Medicare and Medicaid Update

Healthcare Financial Management Association (HFMA)
Great Lakes Chapter

Sept. 25, 2015

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Michigan Health & Hospital Association (MHA)
Who is the MHA?

• Trade association representing all hospitals in Michigan.

• Activities include:
  – State advocacy and policy on Medicaid funding and health policy issues
  – 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 (mklein@mha.org) or Vickie Kunz (vkunz@mha.org) at the MHA.
Examples of MHA Involvement

- Maximize federal funding in state Quality Assurance Assessment Program (QAAP)
- Medical Services Administration Hospital Workgroup and Hospital Reimbursement Reform Initiative
- Provide input on proposed policies and analysis of proposed & final policies
- BCBSM DRG validation audits
- Auto no-fault insurance payment rates
- CFO Forums
  - Oct. 12 (Traverse City), Dec. 11 (Marquette), Jan. 8 (Bay City)
  - Future forums early 2016 in Southeast Michigan & Grand Rapids
• Medicaid
  – FY 2016 Budget
  – Healthy Michigan Plan
  – Medicaid DSH
  – Payment Policy Changes
  – Managed Care Update

• Medicare Rules Overview
  – IPPS – Final
  – Post-Acute Rules – Final
  – OPPS – Proposed
• FY 2016 budget maintains GF funding for Graduate Medical Education, Rural Access Pool and OB Stabilization Pool Payments at FY 2015 pre-EO levels.
• FY 2016 budget includes a $93 million QAAP tax increase.
• FY 2016 HRA pool to be $93 million higher than FY 2015 pool.
• FY 2016 MACI pool amount not yet determined.
• $85 million tax-funded outpatient uncompensated care DSH pool continues into FY 2016
• Reductions:
  • $35 million in hospital capital payments
  • Prospective payments based on a blend of FFS and HMO data. Proposed by MSA in late 2014; opposition by MHA and hospitals resulted in MSA not implementing for FY 2015.
Reliance on hospital tax increases while state general fund support has decreased.
Covering the Uninsured

The 47 Million* uninsured

I can afford it, but I don't want it.

I'm 18-25 years old, and I'm indestructible.

I'm an illegal, and I'm not here.

I'm in between jobs and only temporarily uninsured.

I am eligible for government health programs but have not signed up.

I'm covered, but my parents have not signed me up.

18 million
84 million
12.6 million
94 million
8 million
3.5 million

*Adds up to more because some categories overlap.
Source: MDCH Presentation to House Health Policy Committee, 3/3/2015
• Enrollment: 593,607 as of Sept. 21
• Waiver for cost-sharing submitted Sept. 1.
• Affects individuals between 100 and 133% FPL.
• State law as written requires these beneficiaries 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)
• Waiver must be approved by 12/31 or HMP for all beneficiaries ends 4/30/16
• State officials cautiously optimistic
• Hospitals encouraged to comment to CMS:
• 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 pending.
  – CMS requested that MSA recalculate this amount using a more complete claims set.
  – Approval expected by Dec. 31.

• HRA Payments Approximately $30 million per month
September 2015 DSH payment distributions

- $45 million pool under existing MSA policy (GF)
- Combined $145 million tax-funded pool
- $60 million tax-funded pool, under existing MSA policy
- New $85 million tax-funded pool
  - $15 million to small or rural hospitals
  - $65 million to large and urban hospitals
  - $5 million to large and urban hospitals, adjusted by Medicare value-based purchasing program factor
  - Final $5 million pending CMS approval.
• Hospitals are required to return completed FY 2016 DSH eligibility form to the MSA no later than Oct. 1, 2015.
  
  – Failure to do so will result in hospital forfeiture of all Medicaid DSH payments for FY 2016.
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.
• MSA distributed request to hospitals for HRA and Psych HRA payment data for state FY 2014 that will be used for Step 2 DSH calculation.

• Data due to MSA Oct. 12.

• MHA summarized and distributed FY 2014 HRA data to hospitals Sept. 18.

• MMF Software will be updated to include HMP field
## HRA Amounts

Hospital Medicare Number: _____________

Hospital Name: ____________________________________________


Effective July 1, the MSA implemented a short stay rate for specific diagnosis codes in non-surgical cases.

- Claim includes a qualifying diagnosis code based on MSA policy
- Outpatient claim includes observation revenue code (762)
- Inpatient or outpatient claim does not include surgical revenue code (36x) or cardiac cath revenue code (481)
- Inpatient discharge of same day or next day

Rate of $1,314 applies to Medicaid FFS cases and non-contracted HMO cases

- Rate is inclusive of operating and capital
- Same rate paid to hospitals regardless of hospital determination of inpatient or observation status.
- If patient meets criteria for inpatient admission, patient days will be counted for Medicare DSH purposes.

List of applicable ICD-10 Codes to take effect Oct. 1. released in final policy Sept. 1.
"It's volume one of the ICD-10 code manual. Where do you want it?"
Effective Oct. 1, the MSA is implementing several policy changes:

- **Statewide DRG rate, adjusted for area wage index**
  - one rate for PPS hospitals and another rate for CAHs
  - Budget-neutral statewide; individual hospital impact may vary.
  - Adjusted rates available on MDHHS website.

- **APR-DRGs, simultaneously with ICD-10.**

- **Hospital-specific capital rates developed using a blend of FFS and HMO data.**

- **Rates and relative weights will be updated annually on Oct. 1.**
• Request for Proposal (RFP) released May 8.
• List of bidders is available
• Contract awards to be announced Nov. 1, 2015.
• New contracts will be effective Jan. 1, 2016 for five years with three one-year extensions available.
• Service areas will be Gov. Snyder’s 10 prosperity regions.
• HMOs submitting proposals must provide Medicaid coverage for **all counties within a region**.
  – Key change from current process

• HMOs for Northern Lower Michigan must bid for both Regions 2 and 3.

• MDHHS will develop a common pharmacy formulary that will be administered by each HMO.

• MI Child will be folded into regular Medicaid under the HMO rebid.
• Net 0.5 percent increase to base rates after all adjustments and budget neutrality.
• Capital 0.8 percent update.
• Outlier threshold reduced from $24,626 to $22,544.
  – Will increase # cases eligible for an outlier payment.
<table>
<thead>
<tr>
<th>System Component</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Update</strong></td>
<td>0.5% Net Increase after all adjustments including ATRA Documentation/Coding Adjustment and budget neutrality</td>
</tr>
<tr>
<td><strong>Wage Index</strong></td>
<td>Redefined CBSAs based on 2010 census – besides direct wage index implications, may impact other programs or special designations. Impacted 5 Michigan counties</td>
</tr>
<tr>
<td><strong>VBP Program</strong></td>
<td>1.75% rate reduction with opportunity to earn back amount withheld or more</td>
</tr>
<tr>
<td><strong>Readmissions Reduction</strong></td>
<td>Keep pace with national average or be subject to reduction of up to 3% reduction</td>
</tr>
<tr>
<td><strong>Hospital Acquired Conditions Reduction</strong></td>
<td>Hospitals in top quartile (the worst performing) will be penalized 1% (HAC penalty applies to total payment including DSH, IME, etc.)</td>
</tr>
<tr>
<td><strong>Wage Index Timeline</strong></td>
<td>Accelerated deadline for hospitals to request data changes for FY 2017. Prelim PUF released May 15, with hospitals having until Sept. 2 to request changes. Hospitals can request changes to pension data until Oct. 15.</td>
</tr>
<tr>
<td><strong>DSH</strong></td>
<td>25% of traditional formula calculation; remaining 75% pooled for all DSH hospitals, reduced by uninsured reduction factor and then redistributed to hospitals as uncompensated care (UCC) pool based on low income patient days. No major changes but UCC pool $1.24 billion less than in FY 2015.</td>
</tr>
<tr>
<td><strong>Low-Volume Adjustment</strong></td>
<td>Loosened criteria through Sept. 30, 2017 (MACRA Provision)</td>
</tr>
<tr>
<td><strong>MDH (Medicare Dependent Hospital)</strong></td>
<td>Extended through Sept. 30, 2017 (MACRA Provision)</td>
</tr>
</tbody>
</table>
• Hospital-specific impact analysis distributed Sept. 8.
5.75% at risk in FY 2016 for performance

Hospital Compare

IQR
25% reduction of market basket update for not reporting

EHR Incentive Program

VBP
1.75% of base DRG (goes up to 2% in FY2017)
- Rewards for good performance/penalties for poor performance
- Credit for improvement
- Readmission measures cannot be in VBP; HAC measures eligible for VBP

Readmissions
3.0% of base DRG
- Penalties for excess readmissions
- No credit for improvement
- Up to 3% of base DRG at risk

HAC
1.0% of total payment
- Automatic penalty for one quarter of hospitals deemed as having “worst” performance.
- No credit for improvement
- HAC measures are in VBP too
Preliminary data; actual FY 2016 impact will vary with use of actual data.
• 2% reduction to OPPS conversion factor due to CMS’ proposed correction for Actuarial overestimation of the amount of packaged lab tests.

• Update to two-midnight policy
  – Proposal for QIOs rather than RACs to conduct initial medical reviews of patient status claims

• Changes to the outpatient quality reporting program.

• Hospital-specific impact analysis distributed Aug. 13.

• Final rule expected by Nov. 1, effective Jan. 1.
<table>
<thead>
<tr>
<th>Impact Analysis</th>
<th>Dollar Impact</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated 2015 OPPS Payments</td>
<td>$1,874,901,300</td>
<td></td>
</tr>
<tr>
<td>Marketbasket Update including Budget Neutrality</td>
<td>$47,324,400</td>
<td>2.5%</td>
</tr>
<tr>
<td>ACA-Mandated Marketbasket Reductions</td>
<td>($15,353,900)</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Inflation Adj for Excess Packaged Payments for Laboratory Tests</td>
<td>($38,138,900)</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Wage Index</td>
<td>$8,030,100</td>
<td>0.4%</td>
</tr>
<tr>
<td>Loss of Wage Index Blend</td>
<td>($9,400)</td>
<td>0.0%</td>
</tr>
<tr>
<td>APC Factor/Updates</td>
<td>$1,918,900</td>
<td>0.1%</td>
</tr>
<tr>
<td>Estimated 2016 OPPS Payments</td>
<td>$1,878,673,300</td>
<td></td>
</tr>
</tbody>
</table>

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

$3,772,000 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 2024. It is estimated that the impact of sequestration on CY 2016 OPPS PPS-specific payments would be: -$37,573,400*
FY 2016 IPF Final Rule

- Net 2.1 percent increase to base rates after all adjustments and positive budget neutrality.
- 9.4% increase in outlier threshold from $8,755 to $9,580.
  - Will decrease # cases eligible for an outlier payment.
- Wage index blended 50/50 old/new CBSAs.
- Increased labor share from 69.3 to 75.2%.
- See Sept. 15 hospital-specific impact analysis.
<table>
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<tr>
<th>Impact Analysis</th>
<th>Dollar Impact</th>
<th>Percent Change</th>
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<tbody>
<tr>
<td>Estimated FFY 2015 IPF PPS Payments</td>
<td>$165,503,500</td>
<td></td>
</tr>
<tr>
<td>Marketbasket Update</td>
<td>$4,032,100</td>
<td>2.4%</td>
</tr>
<tr>
<td>ACA-Mandated Marketbasket Reductions</td>
<td>($1,158,600)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Wage Index Budget Neutrality</td>
<td>$690,600</td>
<td>0.4%</td>
</tr>
<tr>
<td>Wage Index and Labor Share</td>
<td>($671,500)</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Impact of Wage Index Transition</td>
<td>$60,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>Change to Rural Adjustment Factor</td>
<td>($52,300)</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Estimated FFY 2016 IPF PPS Payments</td>
<td>$168,403,800</td>
<td></td>
</tr>
</tbody>
</table>

**Total Estimated Change FFY 2015 to FFY 2016**

$2,900,300

1.8%

*The impact shown above does not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress and currently in effect through FFY 2024. It is estimated that the impact of sequestration on FFY 2016 IPF PPS-specific payments would be: -$3,368,100.*
• Net 1.8 percent increase to base rates after all adjustments and positive budget neutrality.

• 2.1% decrease in outlier threshold from $8,848 to $8,658.

  – Will increase # cases eligible for an outlier payment.

• Increased labor share from 69.3 to 71%.

• See Sept. 1 hospital-specific impact analysis.
<table>
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<tr>
<th>Impact Analysis</th>
<th>Dollar Impact</th>
<th>Percent Change</th>
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<tbody>
<tr>
<td>Estimated 2015 IRF PPS Payments</td>
<td>$191,331,700</td>
<td></td>
</tr>
<tr>
<td>Marketbasket Update (Including budget neutrality)</td>
<td>$4,896,700</td>
<td>2.6%</td>
</tr>
<tr>
<td>ACA-Mandated Marketbasket Reductions</td>
<td>($1,371,700)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Wage Index and Labor-Related Share</td>
<td>($547,700)</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Transitional Wage Index</td>
<td>($16,900)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Rural Adjustment</td>
<td>$0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Case-Mix Group (CMG) Updates</td>
<td>$290,400</td>
<td>0.1%</td>
</tr>
<tr>
<td>Estimated 2016 IRF PPS Payments</td>
<td>$194,582,400</td>
<td></td>
</tr>
</tbody>
</table>

**Total Estimated Change FFY 2015 to FFY 2016**

$3,251,200  1.7%

The above impact does not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2024. It is estimated that the impact of sequestration on FFY 2016 IRF PPS-specific payments will be: -$3,891,800.
• Net 1.1 percent increase to base rates after all adjustments and positive budget neutrality.

• See Aug. 27 hospital-specific impact analysis.
### Impact Analysis

<table>
<thead>
<tr>
<th>Impact Analysis</th>
<th>Dollar Impact</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated FFY 2015 SNF PPS Payments</td>
<td>$21,616,800</td>
<td></td>
</tr>
<tr>
<td>Marketbasket Update</td>
<td>$501,900</td>
<td>2.3%</td>
</tr>
<tr>
<td>Forecast Error Adjustment</td>
<td>$(132,500)</td>
<td>-0.6%</td>
</tr>
<tr>
<td>ACA-Mandated Productivity Reduction</td>
<td>$(109,800)</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Wage Index Budget Neutrality</td>
<td>$(17,500)</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Wage Index and Labor-Related Share Impact</td>
<td>$94,000</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Estimated FFY 2016 SNF PPS Payments</strong></td>
<td><strong>$21,952,800</strong></td>
<td>**</td>
</tr>
</tbody>
</table>

**Total Estimated Change FFY 2015 to FFY 2016**

**$336,300** 1.6%

*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 2024. It is estimated that the impact of sequestration on FFY 2016 SNF PPS-specific payments will be: -$439,100*
- Net 1.75 percent increase to base rates after all adjustments and budget neutrality.
- Quality reporting program mandated – LTCHs subject to 2 percent penalty.
  - Skin integrity, incidence of major falls, functional status
- Facility-specific impact analysis to be available in the near future.
• Admission to LTCH was immediately preceded by discharge from an acute care hospital.
• Preceding stay included at least 3 days in ICU; or
• Discharge from LTCH is assigned to a DRG based on the patient’s receipt of at least 96 hours of ventilator services (ventilator criterion).
• LTCH discharge does not have principal diagnosis that is either psychiatric or rehabilitation.
<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rate Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Wage Index</th>
<th>Pay-For-Reporting (P4R) Programs</th>
<th>Coding/Budget Neutrality Adjustments</th>
<th>Other Notable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IRF</strong></td>
<td>+1.84%</td>
<td>3-year transition for loss of rural status; New IRF-specific MB; Facility-level adjustments held constant (LIP, Teaching)</td>
<td>Implementing new wage CBSA with 1-year transition: 50/50 blend</td>
<td>Third year of P4R payment determinations</td>
<td>--</td>
<td>ICD-10 implementation 10/15</td>
</tr>
<tr>
<td><strong>IPF</strong></td>
<td>+2.1%</td>
<td>New IPF-specific rates; Facility-level Adjustments held constant (ED, Teaching, DRG, Patient CC, Patient age, Patient per-diem)</td>
<td>FY 2016 hosp. WI</td>
<td>2.0% of MB at risk</td>
<td>Begin Public Reporting Fall FY 2016</td>
<td>--</td>
</tr>
<tr>
<td><strong>LTCH</strong></td>
<td>+1.75%</td>
<td>New LTCH-specific rate; Site neutral payment method mandated for FY 2016</td>
<td>FY 2016 hosp. WI</td>
<td>2% of MB at risk beginning in FFY 2018. 3 initial measures: skin integrity, falls, functional status</td>
<td>--</td>
<td>2 High Cost Outlier targets and fixed loss thresholds</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td>+1.12%</td>
<td>--</td>
<td>FY 2016 hosp. WI 2nd year of transition to new CBSA</td>
<td>2% of MB at risk</td>
<td>--</td>
<td>SNF VBP 7/19, including an all-cause readmission measure; staffing data electronically submitted 7/16</td>
</tr>
</tbody>
</table>
• 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.
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