MHA
Michigan Health & Hospital Association

Leading Healthcare

Finance Policy Update

Great Lakes HFMA

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Who is the MHA?

- Advocacy organization representing all hospitals in Michigan.
- Activities include:
  - State advocacy on proposed legislation, and policy activity on Medicaid
  - Federal advocacy and policy on Medicare and Medicaid issues
  - MHA Keystone Center – Quality Improvement and Patient Safety Initiatives
  - BCBSM Contract Administration Process
    - Unique to Michigan

Payer Issues

- The role of the MHA is to assist in resolving systematic payer issues.
- Individual hospital contracts determine terms and conditions and take precedence.
- Communicate issues to Marilyn Litka-Klein, Jason Jorkasky or Vickie Kunz at the MHA.

Mission & Vision of 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.*

FY 2018 IPPS Final Rule - Key Provisions

- Using worksheet S-10 data to allocate uncompensated care (UCC) component for Medicare disproportionate share hospital (DSH) payments
- FY 2019 implementation of socio-demographic adjustment for Medicare Readmissions Reduction Program as mandated by the 21st Century Cures Act
- Critical Access Hospital (CAH) 96-hour certification requirement changes
- A net 1.05% operating rate increase after budget neutrality and other adjustments for hospitals that meet inpatient quality reporting (IQR) program and electronic health records (EHR) requirements
- Inpatient quality reporting program & Medicare quality-based program changes

Michigan Estimated FY 2018 Impact

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2017 IPPS Payments	$4,068,890,800		$307,906,000		$4,376,797,200	
Provider Type Changes	($1,391,300)	0.0%	$0	0.0%	($1,391,300)	0.0%
Marketbasket Update (Includes Budget Neutrality)	$99,533,700	2.4%	$6,845,400	2.2%	$106,378,500	2.4%
ACA-Mandated Marketbasket Reductions	($52,801,600)	-1.3%	*Not Applicable*		($52,801,600)	-1.2%
21st Century Cures Act-Mandated Coding Adjustment	$16,305,500	0.4%	*Not Applicable*		$16,305,500	0.4%
2-Midnight Rule Adjustment	($23,739,600)	-0.6%	($1,882,100)	-0.6%	($25,622,500)	-0.6%
Wage Index/GAF	($24,005,900)	-0.6%	($2,157,500)	-0.7%	($26,163,700)	-0.6%
DSH: UCC Payment Changes [1]	$3,965,400	0.1%	*Not Applicable*		$3,965,400	0.1%
MS-DRG Updates	$13,482,300	0.3%	$1,233,300	0.4%	$14,715,800	0.3%
Quality Based Payment Adjustments [2]	$7,475,800	0.2%	$267,600	0.1%	$7,743,700	0.2%
Net Change due to Low Volume Adjustment	($9,339,700)	-0.2%	($599,300)	-0.2%	($9,938,800)	-0.2%
Estimated FFY 2018 IPPS Payments	$4,098,375,200		$311,613,100		$4,409,987,800	
Total Estimated Change FFY 2017 to FFY 2018*	*$29,484,400*	*0.7%* ▲	*$3,707,100*	*1.2%* ▲	*$33,191,900*	*0.8%* ▲

** The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2025. It is estimated that sequestration will reduce FFY 2018 IPPS-specific payments by: -$88,200,500.*

Hospital-Specific Impact Reports

- Final rule takes effect Oct. 1, 2017 unless otherwise noted

- Hospital-specific IPPS impact reports sent to CEO/COO/CFO/Directors of Patient Safety/Quality Improvement/ Reimbursement/Chief Medical Officers on Aug. 25

Transition to Worksheet S-10

- FY 2018 - CMS will use one year of Worksheet S-10 data and two years of proxy data for determining hospital UCC payments
  - S-10 data from FY 2014 (charity care and non-Medicare bad debt expense)
  - “Proxy data” = 2012 & 2013 Medicaid days, 2014 & 2015 Medicare SSI days

Worksheet S-10 Data

- CMS released instructions early October

- CMS developing audit protocols for use in future rulemaking - S-10 data will be subject to desk review beginning with FY 2017 cost reports

- **Amended data for FY 2014 and 2015 cost reports have to be submitted to MAC by Oct. 31 for *possible* use in *FY 2019 and future year* DSH calculations**

CAH 96-hour Certification Requirement

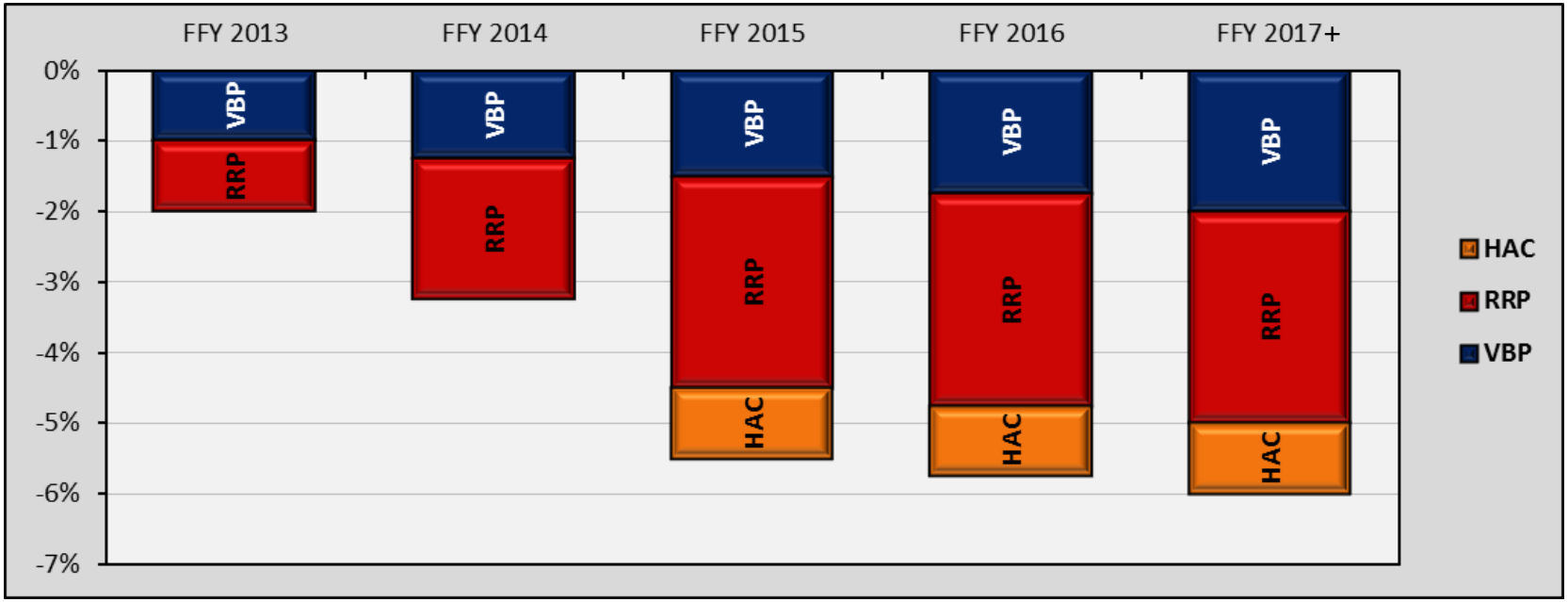
- CAHs subject to requirement that a physician certify an individual may reasonably be expected to be discharged or transferred to another hospital within 96 hours after admission to the CAH

- CMS providing notice to QIOs, MACs, Supplemental Medical Review Contractors and RACs to make the requirement a low priority for medical record reviews conducted on/after Oct. 1, 2017

- In the absence of concerns about probable fraud, waste or abuse of the coverage requirement, these contractors will not conduct medical reviews to determine compliance with the CAH 96-hour certification requirement

General Program Themes

- Medicare Financial exposure (max exposure shown below)



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

Estimated Michigan Impact

	FFY 2017	FFY 2018
Base Operating Dollars Subject to Quality Programs	$3,272,649,100	$3,297,932,800
Value Based Purchasing Program Impact	$1,760,200	$5,095,600
Readmissions Reduction Program Impact	($26,171,300)	($25,503,600)
HAC Reduction Program Impact	($21,462,300)	($17,721,600)
Net Impact of Quality Programs	($45,873,400)	($38,129,600)

Final FY 2018 quality-based programs factors have not been released by the CMS but are expected by 12/31/17.

FY 2018 Medicare Quality-Based Program Factors

- MHA will provide hospitals with updated one-page summary for:
  - Value-based purchasing (VBP) program
  - Readmission reduction program (RRP)
  - Hospital Acquired Conditions (HAC) reduction program

Continuation of 2% Sequestration Cut

- Mandated by Budget Control Act of 2011
- Absent federal legislation, continues through 2025
- 2% cuts IPPS & OPPS FFS payments to Michigan hospitals by $130M annually + post acute care payments
- Applies to GME, bad debts, EHR incentive payments

FY 2018 Medicare Post Acute Care Final Rules

- **Inpatient Rehabilitation Facilities (IRFs)**
  - Rule provides a net rate increase of 0.83%
  - CMS eliminated the 25% payment penalty for late IRF patient assessment instrument submissions
  - Refined dx codes used to determine compliance with the 60% rule
  - Uses **FY 2017** hospital wage index, pre-reclassified, pre-rural floor
- **Inpatient Psychiatric Facilities (IPFs)**
  - Annual update notice released in July provides a net rate increase of 1.3%
  - Uses **FY 2017** hospital wage index, pre-reclassified, pre-rural floor
  - IPPS rule included changes to IPF Quality Reporting Program

Continued, FY 2018 Medicare Post Acute Care Final Rules

- **Long-Term Acute Care Hospitals (LTCHs)**
  - Rule provides a net rate **decrease** of -2.46%
  - Full implementation of site-neutral payment methodology
  - FY 2021+, LTCHs paid at lower site-neutral rate for ALL discharges if less than 50% of patients fail to meet LTCH criteria
  - Uses FY 2018 hospital wage index, pre-reclassified, pre-rural floor
- **Skilled Nursing Facilities (SNFs)**
  - Rule provides a net rate 1.1% increase
  - Uses FY 2018 hospital wage index, pre-reclassified, pre-rural floor

Medicare OPPS Proposed Rule

- Proposed rule released in July, comments due 9/11
- MHA opposed the following:
  - Reduction in payment for drugs purchased through the 340B drug discount program
  - Additional payment cuts for “non-grandfathered” off-campus hospital outpatient departments
  - Removal of Total Knee Arthroplasty procedures from the inpatient only list
  - Packaging of low-cost drug administration services
- Final rule expected by 11/1/17, for 1/1/18, effective date
- Updated hospital-specific analysis will be distributed after release of final rule

Medicare Advantage Plans

- As of July 2017, 35 plans in Michigan
  - 865,000 (43%) of Michigan's 2 million Medicare members
  - Up 131,000 since April
  - 22 plans in some counties
- CAH entitled to Medicare cost reimbursement
- Each MA plan may determine own utilization management model
- Some MA plans have instituted "RAC-like" utilization programs
- Matrix of MA plans by county available at MHA website – updated quarterly, with latest update Aug. 14 MHA *Monday Report* article

Medicaid Managed Care Final Rule Background

- In April 2016, the CMS released the final Medicaid Managed Care rule prohibiting pass-through payments through Medicaid HMOs effective 10/1/26
  - 10/1/17, begins 10-year phase-out of current payment methodology
- Impacts the following hospital supplemental payments ($1.48 billion)
  - HRA payments for Medicaid HMO beneficiaries ($980 million)
  - HRA payments for Healthy Michigan Plan HMO beneficiaries ($415 million)
  - Psychiatric HRA payments ($45 million)
  - Rural access pool managed care component ($28 million)
  - Obstetrics stabilization pool ($11 million)

Potential State Impact

- FY 2017 state retention from HRA quality assurance assessment program (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 that is acceptable to the CMS jeopardizes $2.1 billion in gross annual hospital payments

Key Issues

- Develop a plan that the CMS will approve
- Maintain program where tax-funded hospital payments can be independently calculated for determination of hospital impact
- Ensure hospitals in all geographic areas that provide access to care for Medicaid HMO enrollees are considered to adequately support rural, urban and obstetrical access

Goal

- The goal was to develop a plan to ensure Michigan is one of the first states to obtain approval from the CMS
  - The MSA prefers that other states do not set precedent that limits Michigan's options
  - MSA plan submitted, awaiting CMS approval

Options Considered

A – Convert MACI and HRA payments into higher rate payments

B – Convert only HRA to payments with across-the-board percentage increase

C – Convert HRA to value-based program

D – Add-on payment tied to current services

Option D

New HRA Payment Model Based on Percentage Add-on

- **Pro**
  - Combines the benefits of payment for services with the benefits of a supplemental payment
  - Achieves CMS objective of tying payments to specific services rather than a pool payment

(continued on next slide)

Option D, continued

New HRA Payment Model Based on Percentage Add-on

- **Con**
  - Requires HMOs to submit timely and accurate encounter data
  - The timing of payments will be different from the current method of monthly HRA payments

Core Components of New Framework

- Use more current HMO encounter data as basis for payment vs. data that is two years old
- MSA to develop add-on payment for each claim
- HMOs to provide payments on quarterly basis
- Hospital tax payments due **after** add-on payments received

New HRA Process

- 70% inpatient add-on
- 87.3% outpatient add-on
- FY 2017 HRA add-on for both is 67%

- $200 million gross statewide increase to HRA
  - Absent change in methodology, HRA would decrease by $40 million from FY 2017

Key Operational Details

- Hospitals can use their recent HMO data to estimate HRA payments
- Seasonality of payments vs. prior “smoothing”
- Cash flow impact due to change from monthly to quarterly payments

Rural OB and Revised

- **MSA commitment to rural hospitals to maintain access**
- Stand-alone methodology separate from HRA
  - FFS Rural payments will continue
  - GF only for HMO component since payments don't qualify for federal match
- Process under consideration will add predictability and reduce annual volatility of payments

Comparison of the Current Status of the Programs (gross payment amounts)

	FY 2017	FY 2018
Rural Access Pool (RAP)		
FFS	$6 million (GF/Fed)	$6 million estimated (GF/Fed)
Managed Care	$28 million (GF/Fed)	$9 million (GF only)
OB Stabilization Pool	$11.3 million (GF/Fed)	$4 million (GF only)

MSA Options Considered

- Convert OB and managed care rural to FFS
  - Existing regulations and hospital payment limits

- Convert payments to DSH
  - Pending federal reductions to state's DSH limit
  - Hospitals that lack DSH capacity or don't qualify for DSH

Hospital Payment Volatility

- Using FY 2015, 2016, 2017 HMO Rural Pool Payments
  - Individual hospital payments changed between 13% and 500% annually
    - Little predictability in annual funding amount
  - Payment change varied between $18,000 and $1.5 million, most by an average of $250,000

Communication/Education – New HRA & Rural/OB

- June 6 – MHA overview webinar
- Aug. 18 – MSA correspondence
- Aug. 21 – MHA correspondence – new HRA methodology
- Sept. 5 – MHA correspondence to Rural Access Pool/OB hospitals

Medicaid Inpatient Rates

- Effective 10/1/15, MSA implemented statewide rates and APR-DRG grouper with annual updates
  - 2 rates: CAH and non-CAH
- 10/1/17 updates:
  - APR-DRG relative weights
  - Statewide rates – CAH and non-CAH
  - Hospital cost ratios - for outlier and transplant calculations
  - Hospital-specific capital rates
  - Per diems: rehab units/facilities and LTACHs

SIGMA Conversion

- 10/3/17 state updated its financial system - SIGMA
- Delay in payment and remittance advices from MDHHS
- CHAMPS pay cycle 40 payments (pay date 10/5/17) and RAs will be combined with pay cycle 41 (pay date 10/12/17)

Medicaid DSH

- **Sept. 14** - FY 2017 Step 1 payments distributed to hospitals
- **Sept. 30** – draft audit report for FY 2014 due to MSA, with final report due to CMS by Dec. 31, 2017
- **Oct. 2** – FY 2018 DSH eligibility form and HRA payment data for state FY 2016 due to MSA
  - Sept. 5 MHA distributed data for FY 2016 HRA, HMP HRA and Psych HRA payments
- **Early Oct.**- FY 2015 Step 2 payment amounts will be released for hospitals to review and decline/reduce their payments

Federal DSH Allotment Cuts

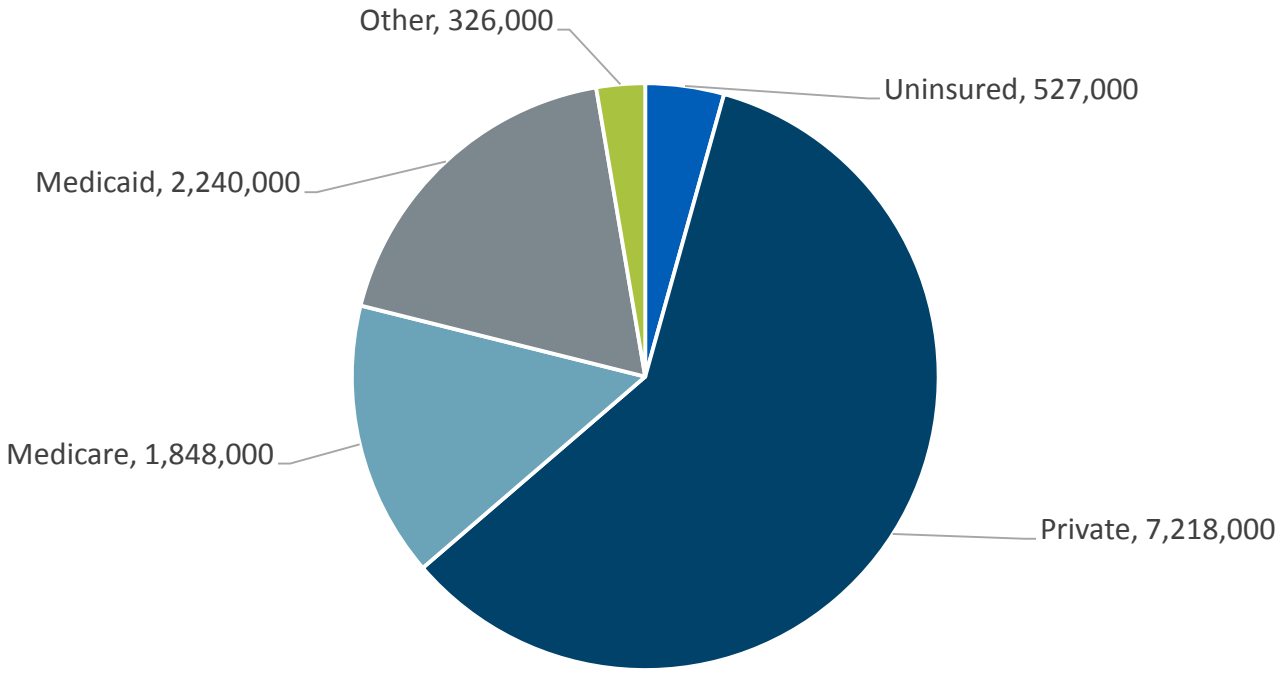
- CMS proposed rule released in late July
- National DSH cuts (ACA) start at $2 billion in FY 2018, and increase by $1 billion annually to $8 billion in FY 2024
- MSA will evaluate options following release of final rule including impact on:
  - regular $45 million DSH pool
  - QAAP tax-funded outpatient uncompensated care DSH pool

FY 2018 Updates

- Annually, the MSA updates data used for:
  - Hospital QAAP tax base
  - HRA – regular, HMP and psychiatric
  - MACI – regular and HMP
  - GME
  - DSH payments
  - FFS Rural Access Pool

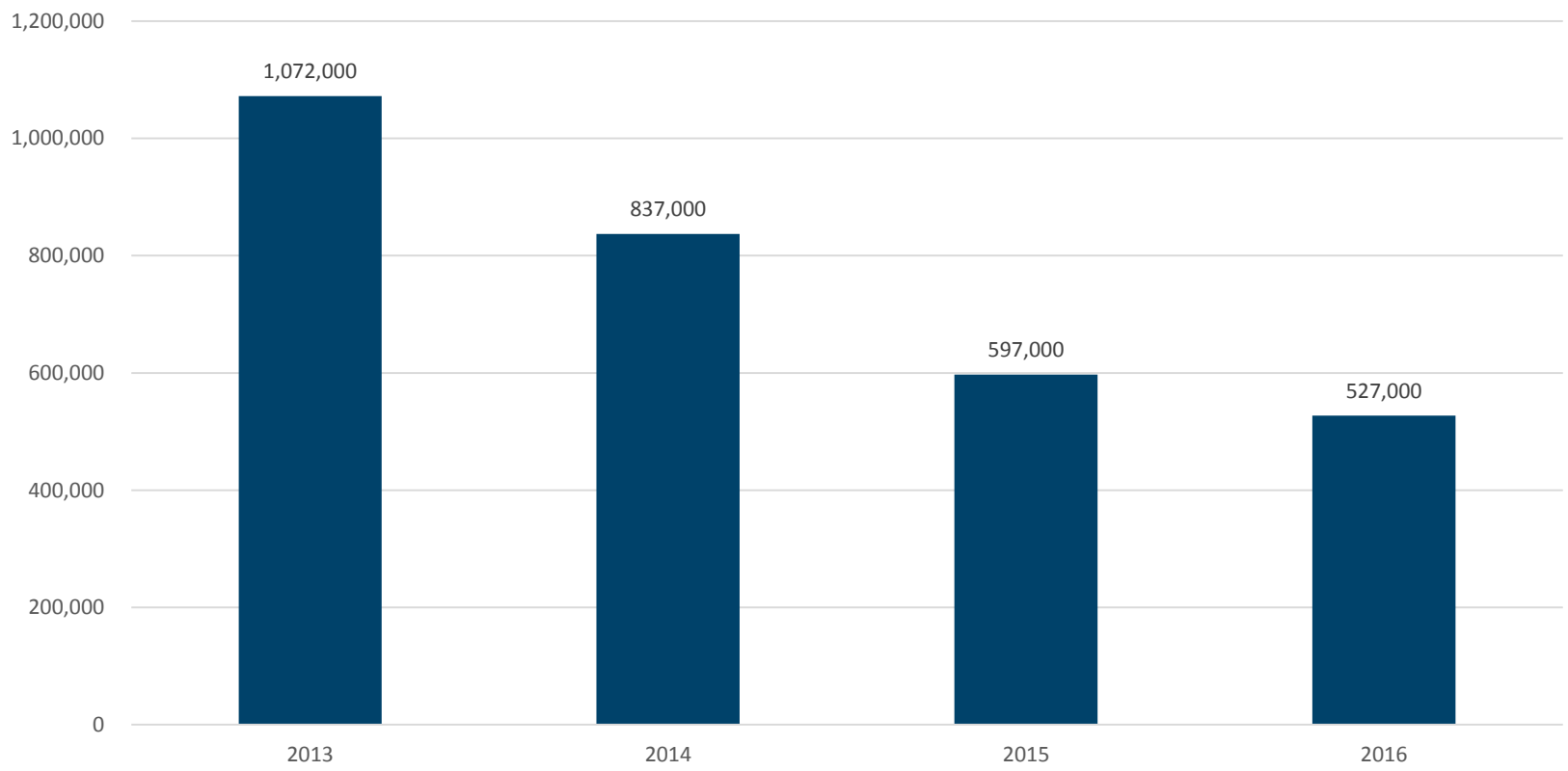
- The use of updated data may result in your hospital's net position being higher or lower than FY 2017 results

2016 Michigan Health Insurance Coverage



Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the period.
Source: US Census Bureau, American Community Surveys

Michigan Uninsured: 2013 - 2016

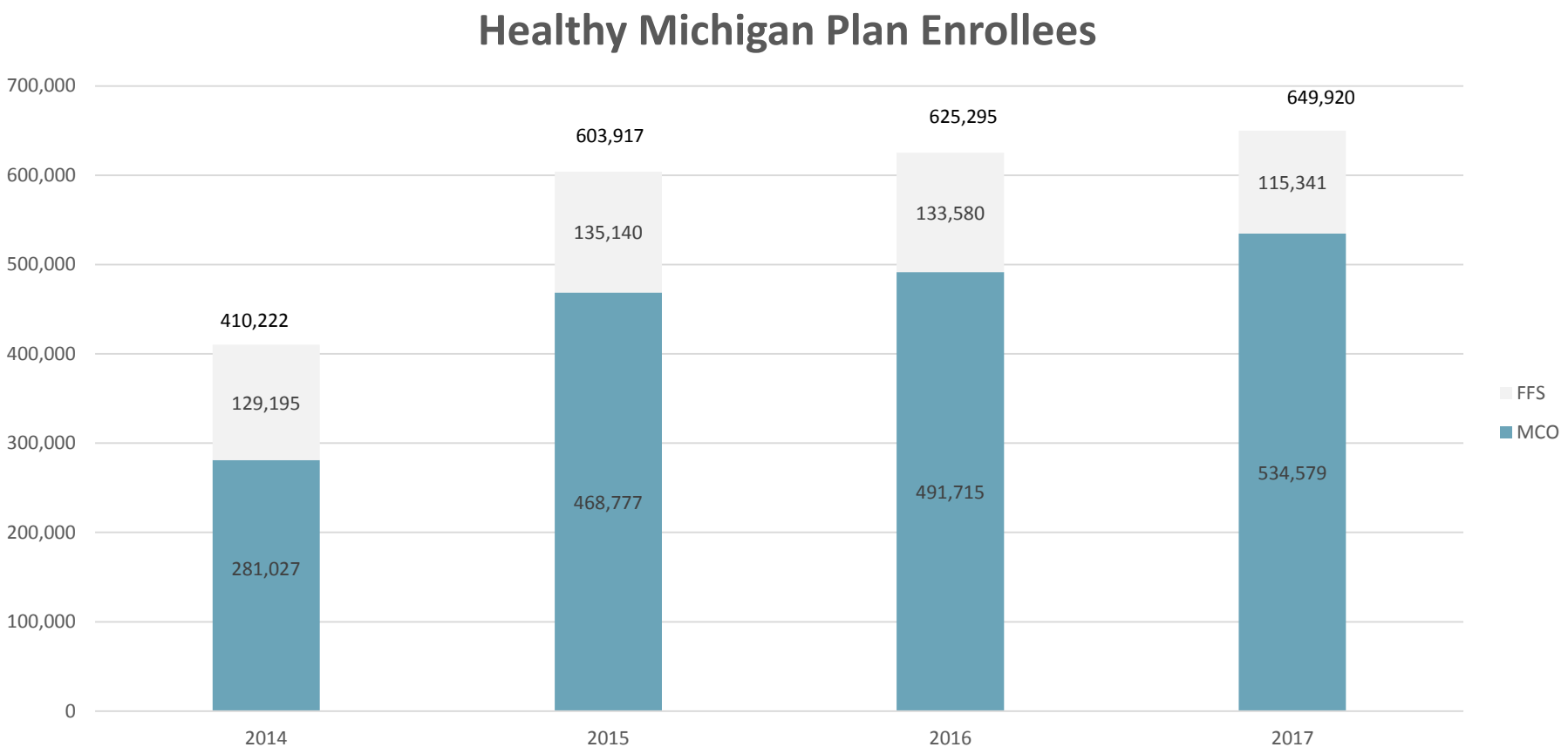


Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the period.
Source: US Census Bureau, American Community Surveys

Michigan Health Insurance Coverage: 2013 - 2016

Payer	2013	2016	2013 -2016 Change	2013 – 2016 Percent Change
Uninsured	1,072,000	527,000	(545,000)	-51%
Private	6,981,000	7,218,000	237,000	3%
Medicare	1,717,000	1,848,000	131,000	8%
Medicaid	1,922,000	2,240,000	318,000	17%
Other	305,000	326,000	21,000	7%

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the period.
Source: US Census Bureau, American Community Surveys

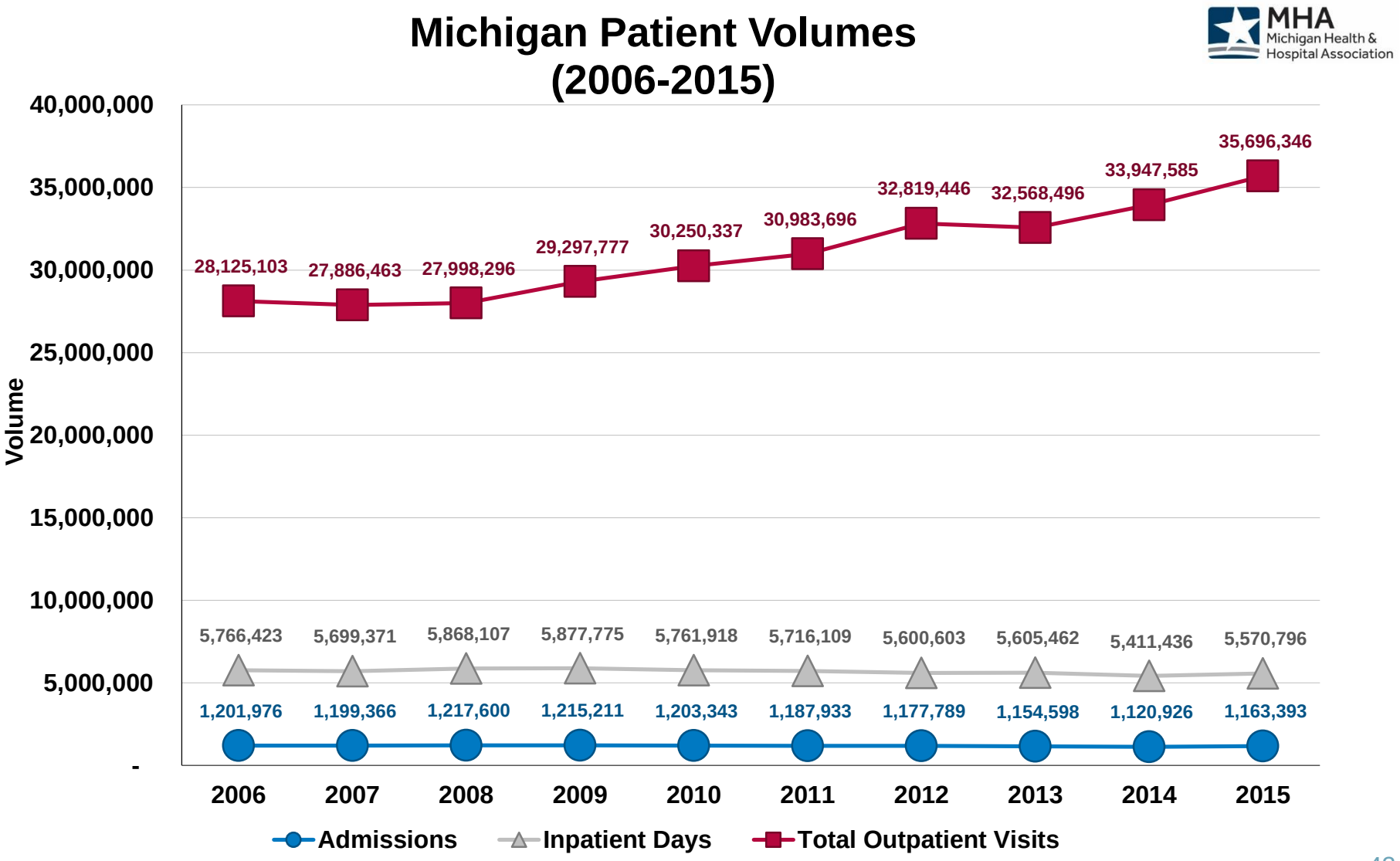


*MDHHS HMP enrollment data as of Sept 1, 2014, 2015, and 2016. 2017 reflects data as of 9/11/17

Medicare Enrollment

Medicare Plan Type	Enrollment
Fee-for-service	**1,258,000**
Medicare Advantage (35 plans) *(5 largest below)*	**865,000**
BCBSM	352,000
Priority Health	134,000
Blue Care Network of Michigan	103,000
Health Alliance Plan of Michigan	84,000
Humana Insurance Company	63,000

Michigan Patient Volumes (2006-2015)



Hospital Margins

Patient

	MI	US
2015	**0.8%**	1.7%
2014	-1.4%	0.6%
2013	-2.1%	-0.3%

Operating

	MI	US
2015	5.1%	7.4%
2014	3.5%	6.4%
2013	3.4%	5.7%

Source: AHA Survey data

History of Hospital Volume

	Inpatient	Outpatient
2000		
Michigan	57%	**43%**
US	65%	35%
2015		
Michigan	48%	52%
US	53%	**47%**

Median O/P for Michigan's hospitals is **62%**

Cost per Equivalent Discharge

	2006	2015
Michigan	$9,243	$11,959
Vs Great Lakes average	-1.7%	-4.8%
Vs US average	-10.9%	-11.7%

Despite a 29% increase in cost during 2006-2015 Michigan's cost per equivalent discharge remains below the Great Lakes and US average, and at a lower rate than in 2006

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 in 14 states

MFS, Continued

- Benefits of hospital use:
  - Timely data for Michigan and national benchmarking
    - Useful for budgeting, marketing, and internal management
  - 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

MHA Resources

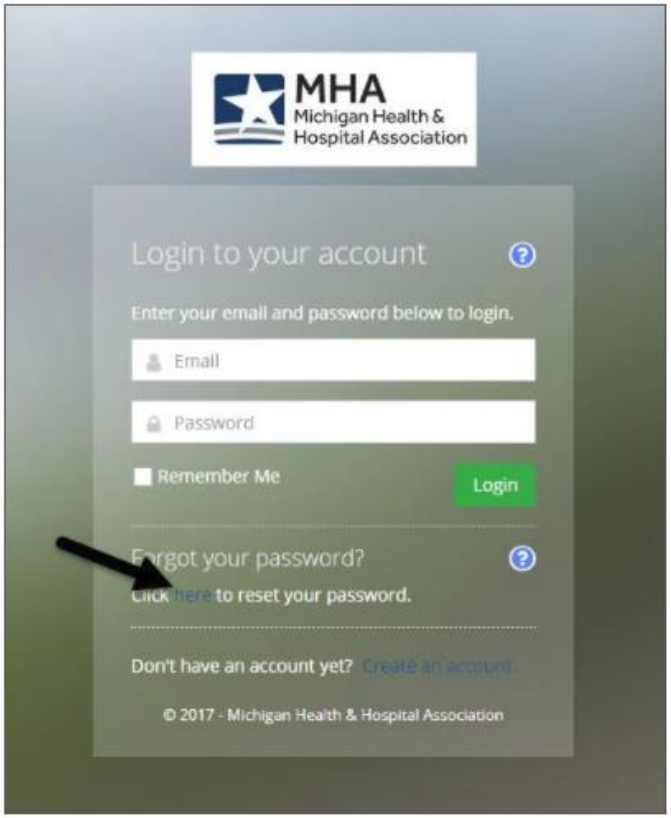
- Monday Report is available **FREE** to anyone and is distributed via email each Monday morning
  - Go to www.mha.org, select “Newsroom”, then select “Monday Report “ and click on “Contact Us” to subscribe
- **Request a new website password**
- Hospital specific mailings as needed for various impact 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

MHA Member Portal

- The new MHA Member Portal is now online. **Members can begin to use the portal for event registration and to access the MHA Community site.** The MHA will be working to expand its use as part of the association's efforts to continually improve the services provided to its members.

- To use the site, employees of member organizations should access the login page, (https://member.mha.org/account/login.aspx) enter their work email, and click on the reset password link to reset their password for the new system. Members with questions or who need assistance should email memberhelp@mha.org.

- A training event will be held Oct. 25 for member organizations' executive assistants. For more information, visit the member portal (https://member.mha.org/events/upcoming-events) or contact Erica Leyko at eleyko@mha.org.



Questions

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