Great Lakes Healthcare Financial Management Association (HFMA)

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About MHA

- Established in 1919; Nonprofit (501c 6)
- Approximately 100 employees
- Locations: Okemos (HQ and MHASC); Downtown Lansing (CAC)
- Primary Membership: hospitals/health systems (132)
- LTCH, state & federal psych & rehab (33)
- Total members (260)
- Governance: 21-member Board; committees/councils/task force structure

MHA Service Corporation (for-profit)

- Unemployment Compensation
  - Career Center – www.healthcareercenter.com
  - BASIC – FMLA and Attendance Management Systems
- Data Services (MIDB, MODB)
  - Community Benefits Tracker
  - ReAdmetrix
  - MHA Salary Survey
  - Data Koala
- Healthcare Loan Program (HeLP)
- Accounts Payable Program
- Class Action Capital
  - Revenue from settlement claim recovery
- Hospital Blue Program – Third Party Administrator claims processing program with BCBSM

Mission and Vision

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

Transforming Healthcare

- 1980: 236 hospitals –nearly all independent and primarily inpatient volume
- 2016: 132 hospitals
  - 17 systems = 102 hospitals
  - 9 multi-state systems (3 for-profit)
  - Peer Group 5 (45 hospitals/24 independent)
- Substantial outpatient growth
- 65% of practicing physicians are either employed or “near employed” by health systems

National Health Systems – Corporate Offices

Aspirus
Trinity
ProMedica
OSF
Select
Ascension
LifePoint
CHS
Prime
Tenet

Key Medicare Policy Activities

- Review and analysis of Medicare proposed rules generally released in mid-April
- Comment letters to Centers for Medicare and Medicaid Services (CMS)
  - MHA letter available via Monday Report
- Review and analysis of Medicare final rules generally released for Oct. 1
- Including distribution of hospital-specific impact reports for proposed and final rules to update Medicare prospective payment systems
  - Includes Inpatient, Outpatient, Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies

Medicare Payment Analyses

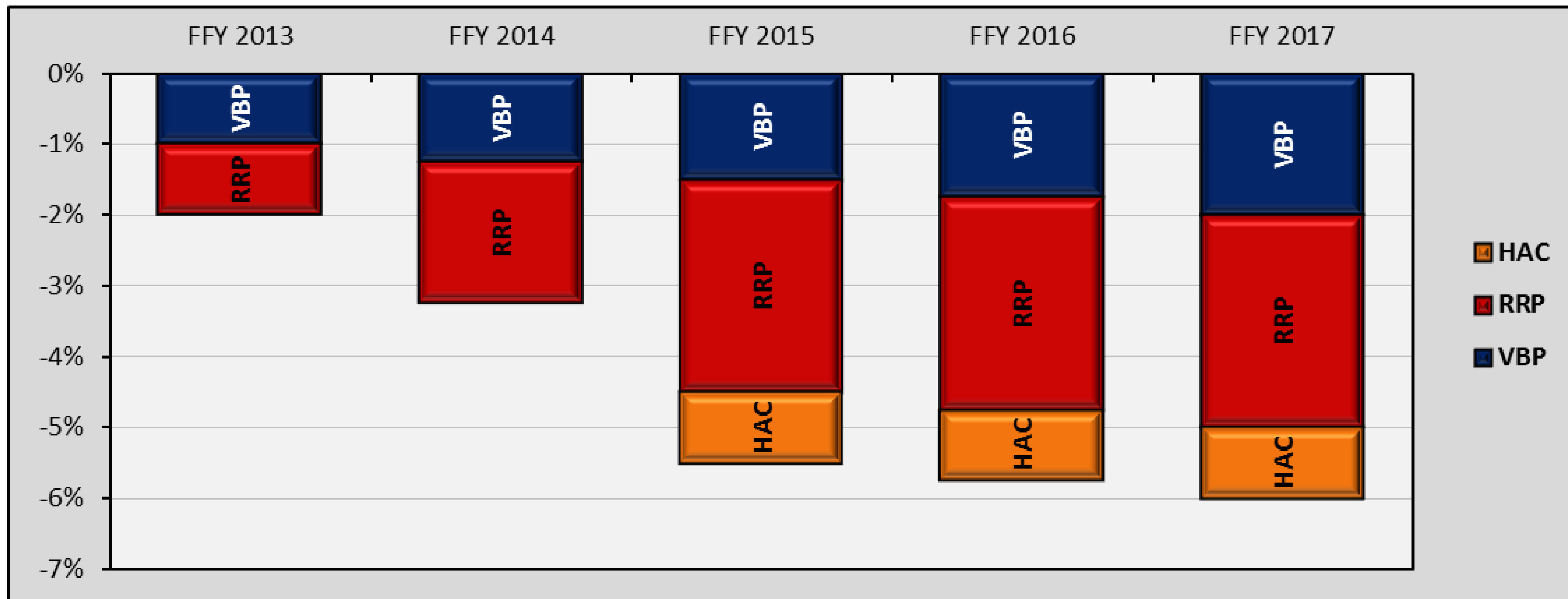
Then	**Now**
IPPS, OPPS	IPPS, OPPS, Skilled Nursing Facilities, Home Health, Long Term Care, Rehab, Psych, Value-based Purchasing, Hospital-acquired Conditions, Bundled Payment Models, 10-year Legislative & Budget Policy Cuts
CEO, CFO	CEO, CFO, Reimbursement Director, Quality Improvement Patient Safety, CMO, COO, Government Relations

Cont., Key Medicare Policy Activities

- Analysis of financial impact of Medicare quality-based programs
  - Value-based purchasing (VBP)
  - Readmissions-reduction program (RRP)
  - Hospital-Acquired Conditions (HAC) reduction program

General Program 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

Other Policy Activities

- Medicaid Quality Assurance Assessment Program (QAAP) activities
- Review and analysis of various Medicaid budget and policy issues including comment letters to Medical Services Administration (MSA)
- Medicaid Managed Care Final Rule
- BCBSM Contract Administration

Continued, Other Policy Activities

- Medicare wage index analysis and issues
- Various ad-hoc issues including recent sleep lab accreditation changes by WPS
- Analysis of American Hospital Association (AHA) annual survey results.
  - Michigan vs US and Great Lakes States
    - Utilization and financial benchmarking
- MHA Monthly Financial Survey (MFS)

WPS Change – Sleep Lab Services

- Effective Feb. 16, 2017, WPS implemented a local coverage determination (LCD) that requires providers to be accredited by one of three organizations to receive payments for Medicare FFS patients:
  - The Joint Commission **sleep specific credentials for ambulatory care sleep centers**
  - Accreditation Commission for Health Care (ACHA) accreditation
  - American Academy of Sleep Medicine (AASM)
- Inadequate notice and time for providers to obtain the required accreditation

Continued, WPS Change – Sleep Lab

- Has resulted in patient access issues particularly in rural areas
- MHA joined five other states and requested a delay by CMS to allow providers time to obtain the required accreditation which will take 3-6 months
- Alternative solution would be to allow hospitals accredited by The Joint Commission to be grandfathered until their next survey

FY 2018 IPPS Proposed Rule

- 1.45% net inpatient rate increase after all adjustments
- 3-year phase-in to use worksheet S-10 data for allocating uncompensated care component of Medicare DSH payments
- $1 billion increase in overall Medicare DSH payments due to changing source data used to determine the number of uninsured
- Updates to inpatient quality reporting program and Medicare quality-based programs

Medicare Enrollment

Medicare Plan Type	Enrollment
Fee-for-service	**1,274,000**
Medicare Advantage (35 plans) *(5 largest below)*	**734,000**
BCBSM	301,000
Priority Health	134,000
Blue Care Network of Michigan	85,000
Health Alliance Plan of Michigan	61,000
Humana Insurance Company	57,000

As of April 2017

Medicare ACA Cuts – Michigan Impact

			Impact of Enacted Cuts (2010-2016)	Impact of Enacted Cuts (2017-2026)	Total Impact (2010-2026)
Legislative (1)	ACA Marketbasket Cuts	IPPS Marketbasket Reduction	($707,259,600)	($4,184,594,600)	($4,891,854,200)
		OPPS Marketbasket Reduction	($340,449,400)	($2,057,249,500)	($2,397,698,900)
		IRF Marketbasket Reduction	($29,219,200)	($179,023,200)	($208,242,400)
		LTCH Marketbasket Reduction	($43,443,600)	($246,654,700)	($290,098,300)
		IPF Marketbasket Reduction	($15,942,400)	($135,657,500)	($151,599,900)
		HH Marketbasket Reduction	($14,623,200)	($59,683,000)	($74,306,200)
		SNF Marketbasket Reduction	($4,965,000)	($22,321,800)	($27,286,800)
	Ot	Medicare DSH Cuts	($207,366,000)	($1,328,004,700)	($1,535,370,700)
QBPR (3)		Readmissions Reduction Program	($65,849,100)	($305,798,200)	($371,647,300)
		Hospital Acquired Condition Reduction Program	($26,005,000)	($227,914,300)	($253,919,300)
		Value-based Purchasing	($4,651,000)	$18,880,000	$14,229,000
Total Enacted Cuts			**($1,459,773,500)**	**($8,728,021,500)**	**($10,187,795,000)**

Background – Medicaid

- Medicaid is a joint federal/state-funded program to provide health care coverage to low-income and financially needy individuals
  - Regular Medicaid funded by 65% federal and 35% state
  - Healthy Michigan Plan funded by 95% fed and 5% state
- The Medicaid program is administered by the 50 states, with rules and coverage varying in each state
- Michigan population approx. 10 million
  - 2017 enrollment
    - Regular Medicaid 18%
    - Healthy Michigan Plan 6%

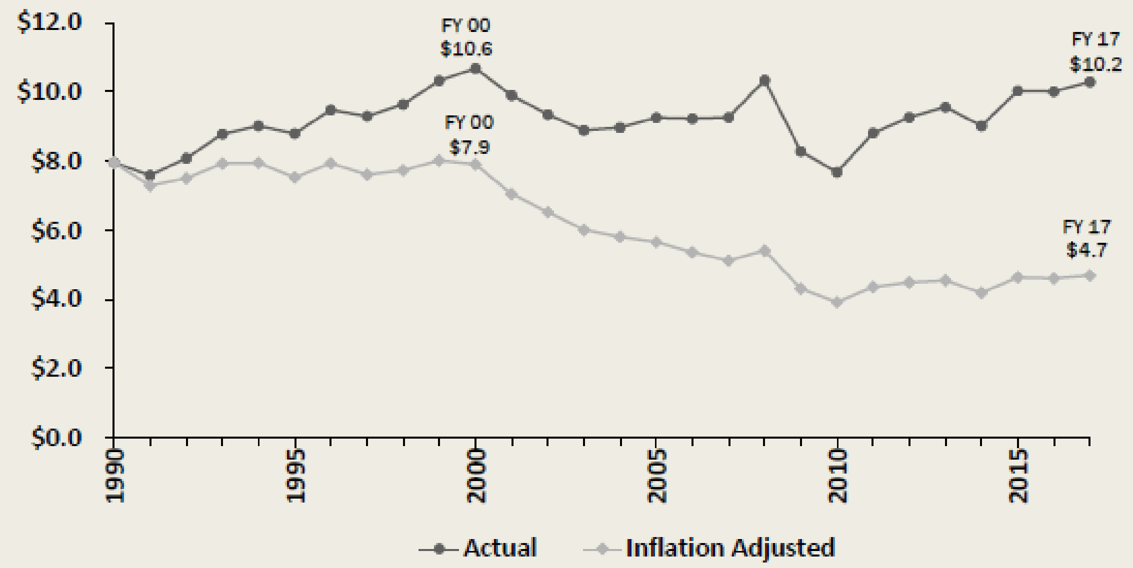
Purpose - QAAP Programs

- These programs are necessary since state general funds are not available to fully fund provider rates
  - No state-funded Medicaid fee-for-service rate increases since FY 2000
- Hospitals voluntarily tax themselves to draw increased federal funds for hospital services in absence of state GF funding
  - Total FY 2017 QAAP tax (including retention) $862.6 million will result in $2.16 billion in gross supplemental payment pools
- A portion of the QAAP tax assessed is retained by the state, with the remaining tax used to obtain federal matching funds for supplemental pool payments
  - FY 2017 state retention totals $311 million

Purpose - QAAP Programs

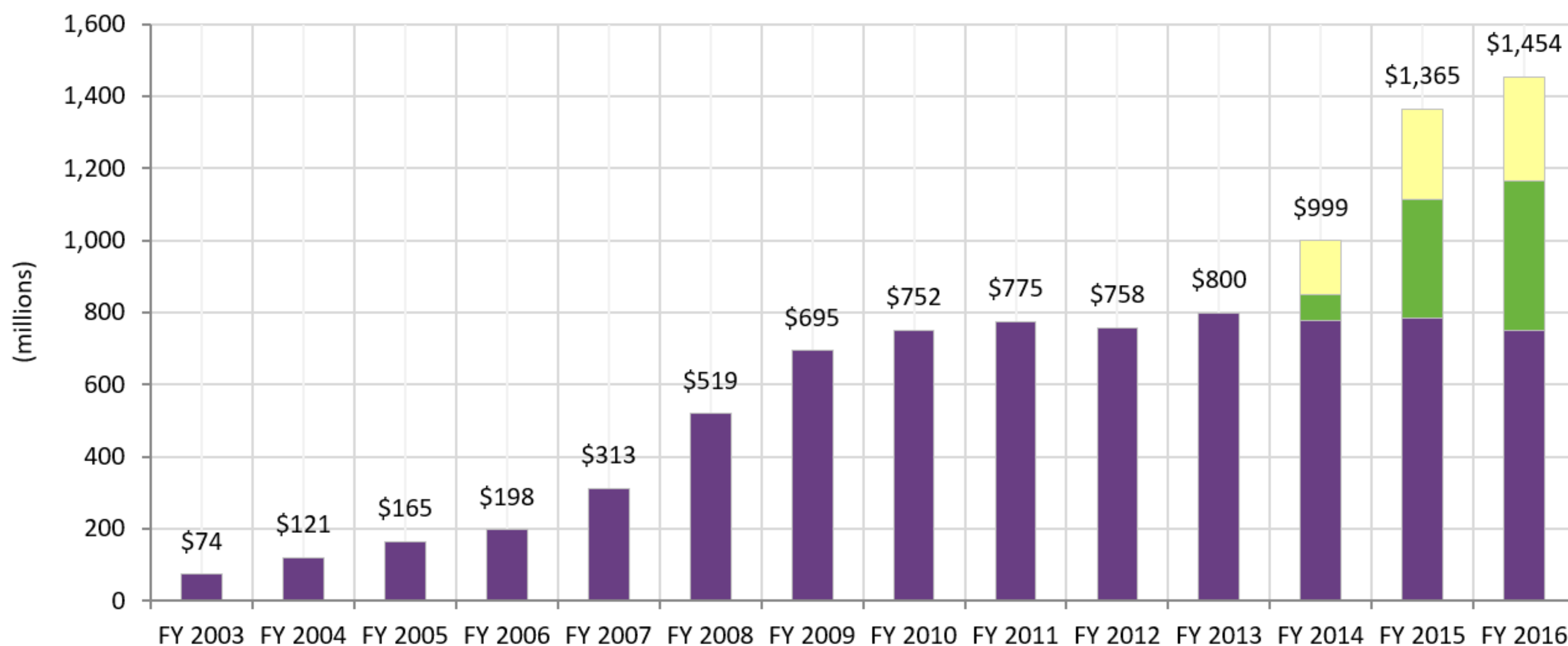
- State retention was designed to augment general funds for Medicaid hospital payments
- The state retention increased from $24 million in FY 2003 to approximately $309 million in FY 2016
- Combined with the federal match, the state retention results in approximately $900 million to fund Medicaid payments

General Fund Revenue: Flat Since 2000



Income tax	$6.9 billion
Sales & Use	$1.8 billion
Insurance	$406 million
CIT/MBT	$269 million
Cigarette	$184 million
Other taxes	$219 million
Non-Tax Revenue	$378 million
TOTAL	**$10.2 billion**

FY 2003-2016 Net QAAP Benefit to Hospitals



	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
FFS	$74	$121	$165	$198	$212	$264	$306	$311	$311	$331	$293	$406	$470	$488
HMO					$101	$214	$360	$378	$400	$375	$440	$536	$770	$863
Psych								$19	$26	$24	$24	$24	$24	$24
DSH						$41	$29	$44	$38	$27	$43	$33	$78	$78

■ **Regular** ■ HMO HMP ■ FFS HMP

Healthy Michigan Plan Supplemental Payments

- April 1, 2014 - Healthy Michigan Plan took effect
- Provides coverage to individuals up to 138% Federal Poverty Level
  - For 2017, approx. $16,700/individual; $34,000/family of four

Healthy Michigan Plan QAAP Impact

Estimated Impact*

	FYs 2014/2015	FY 2016	FY 2017
MACI	$400 million	$287 million	$257 million
HRA	$400 million	$418 million	$418 million
TOTAL	**$1.4 billion**		

*** excludes Medicaid rate payments**

Coverage Snapshot: Medicaid Expansion

More than 1 million Michiganians uninsured in 2013

Where do we stand today?*

Healthy Michigan

2/28/17

Covered by:

McLaren HEALTH PLAN

UnitedHealthcare Community Plan

MOLINA HEALTHCARE

PriorityHealth

TOTAL HEALTH CARE USA

Blue Cross Blue Shield Blue Care Network of Michigan

HARBOR HEALTH

Meridian Health Plan

MIDWEST HEALTH PLAN

Upper Peninsula Health Plan

aetna

AETNA BETTER HEALTH® OF MICHIGAN

MHA FY 2018 Medicaid Budget Priorities

- Protect existing funding
  - Rates, GME, Small & Rural Access Pool, OB Stabilization Pool
- Protect against excessive retention as state general fund requirement for HMP increases
- Renew Healthy Michigan Plan funding
  - Including required match = $200m (state GF share)
- Prevent GME payment penalties and reporting to Leapfrog mandate

CMS Medicaid Managed Care Rule

Beginning Oct. 1, 2017, requires a 10-year phase-out of current methodology for state-directed managed care pass-through payments to hospitals, physicians and nursing homes

- First year continues 100% of current methodology
- Impacts $1.4 billion in gross payments ($900 million net to hospitals after tax deducted)
- Hospital Rate Adjustment (HRA) is supplemental payment to hospitals included in the HMO capitation rate and then transferred to hospitals
- HRA, HMP HRA, Psych HRA, Rural Access Pool (Managed Care Component), and Obstetrical Stabilization Fund

Potential State Impact

- FY 2017 state retention from HRA QAAP tax is $250 million
- With federal match, this is $700 million in gross Medicaid payments to hospitals (in addition to pool payments)
- Failure to develop an alternative acceptable to the CMS jeopardizes $2.1 billion in gross annual hospital payments

Healthcare is Entering a Period of Disruption

- Payment models are not defined
- Hospital/System readiness is varied
- Payers are not ready for alternative payment models, included necessary IT systems
- Physicians are caught in the middle of insurers, hospitals and patients and becoming more frustrated

Common Definition of Triple Aim Components

- Three major components include:
  - Improving patient experience
  - Improving population health
  - Reducing per capita cost
- Issues identified for further discussion:
  - Is cost what employers/individuals are charged, which includes provider payments, co-pays, BCBSM admin cost & margin?
  - Need appropriate risk adjusters
- Further discussion needed on patient experience and population health

Current Healthcare Landscape

What you can't control:

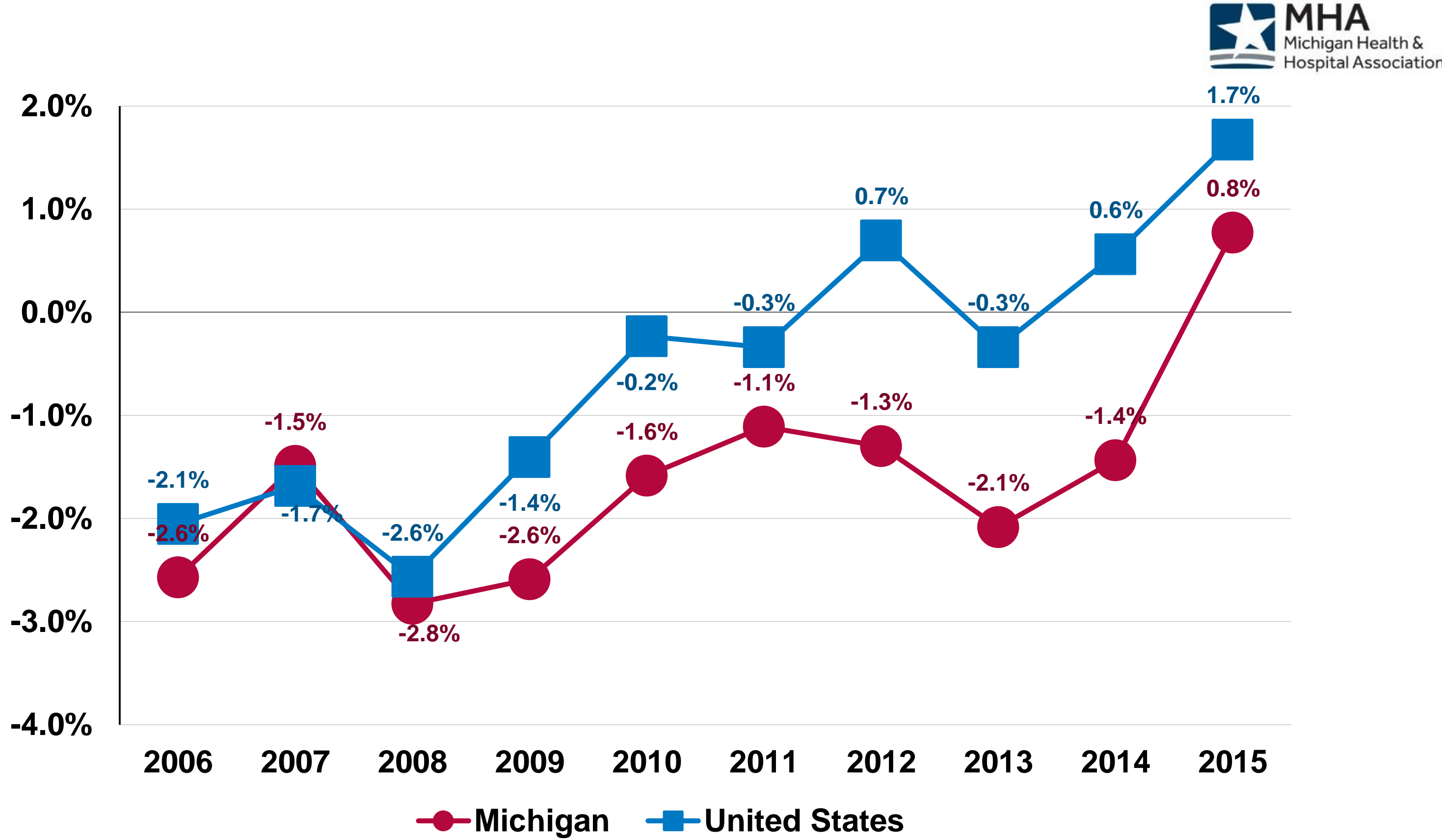
- Impact of President Trump
- Impact of Congress
- Employer benefit changes, including high deductible plans
- Encroachment of alternative providers on healthcare delivery lines
- Ever expanding consumer involvement and direction of their healthcare

Current Healthcare Landscape – Cont.

What you **can** control:

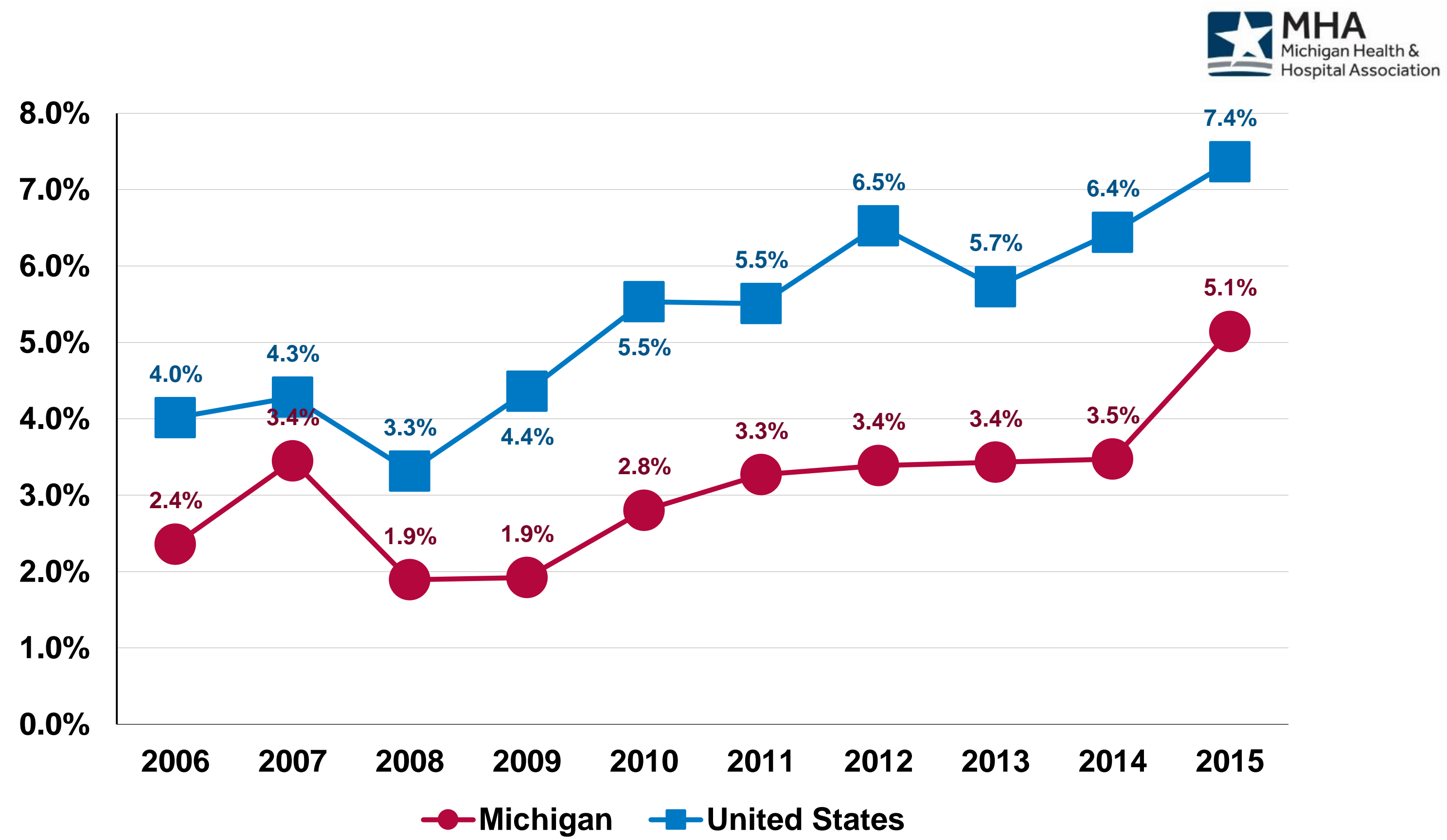
- Monitor Hospital operations to ensure expenses match revenues
- Focus on streamlining operations
- Eliminate variations in all aspects of hospital operations
- Standardize care delivery
- Review operations from a patient's perspective

Michigan and United States Patient Margin (2006-2015)



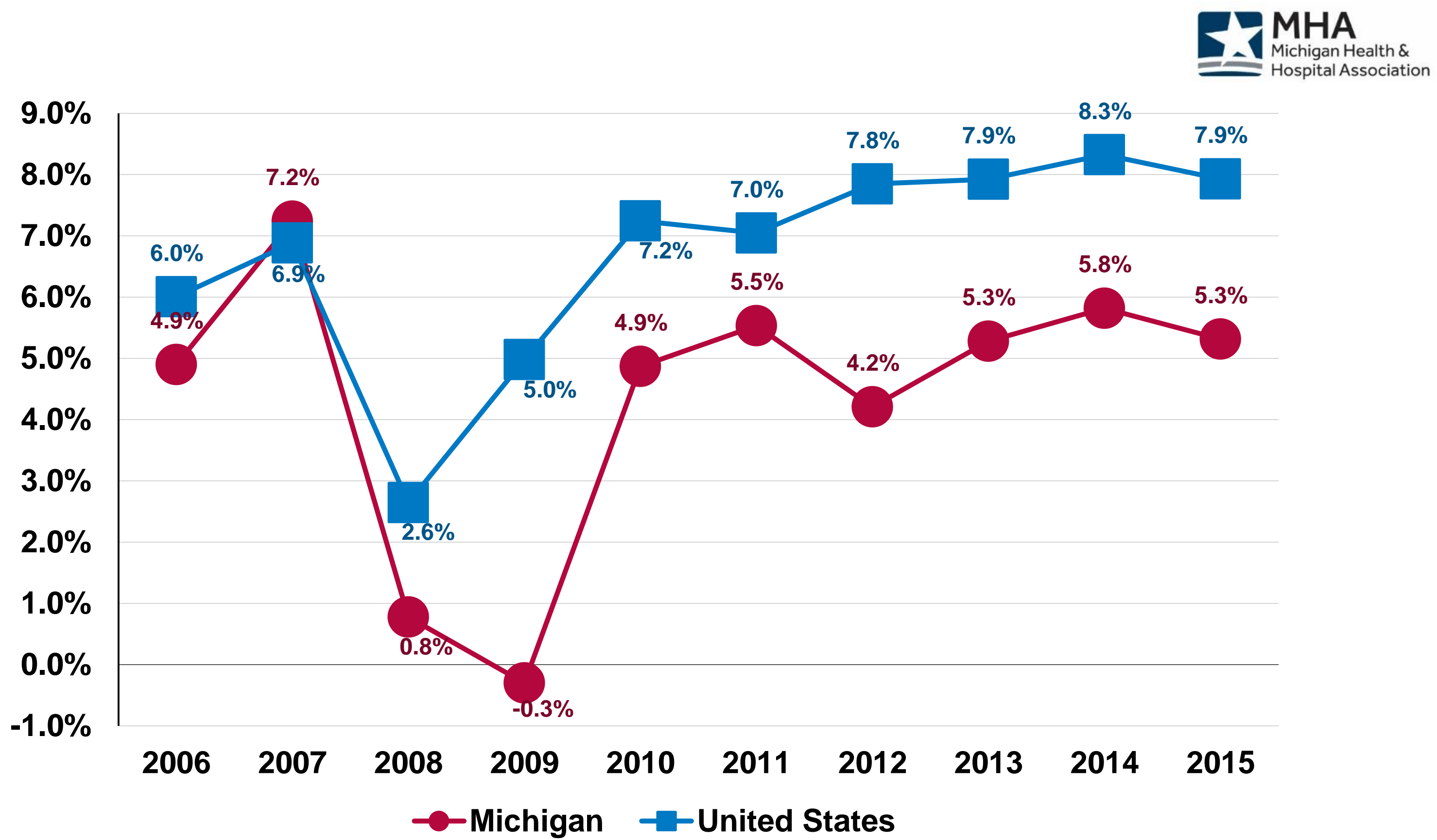
Source: 2015 American Hospital Association Annual Hospital Survey

Michigan and United States Operating Margin (2006-2015)



Source: 2015 American Hospital Association Annual Hospital Survey

Michigan and United States Total Margin (2006-2015)



Source: 2015 American Hospital Association Annual Hospital Survey

MHA Monthly Financial Survey (MFS)

- State and national benchmarking tool currently available free to members through the MHA
- Collects key data elements from hospital operations, one hour of staff time monthly
- Approximately 500 hospitals nationwide participating

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

MHA Information Needs

- Longer term
  - Current data on volumes, margins and uncompensated care
  - Assist MHA Advocacy & Policy in conveying key messages to lawmakers and policy staff with state and federal administrations
  - MHA Board of Trustees passed motion encouraging hospital participation

Member Communications

- Weekly electronic Monday Report
- MHA Website – www.mha.org
- Policy Briefs
- Special Reports
- Member Toolkits
- Social Media
- Member Forums
- ***In-person presentations***

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