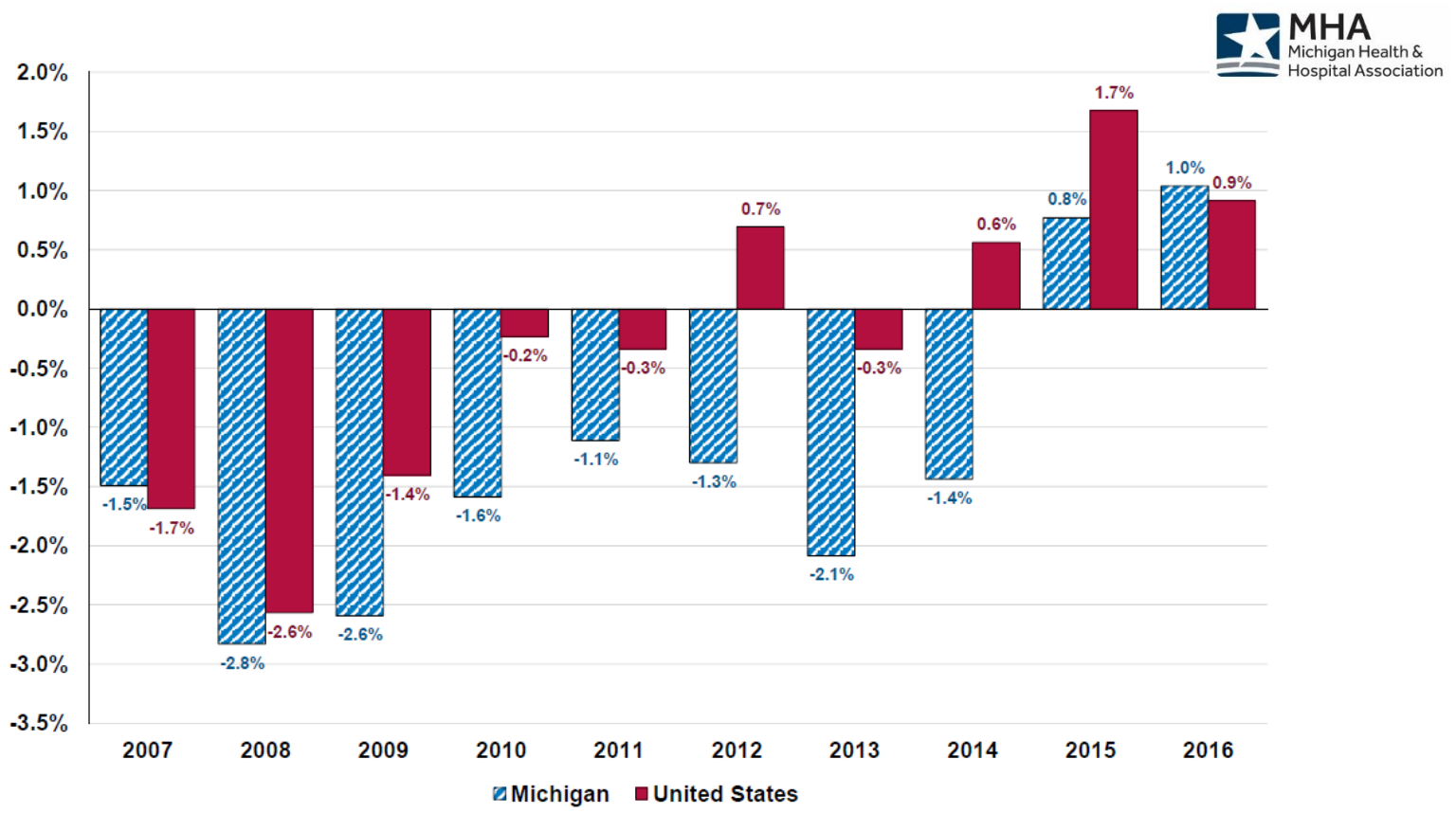
BCBSM

- BCBSM will re-engage hospital CEO/CFO group for peer group 5 hospitals
  - Timing to be determined

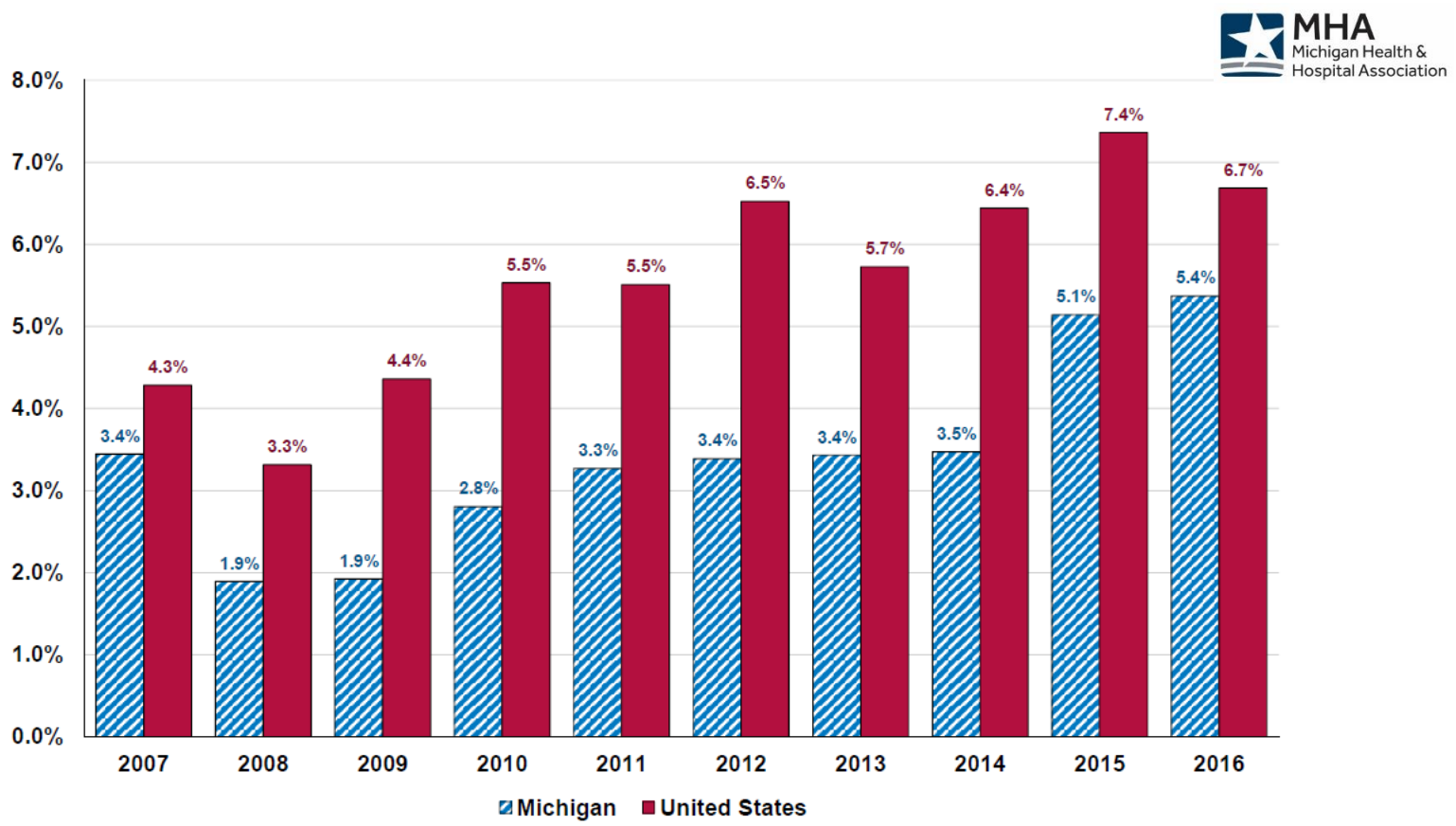
Michigan Patient Volumes (2007-2016)



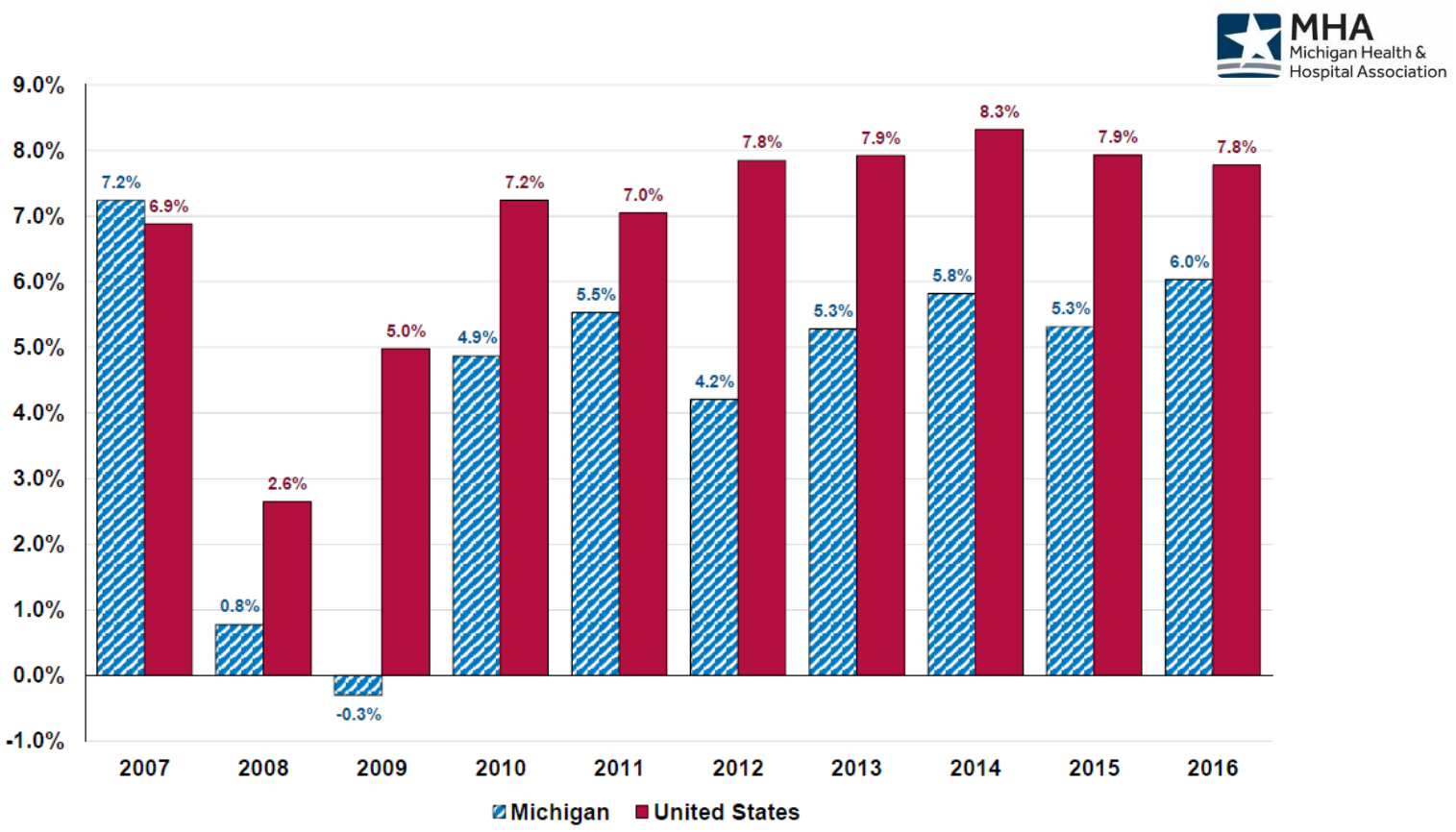
Michigan and United States Patient Margin (2007-2016)



Michigan and United States Operating Margin (2007-2016)



Michigan and United States Total Margin (2007-2016)

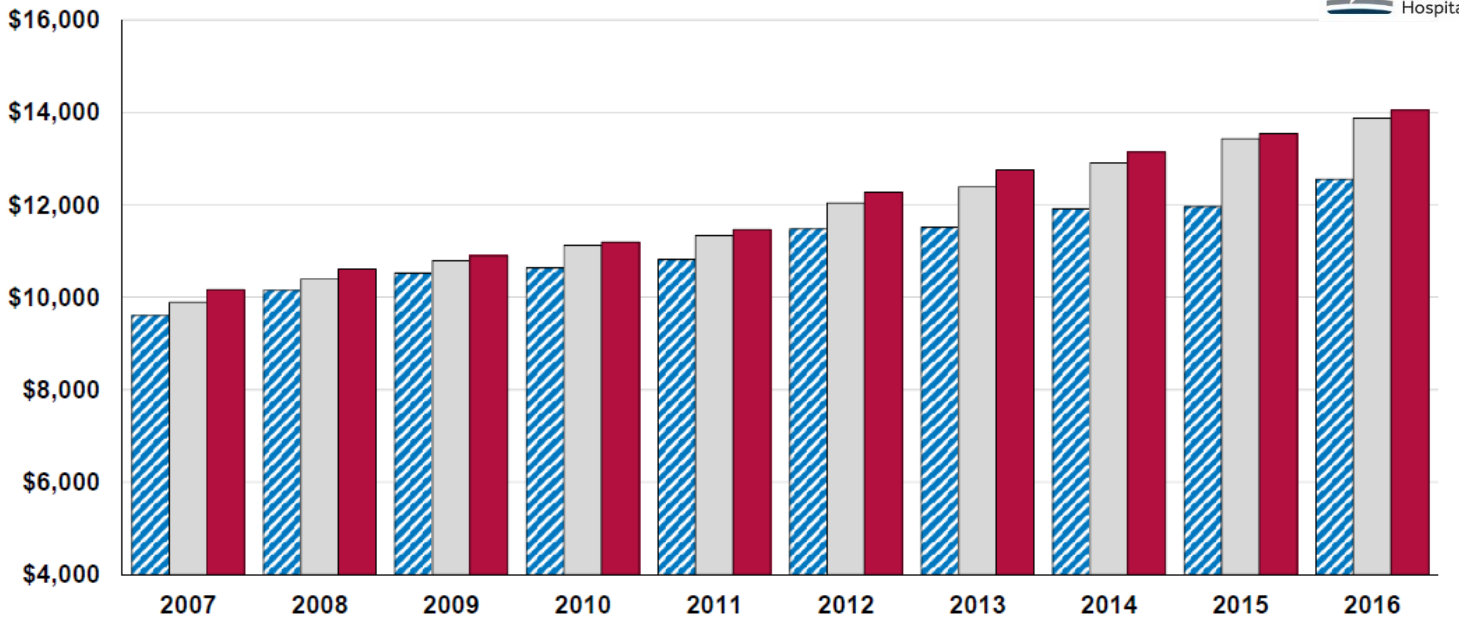


Cost per Equivalent Discharge

	2007	2016
Michigan	$9,604	$12,554
vs Great Lakes average	-3.0%	-10.5%
vs US average	-5.8%	-11.9%

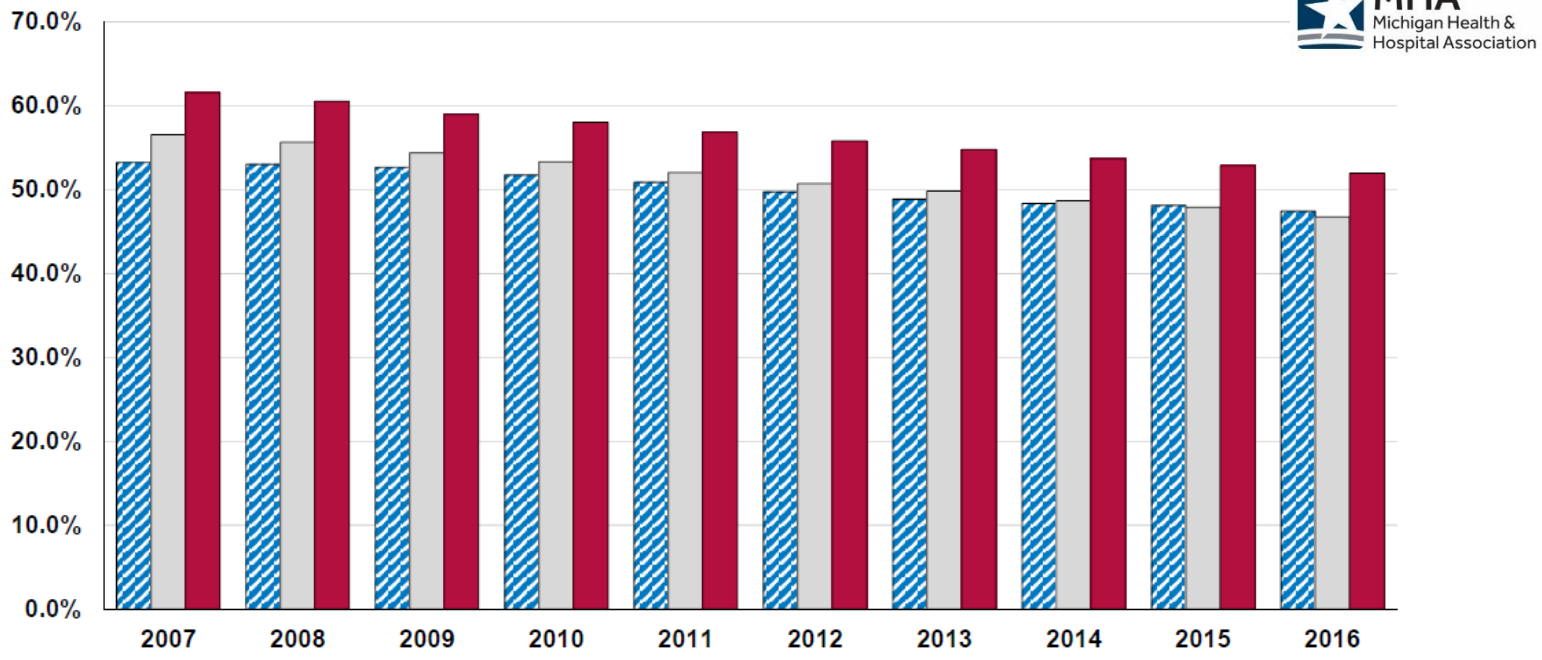
Despite a 31% increase in cost during 2007-2016 Michigan's cost per equivalent discharge remains below the Great Lakes and US average

Michigan, Great Lakes and United States Cost per Equivalent Inpatient Admission (2007-2016)



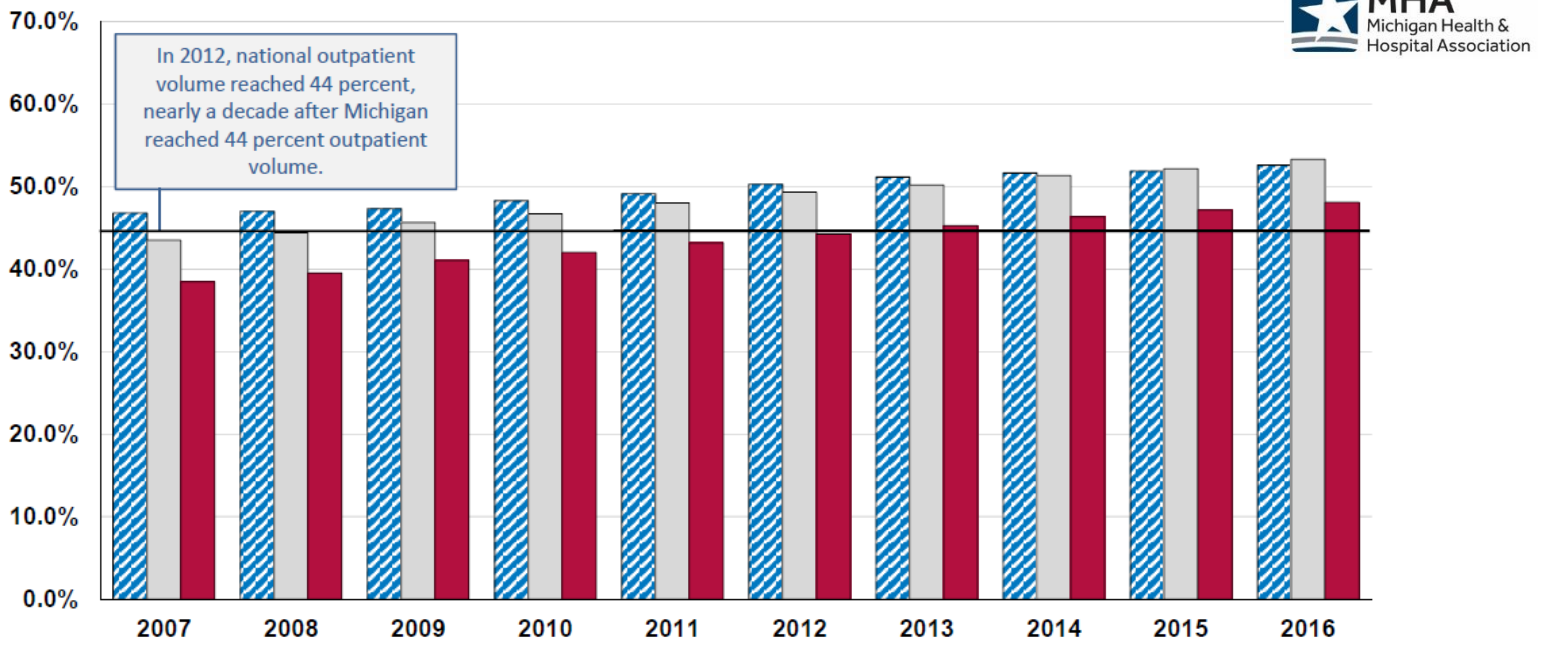
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Ten-Yr % Change
MI	9,604	10,149	10,525	10,636	10,819	11,478	11,512	11,918	11,959	12,554	30.7%
GL avg.	9,890	10,391	10,790	11,119	11,336	12,039	12,390	12,911	13,424	13,873	40.3%
US	10,163	10,608	10,899	11,190	11,463	12,272	12,751	13,145	13,541	14,044	38.2%

Michigan, Great Lakes and United States Inpatient Volume (2007-2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Ten-Yr % Change
MI	53.2%	53.0%	52.7%	51.7%	50.9%	49.7%	48.9%	48.4%	48.1%	47.4%	-10.9%
GL avg.	56.5%	55.6%	54.4%	53.3%	52.0%	50.7%	49.8%	48.7%	47.9%	46.7%	-17.3%
US	61.6%	60.5%	59.0%	58.0%	56.8%	55.8%	54.7%	53.7%	52.9%	51.9%	-15.6%

Michigan, Great Lakes and United States Outpatient Volume (2007-2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Ten-Yr % Change
MI	46.8%	47.0%	47.3%	48.3%	49.1%	50.3%	51.1%	51.6%	51.9%	52.6%	12.4%
GL avg.	43.5%	44.4%	45.6%	46.7%	48.0%	49.3%	50.2%	51.3%	52.1%	53.3%	22.5%
US	38.4%	39.5%	41.0%	42.0%	43.2%	44.2%	45.3%	46.3%	47.1%	48.1%	25.0%

MHA Monthly Financial Survey (MFS)

- Provides free benchmarking of hospital financial and utilization results
- Some Michigan hospitals have participated since 1999
- Approximately 500 hospitals in 14 states participate nationally
- Full participation endorsed by MHA board at its February 2016 meeting

MFS, Continued

- Benefits of hospital use:
  - Timely data for Michigan and national benchmarking of hospital financial and utilization results
    - Useful to hospital administration for budgeting, marketing, and internal management
  - Hospitals can obtain reports for any time period for which they've submitted data
  - Ability to review volume and other trends at other hospitals in Michigan and US.
  - Peer group benchmarking to specific hospitals
    - Requires minimum of five hospitals

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