MHA Finance and Policy Update

Healthcare Financial Management Association (HFMA)
Western Michigan Chapter

Jan. 20, 2016

Nathanael Wynia, CPA
Director of Finance
Michigan Health & Hospital Association (MHA)
Finally... a nasty, senseless, bloody brawl that has nothing to do with the fiscal cliff or the debt ceiling!
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
• 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 or Vickie Kunz at the MHA.
Examples of MHA Involvement

• Maximize federal funding in state Quality Assurance Assessment Program (QAAP)
• Provide input on proposed policies and analysis of proposed and final policies.
• BCBSM DRG validation audits
• Auto No-Fault Insurance
• CFO Forums
Upcoming Events

- CFO Forums
  - Changes in the Financial Landscape
    - Wednesday, Feb. 24 – Grand Rapids – 1:30-4:00p.
    - Agenda includes:
      - Insurance Landscape
      - Hospital Landscape
      - Medicaid, Medicare and BCBSM.
  
- DSH Audit Education Session Feb. 25
  - MHA HQ in Okemos or via Conference Call
• Overall rate update of **negative 0.4 percent** after 2.4% MB is reduced for 0.7 percent point ACA reductions and 2 percentage point reduction to account for the Office of the Actuary’s previous overestimation for the amount of package lab tests.

• Hospitals that do not publicly report quality measure data would be subject to statutory 2.0 percentage point additional reduction.
## Estimated Impact – OPPS Final Rule

### Michigan

<table>
<thead>
<tr>
<th>Impact Analysis</th>
<th>Dollar Impact</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated CY 2015 OPPS Payments</td>
<td>$2,033,702,900</td>
<td></td>
</tr>
<tr>
<td>Marketbasket Update including Budget Neutrality Adjustments</td>
<td>$43,317,800</td>
<td>2.1%</td>
</tr>
<tr>
<td>ACA-Mandated Marketbasket Reductions</td>
<td>($14,236,100)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Inflation Adj for Excess Packaged Payments for Laboratory Tests</td>
<td>($41,364,700)</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Wage Index</td>
<td>$6,264,200</td>
<td>0.3%</td>
</tr>
<tr>
<td>Loss of Wage Index Blend</td>
<td>($10,000)</td>
<td>0.0%</td>
</tr>
<tr>
<td>APC Factor/Updates</td>
<td>$2,654,200</td>
<td>0.1%</td>
</tr>
<tr>
<td>Estimated CY 2016 OPPS Payments</td>
<td>$2,030,328,300</td>
<td></td>
</tr>
</tbody>
</table>

**Total Estimated Change CY 2015 to CY 2016**

|                                                                 | ($3,374,600) | -0.2% |

*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 2016 OPPS PPS-specific payments would be: -$40,606,800*
• Hospital-specific impact analyses distributed via email Dec. 2.

• CEO/COO/CFO/Directors of Reimbursement.
CMS finalized its proposal that certain hospital inpatient services that do not cross two midnights may be appropriate for payment under Medicare Part A if a physician determines and documents in the medical record that the patient requires reasonable and necessary admission as an inpatient.
Relevant factors in determining whether an inpatient admission is appropriate where patient stay is expected to be less than two midnights:

– Severity of patient’s signs and symptoms
– Medical predictability of adverse patient outcomes
• Quality Improvement Organizations (QIOs) rather than Recovery Audit Contractors (RACs) of Medicare Administrative Contractors will conduct first-line medical reviews of the majority of patient status claims and to educate hospitals about claims that were denied under the two-midnight policy.
  – Effective Oct. 1, 2015

• RACs will focus on hospitals with consistently high denial rates.
Recent RAC Improvements

• A reduction in the number of claims that the RAC may audit for providers other than physicians and suppliers.
• A decrease in additional documentation request (ADR) from 2% to 0.5% of total Medicare paid claims from previous year.
• Diversification of RAC audits across all claim types for a facility, limiting the RAC’s ability to target care provided in a particular setting.
• Adjustment of the ADR up or down based on provider’s claim denial rate.
• RAC look-back period limited to 6 months from DOS for patient status reviews in cases where hospital submits a claim within 3 months of DOS.
• Hospitals encouraged to submit data to the quarterly RACTrac survey by Friday, Jan. 22.

• Survey results helps the AHA gauge the impact of the RAC program and advocate for needed changes.

• Contact RACTrac support at 888-722-8712 or ractracsupport@providerscs.com.

• See Jan. 18 MHA Monday Report for additional info including technical assistance.
Mandatory Bundled Payments Model

- Finalized by CMS in November – implements the first mandatory bundled payments model in US.
- Applies to all acute care hospitals located in 67 Metropolitan Statistical Areas of the US – including Flint and Saginaw.
- Takes effect April 1, 2016, runs for almost 5 years.
- Applies to Major Joint Replacements – discharges assigned to MS-DRGs 469 or 470.
- Includes all Medicare Part A and B services, including post-acute care, with limited exclusions for 90 days.
• Hospital-specific reports distributed Jan. 6 to all hospitals, including non-mandatory reporting areas
• CMS will likely expand to other MSAs and other MS-DRGs in the future.
Medicare Quality-Based Programs

• 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
Hospital-specific reports distributed Jan. 12 regarding hospital performance and estimated financial impact of FY 2016 VBP, RRP and HAC reduction programs.

**Michigan Impact:**
- VBP Program - 52 hospitals earning $4.6M more than their contribution while 35 hospitals earn $5.9M less than their contribution.
- RRP – 96 hospitals subject to $20M payment reduction.
- HAC program – 24 hospitals subject to $13M payment reduction.
State of the State
Jan. 19, 2016
• Enrollment: 590,464 as of Jan. 11
• Traditional Medicaid: 1.75 million
State law as written required beneficiaries between 100 and 133% FPL after 48 months to either:

- Purchase exchange plan (eligible for tax credits) OR
- Incur cost-sharing up to 7% of income to remain on HMP (can reduce contribution by participating in healthy behavior activities)

“Second Waiver” -- to allow this level of cost-sharing submitted Sept. 1.
• Medically frail individuals exempt from cost-sharing provision

• Without waiver approval HMP for all beneficiaries would have ended Apr. 30, 2016
• CMS approved Second Waiver Dec. 17.
• Effective April 1, 2018, after 48 months of cumulative coverage, HMP enrollees with incomes between 100 - 133% FPL must elect to either purchase coverage on the health insurance exchange or work with their physicians on certain health improving strategies
• Few, if any, individuals will pay more than 5% of income in cost-sharing
• Coverage preserved for all HMP beneficiaries
• Service areas are Gov. Snyder’s 10 prosperity regions.
• Coverage includes MIChild
• Effective Jan. 1, 2016 for five years with extensions available
• Region 4 (Grand Rapids):
  – BCBSM, McLaren, Meridian, Molina, Priority, UHC
• Region 8 (Kalamazoo):
  – Aetna, McLaren, Meridian, Molina, Priority, UHC
• Region 7 (Lansing):
  – BCBSM, McLaren, Meridian, Molina
• Sparrow PHP (Region 7) and HAP Midwest (Southeast Michigan) not awarded contracts; appeals to State Administrative Board denied.
• PHP sold Medicaid service line and transferred 21,000 beneficiaries to BCBSM
• HAP sold Region 10 Medicaid service line and transferred 85,000 beneficiaries to Molina
• Automatic coverage Jan. 1.
• Communicate any systematic payer issues to Marilyn Litka-Klein or Vickie Kunz at the MHA.

• Goal is to streamline coverage for beneficiaries and providers.

• Jan. 1 to March 31– Contracted health plans code and test Common Formulary in their claims systems.

• Apr. 1- Health plans start to transition members to the Common Formulary.

• Sept. 30- All members are transitioned to the Common Formulary.
• Quality Assurance Assessment Programs - four hospital provider tax funded programs

• Two largest programs are MACI and HRA

• Medicaid Access to Care Initiative (MACI)
  – Medicaid FFS program began in FY 2003.
  – Tax and payments issued quarterly
  – Designed to fill the gap between the Medicaid payment rate what Medicare would pay

• Hospital Rate Adjustment (HRA)
  – Through the Medicaid HMOs, started January 2007
  – Tax and payments issued monthly
• Based on calculations completed in December 2015, MACI pool decreasing from $525 million in 2015 to $402 million in 2016 due to Medicaid FFS enrollment and utilization decreases.
• CMS approved FY 2014 HMP MACI pool of approx. $149 million.
  – Payments distributed Sept. 17.
  – Minimal $3.5 million QAAP tax associated with these payments for individuals that would have qualified for traditional Medicaid.

• FY 2015 HMP MACI pool amount estimated at $252 million.
  – Approval expected; timeline unclear.
• HMP HRA payments targeted at approximately $34 million monthly
• Medicaid cost report includes new forms to report HMP cost, payments, and HRA payments
• FY 2011: Audit complete; Step 3 payment recovery and redistribution awaiting outcome of Washington and Texas litigation

• FY 2012: Audit complete; Final report submitted to CMS in December 2015.
  – After accounting for CPE transactions, recoveries limited to 1 hospital that received payments in excess of its DSH limit
• FY 2013 Step 2 recalculation was placed on hold due to federal litigation

• FY 2013 DSH audit expected to begin in February/March 2016.
  – MHA hosting DSH audit education session Feb. 25 – attend in-person or by conference call

• FY 2014 Step 2 recalculation expected in 2016

• FY 2015 Step 1 payments made Sept. 24
  – Payments will be recalculated in Step 2
  – Consider impact of reduction in uninsured on DSH limits
• Demo is live in 8 Southwest Michigan counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St Joseph, Van Buren.

• All counties in the Upper Peninsula
• Wayne and Macomb Counties in Southeast Michigan
• MDHHS Website:
  http://michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077-335615--,00.html.

• Hospitals encouraged to contact special mailbox:
  – IntegratedCare@Michigan.gov

• Also encouraged to contact Vickie Kunz at MHA.
• Effective Jan. 1.
• Final policy released Dec. 1.
• Program currently covers approx. 35,000 children up to age 18 with a household income below 212 FPL and no other source of comprehensive insurance.
• MIChild families pay $10 monthly premium
• Provides access to full range of Medicaid-covered services including behavioral healthcare and Healthy Kids dental.
• MI Child transition to Medicaid enables retroactive coverage

• Under previous rules, a MIChild application received during January would have an eligibility begin date of March

• Under new rules, child may be enrolled in the month of application with retroactive coverage for 3 months or back to date of program change (Jan. 1, 2016).

• Hospital and other providers should bill the MHP rather than Medicaid FFS unless the newborn is placed into foster care.

• Providers encouraged to validate mother’s MHP enrollment to ensure that correct payer is billed.
• Medicare Advantage Enrollment approx. 648,000 as of January 2016.
  – 34% of MI’s 1.9 million Medicare beneficiaries
  – 348,000 in BCBSM / BCN.
  – 107,000 in Priority Health.
  – 44,000 in HAP Midwest
  – 56,000 in Humana

• Enrollment matrix updated quarterly; will be published in Jan. 26 Monday Report
• Health Insurance Exchange Enrollment
  – 323,000 enrolled as of Dec. 26 compared to 341,000 enrolled during 2015 open enrollment
  – 65% of enrollees are BCBSM / BCN
  – Open enrollment continues until Jan. 31.
  – Average premium increase 6.5%
Community Survey

- 2015 Health Insurance Status for those Uninsured in 2014

Kevin Callison, Ph.D.; Leslie Muller, Ph.D.; Gerry Simons, Ph.D.; Paul Isely, Ph.D.; and Kathleen Pedres, graduate assistant; editors
Grand Valley State University, Seidman College of Business
  – $575 million surplus for FY 2015 due to higher than expected tax collections and lower than expected Michigan business tax refunds
• Where the surplus could go...
  – Current year (2016) general fund revenue estimates lowered by $38 million
  – 2017 revenue estimates lowered by $20 million

• Gov. Snyder’s Executive Budget Recommendation for FY 2017 scheduled to be released Feb. 10.
Healthcare Budget Challenges for FY 2017:

• State matching funds for Healthy Michigan Plan
• Cost of specialty drugs for Medicaid beneficiaries
• Increase in state match for traditional Medicaid
• Potential Dec. 31, 2016 loss of HICA tax

Competing Priorities:

• Higher Education
• Detroit Public Schools
• Flint Water Crisis
• Roads/Infrastructure
• Monday Report is available **FREE** to anyone and is distributed via email each Monday morning.
  – Go to website and select “Newsroom”, then Monday Report
• MHA Monday Report – electronic publication issued weekly
• 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.
Nathanael Wynia
Director of Finance
Michigan Health & Hospital Association
110 West Michigan Avenue, Suite 1200
Lansing, MI 48933
Phone: (517) 703-8625
Email: nwynia@mha.org