Indiana Medicaid Update

HIP 2.0 Financing, HAF, Medicaid DSH and Other Updates

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CPAs / ADVISORS

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Why the HAF Was Created

- "Cliff" with respect to supplemental payments
  - Pressure from hospitals that did not qualify for DSH or did not receive a "full share"
- HCI payments to all hospitals for uncompensated care no longer available
- Zero-sum game without new dollars
- Fundamental issue was Medicaid underpayment
  - Almost two decades since last hospital rate increase
  - At best, $0.35 for each dollar of cost
  - 5% cuts implemented in 2010, currently 3% cuts

Key Improvements

- Fee is broad-based, with burden and perceived control not resting with a few hospitals
- Increased Medicaid rates to the maximum possible level (FFS and managed care)
- Currently using shorter DSH eligibility periods (two years), reflecting more timely data
- Primarily pays hospitals for treating Medicaid patients when claims are paid, not years later

Basics of the HAF

- Who is assessed or exempt
- Basis of fee
- Fee rates
- Level of Medicaid payment increase
- DSH pools and payment order
- $2 M state dollars for private psychiatric hospitals

Legal Authority

- HAF exists in the Indiana Code as enacted by the General Assembly
- The Medicaid State Plan governs the HAF factors along with DSH eligibility and payment order
  - Changes must be submitted by the end of the first quarter of the SFY to be effective for a SFY
- There is a waiver from CMS that allows Indiana to make exceptions to fees so that they do not have to be "broad-based" and/or uniform
  - Changes in exemptions or fee rates require changes to the waiver and must meet statistical tests that prove the fee is not redistributive
- Changes to any of the above can create long delays

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Who is Assessed or Exempt

- Facilities within the class that are assessed
  - Acute care hospitals
  - Freestanding psychiatric hospitals
- Facilities exempt from the fee
  - Long-term care hospitals
  - Freestanding rehabilitation hospitals
  - Hospitals owned by the state or federal government
  - Freestanding psychiatric hospitals with greater than 40% of admissions having a primary diagnosis of chemical dependency
  - Freestanding psychiatric hospitals with greater with > 90% of admissions comprised of individuals 55 or older having a primary diagnosis of Alzheimer's disease or certain neurologic disorders related to trauma or aging

Basis of the Fee

- Inpatient days as basis for most of program
  - Net of all out-of-state days (OOS) and swing bed days
  - "Day is a day"; cannot be manipulated like other statistics
- Outpatient fee assessed for amount over 6% of net inpatient revenue
  - Outpatient fee based on OP-equivalent patient days
  - Excludes same days as above
  - This portion has been between 14%-21% of total fees in past but is 0% for current year (SFY 2016)

NOTE: *IHA internal task force has discussed rebalancing fees on IP/OP revenue. Also, HIP 2.0 funding may lead to a future shift to fees on OP activity even if fee basis is not adjusted.*

Basis of the Fee

- Fees are based on cost reports on file at end of Feb. for upcoming fee year
  - SFYs 2016-17 were based on reports on file Feb. 2015
- This data is the basis of a hospital's fees for a two-year period, but the amount assessed will change based on total program expenditures
- New hospitals are not assessed until a cost report is on file, but also do not receive any MCE add-on payments

"Rate" of the Fee

- Three "tiers"
  - Most hospitals pay on 100% of days (net of OOS and swing bed day exclusions)
  - 75% of days for acute care DSH hospitals, including municipal hospitals that qualify under the MIUR/LIUR thresholds
  - 50% of days for (1) certain LIUR hospitals; (2) and all DSH-eligible hospitals with OOS Medicaid days more than 25% of total Medicaid days

Medicaid Increase

- Fully increasing Medicaid payment to aggregate Medicare levels (not provider specific)
- Increased payment through higher rates; no separate UPL pool
- Additional payments ("add-ons")
  - Medical education and capital payments not adjusted

HAF Factors

SERVICE	SFY 2012 & SFY 2013	SFY 2014	SFY 2015 & SFY 2016
Inpatient			
Base	3.0	3.0	2.1
Psych	2.2	2.2	2.2
Rehab	3.0	3.0	2.6
Burn	1.0	1.0	1.0
Outpatient	3.5	3.2	2.7

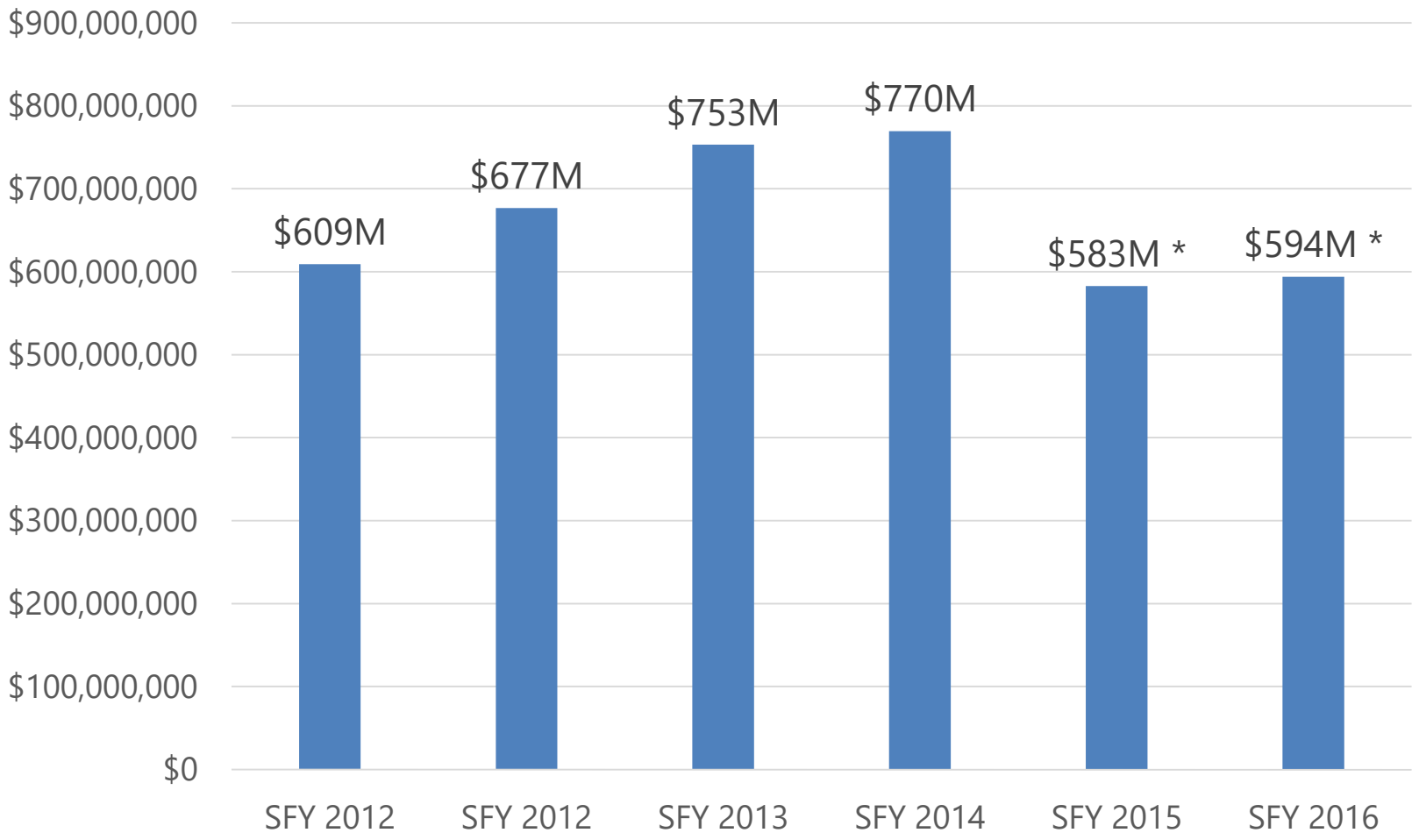
Medicaid DSH

- DSH is distributed to eligible recipients based on each hospital's Hospital Specific Limit (HSL or "DSH cap")
- Historically the HSLs exceed the available State DSH Allotment and therefore the payment order is defined as:
  - Municipal hospitals are paid the lower of their actual HSL or their net 2009 Muni UPL payment
  - DSH eligible acute care hospitals in Lake County are paid up to their HSLs
  - Private acute care hospitals are paid based on their HSLs up to the remaining DSH and prorated based on dollars available
  - And if dollars remain after the acute care hospitals are paid up to their HSLs, DSH-eligible freestanding psychiatric hospitals licensed under IC 12-25 may receive payments equal to their HSLs (after all other Medicaid payments have been made)

Medicaid DSH AUPs vs Audits

- HSLs required for each new eligibility period. HSLs prepared in the form of Agreed Upon Procedures (AUPS) by independent CPAs and cover the same period as the DSH year
- Sometimes HSLs are trended for second year of eligibility
- New in SFY 2011, CMS required audits of the HSLs to ensure that DSH payments did not exceed hospitals' uncompensated care costs and Medicaid shortfalls
- Hospitals can owe funds back to CMS depending on the outcome of the audits
- Working with the State to minimize the variances between the AUPS and audits and avoid exposure

Changes in Total Fees



* Initial estimates not yet reconciled using actual paid claims

Current and Future Issues

- Each new DSH eligibility determination impacts DSH payments, but also the level of assessment. Current SFY 2016 fees will be reconciled **back to 7/1/2015** (100%, 75%, or 50% of fees) once eligibility is completed
  - Under current approach, eligibility will occur every other year
  - SFY 2016 eligibility will be based on the hospitals' years ended in SFY 2015 (*see 2016 work plan*)

- HIP 2.0 currently paid at both Medicare-like rates (original HIP) and at Medicaid rates depending on benefit category
  - IHA has worked with FSSA to pay services for all HIP 2.0 patients at full Medicaid HAF rates *(detail follows on next slide)*

Upcoming HIP Changes

- Moving to full Medicaid HAF rates for all HIP claims will:
  - Allow tracking at patient level and provide for only one payment method
  - Provide for higher level of reimbursement than the old "HIP 1.0" approach
- Implementation will begin in February with ***inpatient*** HIP claims reprocessed retro to Jan. 1, 2016 at the correct HAF reimbursement
- No more inpatient HAF add-ons will be paid (other than the December 2015 payment that would still be paid in January)
- ***Outpatient*** claims will be paid at HAF rates beginning in March
- For various reasons, this outpatient change will be prospective and reprocessing would occur only back to March 1
- Add-on payments for outpatient services will continue until this change occurs

Legislative Issues

- HAF expires in state law June 30, 2017
  - May seek another renewal of at least four years?
- External threats, like legal challenges from net contributors
- Possible federal limitations, such as reducing 6% limit on provider fee programs
- Federal DSH reductions under ACA
  - Delayed until FY 2018 under H.R. 2

HIP 2.0 Funding

- Per Term Sheet, no HAF funding used in until SFY 2017 for HIP 2.0 program
- Use of HAF is strictly limited to expansion expenses (payment to MCEs for medical expenses, POWER account funding, and limited administrative costs) and increases for physician payments in the current Medicaid program
- Hospitals' obligation to fund these expenses ceases immediately if the waiver is terminated for any reason

ACA Enhanced Medicaid Match

CY	FMAP
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

Non-HAF Funding Sources

- The portion of the tobacco tax that was established for funding HIP 1.0 will represent the "first dollar" commitment to the program, reducing the amount needed from the HAF (this revenue is currently about $112 M per year)

- In addition, the balance of the HIP Trust Fund will remain dedicated to the program, either for regular expenses or in case of a phase-out (current balance is around $338 M)

- IHA will work to explore other funding sources (other provider fees, excise taxes, etc.) in the future that could supplement HAF contributions

Other HAF Provisions

- Prior to implementing the assessment for HIP 2.0, the State and IHA will agree upon a process for accounting for actual costs incurred
- It is important to note that HAF funding for the State's costs will be based on enrollment or actual costs incurred, and the most accurate, timely, consistent, and verifiable data possible will be used
- IHA and the State will agree on a mechanism for ensuring that HAF funding for the program that will be clearly and separately distinguished from funding for the existing Medicaid program

Hoosier HealthWise (HHW)

- Initially, the monthly checks from the MCEs were only for Hoosier HealthWise
- These add-on payments represent the difference between base Medicaid rates and Medicare in the aggregate (which is how HAF factors are determined)
- Each hospital gets a fixed percentage/allocation of the statewide total of monthly managed care enrollment, and the percentage is based on actual MCE paid claims from prior base year (for example, SFY 2014 claims are used for SFY 2016 & 2017 allocations)
- These percentages have been set for each two-year HAF period

Hoosier Care Connect (HCC)

- The Hoosier Care Connect program began April 1, 2015 with patients transitioned through June 30, 2015
- Like HHW, payments are based on some percentage of the Medicaid fee schedule with a lump sum HAF payment based on:

  a fixed percentage/allocation of the statewide total of monthly HCC managed care enrollment. The percentage is based on actual non-dual paid claims from prior base year (for example, SFY 2014 claims are used for SFY 2016 and 2017 allocation)

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Those Monthly Checks

- We are now in the fifth year of the HAF program, and the MCE payments have tripled
  - Original estimate was $250 M in MCE add-on payments
  - SFY 2016 estimates from Milliman are based on $326M for HCC and $278M for HHW and $150M for HIP 2.0
- With so much reimbursement moving from FFS to managed care, we are re-examining this approach
- Proposed federal rules on Medicaid managed care may signal that CMS wants to scale back "pass-through" payments, and FSSA is interested in reviewing impact
- With the State's agreement to move toward full HAF payment for HIP 2.0, the next step is for the same process for HHW and HCC in 2017

Those Monthly Checks

- Several advantages to eliminating add-on payments
  - Dollars follow the patient and reflect where services are provided today
  - Timing of payment should be sped up – no waiting for delayed or missing checks
  - Perhaps easier to forecast for hospitals
  - Less administrative burden (State and IHA review base year claims, adjust allocations, etc.)
- Important to note that because the allocation is based on past years, moving away from the add-ons would allow a new facility to receive full Medicaid reimbursement sooner
- Only concern is whether or not full amount can be passed through to hospitals

2016 Work plan

- SFY 2016 Medicaid DSH Eligibility Surveys which impact DSH payments and the level of HAF fees retro back to 7/1/2015
- DSH caps or HSLs for SFY 2015 (partials made for 60%-80% of potential payments per State estimates)
- DSH audits for CMS for SFY 2013 (this period was trended so audits will be more comprehensive than SFY 2012 audits)

Thank you and Questions?

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