Great Lakes HFMA Chapter
Feb. 16, 2018

Kellen Teel

Manager, Health Finance

Who is the MHA?

- **Mission**: *We advance the health of individuals and communities.*
- **Vision**: *Through our leadership and support of hospitals, health systems and the full care continuum, we are committed to achieving better care for individuals, better health for populations and lower per-capita costs.*

Topics

- New MHA Transparency Website
- Medicare OPPS Final Rule
  - 340B Payment Cuts
- Changes to Clinical Lab Fee Schedule Payments
- FY 2018 Medicare Quality-Based Program Final Factors & Estimated Financial Impact
- Medicare MBI/SSN Removal
- Medicaid HRA Program Changes
- Medicaid Managed Care Provider Enrollment

VerifyMICare

- New MHA transparency website launched to help patients and their families make smart healthcare decisions
- http://verifymicare.org/
- Provides information about quality and safety measures at hospitals
- Future updates will include pricing info

Estimated Change in Medicare OPPS Payments

Michigan

Impact Analysis	Dollar Impact	Percent Change
Estimated CY 2017 OPPS Payments	*$2,232,280,100*	
Marketbasket Update	$50,044,700	2.24%
ACA-Mandated Marketbasket Reductions	($25,022,600)	-1.12%
340B Drug Payment Reduction BN Adjustment	$59,924,400	2.68%
Other BN Adjustments	$4,885,000	0.22%
Wage Index	($11,330,200)	-0.51%
APC Factor/Updates (Includes 340B Reduction)	($63,638,500)	-2.85%
Estimated CY 2018 OPPS Payments	*$2,247,142,900*	

Total Estimated Change CY 2017 to CY 2018	***$14,862,800***	***0.67%***

The impact shown above does not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2025. It is estimated that the impact of sequestration on CY 2018 OPPS PPS-specific payments would be: -$44,943,100

2018 OPPS Final Rule - Key Provisions

- Issued Nov.1 and effective Jan. 1
- Payment reduction for drugs acquired under 340B discount program
  - Old: ASP plus 6%
  - New: ASP minus 22.5%
  - Impact: $1.6 billion annual shift
- 4.85% conversion factor increase
- Moratorium on direct supervision requirement for OP therapeutic services at CAHs/rural hospitals – 2018 & 2019

Impact of 340B Provisions

- Statewide $13M Net Payment Decrease
  - 340B Drug Payment Reduction Budget Neutrality Adjustment - $60M Increase
  - 340B Payment Cut - $73M Decrease
- Federal advocacy efforts continue

2018 OPPS Final Rule - Continued

- Removal of 6 measures from Quality Reporting Program
- TKA (knee) and 5 laparoscopy procedures removed IP only list
  - Hospital impact analysis included estimate for all TKA procedures moving to outpatient setting
- Hospital-specific impact analyses distributed via email Dec. 15
  - Email Crystal Mitchell at crmitchell@mha.org to obtain a copy for your hospital

Clinical Lab Fee Schedule Changes

- Hospital-specific impact of Protecting Access to Medicare Act (PAMA) of 2014 distributed Jan. 24
- PAMA requires new payment methodology for lab services paid under the clinical lab fee schedule
- Payments will be based on the median commercial payment rate
- Michigan impact $11 million reduction in 2018, increasing to nearly $40 million in 2021
  - Impact may be higher depending upon contractual terms of Medicare Advantage contracts
- These cuts only apply to hospital lab services that are paid separately, with **no impact** on those that are part of a bundled payment such as an APC payment

Medicare Quality-Based Program Factors

- Jan. 5 MHA distributed a hospital-specific one-page impact report summarizing the estimated financial impact of the 3 Medicare quality-based programs for Michigan hospitals
- **Value-Based Purchasing (VBP) Program**:

# Hosps			
55	+	$9.2 Million	
30	-	$4.7 Million	
Net	+	$4.5 Million	

- **Readmissions Reduction Program** (RRP): 71 hospitals subject to $26M RRP penalty compared to 78 hospitals subject to $26M penalty for FY 2017
- **Hospital Acquired Conditions (HAC) Reduction Program**: 19 hospitals subject to 1% HAC penalty, est. at $11M compared to 27 hospitals subject to $21M penalty for FY 2017

Medicare Spending per Beneficiary Reports

- Jan. 31 MHA distributed a hospital-specific one-page report that reflects Medicare fee-for-service spending per beneficiary (MSPB) data released by CMS on Hospital Compare for Q4 2016
- Reports compare hospital MSPB to Michigan and US data by type of service including IP, OP, physician, SNF, hospice, home health, DME and total for the three time periods evaluated by the CMS including:
  - One to three days prior to index hospital admission
  - During index hospital admission
  - One to 30 days after discharge from index hospital

Medicare Bundled Payment Models

- In December, CMS finalized a rule that cancelled the Episode Payment Models (EPMs) and made the Comprehensive Care for Joint Replacement (CJR) voluntary for hospitals in 33 of the 67 metropolitan statistical areas, including Flint and Saginaw
- Mandatory CJR participation for hospitals in the voluntary MSAs ended Dec. 31
- Hospitals had opportunity to continue participation by notifying CMS by Jan. 31
  - Program effective Feb. 1, 2018 – Dec. 31, 2020

New Bundled Payment Models

- In early January, CMS announced the Bundled Payment for Care Improvement (BPCI) Advanced program which is a new Medicare FFS voluntary bundled payment model that offers participants both upside and downside financial risk
- Program includes 29 inpatient and 3 outpatient 90-day clinical episodes
- Interested providers must submit an application and all required documents to CMS through the BPCI Advanced Application Portal by March 12
- Program effective Oct. 1, 2018 through Dec. 31, 2023
- CMS to provide a second application opportunity in January 2020
- BPCI Advanced model will qualify as an advanced APM under the Medicare physician quality payment program

New Medicare IDs & Cards

- MACRA requires removal of Social Security Numbers from Medicare cards which will use a random 11 character Medicare Beneficiary Identifier (MBI)
- Timeline
  - Beginning April 1, 2018
  - Complete April 1, 2019
  - CMS providing 21-month transition (April 1, 2018 – Dec. 31, 2019) for providers to use either ID
- **Encourage health systems to ensure IT systems prepared for change**

Cont., New Medicare IDs & Cards

- Beginning in February, Medicaid Third Party Liability (TPL) will be removing the SSN or policy number from the monthly Pending Void Report when the payer is Medicare
- The appropriate policy number per beneficiary will be available directly in CHAMPS if needed

MEDICAID

CMS Approved New HRA Methodology

- Core Components of New Framework
  - Use current MCO encounter data as basis for payment
  - Add-on payment for each claim
  - MCOs to pay hospitals quarterly
  - Hospital QAAP tax payments due to State **after** HRA payments received

New HRA Methodology

- 70% inpatient add-on = $223 million in Q1 HRA payments
- 87.3% outpatient add-on = $185 million in Q1 HRA payments
- FY 2017 add-on roughly 67%
- $200 million gross increase over FY 2017 payments
- Q1 payments tentatively scheduled for Feb. 9

Key Operational Details

- Hospitals can use recent MCO data to estimate payments
- Seasonality of payments vs. prior “smoothing”
- Cash flow impact due to change from monthly to quarterly
- System conversions will likely result in hospitals experiencing decreases in quarterly HRA payments with increase in future quarters

Rural Access Pool Payments

- FY 2018 FFS payments total approximately $5 million, and will be distributed on a quarterly basis
- Q1 FFS payments distributed in December, with Q2 payments scheduled for Feb. 15
- CMS Medicaid managed care rule required a change for payments previously made thru the HRA process
- Federal match not available for these GF payments of approx. $10M,which will be paid as grant payments through Medicaid
- Anticipated that MSA will distribute these payments proportionately based on FY 2016 MCO outpatient encounter data
  - Payment distribution expected by Feb. 28
- Previous distribution based on proportion of each hospital’s unreimbursed outpatient cost for Medicaid MCO services

OB Stabilization Pool Payments

- CMS Medicaid managed care rule required a change for payments previously made thru the HRA process
- Federal match not available for these GF payments of approx. $4M,which will be paid as grant payments through Medicaid
- Anticipated that MSA will distribute these payments proportionately based on FY 2016 births and deliveries
  - FY 2018 payment distribution expected by Feb 28
- Previous distribution used FY 2013 births and deliveries with these payments made as part of Oct/Nov/Dec HRA payments

Rural & OB Stabilization Pool Payments

- MHA Advocacy efforts resulted in an additional $7 million in general funds available for the RAP and OB hospitals
- MSA indicated that these payments will be distributed later during FY 2018
- Unsure how funds will be split between RAP and OB pools

Annual DSH Audit Education Session

- MSA intends to process FY 2015 Step 2 DSH payment recovery/redistribution transactions by Feb. 28
- Myers and Stauffer LC will distribute the FY 2015 DSH audit request in the next few weeks
- MHA coordinating a **webinar** with Myers and Stauffer staff and MSA on March 7; 1:30-3:30 pm
- Registration info available

Medicaid Timeline Filing Policy

- Effective Jan. 1, 2018, MSA policy revised to allow providers to bill 6 months after retro-eligibility determined

Medicaid OPPS & ASC Payment Factor

- For services provided on and after Jan. 1, 2018, Medicaid will pay 50.9% of the Medicare OPPS and ASC rate, down from 51.7%
  - No area wage adjustment

- Annual adjustment necessary to maintain budget neutrality of Medicaid payment system

MCO Provider Enrollment

- Effective Jan. 1, 2018, MSA final policy (MSA 17-48) requires all MCO providers to be enrolled in CHAMPS
  - Includes physicians, physician assistants, certified nurse practitioners, dentist and chiropractors
- Effective March 1, MDHHS will prohibit MCOs from making payments to all typical rendering, referring, ordering, and attending providers not enrolled in CHAMPS
- Effective for dates of service on/after May 1, MDHHS will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS

United Healthcare

- MHA recently requested clarification of Dec. 1, 2017 policy regarding a review of Emergency Department visits in select states including Michigan
- Policy informed providers that ED claims will be reviewed to determine whether visits with Level 4 or 5 Evaluation and Management codes will be downward adjusted or denied
  - UHC to use an Optum ED Claim Analyzer tool
- Footprint in Michigan
  - Approx. 254,000 Medicaid enrollees
  - Fewer than 5,000 marketplace enrollees
  - No Medicare Advantage enrollees as of December 2017

Medicare Advantage Plans

- As of December 2017, 35 plans operating in Michigan, with 729,000 or approximately 37% of Michigan's 2 million Medicare beneficiaries enrolled
  - Enrollment down 5,000 since October
  - Up to 27 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

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
- Contact Vickie Kunz at vkunz@mha.org for additional info

MHA Resources

- Monday Report is available **FREE** to anyone and is distributed via email each Monday morning
  - Go to mha.org, select “Newsroom”, then select “Monday Report “ and click on “Contact Us” to subscribe
- Request website password if you don’t have one
- Hospital specific mailings as needed for various impact analyses, etc.
- Periodic member forums
- See www.mha.org for other resources, including the latest info on ACA Repeal and Replace
- Monthly Financial Survey (MFS) provides free benchmarking of financial and utilization statistics

2112 University Park Drive | Okemos, MI 48864

(517) 323-3443 | www.mha.org

For more information, contact:

Kellen Teel

Manager, Health Finance

kteel@mha.org

(517) 703-8625