MHA Medicare and Medicaid Update Sept. 23, 2016

MHA Michigan Health & Hospital Association

Nathanael Wynia, CPA
Director, 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.*

Who is the MHA?

- Advocacy organization representing all hospitals in Michigan
- Activities include:
  - State advocacy on proposed legislation, including Medicaid funding and policy activities
  - 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.

Examples of MHA Involvement in Other Issues

- Maximize federal funding in state Quality Assurance Assessment Program (QAAP)
- Provide input on proposed policies and analysis of proposed and final policies.
- Auto No-Fault insurance payment rates
- Member Finance Forums

Agenda

- Major Medicare Rules Update
  - IPPS Final
  - OPPS Proposed
- Delivery and Reimbursement Innovation - Alternative Payment Models
  - State Innovation Model (SIM)
  - Medicare Access to Care Reform Act (MACRA)
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Bundled Payment Initiatives
- Medicaid Finance and Policy Changes

Medicare Rules Update

Medicare CY 2017 OPPS Proposed Rule

- Comment period closed Sept. 6
- Proposed implementation of “Site Neutral” policy mandated by Section 603 of the Bipartisan Budget Act of 2015
- Would limit the ability of existing off-campus provider based departments to relocate or expand beyond services offered Nov. 1, 2015, and be paid under the OPPS
- MHA urged CMS to modify and delay implementation of the proposed changes
- Final rule expected by Nov. 1, for a Jan. 1, 2017 effective date

MHA | Continued, OPPS

- Implements 25 new comprehensive APCs
  - Bundle payments for device-dependent procedures
- Expands list of services packaged into APCs – not separately paid
- Removes “pain management” from 2018 hospital VBP program
- 20% payment reduction for imaging services using film based X-rays

Continued, OPPS

- Provides 1.6% update to conversion factor
  - Includes MB, ACA productivity, ACA MB reduction, and BN adjustments
  - Does not include site neutral impact
- Michigan estimated impact
  - $38.4 million, or 2.0% increase from 2016
  - Does not include site neutral impact
- Individual hospital reports July 28

Medicare FY 2017 IPPS Final Rule

- Statewide impact estimated at $20 million, or 0.5% increase when all changes are considered; individual hospital impact will vary
- Net 0.9% increase to base rates after all adjustments and budget neutrality
  - Includes MB, ACA productivity, ACA MB reduction, and BN adjustments
  - For hospitals that comply with IQR and EHR requirements
- Capital rate up 1.9%
- No change in labor share; 69.6% for hospitals with AWI of 1.0 or more; 62% for AWI < 1.0

MHA | Continued, IPPS

- Includes $429 million reduction to uncompensated care component of Medicare DSH
  - Comprises 75% of Medicare DSH program
  - Reduces Michigan DSH payments by approx. $15 million
  - Remaining 25% of Medicare DSH based on traditional formula
- CMS did **not** finalize its proposal for a three-year phase-in to use cost report worksheet S-10 data beginning in FY 2018
- MHA distributed hospital-specific impact analysis week of Sept. 6

Impact of Medicare Quality-based Programs

- Value-based purchasing program – hospital contribution increases from 1.75% to 2%
  - Hospitals can remain whole; or earn < or >
- Readmissions reduction program – hospitals with "excess" readmissions are subject to payment reduction of up to 3% based on readmissions for six select medical conditions
  - AMI, HF, Pneumonia, COPD, THA/TKA
  - CABG added to list of medical conditions in 2017
  - Hospitals remain whole or lose to CMS
  - No other changes proposed or adopted

MHA | Continued, Quality-based Programs

- Hospital Acquired Conditions (HAC) reduction program
  - Hospitals remain at risk for 1% payment reduction depending on HAC score on two domains relative to hospitals nationally
    - Domain 1 = claims based measures
    - Domain 2 = chart abstracted measures
  - Top quartile (worst performing) subject to penalty
  - Hospitals remain whole or lose to CMS
    - Score of 7.0 or > resulted in FY 2015 penalty
    - Dropped to 6.75 for FY 2016
    - Estimated at 6.45 for FY 2017

HAC Program Changes

- For FY 2018, CMS adopted a modified version of the PSI-90 composite measure titled “Patient Safety and Adverse Events Composite” comprised of 10 component indicators instead of 8
- Revised scoring methodology beginning in FY 2018. Currently a hospital’s individual HAC score can range from 1 to 10, based upon which national performance decile they fall into
- CMS adopted a new methodology in which hospitals would receive a score for each measure that compares performance to the national mean
  - Impact will vary by individual hospital; statewide impact estimated at positive $1.1 million

Medicare Outpatient Observation Notice (MOON)

- Aug. 6, 2015 – Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), which requires PPS and critical access hospitals to provide written notification to individuals who receive observation services for more than 24 hours
- CMS will implement the NOTICE Act and requires use of a new CMS-developed standardized notice, the MOON
  - Impact on co-pays/deductibles
  - Administrative burden for hospitals
- Comment period closed Sept. 1

MOON, Continued

- Notice and oral explanation must be provided to all Medicare beneficiaries (both FFS and MA) who have received outpatient observation services for more than 24 hours
  - Beginning at the clock time documented in the patient's medical record
- Provision of the MOON must be no later than 36 hours after the start of observation services
  - Must be furnished sooner if the patient is transferred, discharged or admitted to inpatient within that timeframe

MOON, Continued

- Notice must be signed by patient or representative acknowledging that notice was provided
- If patient or rep refuses to sign, the notification must be signed by the staff member who presented the written notification, including name, title and certification statement that the notification was presented, and the time/date it was presented
- The MOON must be provided to Medicare beneficiary, regardless of whether the services provided are payable under Medicare
- MOON expected to be effective early December/early January
  - Other payers expected to follow

Two Midnight Reviews

- Quality Improvement Organizations (QIOs) resumed claim reviews for two-midnight admissions policy Sept. 12
- Two-midnight reviews previously suspended in May to standardize criteria and process following hospital concerns

Two Midnight Reviews

Suspension lifted because QIOs

- Successfully completed re-training on the Two-Midnight policy;
- Completed a re-review of claims that were previously formally denied;
- QIOs performed provider outreach on claims impacted by the temporary suspension; and
- QIOs initiated provider outreach and education regarding the Two-Midnight policy.

- CMS examined and validated the QIOs peer review activities related to short stay reviews

Delivery and Reimbursement Innovation – Alternative Payment Models (APMs)

State Innovation Model (SIM)

- State awarded $70 M grant to develop and test healthcare delivery & payment models
  - IHI Triple Aim:
    - Improving patient experience of care
    - Improving health of the population
    - Reducing per capita cost of care
- Multi-payer
- 5 pilot regions
  - Genesee County
  - Jackson County
  - Muskegon County
  - Northern Region (Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Manistee, Missaukee and Wexford counties)
  - Livingston & Washtenaw counties

Continued, SIM

- Focus of SIM
  - Coordinating care
  - Transition planning
  - Data interoperability
  - Integrating behavioral and physical health
  - Shift reimbursement to value- or outcome-based models

MHA | Continued, SIM

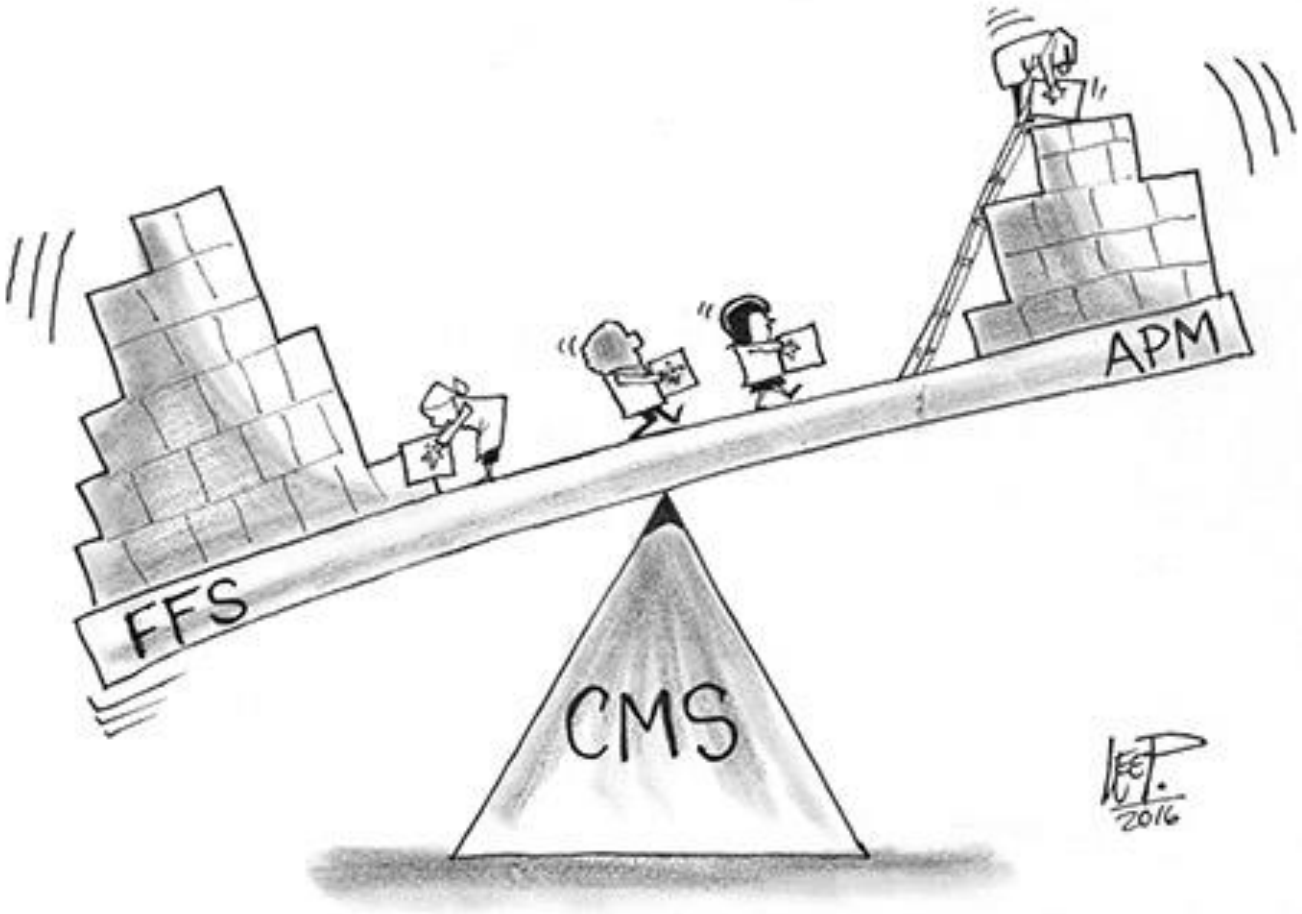
- Community Health Innovation Regions (CHIRs)
  - Entity to coordinate and organize community efforts linking healthcare and other social services
  - Develop consolidated health needs assessment and comprehensive improvement plan
  - Areas of focus
    - ED utilization (year 1)
    - Chronic condition management
    - At-risk pregnancies

Continued, SIM

- SIM Summit Aug. 10 – 11
- PCMH initiative
  - Begins 1/1/17
  - 450-500 expected practices
  - $22M gross included in FY 2017 Medicaid HMO rates
  - Medicaid HMOs will receive care coordination and practice transformation payments
- CPC+ begins 1/1/17
- MiPCT ends 12/31/16

CMS Payment Goals

- By 2018
  - 50% of Medicare payments through alternative payment models
  - 90% of Medicare payments tied to quality
- Examples
  - CPC models
  - Hospital VBP program, RRP, and HAC program
  - CJR
  - MSSP and ACO models


FFS
APM
CMS
2016

Medicare Access to Care Reform Act (MACRA)

- Repeals Medicare physician SGR methodology
- Establishes value-based physician quality programs beginning in 2019 for Medicare FFS
  - Default Merit-based Incentive Payment System (MIPS) or
  - Advanced alternative payment models (APMs)
- Applies to physicians, PAs, NPs, CRNAs

MHA | Continued, MACRA

- MIPS 1st year performance categories:
  - Cost at 10%
    - No new reporting; based on Medicare claims
  - Quality at 50%
    - Choose 6 measures from more than 200
    - One must be outcome measure and one cross-cutting
  - Clinical Practice Improvement Activities at 15%
    - Choose from more than 90 options
  - Advancing Care Information at 25%
    - Replaces EHR/MU and moves away from all-or-nothing measurement
    - Report key measures of interoperability and info. exchange

MHA | Continued, MACRA

- MIPS performance results in a composite score
  - Provides positive or negative adjustments
    - 2019 = 4%
    - 2020 = 5%
    - 2021 = 7%
    - 2022 & later = 9%
  - First 5 years allows additional $500M (not part of BN) for highest performers
- Exempt from MIPS if:
  - Newly enrolled in Medicare
  - Less than or equal to $10,000 in Medicare charges or 100 Medicare patients
  - Participating in an advanced APM

MHA | Continued, MACRA

- Advanced APM – 5% bonus payment incentives
- Limited APMs qualify as advanced
  - Comprehensive ESRD Care, CPC+, MSSP Tracks 2 and 3, Next Gen ACO, Oncology Care Model
  - CMS to update list annually
- Advanced APM standards
  - Require clinicians to bear certain amount of financial risk
  - Payments based on quality measures comparable to those used in MIPS quality performance category
  - Require clinicians to use certified EHR technology

MHA | Continued, MACRA

- To qualify for payment advanced APM payment incentives, must meet payment or patient requirements
- Standards increase over time

Payment Year	2019	2020	2021	2022	2023	2024 and later
Pct of Payments through aAPMs	25%	25%	50%	50%	75%	75%
Pct of Patients through aAPMs	20%	20%	35%	35%	50%	50%

- Starting 2021, participation requirements for advanced APMs expands to include non-Medicare payers/patients

MHA | Continued, MACRA

- Final rule expected by Nov. 1
- New guidance from CMS on 9/8/16: Practitioners will be able to pick from 4 options for performance year 1
  - Option 1: test the program
    - No negative payment adjustment if some data is submitted after Jan. 1, 2017
  - Option 2: participate for part of the CY
    - Partial performance period could qualify for a “small” positive adjustment

Continued, MACRA

- Option 3: participate for full CY
  - Full year participation could qualify for "modest" positive payment adjustment
- Option 4: participate in advanced APM
  - Could qualify for 5% bonus/incentive payment


MACRA
"GET READY? FOR WHAT?
RUMBLE!

Medicare CJR

- Mandatory bundled payment model
- For hospitals in 67 MSAs nationally - Flint and Saginaw in Michigan
- Effective April 1, 2016 through Dec. 31, 2020
- Applicable to Medicare FFS beneficiaries paid under PPS
  - MS-DRGs 469 and 470 – major joint replacements (hips and knees)
- Hospitals financially accountable for eligible episodes of care
  - Includes hospital, physician, and post-acute care
  - Episode continues for 90 days post discharge

Continued, Medicare CJR

- CMS establishes episode prices (risk stratified) for participating hospitals
  - Phased regional pricing
  - Specific pricing for hip fracture patients
  - Inclusive of all services after discharge
- Providers will receive traditional FFS payments
- Actual spending compared to episode prices
  - Hospitals may receive additional payment or repay portion to CMS

Medicare Proposed EPMs

- Proposed mandatory bundled payment models – episode payment models (EPMs)
- Applicable to Medicare FFS beneficiaries paid under PPS
  - Acute myocardial infarction (AMI) - MS-DRGs 280-282 and 246-251 with AMI diagnosis codes
  - Coronary artery bypass graft (CABG) – MS-DRGs 231-236
  - Surgical hip/femur fracture treatment (SHFFT) – MS-DRGs 480-482
- Effective July 1, 2017 through Dec. 31, 2021
- Comment period ends Oct. 3

Continued, Medicare EPMs

- Applicable MSAs
  - For SHFFT, same 67 MSAs as CJR
  - For AMI and CABG, random selection of 98 MSAs
- Hospitals financially accountable for eligible episodes of care
  - Includes hospital, physician, and post-acute care
  - Episode continues for 90 days post discharge

Continued, Medicare EPMs

- CMS establishes episode prices (risk stratified) for participating hospitals
  - Phased regional pricing
  - Inclusive of all services after discharge
- Providers will receive traditional FFS payments
- Actual spending compared to episode prices
  - Hospitals may receive additional payment or repay portion to CMS

Comprehensive Primary Care Plus (CPC+)

- 5-year, multi-payer patient-centered medical home (PCMH) model
- 5 primary care functions
  - Access and continuity
  - Care management
  - Comprehensive and coordinate care
  - Patient and caregiver engagement
  - Data-driven population health management
- 2 track model with Track 2 having additional requirements

Continued, CPC+

- Payers solicited proposals sought by CMS between April 15 - June 1
  - 14 regions selected nationally early August including Michigan statewide
  - BCBSM and Priority Health provisional payers
- Practice applications were accepted by CMS between Aug. 1 and Sept. 15
  - Up to 5,000 practices
- Program begins Jan. 1, 2017

Continued, CPC+

- Financing
  1. Care management fees: risk adjusted, non-visit based, PMPM payments
  2. Performance-based incentive payment: payment for patient experience, clinical quality, and utilization
  3. Physician fee schedule:
     - Track 1- FFS payments only
     - Track 2- hybrid of FFS payments plus percentage of E&M payments up-front

Continued, CPC+

- CPC+ model meets CMS proposed MACRA advanced APM criteria
  - Practices exempt from MIPS
  - Practices eligible for MACRA APM bonus payments

HERE. TRY THIS . . . . .

Medicaid Finance and Policy Changes

Medicaid DSH Payments

- FY 2011 & 2012 Audits completed
  - Additional $18 million in DSH payments distributed, resulting in a $10 million net benefit
  - Payments distributed in June 2016
- FY 2013 Step 2 DSH process completed in June
  - Impacted payments from both $45 million regular DSH pool and tax-funded outpatient uncompensated care DSH pool
- FY 2014 Step 2 DSH process expected to be completed by MSA this fall
- Hospitals asked to provide FY 2015 regular HRA, HMP HRA and Psych HRA payment data to MSA by Oct. 3 for use in 2015 Step 2 process
  - MHA provided data to hospitals with payment amounts needed for reporting

Continued, Medicaid DSH Payments

HRA Amounts

Hospital Medicare Number: _____

Hospital Name: _____

SFY 2015 (Oct. 2014 – Sept. 2015) HRA Amount: $_____
SFY 2015 (Oct. 2014 – Sept. 2015) HRA HMP Amount $ _____

SFY 2015 (Oct. 2014 – Sept. 2015) Psych HRA Amount: $_____
SFY 2015 (Oct. 2014 – Sept. 2015**) Psych HRA HMP Amount $**_____

Continued, Medicaid DSH Payments

- In Mid-August, MSA distributed preliminary FY 2016 Step 1 payment data to hospitals for review
- FY 2016 Step 1 payments to be distributed by Sept. 30
- FY 2017 DSH eligibility forms must be submitted to MSA via file transfer site by Oct. 3
  - Failure to do so will result in forfeiting DSH payments

Continued, Medicaid DSH Payments

I certify that the following DSH Eligibility Status applies for the above facility for the state fiscal year as of the date of submission of this form as it was entered on the DSH Eligibility Status Report.

☐ 1. At least two (2) obstetricians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

First Physician Name and NPI: _____

Second Physician Name and NPI: _____

☐ 2. This hospital is located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and at least two (2) physicians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

First Physician Name and NPI: _____

Second Physician Name and NPI: _____

☐ 3. This hospital serves as inpatients a population predominantly comprised of individuals under 18 years of age.

☐ 4. On December 22, 1987, this hospital did not offer obstetric services to the general population, except in emergencies.

☐ 5. None of the above apply. The hospital is not eligible for a disproportionate share adjustor.

MHA | Quality Assurance Assessment Programs

- Four hospital provider tax funded programs
- Medicaid Access to Care Initiative (MACI)
  - Medicaid FFS program began in FY 2003.
  - $410 million in FY 2016
- Hospital Rate Adjustment (HRA)
  - Through the Medicaid HMOs, started January 2007. $966 million in FY 2016
- Disproportionate Share Hospital (DSH)
  - Outpatient Uncompensated Care DSH pool started FY 2008. Increased to $145 million in FY 2015.
- Psych HRA – Started FY 2010. $45 million annually

FY 2017 Supplemental Payment Pools

- MACI and HRA payment amounts not yet known
- DSH and Psych HRA continue at current funding levels
- Rural Access Pool and OB Stabilization Pools (GF-funded) continue at FY 2016 levels

HMP MACI Payments

- $400 million in HMP MACI payments distributed for fiscal years 2014 and 2015
  - $148 million – FY 2014 – paid Dec. 2015
  - $252 million – FY 2015 – paid April 2016
- FY 2016 payments expected to be distributed by Dec 31 -- Amounts not yet available.
- MSA goal is for quarterly payment distribution in FY 2017
- Hospitals will be subject to 5 percent tax related to HMP MACI and HRA payments effective Jan. 1
  - Tax will increase to 10% by 2020

Medicaid & CHIP Managed Care Final Rule

- Key provisions include:
  - Establishment of a medical loss ratio standard
  - Requirements for determining actuarially sound rates
  - Flexibility for institutes for mental disease funding for up to 15 days
  - Quality requirements for states
    - Quality rating system, state managed care quality strategy, external quality reviews

Continued, CMS Medicaid & CHIP Managed Care Final Rule

Key Provisions (continued)

- Emphasis on value-based purchasing models for provider reimbursement
  - Pay-for-performance
  - Bundled payments models
  - Other models that recognize outcomes rather than volume of services
- Eventual elimination of contractually-required pass-through payments

- Timeframes vary by provision


#!?%@*!
ACA
GOAL

MHA Resources

- Monday Report is available **FREE** to anyone and is distributed via email each Monday morning
  - Go to website and select “Newsroom”, then Monday Report
- Request password if you don’t have one
  - Email Donna Conklin at dconklin@mha.org to obtain MHA member ID number
- Advisory Bulletins – Extensive communications available only to MHA members, as needed (Require password to obtain from website)
- Hospital specific mailings as needed for various impact analyses, etc.
- Periodic member forums
- See mha.org for other resources
- Monthly Financial Survey (MFS) provides free benchmarking of financial and utilization statistics

Questions

Nathanael Wynia

Director, Finance

(517) 703-8625

nwynia@mha.org