MHA Update

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HFMA
Spring Conference
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Medicare

- ARRA – HIT Provisions
- Inpatient Hospital Proposed Rule
- Inpatient Psychiatric Facility Update
- Inpatient Rehabilitation Proposed Rule
- Skilled Nursing Facility Proposed Rule
- Recovery Audit Contractor
- Medicare Advantage (MA) Plans
- Other rules & changes

HIT Provisions of ARRA

- Health Information Technology – $19 Billion Nationally
- $505 Million Maximum HIT Add-on for Michigan
- Hospitals can qualify for both Medicare and Medicaid incentives.
- Hospitals must have in place a "certified electronic health record system" and be a "meaningful user".
- Includes using a "certified EHR system" that can exchange health information and report on quality measures.
- Criteria, not completely defined, will be established by the CMS staff.

Continued, Medicare HIT

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- Medicare incentive payments to hospitals:
  - Base of $2 million per hospital per year – total capped at $11 million per hospital.
  - Adjusted upward based on hospitals' total all payer discharges and downward based on hospitals' Medicare percent.
  - Depending on first qualifying year, hospitals can receive payments for up to 4 years beginning in FY 2011.
  - Penalties through MB reductions, starting in FY 2015 for hospitals that are not "meaningful users."

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Cont., Medicare HIT

- Incentive payments available for IPPS and CAHs.
- Psychiatric, rehabilitation, cancer, children’s and long term acute care hospitals are NOT eligible.
- See MHA Advisory Bulletin on March 23.
- Excel model distributed to hospitals week of March 23.
  - Hospitals can modify based on current data.

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Medicare Rules

Release	Rule	Eff Date
• April	FY 2010 IPPS Proposed	Oct 1
• May	FY 2010 SNF Proposed	Oct 1
• May	FY 2010 IPF Final	July 1
• May	FY 2010 IRF Proposed	Oct 1
• July	FY 2010 IPPS Final	Oct 1
• July	FY 2010 OPPS Proposed	Jan 1
• Nov	FY 2010 OPPS Final	Jan 1

2010 IPPS Proposed Rule

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- MHA Advisory Bulletin, dated May 11, 2009.
- Rule published in May 22 *Federal Register*.
  - Display copy released May 1, 2009.

- 2.1 percent marketbasket update for hospitals that submit required quality data BUT actual change is a 0.5 percent **decrease** after 1.9 percent “behavioral offset” and budget neutrality adjustment.
- Overall, proposed rule is expected to **decrease** Medicare IPPS payments by $120 Million, or 2.6%, compared to FY 2009 increase of $168 Million.

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IPPS Payment Update

- Net 0.5 % **decrease** after 2.1% marketbasket update for hospitals that submit quality data offset by 1.9% “behavioral offset”.
- Hospitals that fail to submit quality data will be penalized by 2 percentage points, resulting in a **decrease** of 2.5%.

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Standardized Operating Amounts

For Hospitals with an Area Wage Index Greater Than 1.0

(67.1 Percent Labor Share / 32.9 Percent Nonlabor Share)

Full Update		Reduced Update	
Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
$3,441.26	$1,687.30	$3,373.85	$1,654.25

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Standardized Operating Amounts, cont'd.

For Hospitals with an Area Wage Index Less Than or Equal to 1.0

(62.0 Percent Labor Share / 38.0 Percent Nonlabor Share)

Full Update		Reduced Update	
Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
$3,179.71	$1,948.85	$3,117.42	$1,910.68

Capital Payment Update

- Proposed rate of $420.67, an 8.25 percent decrease from the current rate of $424.17
  - includes 1.9% “behavioral offset.”

Cost Outlier Threshold

- Current FY 2009 threshold: $20,045
- FY 2010 proposed threshold: $24,240

- Represents a 20.9 percent increase in the cost outlier threshold, resulting in fewer cases being eligible for outlier payments.
- For FY 2009, the CMS estimates that it will pay out 5.4%, or 0.3% more than the 5.1% pool set aside for outlier cases.

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IME Payments

- Proposed rule would continue the Indirect Medical Education (IME) Adjustment factor at the current 5.5 percent for every 10% increase in the hospital's resident-to-bed ratio.
- Despite opposition, the CMS proceeded with eliminating capital IME in FY 2010.
  - Michigan impact estimated at $25 million annually.

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Other IME Changes

- Beginning Oct. 1, 2009, patient days associated with beds used for observation services should **not** be included in determining the number of available beds used in a hospital's IME (and DSH) adjustments.
- Hospital required to report total observation bed days in order for those days to be deducted from bed count for IME and DSH.
- Hospital no longer required to distinguish between observation bed days and observation patient days for patients who are not, and for who are ultimately admitted as inpatients.

New Residency Programs

- Clarification that a new medical residency program is one that receives initial accreditation for first time, as opposed to reacrreditation of a program that previously existed at the same or another hospital.
- Hospital that wishes to claim an adjustment to FTE caps due to a new residency program must first evaluate whether the program is “new” for Medicare purposes.

DRG Weights & Classification

- FY 2010 is the second year with weights based 100% on cost and MS-DRGs.
- CMS utilized the same methodology as in FY 2009 for calculating cost-based MS-DRG relative weights.
- Very few changes from FY 2009.
- 746 MS-DRGs, the same as FY 2009.

Continued, MS-DRGs

- FY 2010 MS-DRG weights based on data from the Sept. 2008 update of the FY 2008 MedPAR file, which contains hospital bills received through Sept. 30, 2008, for discharges occurring during FY 2008.
- FY 2009 final weights based on FY 2007 MedPAR file for claims received through March 31, 2008.

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“Behavioral Offset” Adjustment

- When the transition to MS-DRGs began in FY 2007, CMS projected that average CMI would increase, especially in the initial years due to improved medical record documentation as well as more complete and accurate coding.
- CMS actuaries estimated that a 4.8% adjustment was needed to maintain budget neutrality, with this adjustment phase in over 3 years.
  - Known as “behavioral offset”

Continued, “Behavioral Offset”

- In the final FY 2008 rule, CMS phased in this 4.8% adjustment with prospective documentation and coding adjustments scheduled to be:
  - FY 2008 -1.2 percent
  - FY 2009 - 1.8 percent
  - FY 2010 - 1.8 percent

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Continued, “Behavioral Offset”

- As a result of concern from hospitals that the adjustments were too large, Congress enacted subsequent legislation that reduced the documentation and coding adjustment to -0.6 percent for FY 2008 and 0.9 percent for FY 2009 but did not adjustment the 1.8 percent adjustment for FY 2010.
- Legislation granted CMS authority to retroactively adjust for differences between the offsets applied during FY 2008 and 2009 and the actual coding impacts for those years.
- CMS found that the actual FY 2008 CMI increase related to a coding improvement is 2.5% compared to the 0.6% “behavioral offset: adjustment that was applied for FY 2008.
- As a result, the CMS is proposing to apply a 1.9% reduction to the FY 2010 standard amount and intends to complete a similar analysis for FY 2009.

Hospital-Specific Rate

- CMS is proposing to reduce hospital-specific rates by 2.5 percent for FY 2010.
- These rates are used by sole community hospitals and rural referral centers.
- CMS did not apply the 0.6 percent behavioral offset reduction to FY 2008 hospital-specific rates.

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DRG Changes – Coronary Bypass

- MDC 5 – Diseases & Disorders of the Circulary System – Intraoperative Fluorescence Vascular Angiography (IFVA) - CMS invites comments on the proposal **not** to make any MS-DRG modifications for IFVA
  - MS-DRGs 235 & 236 – Coronary Bypass without Cardiac Catheterization with & without MCC
  - MS-DRGs 233 & 234 – Coronary Bypass with Cardiac Catheterization with & without MCC

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DRG Changes – Hip/Knee Replacements

- MDC 8 – Diseases & Disorders of the Musculoskeletal System and Connective Tissue: Infected Hip & Knee Replacements
- CMS received a DRG reassignment request for cases involving patients who have undergone hip/knee replacement procedures that have subsequently become infected and who are then admitted for IP services for removal of the prosthesis.
- CMS proposes to move procedure codes 80.05 and 80.06 from their current assignments in MS-DRGs 470, 481, and 482, 495, 496, and 497 and assign them to MS-DRGs 463, 464, and 465.

MS-DRG Proposed Weights

- Excel file containing final FY 2009 MS-DRG relative weights and proposed FY 2010 MS-DRG relative weights is available via link to MHA *Advisory Bulletin* # 1263, dated May 11, 2009.

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Quality Measure Reporting

- Currently, hospitals must report 30 measures in order to receive the full update, up from 27 measures in FY 2008.
- For the FY 2010 payment determination, the CMS added 15 new measures and retired two measures, increasing the total required measures to 43.

Continued, Quality Measures

- Two measures retired
  - Oxygenation assessment for pneumonia care
  - Beta blocker on arrival for heart attack care
- 15 additional measures
  - Surgical care, patient safety, inpatient quality, nursing care and readmissions.

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Cont., Quality Measures

- For FY 2011 payment determinations, CMS proposes to continue to use the chart validation requirements in place in previous years, but for FY 2012, major modifications to the validation process are being proposed.

Value Based Purchasing

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- The proposed rule did not include regulatory language regarding any of President Obama's proposals for VBP, readmissions or payment bundling.
  - Senate Finance Committee Options Paper
- CMS also did not provide additional information regarding the HIT provisions included in the ARRA.

New Technology Payments

- 3 qualifying criteria
  - New
    - Limited to 2-3 years
  - Significant cost
  - Significant clinical improvement
    - Reduces mortality, decreases hospitalization or physician visits, or reduces recovery time.

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Continued, New Technology

- MMA Section 503 – removed the requirement that add-on payments for new medical services or technologies must be budget neutral.
  - As a result, these payments do not reduce Medicare payments for other inpatient services.

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New Technology Payments

- CMS approved one application for FY 2009:
  - CardioWest Temporary Artificial Heart System a device used as a bridge to heart transplant patient with end-stage biventricular failure.
  - Triggered by ICD-9-CM procedure code 37.52 (implantation of total heart replacement system), condition code 30, and diagnosis code V70.7 which reflects clinical trial.
  - Maximum add-on payment of $53,000
  - CMS proposes to continue this as a new technology payment in FY 2010.

Cont., FY 2010 Applications

1. The AutoLITT System – an MRI-guided catheter tipped laser designed to destroy malignant brain tumors with thermal energy. Not yet approved by the FDA.
2. CLOLAR Injection – chemotherapeutic agent that is administered intraveneously and is being evaluated for patients with acute myeloid leukemia. Not yet approved by the FDA.

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Cont., New Technologies

1. LipiScan – Coronary Imaging System – diagnostic tool that uses Intravascular Near Infrared Spectroscopy (INIRS) during an invasive coronary catheterization to scan the artery wall in order to determine coronary plaque composition.
2. Spiration IBV Valve System – a device used to place, via bronchoscopy, small, one-way valves into small airways in the lung in order to limit airflow into selected portions of lung tissue that have prolonged air leaks following surgery.

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Cont., New Technologies

1. TherOx Downstream System – uses Super Saturated Oxygen Therapy that is designed to limit myocardial necrosis by minimizing microvascular damage in AMI patients following PTCA and coronary stent placement.
2. Not yet approved by the FDA.

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Cont., New Technologies

- CMS received six applications for FY 2010, including one that was withdrawn in 12/08.
- In the FY 2009 IPPS rule, CMS set July 1 as the deadline by which new technology add-on payment applications must receive FDA approval.
- Applications that have not received FDA approval by July 1 would NOT be considered in the final rule.

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FY 2010 Wage Index Issues

- CMS did not include an anticipated major overhaul of the hospital wage index methodology, but includes restrictions on future wage index reclassifications.
  - FY 2009 rule indicated that research would continue for FY 2010 proposed rule
- CMS proposes to use the same methodology to develop the FY 2010 unadjusted hospital wage index as used in FY 2009.
- Proposed rule would decrease the labor-related share from 69.7% to 67.1% for hospitals with AWI greater than 1.0.

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Reclassification Thresholds

- In the FY 2009 rule, the CMS increased over two years the criterion for the comparison of a hospital's AHW to that of the area to which it seeks reclassification.
- FY 2010 is year two of this transition.

Reclassification Thresholds

- For FY 2010 Reclassifications:
- Urban – 86 percent
- Rural – 84 percent
- Group – 86 percent
- For FY 2011 Reclassifications:
- Urban – 88 percent
- Rural – 86 percent
- Group – 88 percent

Est. Impact – Threshold Changes

- CMS estimated that 15% of hospitals with individual reclassifications and 9% with group reclassifications will no longer qualify under the new wage reclassification criteria.

FY 2011 Geographic Reclasses

- Hospitals must submit application to Medicare Geographic Classification Review Board by 5 pm in on ~ Sept. 1
  - exact date not known until late July
- To assist hospitals in determining eligibility, MHA will provide an Excel model in August for both wage tests.
- Hospital would need to utilize other resources to determine whether it meets proximity requirements.

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FY 2010 Area Wage Index

- FY 2010 national AHW $33.52
- FY 2009 national AHW $32.24
- FY 2010 national AHW increased 3.9 percent compared to FY 2009.
  - Hospitals that failed to keep pace will experience a decrease in AWI.
- Based on cost report data for hospital FYEs between Sept. 30, 2006 and Aug. 31, 2007.

Michigan FY 2010 AWI

- Based on data released on CMS website on May 1, the wage index for 10 of Michigan’s 16 CBSAs will decrease compared to FY 2009.
- CBSA table included in MHA *Advisory Bulletin* # 1263, dated May 11.

Wage Index Timeline

- May 8 – CMS PUF release revised FY 2010 wage and occupational mix data
- May 15 – MHA distributed May 8th PUF data
- June 8 – Hospital must notify both CMS and NGS of processing errors.
- Aug. 1 – Approximate date for publication of the FY 2010 final rule.
- ~ Sept. 1 – MGCRB applications due for FY 2011
- Oct. 1 – Effective date of FY 2010 AWI
- Early Oct. – Release of PUF for FY 2011 AWI
- Early Dec. – Deadline for change requests for FY 2011 AWI.

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Data Reporting Changes

- Contract Services Reportable on Line 22.01
- Fall 2007, the CMS clarified that hospitals can include the cost of administrative and general contract services.
- Only the personnel costs (wage and wage related costs) associated with the contract are includable.
- Include legal, consulting, information and data processing services, tax/cost report preparation, and purchasing services.
- Level of documentation is unclear.
- Includable amounts are generally much higher than national average wage.

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Occupational Mix Data

- Hospital survey required every 3 years.
- FY 2010 OM adjustment based on data collected on revised 2007-08 survey for July 1, 2007 – June 30, 2008, submitted by hospitals by Sept. 1, 2008.
- Data from 2008 survey will be used to adjust FY 2010, 2011 and 2012 area wage index.
- CMS became concerned about the increasing number of hospitals that failed to submit occupational mix data and the impact it may have on future wage indexes.
- **Penalty considered but not imposed at this time.**

Continued, Occupational Mix

- Applying the OM adjustment to the wage data results in increased AWI values for 46.8% of urban areas and 70.2% of rural areas.

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FY 2010 Reclassifications

- 292 hospitals approved by the Medicare Geographic Classification Review Board
  - FY 2008 – 313 hospitals approved
  - FY 2007 – 271 hospitals approved

MMA Section 508 Reclasses

- Without legislation, these special reclasses will expire Sept. 30, 2009.
- 35 Michigan hospitals

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DSH Calculations

- CMS proposes to include patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor/delivery services at the time the inpatient routine census was taken in the DPP of the DSH calculation.
- Effective for CR periods beginning on/after Oct. 1, 2009.

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Medicaid Eligible Days

- CMS proposes to allow hospitals to report days for the numerator of the Medicaid fraction of the DPP based on one of three methodologies
  - – Date of admission
  - – Date of discharge
  - – Dates of service
- Each state reports Medicaid days using different methodologies.

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Observation Beds

- Proposes that hospitals report observation bed days for CR periods beginning on/after Oct. 1, 2009, so that can be deducted from the bed day count for DSH and IME payment adjustments.

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Inpatient PPS Final Rule

- Hospital-specific impact analysis to CEOs, CFOs and RDs will be distributed within a few weeks.
- MHA will make its comment letter available via link to MHA *Monday Report*.
- Comments due to CMS June 30.
- Watch MHA *Monday Report* for further information.

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Inpatient Psych Final Rule

- No significant policy changes
- Issued as an update notice for third consecutive year.
- 2.2% marketbasket increase for FY 2010, which begins July 1, 2009.
- Per diem rate will increase from $637.78 to $651.76.

Continued, IPF Final Rule

- Beginning in FY 2009, all IPFs reimbursed 100 percent based on the PPS, which was phased in over 3 years, rather than previous cost-based system.
- Cost outlier threshold will increase by 7.4% from $6,113 to $6,565, resulting in fewer cases qualifying for outlier payments.
- On May 14, MHA distributed detailed summary and facility-specific impact analysis.

Statewide IPF Impact

• Update Factor	+ $ 3.9 Million
• Wage Index	- $ 0.6 Million
• ECT	+ $ 0.0 Million
• Total Change	+ $ **3.3 Million**

- 1.8% Increase Overall compared to 2.8% increase in FY 2009

CMS Seeking Comments

- Development of a stand-alone IPF marketbasket index
  - Would reflect the cost structure of only IPF providers using cost report data from both hospital-based IPFs and free-standing IPFs
- Full-time equivalent (FTE) intern and resident cap adjustment
  - Would allow an increase in the FTE resident cap when residents are relocated to another IPF due to the closure of an IPR or psychiatry residency program.

IRF Proposed Rule

- Published in May 6 *Federal Register*.
- Effective Oct. 1, 2009.
- 2.4% marketbasket update
- 4.85% increase after MB update and budget neutrality adjustments
- Standard payment conversion factor would increase from $12,958 to $13,587.

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Cont., IRF Final Rule

- MMSEA included permanent reduction of the compliance threshold to 60 percent.
- Permanently expands the “75% rule” to include cases that have qualifying comorbidities, which is estimated to increase IRF compliance by an additional 5 to 10 percent.

Cont., IRF Final Rule

- CMS proposes to reduce the rural add-on from 21.3% to 18.27%.
- CMS also proposes to decrease the low-income patient (LIP) adjustment from 0.6229 to 0.4372.
- CMS proposes to increase the multiplier for the teaching adjustment from 0.9012 to 1.0494.
- Update the case-mix classification system that is used in FY 2009, using claims data from FY 2007.
- CMS proposes to decrease the outlier threshold from $10,250 to $9,976.

Cont., IRF Proposed Rule

- Proposed wage index is updated to reflect FY 2009 hospital wage index data, excluding occupational mix adjustments, reclassifications and rural floors.
- Labor-related share would increase from 75.464 to 75.904.

Cont., IRF Proposed Rule

- CMS proposes several pre-admission requirements for a patient to meet in order to be admitted to an IRF. The proposed screening process would be detailed and comprehensive for every patient.
- As a result, CMS proposes to eliminate the need for an extensive post-admission evaluation period.

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Cont., IRF Proposed Rule

- MHA will distribute a facility-specific impact analysis within the next few weeks.
- MHA will make its draft comments available via the MHA Monday Report.
- Comments due to CMS June 29, 2009.
- Overall, CMS estimated that IRF payments will increase by 2.6% in FY 2010.

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SNF Proposed Rule

- Published in May 12 *Federal Register*.
- Effective October 1, 2009.
- 1.2% payment **reduction** after 2.1% market basket update offset by a 3.3% “behavioral offset”.
- The CMS proposes to revise the SNF case-mix classification system from RUG-III to RUGS-IV with implementation starting in FY 2011.
- Modify 8 levels of hierarchy and increase the case-mix groups from 53 to 66.

Cont., SNF Proposed Rule

- Parity Adjustment – CMS propose to apply a "parity adjustment" in FY 2011 in order to neutralize for utilization changes that would be caused by the shift when moving to a RUG-IV model from a RUG-III model.
- CMS estimates that new RUG-IV would lower overall SNF payments.
- Upward adjustment of approx. 52.6% needed.

Statewide SNF Impact

- MHA will distribute a facility-specific impact analysis in the next few weeks for hospital-based SNFs.
- MHA will make its comment letter available via the MHA Monday Report.
- Comments due to CMS June 30.

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Medicare Revenue Forecaster

- Excel-based budgeting tool that projects hospital Medicare revenues for budgeting and financial planning.
- Incorporates all aspects of reimbursement, providing a comprehensive approach that includes:
  - Capital, DSH, IME, GME, Fee-based lab services, HHA, Psych, Rehab, SNF, swing beds, etc.
- Software updated within 3-4 weeks to reflect regulatory and legislative changes.
- Free Quarterly Marketing/training web-session available through the MHA.
  - Demo model available FREE for 30 days
- Additional training provided after purchase.
- Model available for Critical Access Hospitals

Recovery Audit Contractors

- In early April, the MHA hosted a member forum with representatives from CMS and CGI Technologies.
- List summarizing the questions and answers from the forum is available on MHA website.
  - See April 17 Monday Report article

Medicare Advantage Plans

- As of April 2009, 32 plans operating in Michigan.
  - Up to 20 plans in some counties.
- Currently, approximately 395,000 of Michigan's 1.5 million (or 26%) Medicare beneficiaries, are enrolled in an MA plan.
- 139% increase in number of MA enrollees since January 2007 enrollment of approx. 165,000.
- Excel file available on MHA website listing all Michigan counties and all MA plans in each.
- Updated quarterly.

Continued, MA Plans

- Unlike Medicare FFS, each MA plan may determine its own utilization model and is not required to maintain uniform electronic payment processes with hospitals.
- As Medicare enrollees continue to select MA plans, the variety of plans and payment processes may result in increased utilization scrutiny and administrative effort at hospitals.

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Medicaid

- FY 2009 Executive Order Cuts
- FY 2010 Budget
- Change in FY 2009 MACI Pools
- FY 2009 OP Uncomp DSH Pool
- CHAMPS Implementation
- Medicaid Enrollment & Unemployment
- Medicaid HMOs

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Executive Order Cut

- FY 2009 state budget slashed by over $349 million in general funds
- Effective July 1- Sept 30, 2009
- 4% reduction to hospital and other provider payments
  - – $14 million FFS and HMO reduction when lost federal funds are included
    - $4.3 million in state GF and $9.7 million federal funds
  - – Hospital-specific info distributed on May 8

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FY 2010 Budget

Executive and House versions include:

- No provider rate cuts
- No eligibility cuts

These budgets were developed prior to the recent Executive Order.

Budget Currently in the Senate

Budget matrix available in May 18 Monday Report.

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Mandatory HMO Enrollment

- MSA released policy that would require enrollment of Medicaid-eligible pregnant women into HMOs rather than FFS.
- Numerous hospital implications including:
  - Development of CCRs, hospital rates and DRG weights
  - MACI and HRA pools
  - GME pools
  - MIP (adjustment in process by MSA)

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FY 2009 MACI Pools

- In mid-April, MSA distributed correspondence regarding revised inpatient MACI pools amounts.
- Pools reduced by $53.8 million to reflect shift of maternity cases from Medicaid FFS to HMOs.
- MSA estimates that 15,633 cases will shift in FY 2009.
  - Annual shift projected at 25,000.
- HRA pools will increase by $53.8 million.
- Although budget-neutral on a statewide basis, **individual hospital impact will vary.**
  - Some hospitals will experience a significant reduction in total MACI and HRA payments for FY 2009.

MIP & NPI

- At the April MSA hospital workgroup meeting, MSA announced its intention to discontinue MIP if hospitals had only one National Provider Identification (NPI) number for both inpatient and outpatient services when CHAMPS goes live in late summer 2009.
- During initial roll out of NPI, hospitals evaluated their business needs and determined that one NPI would best serve their operation and developed administrative processes around a single NPI.
- As a result of hospital feedback, MSA is developing an alternative approach which will enable hospitals to maintain one NPI and continue receiving MIP.

Medicaid HMOs

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- Medicaid enrollment is approximately 1.7 million, or nearly one of every 6 Michigan citizens.
- In April, Medicaid HMO enrollment was approximately 1.05 million, with approx. 63% of beneficiaries enrolled in one of the 14 Medicaid HMOs.
- # of HMOs in each county varies from 1 to 8 plans.
- A list of Medicaid HMOs operating in each county, including enrollment information, is available on the MHA website.
- HMO rebid process currently underway for FY 2010
- See April 17 MHA Monday Report article.

OP Uncomp Hospital DSH Pools

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- MSA issued a final policy in Dec. 2008 to distribute $60 million to hospitals.
  - $30 Million - Rural Hospitals
  - $30 Million - All others

- Tax-funded DSH Payments
- MSA will distribute payments and tax bills in the near future.

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Final DSH Eligibility Policy

- Policy 08-18, effective May 1, 2008.
- Eliminates eligibility form from Medicaid cost report.
- New form distributed annually for current fiscal year.
- For FY 2009, form was submitted by hospitals in Oct. 2008.
- Hospital eligibility status will be based on date form is completed.
- Data will be used for all Medicaid DSH distributions.
  - $45 million DSH pool
  - $ 5 Million DSH Pool
  - $ 60 Million OP Uncompensated Care DSH Pool

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Provider Tax Programs

- Through FY 2009, these programs have increased federal funds to Michigan hospitals by nearly $2 Billion.
- FFS program implemented in Michigan in FY 2003.
- HMO program implemented in Michigan in FY 2007, with Jan 1, 2007 effective date.
  - First state in the US with hospital provider tax program distributed through HMOs.
- Combined these programs are projected to result in a FY 2009 net benefit of $625 million.

Hospital Cost/Charge Limits

- These limits do NOT apply to new DSH pool or HRA program.
- Federal regulation requires that Medicaid FFS inpatient payments (including capital, QAAP, GME) to hospitals cannot exceed charges for inpatient services.
- Medicaid state plan stipulates that Medicaid FFS outpatient payments cannot exceed cost as computed on cost report.
  - Ensure that QAAP tax is included as an allowable expense on Medicare and Medicaid cost reports.

GME & HRA Transactions

May GME	May 26
May HRA	June 8
May HRA Tax	June 15
June GME	June 22
June HRA	July 6
June HRA Tax	July 13

Medicaid GME & DSH

- For FY 2009, MSA will distribute $69 million fee-for-service GME and $50 million DSH payments in September.
  - Does **not** impact monthly GME paid thru the HMOs
- FFS GME payments will be calculated quarterly and distributed annually to hospitals.

Prior Engler EO Reductions

- Continue in FY 2009 and future years.
- $45.9 million reduction to inpatient DRG and rehab per diem payments.
  - Carry forward from 2002, 2003, & 2005 Executive Orders
- MSA will recoup via lump sum reduction to MIP amounts during 4th Quarter.
- Maintains higher DRG payment rates from HMOs.

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Medicaid Capital Rates

- MSA updated inpatient hospital capital rates effective for admissions on/after April 1, 2009, available on MSA website.
- Based on hospital cost report data from FYEs 9/01/2007 – 8/31/2008.
- Applicable to HMO patients in the absence of a contract.
- Medicaid HMOs are required to pay out-of-network hospitals an operating and capital payment for inpatient services provided to their members.

MMIS Replacement

- Medicaid Management Information System (MMIS) will be replaced with CHAMPS (Community Health Automated Medicaid Processing System), which the MSA expects to implement Summer 2009.

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AHA Survey Results

- Annual MHA Advisory Bulletin that compares 2007 AHA Survey results for Michigan hospitals to those nationally.
- Includes margins, ED visits, OP visits, IP admissions, days, births, ALOS, etc.
- See MHA Advisory Bulletin # 1252, included in 1/26/09 weekly mailing.
- Powerpoint and Excel files available.

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MHA Resources

- Monday Report is available FREE and is distributed via email each Monday morning.
  - Go to website and select “Newsroom”, then Monday Report
- MHA Monday Report – electronic publication issued weekly (bi-weekly during Summer).
- Website: www.mha.org
- 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

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More MHA Resources

- Feb. 2009 - Michigan's Health Care Safety Net: In Jeopardy
- 2009 Michigan Community Hospitals: A Healthy Dose of the Facts
- 2007-2008 State Legislative Session in Review
- 2008 Hospital Community Benefits Report
- 2008 Economic Impact of Health Care in Michigan
- MHA Monthly Financial Survey (MFS)
- Electronic versions of reports: **www.mha.org/mha/reports/index.jsp**

???Questions???

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