CHRT
CENTER FOR HEALTHCARE RESEARCH & TRANSFORMATION

The Impact of the Affordable Care Act in Michigan

March 2015

Since becoming law on March 23, 2010, the Affordable Care Act (ACA) has significantly affected how health care is purchased, accessed and delivered. The law has made broad changes to the health care landscape, which has had an impact on consumers, health insurers and health care providers in interconnected yet unique ways.

Covering the first year of expanded health insurance options, this brief provides an overview of ACA initiatives that are transforming health care and specifically, their effect on health care consumers and insurers in Michigan. The brief also reviews some of the major changes providers have faced over the five years of the ACA's existence.

Consumers

The ACA's coverage expansions provided Michigan consumers with two new options: the Healthy Michigan Plan and the Health Insurance Marketplace. On April 1, 2014, Michigan residents below 138 percent of the Federal Poverty Level (FPL) who were not previously eligible for Medicaid became eligible for the Healthy Michigan Plan, Michigan's expanded Medicaid program. Beginning in January 2014, eligible individuals could enroll in private health insurance coverage through the Health Insurance Marketplace. In CHRT's most recent survey of Michigan adults, 13.9 percent of respondents reported being uninsured in 2012, compared to 7.0 percent in late 2014.[1] These two new options have likely contributed significantly to this decrease.

Healthy Michigan Plan

As of February 2015, 29 states—including Michigan—and the District of Columbia have expanded Medicaid under the ACA. To date, the Centers for Medicare and Medicaid Services (CMS) has approved Section 1115 Medicaid waivers from five states to implement expansion in a way that differs from federal rules: Arkansas, Iowa, Michigan, Pennsylvania and Indiana.[2] After CMS's approval in December 2013, the state of Michigan launched the Healthy Michigan Plan on April 1, 2014. The Healthy Michigan Plan covers residents between 19 and 64 years of age who have a household income below 138 percent of the Federal Poverty Level (FPL) and do not qualify for Medicare or other Medicaid programs.[3]

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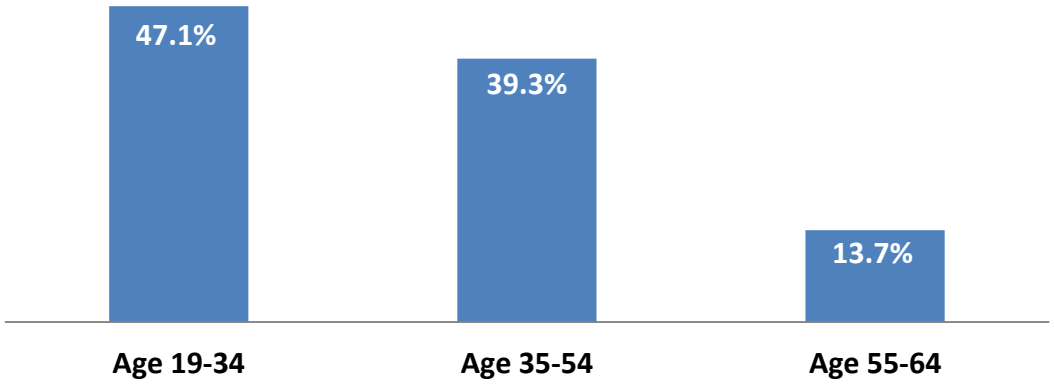
[1] M. Smiley, M. Riba, E. Ndukwe, and M. Udow-Phillips, *Cover Michigan Survey 2014: Coverage and Health Care Access* (Ann Arbor, MI: Center for Healthcare Research and Transformation, March 2015).
[2] R. Rudowitz, S. Artiga, and M. Musumeci, "The ACA and Medicaid Expansion Waivers," Kaiser Family Foundation, February 17, 2015: http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/ (accessed 3/20/2015).
[3] "Healthy Michigan Plan Frequently Asked Questions," Michigan Department of Community Health, 2015: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-325160--,00.html (accessed 3/20/2015).

Healthy Michigan Plan enrollment has far exceeded the initial state enrollment expectations. The state of Michigan projected that 320,000 out of the estimated 1.2 million residents who were newly eligible would enroll in the program's first year.[4] The Healthy Michigan Plan surpassed this target on July 10, 2014, within four months of the program's launch.[5] As of March 23, 2015, 596,246 people had enrolled.[6] As of late February, approximately 86 percent of those enrolled had incomes below 100 percent of FPL, 52 percent were women,[7] and 47 percent were between 19 and 34 years of age (*Figure 1*).[8]

Figure 1: Age Distribution Among Healthy Michigan Plan Enrollees, as of March 2015



Source: Michigan Department of Community Health. March 9, 2015.

For the first six months, beneficiaries enrolled in Healthy Michigan do not pay any cost-sharing. After six months, enrollees pay some level of cost-sharing (monthly contributions and co-pays) depending on income. The Healthy Michigan Plan requires that beneficiaries above 100 percent of FPL pay monthly contributions up to 2 percent of income. All beneficiaries also pay cost-sharing into health accounts (the MI Health Account); total cost-sharing cannot exceed 5 percent of beneficiary income.[9] The beneficiary's average co-pay amount is calculated every six months to reflect their past six months of health care utilization and applied prospectively.[10] For example, if a beneficiary used $6 of health care in the prior six months, over the next six months the beneficiary will pay $1 per month into the MI Health Account (in addition to the monthly contribution).

Enrollees who complete a health risk assessment (HRA) with their primary care provider (PCP), and agree to maintain healthy behaviors, like tobacco cessation, are eligible for incentives.[11] The incentives differ depending on

[4] L. Snyder, K. Gifford, E. Ellis, and J. Walls, "Putting Medicaid in the Larger Budget Context: An In-Depth Look at Four States in FY 2014 and 2015," Kaiser Family Foundation, Oct. 14, 2014: http://kff.org/report-section/putting-medicaid-in-the-larger-budget-context-michigan/ (accessed 3/20/2015).
[5] K. Bouffard, "New Michigan Medicaid enrollment exceeds 400K," The Detroit News, September 25, 2014: http://www.detroitnews.com/story/news/politics/2014/09/25/new-michigan-medicaid-enrollment-exceeds-k/16209081/ (accessed 3/20/2015).
[6] Healthy Michigan Plan Enrollment Statistics, Michigan Department of Community Health, March 23, 2015: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797---,00.html (accessed 3/23/2015).
[7] Healthy Michigan Plan, Health Management Associates, February 25, 2015: http://www.healthmanagement.com/news-and-calendar/article/345 (accessed 3/20/2015).
[8] Ibid.
[9] "Healthy Michigan Plan Frequently Asked Questions," Michigan Department of Community Health, 2015: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-325160--,00.html (accessed 3/20/2015).
[10] "MI Health Account Operational Protocol," Michigan Department of Community Health, May 2, 2014: http://www.michigan.gov/documents/mdch/MI_Health_Account_Protocol_for_Comment_455149_7.pdf (accessed 3/20/2015).
[11] "Healthy Michigan Plan Frequently Asked Questions," Michigan Department of Community Health, 2015: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-325160--,00.html (accessed 3/20/2015).

income level. Healthy Michigan members below 100 percent of FPL who complete an HRA with their PCP and agree to maintain healthy behaviors receive a $50 gift card (once annually) and a copay reduction. Members between 100 and 138 percent of FPL receive both lower monthly contributions and lower co-pays.[12]

All new Healthy Michigan Plan members are required to schedule a preventive health visit with a PCP within 60 days of enrollment.[13,14,15] As of January 2015, 96 percent of beneficiaries (158,764) had completed the telephonic portion of the HRA while choosing their health plan.[16] Following this portion, the beneficiary completes the rest of the HRA during their initial visit to their PCP. As of December 2014, approximately 86 percent of the beneficiaries that have completed the HRA with their PCP agreed to address health risk behaviors.[17] Early figures suggest that Healthy Michigan plan members are accessing preventive and primary care, with 289,875 primary care visits among members as of February 2015 (*Figure 2*).

Figure 2: Healthy Michigan Plan Beneficiaries Accessing Care (as of February 5, 2015)

Type of Visit	Men	Women	Total
Primary Care	121,440	168,435	289,875
Preventive visit	32,360	61,072	93,332
Colonoscopies/Colon Cancer Screening	6,172	7,959	14,131
OB (Antepartum, Delivery, Postpartum)	-	-	1,980
Mammograms	-	-	28,899

Source: Medicaid Reform: Leading to a Healthier Michigan, Michigan Department of Community Health.

The state of Michigan plans to submit a second waiver to CMS by December 2015 that, if approved, will increase the cost-sharing maximum from 5 to 7 percent of income for beneficiaries between 100 and 138 percent of FPL who remain enrolled in Medicaid for longer than 48 cumulative months. Under the second waiver, these beneficiaries could also opt to purchase coverage through the marketplace (using tax credits and cost-sharing subsidies).

[12] "Healthy Michigan Plan Healthy Behaviors Incentives Operational Protocol," Michigan Department of Community Health, May 1, 2014: http://www.michigan.gov/documents/mdch/Healthy_Behaviors_Incentives_Protocol_for_Comment_455147_7.pdf (accessed 3/20/2015).
[13] There is no penalty if Healthy Michigan Plan beneficiaries do not schedule a visit within the 60 day timeframe. Beneficiaries are not required to complete the initial visit or HRA within a specific timeframe to be eligible for incentives.
[14] *The Healthy Michigan Plan Handbook,* (Lansing, MI: Michigan Department of Community Health), 2014: http://www.michigan.gov/documents/mdch/Healthy_Michigan_Handbook_Final_447363_7.pdf (accessed 3/20/2015).
[15] "Healthy Michigan Plan Healthy Behaviors Incentives Operational Protocol," Michigan Department of Community Health, May 1, 2014: http://www.michigan.gov/documents/mdch/Healthy_Behaviors_Incentives_Protocol_for_Comment_455147_7.pdf (accessed 3/20/2015).
[16] S. Fitton, "Medicaid Reform: Leading to a Healthier Michigan," Michigan Department of Community Health, March 20, 2015.
[17] *Healthy Michigan Plan - Health Risk Assessment Report*, December 2014 (Lansing, MI: Bureau of Medicaid Care Management and Quality Assurance, Michigan Department of Community Health): http://www.michigan.gov/documents/mdch/HMP_HRA_Report_FINAL_468616_7.pdf (accessed 3/20/2015).

Health Insurance Marketplace

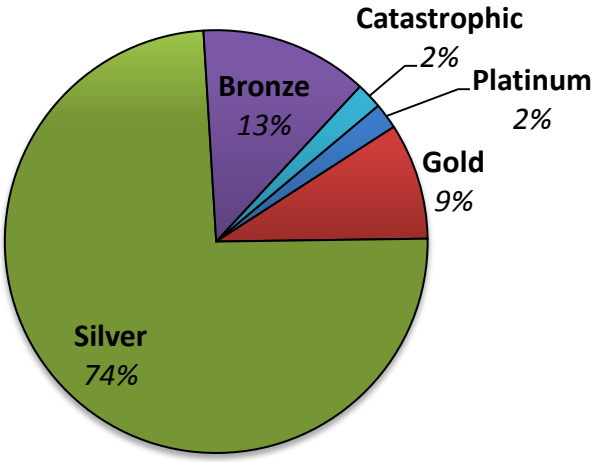
Governor Rick Snyder initially proposed that Michigan create a state-based marketplace, rather than a state-partnership or federally-facilitated marketplace. The state Senate passed this proposal on November 10, 2011, but the House did not approve it. Subsequently, the Governor proposed that Michigan have a state-partnership marketplace and submitted its blueprint with this plan. The state Senate did not approve this approach and blocked a federal grant to support some of Michigan's partnership activities. As a result, Michigan has plan management responsibilities but is one of 37 states that used Healthcare.gov as its marketplace enrollment platform in 2015.[18,19]

State enrollment in Michigan's marketplace surpassed the U.S. Department of Health and Human Services (HHS) first year projections. At the conclusion of the 2014 open enrollment period, 272,539 Michigan residents had selected a plan on the marketplace, compared to the HHS enrollment target of 161,000.[20,21] Thirty-nine percent of Michigan's potential marketplace population enrolled in a plan during the first enrollment period; Michigan ranked fourth nationally by this measure.[22] As of February 2015, an estimated 341,183 people selected a plan on the marketplace during the second open enrollment.[23] Estimates indicate that 58 percent were consumers from the previous year who re-enrolled, while 42 percent were new consumers.[24]

During the 2014 open enrollment, 75 percent of Michigan residents who purchased coverage on the marketplace opted for silver level plans (*Figure 3*).[25] Notably, 87 percent of Michigan marketplace consumers purchased coverage with financial assistance. Individuals under age 34 comprised 35 percent of marketplace purchasers (*Figure 4*).

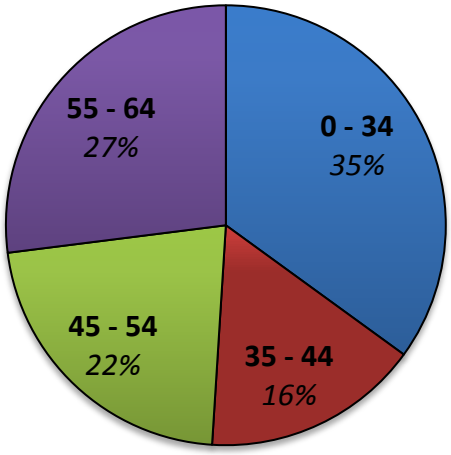
[18] "State Health Insurance Marketplace Types," 2015, Kaiser Family Foundation: http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (accessed 3/20/2015).
[19] *HEALTH INSURANCE MARKETPLACES 2015 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT*, (Department of Health and Human Services: Washington, D.C., March 10, 2015): http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf (accessed 3/20/2015).
[20] "PROFILE OF AFFORDABLE CARE ACT COVERAGE EXPANSION ENROLLMENT FOR MEDICAID / CHIP AND THE HEALTH INSURANCE MARKETPLACE, Michigan," Office of the Assistant Secretary for Planning and Evaluation, 2014: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/mi.pdf (accessed 3/20/2015).
[21] "Projected Monthly Enrollment Targets for Health Insurance Marketplaces in 2014," Department of Health and Human Services, 2014: http://waysandmeans.house.gov/uploadedfiles/enrolltargets_09052013_.pdf (accessed 3/20/2015).
[22] Marketplace Enrollment as a Share of the Potential Marketplace Population, Kaiser Family Foundation, April 2014: http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2014/ (accessed 3/20/2015).
[23] "Open Enrollment Week 13: February 7, 2015 – February 15, 2015," Department of Health and Human Services, Feb. 18, 2015: http://www.hhs.gov/healthcare/facts/blog/2015/02/open-enrollment-week-thirteen.html (accessed 3/20/2015).
[24] *HEALTH INSURANCE MARKETPLACES 2015 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT*, (Department of Health and Human Services: Washington, D.C., March 10, 2015): http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf (accessed 3/20/2015).
[25] "PROFILE OF AFFORDABLE CARE ACT COVERAGE EXPANSION ENROLLMENT FOR MEDICAID / CHIP AND THE HEALTH INSURANCE MARKETPLACE, Michigan" Office of the Assistant Secretary for Planning and Evaluation, 2014: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/mi.pdf (accessed 3/20/2015).

Figure 3: Michigan Marketplace Plan Selection by Metal Level, 2013-2014 Open Enrollment



Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Figure 4: Age of Michigan Residents Purchasing Marketplace Coverage, 2013 - 2014 Open Enrollment



Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Results from CHRT's most recent Cover Michigan Survey noted that consumers who purchased coverage individually weighed the plan's cost more heavily than the network of available providers.[26] When selecting a plan, 74 percent said that cost of the premium was very important, 72 percent answered that cost of the deductible was very important, 66 percent said that the cost of copays were very important, and 60 percent responded that costs of coinsurance were very important. Conversely, 49 percent responded that physician choice was very important during their plan selection. This is aligned with existing surveys that suggest consumers purchasing their own insurance prefer to save money and accept a narrower network of providers.[27, 28]

[26] M. Smiley, M. Riba, E. Ndukwe, and M. Udow-Phillips, *Cover Michigan Survey 2014*. (Ann Arbor, MI: Center for Healthcare Research and Transformation, March 2015).
[27] "Kaiser Health Tracking Poll: February 2014," Kaiser Family Foundation, February 26, 2015: http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/ (accessed 3/20/2015).

Health Insurers

The ACA has fundamentally changed the landscape in which insurers operate. The ACA introduced more regulation of insurers to establish common standards among plans, limiting the ways in which insurers can alter their offerings. For example, insurers must cover 10 essential health benefits in order to offer qualified health plans, may not withhold coverage due to pre-existing conditions, and must comply with the medical loss ratio by spending 80 percent of premiums on health care and quality improvement for individual and small employer groups, or 85 percent for large employer groups.[29]

Individual Market

In 2014, 10 issuers offered Michigan consumers 60 plans on the Health Insurance Marketplace. In 2015, 14 issuers offered 193 plans, more than three times the number of options available in 2014.[30] The average benchmark plan's premium increased by just 1 percent, and the lowest bronze plan premium increased by 7 percent (*Figure 5*).[31] Across the state, there was much variation in plan choice and premium changes by county.[32]

Figure 5: Premium Changes from the 2014 Open Enrollment Period to the 2015 Open Enrollment Period

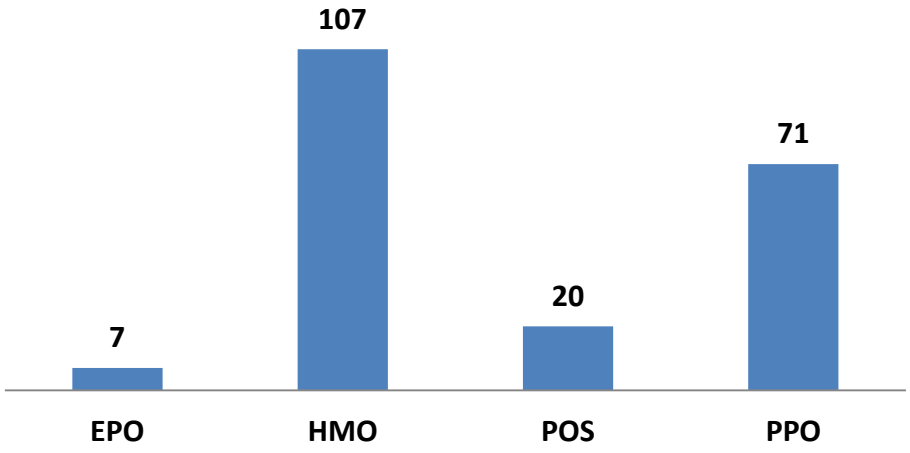
	2014	2015	Percent change
Average benchmark plan premium (50 year old, non-smoker)	$371	$373	1% increase
Average lowest bronze premium (50 year old, non-smoker)	$266	$284	7% increase

Source: Avalere. November 24, 2014. 2015 Exchange Premium File.

The plan offerings aimed to compete in a changing consumer-oriented market environment. Many insurers offered plans with lower out-of-pocket costs by creating narrow or geographically-limited provider networks. The vast majority of plans offered in Michigan were either HMO or PPO plans. Exclusive Provider Organization plans are a new trend likely spurred by the ACA. (*Figure 6*).[33]

[28] A. Mathews, Price, Price, Price: Health-Insurance Shoppers Have Priorities, The Wall Street Journal, July 15, 2013: http://www.wsj.com/articles/SB10001424127887323300004578555560447477062 (accessed 3/20/2015).
[29] J. Linder, J. Moore, J. Fangmeier, and M. Udow-Phillips, "The Affordable Care Act and its Effect on Health Insurance Market Segments" (Ann Arbor, MI: Center for Healthcare Research and Transformation: Aug. 13, 2012): http://www.chrt.org/publication/affordable-care-act-effect-health-insurance-market-segments/ (accessed 3/20/2015).
[30] More Michigan Insurers Submit Plans for Second Year of Federal Health Insurance Marketplace, Department of Insurance and Financial Services, June 11, 2014: http://www.michigan.gov/difs/0,5269,7-303-13222_13250-330428--,00.html (accessed 3/20/2015).
[31] C. Pearson, "Avalere Analysis: 2015 Exchange Premium File," Avalere, Nov. 14, 2014: http://avalere.com/expertise/life-sciences/insights/avalere-analysis-2015-exchange-premium-file (accessed 3/20/2015).
[32] J. Fangmeier, *Rate Analysis: 2015 Michigan Health Insurance Marketplace* (Ann Arbor: Center for Healthcare Research and Transformation, Jan. 23, 2015), http://www.chrt.org/publication/rate-analysis-2015-michigan-health-insurance-marketplace/ (accessed 3/20/2015).
[33] CHRT analysis of Healthcare.gov data.

Figure 6: 2015 Michigan Qualified Health Plans by Type



Source: CHRT analysis of Healthcare.gov data.

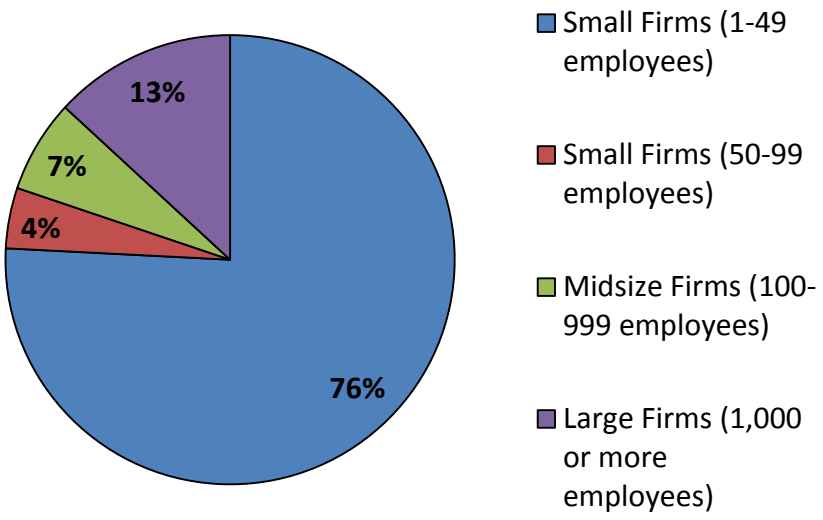
Employer-Sponsored Insurance

Although the ACA has provided alternative coverage options, most Michigan residents have continued to receive insurance coverage through their employers. In 2011, 60 percent of residents received employer-sponsored insurance (ESI), down from 65 percent in 2008.[34]

The majority of business establishments in Michigan (76 percent) are part of small firms that employ 1-49 employees, followed by large firms with 1,000 or more employees (*Figure 7*). Large firms employ nearly 45 percent of Michigan workers. Historically, small firms have been less likely to offer insurance coverage to their employees than larger businesses. From 2001 to 2012, the percent of Michigan's small firms offering coverage decreased from 60 to 33 percent. In 2013, this figure increased to 40 percent, but it is unclear what caused this increase and whether it will continue. In 2013, among firms with 50-999 workers, more than 90 percent offered health insurance coverage, a relatively stable percentage over the prior five years. Virtually all firms with 1,000 or more employees offered coverage in 2013 (*Figure 8*).

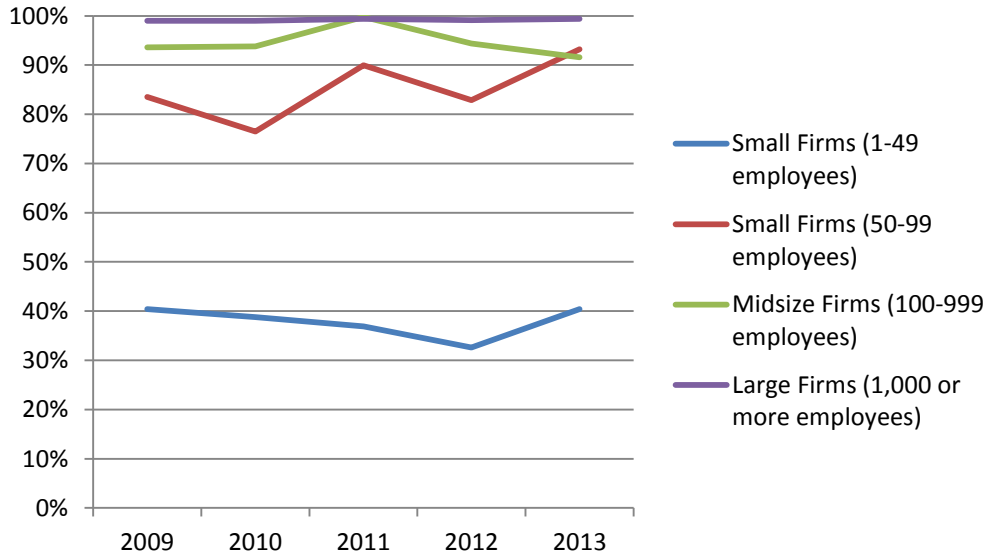
[34] A. Hammoud, T. Dreyer, N. Baum, and M. Udow-Phillips, *Private Health Insurance in Michigan, 2008 to 2011, Cover Michigan 2013* (Ann Arbor, MI: Center for Healthcare Research & Transformation, Sept. 2011).

Figure 7: Michigan Private-Sector Establishments by Firm Size, 2013



Source: The Affordable Care Act and Its Effect on Employers: 2015 Update, CHRT.

Figure 8: Percent of Michigan Private-Sector Establishments that Offer Health Insurance by Firm Size, 2013



Source: The Affordable Care Act and Its Effect on Employers: 2015 Update, CHRT.

Health Care Providers

The way in which providers deliver and receive reimbursement for health care services has shifted considerably under the ACA. The ACA has resulted in a concerted shift toward value-based payment and delivery. Providers have experienced changes in reimbursement levels and methodologies. In addition, the ACA has implemented many provider facing demonstration projects that test innovative payment and delivery models

Reimbursement Changes

The ACA has been a catalyst for shifting provider payment and quality structures. The law has introduced value-based purchasing approaches, such as readmissions reduction and hospital-acquired conditions programs and the value-based payment modifier. At the same time, market basket update factors and disproportionate share hospital payments were reduced relative to methodologies prior to the ACA. Conversely, the ACA increased payments to primary care physicians in the Medicaid program, funded federally, for 2013 and 2014. Some of the most significant provider changes are described below.

Hospitals and other Facility Providers

Market Basket Updates

Each year, CMS has issued regulations to update Medicare's payment rates to reflect price increases. CMS has updated many of the rates using a provider-specific market basket index, which measures the change in the price of goods and services purchased to deliver a service.[35]

To reduce the growth of Medicare spending, starting in 2010, the market basket updates reduced the annual Medicare payment update for inpatient hospitals, home health, skilled nursing facilities, and other Medicare providers. The updates reduced payment by:

- 0.25 percentage points from 2010-2011;
- 0.1 percentage points from 2012 – 2013;
- 0.3 percentage points in 2014;
- 0.2 percentage points in 2015-2016; and
- 0.75 percentage points from 2017-2019.

The law also reduced market basket updates for certain providers to account for gains in productivity. In 2010, the CBO estimated that these changes would reduce Medicare payments to providers by $157 billion between 2010 and 2019.[36]

Disproportionate Share Hospital Payments

Under the ACA, uncompensated care provided by hospitals was expected to decrease as more patients gained health coverage, particularly Medicaid coverage. In anticipation of that change, the ACA required that Medicare and Medicaid disproportionate share payments to hospitals be gradually reduced. These rates are being reduced across all states, regardless of whether or not a state decided to expand its Medicaid program.

[35] Centers for Medicare and Medicaid Services, *Market Basket Definitions and General Information,* (N.d.): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/info.pdf (accessed 3/20/15).
[36] D.W. Elmendorf, Letter to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 5 (Washington, DC: Congressional Budget Office, March 20, 2010): https://www.cbo.gov/sites/default/files/amendreconprop.pdf (accessed 3/20/15).

Medicare DSH Program

In FY2014, hospitals began receiving 25 percent of their previous Medicare disproportionate share (DSH) funds, while the remaining 75 percent of what they previously received was placed into a separate funding pool and distributed by CMS to hospitals based on the share of uncompensated care the hospital provided. Over time, this pool will be reduced proportionally for every percentage point reduction in the uninsured rate. The new Medicare DSH payment formula is expected to cut payments to hospitals nationally by over $22.1 billion between 2014 and 2019.[37,38]

Medicaid DSH Program

The federal government's reduced contribution to state Medicaid DSH programs was to take effect in FY2014 but was delayed by Congress. The cuts will now begin in FY2017 and run through FY2024, reducing payments by $35 billion over eight years.[39,40] *The formula to determine how much each state's DSH payments will be reduced in FY2017 and beyond will be determined once more data become available on the impact of coverage expansion provisions in the ACA.*[41]

Hospital Readmission Reduction Program

To reduce potentially preventable readmissions, the ACA created the Hospital Readmission Reduction Program. Under this program, CMS reduces Medicare payments to hospitals with readmissions above a certain rate for certain conditions.[42,43,44] In FY2015, the program's third year, hospitals can lose up to 3 percent of inpatient Medicare reimbursement across all conditions; in future years, 3 percent will remain the ceiling for penalties to hospitals. In FY2015, an estimated $428 million in penalties will be applied to 2,610 (77 percent) of the 3,382 participating hospitals.[45,46] In Michigan, 71 hospitals (52 percent of Michigan hospitals) will be penalized, receiving an average payment reduction of 0.64 percent for Medicare inpatient stays.[47]

[37] D.W. Elmendorf, Letter to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 5 (Washington, DC: Congressional Budget Office, March 20, 2010): https://www.cbo.gov/sites/default/files/amendreconprop.pdf (accessed 3/20/15).
[38] U.S. Department of Health and Human Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Final Rule," *Federal Register*, 78(181): 57293–57313, Sept. 18, 2013.
[39] Congress delayed the Medicaid DSH payment cuts via the Bipartisan Budget Act of 2013 and the Protecting Access to Medicare Act of 2014.
[40] Protecting Access to Medicare Act of 2014 (P.L. 113-93).
[41] U.S. Department of Health and Human Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Final Rule," *Federal Register*, 78(181): 57293–57313, Sept. 18, 2013.
[42] CMS defines "excess" readmissions as readmissions that surpass a hospital's expected readmission rate: the national mean readmission rate, adjusted for demographic and severity factors of the hospitals' patients.
[43] Initially, CMS penalized hospitals if they had excess readmissions for three conditions: acute myocardial infarction, heart failure, and pneumonia. In FY2014, CMS added two new conditions: chronic lung problems (such as bronchitis and emphysema) and elective hip and knee replacements. In FY2015, the program was expanded to all patient stays.
[44] J. Rau, "A Guide To Medicare's Readmissions Penalties And Data," *Kaiser Health News*, Oct. 2, 2014: http://kaiserhealthnews.org/news/a-guide-to-medicare-readmissions-penalties-and-data/ (accessed 3/20/15).
[45] Centers for Medicare and Medicaid Services, *Readmissions Reduction Program*, Aug. 4, 2014: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/ (accessed 3/20/15).
[46] There are 5,686 total registered hospitals in the U.S., according to the American Hospital Association.
[47] J. Rau, "A Guide To Medicare's Readmissions Penalties And Data," *Kaiser Health News*, Oct. 2, 2014. http://kaiserhealthnews.org/news/a-guide-to-medicare-readmissions-penalties-and-data/ (accessed 3/20/15).

Hospital-Acquired Conditions (HAC)

Under the ACA, Medicare reduces payments to hospitals that have patient complication rates higher than their peers. There are 11 categories of conditions that were designated by CMS under this measure, including foreign object retained after surgery, air embolism and blood incompatibility.[48] These conditions met certain criteria including that they were not present upon initial hospitalization and could have been reasonably prevented.[49] In December 2014, the federal government announced that HAC penalties would be applied to 721 hospitals nationally, 13 percent of total hospitals. Total penalties are estimated at $373 million, with a particular impact on academic medical centers.[50] In Michigan, 21 hospitals (22 percent of total Michigan hospitals) were penalized in FY2015.[51] Recent reports indicate a 17 percent decline in HACs nationally from 2010 to 2013.[52]

Hospital Value-Based Purchasing

The ACA established the Hospital Value-Based Purchasing (VBP) Program, a CMS effort to tie Medicare inpatient hospital reimbursement to value and quality scores. The program affects Medicare inpatient reimbursement for over 3,500 acute-care hospitals nationwide, 62 percent of total hospitals. Under this initiative, a hospital's base operating Diagnosis-related Group (DRG) amount is adjusted and incentive payments are provided to certain hospitals based on their Total Performance Score (TPS);[53] the total incentive amount is equal to the total reduction of base operating DRG amounts across participating hospitals.

The TPS is comprised of four domains: clinical process of care, patient experience, outcomes and efficiency. CMS can alter the weight of each domain from one fiscal year to the next (*Figure 9*).

Figure 9: FY2015 and FY2015 Domains for Hospital Total Performance Score

Domain	FY2015 Weight	FY2016 Weight
Clinical Processes of care	20%	10%
Patient Experience of Care	30%	25%
Outcome	30%	40%
Efficiency	20%	25%

Source: Hospital Value-Based Purchasing, QualityNet.

[48] Centers for Medicare and Medicaid Services, *Hospital-Acquired Conditions*, Aug. 28, 2014: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html (accessed 3/20/15).
[49] Centers for Medicare and Medicaid Services. *Hospital-Acquired Conditions (HAC) Reduction Program*, Dec. 18, 2014: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html (accessed 3/20/15).
[50] J. Rau, "Medicare Cuts Payments To 721 Hospitals With Highest Rates of Infections, Injuries," *Kaiser Health News*, Dec. 18, 2014: http://kaiserhealthnews.org/news/medicare-cuts-payments-to-721-hospitals-with-highest-rates-of-infections-injuries/ (accessed 3/20/15).
[51] J. Rau, "Hospital-Acquired Condition Penalties By State," *Kaiser Health News*, Dec. 19, 2014: http://kaiserhealthnews.org/news/hospital-acquired-condition-penalties-by-state (accessed 3/20/15).
[52] Agency for Healthcare Research and Quality. *Efforts To Improve Patient Safety Result in 1.3 Million Fewer Patient Harms: Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013*, Dec. 2014: http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html (accessed 3/20/15).
[53] Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Hospital Value-Based Purchasing Program*, March 9, 2012: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/FY-2013-Program-Frequently-Asked-Questions-about-Hospital-VBP-3-9-12.pdf (accessed 3/20/15).

CMS began incorporating the VBP program into hospital payment at the start of FY2013, based on the hospital's performance from July 1, 2011 until March 31, 2012.[54] In FY2013, hospitals were at risk of losing 1 percent of base operating DRG amounts, with an eventual increase to 2 percent by FY2017.[55] In FY2015, approximately $1.4 billion was available for value-based payment incentives.[56]

Initially, hospitals had more reductions to their base DRG amounts than they gained in incentives. In FY2014, 1,451 hospitals received lower Medicare payments while 1,231 received higher payments.[57] In FY2015, the opposite was true; 1,714 hospitals received a positive adjustment to Medicare payments, while 1,375 received lower Medicare payments.[58]

Physicians

Value-Based Payment Modifier

The Centers for Medicare and Medicaid Services began experimenting with value based payments to physicians before the ACA. But, the ACA furthered those approaches with a goal to increase the proportion of payments made to physicians based on quality rather than volume. CMS is using the value based payment modifier to adjust payments to physicians based on quality and the cost of care. This program is intended to be budget neutral in the aggregate. The Value-Based Payment Modifier uses the Physician Quality Reporting System (PQRS) and Medicare cost data to create an overall value score for a provider. Providers with high value scores receive increased payments and providers with lower scores receive decreased payments. Starting in 2015, CMS began to phase in the program to groups of 100 or more eligible professionals who submitted claims to Medicare, with quality scores based on performance in calendar year 2013. By 2017, the program will include all physicians who participate in Fee-For-Service Medicare, including solo practitioners and groups of two or more eligible professionals.[59]

Primary Care Uplift

Historically, many state Medicaid programs struggled to attract providers because of lower reimbursement rates compared to Medicare and private payers. In 2012, for instance, Michigan's Medicaid program paid less than 50 percent of Medicare fees for primary care services.[60] Because the ACA was intended to increase the number of Medicaid recipients, the ACA increased Medicaid reimbursement for select primary care services in 2013 and 2014 to help improve access to primary care. This fee change was known as the Primary Care Uplift. Between 2013 and 2014, the Michigan Department of Community Health received approximately $175 million to increase

[54] Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Hospital Value-Based Purchasing Program*, March 9, 2012: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/FY-2013-Program-Frequently-Asked-Questions-about-Hospital-VBP-3-9-12.pdf (accessed 3/20/15).
[55] Ibid.
[56] Centers for Medicare and Medicaid Services, "CMS releases data on quality to help patients choose providers," *The CMS Blog*, Dec. 18, 2014: http://blog.cms.gov/2014/12/18/cms-releases-data-on-quality-to-help-patients-choose-providers/ (access 3/20/15).
[57] J. Rau, "Nearly 1,500 Hospitals Penalized Under Medicare Program Rating Quality," *Kaiser Health News*, Nov. 14, 2013: http://kaiserhealthnews.org/news/value-based-purchasing-medicare/ (accessed 3/20/15).
[58] Centers for Medicare and Medicaid Services, "CMS releases data on quality to help patients choose providers," *The CMS Blog*, Dec. 18, 2014: http://blog.cms.gov/2014/12/18/cms-releases-data-on-quality-to-help-patients-choose-providers/ (access 3/20/15).
[59] Centers for Medicare and Medicaid Services, *Value-Based Payment Modifier*, March 19, 2015: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html (accessed 3/20/15).
[60] S. Zuckerman, D. Goin, *How Much Will Medicaid Phsician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees* (Washington, DC: Kaiser Family Foundation, Dec. 2012): https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf (accessed 3/20/15).

primary care Medicaid reimbursement to the level of Medicare rates.[61] During the uplift period, more Michigan physicians reported accepting new Medicaid patients, increasing from 54 percent in 2012 to 64 percent in 2014.[62] In FY2015, the Michigan legislature allocated general funds and the associated federal matching funds to continue increased primary care rates at 78 percent of Medicare. This rate was somewhat less than the full, federal uplift but considerably higher than the rates in effect prior to the ACA. Fourteen other states also chose to continue with some degree of higher fee for Medicaid primary care practitioners relative to pre ACA levels.[63]

Demonstrations and Delivery Reform

The ACA has also promoted demonstration projects to test new ideas in delivery and payment. Namely, the law established the Center for Medicare and Medicaid Innovation (the Innovation Center) within CMS, which has facilitated programs and experiments to test how providers can offer higher quality care at lower costs. Michigan providers are actively participating in the Innovation Center's programs, including accountable care organizations, bundled payments and the Multi-Payer Advanced Primary Care Practice Demonstration. These three programs intend to promote care coordination and avoid unnecessary health care services.

MiPCT (Multi-Payer Advanced Primary Care Demonstration)

The Multi-Payer Advanced Primary Care demonstration program (MAPCP) was one of the early demonstration projects implemented under the ACA. MAPCP is designed to coordinate and integrate multiple payers, including Medicare, Medicaid and private payers. The program provides common incentives and approaches to improve the coordination and integration of primary care through a patient-centered medical home model. The initiative has a particular focus on patients with chronic disease.[64] The MAPCP began in 2011 with eight participating states, including Michigan.[65] In Michigan, the program is known as the Michigan Primary Care Transformation (MiPCT).

MiPCT is the nation's largest PCMH demonstration, incorporating care managers in physician organizations and practices in Michigan.[66] Across the state, 1,800 participating providers, over 400 specially-trained care managers, and 355 primary care practices have participated in the MiPCT program. Five payers, both public and private, have also been involved (Blue Cross Blue Shield of Michigan, Blue Care Network, Medicaid, Medicare, and Priority Health).[67] In the program's first year, MiPCT saved an estimated $148 per Medicare fee-for-service beneficiary

[61] J. Greene, "Physicians face smaller Medicaid payments – but it could have been worse," *Crain's Detroit Business*, Jan. 11, 2015: http://www.crainsdetroit.com/article/20150111/NEWS/301119972/physicians-face-smaller-medicaid-payments-but-it-could-have-been (accessed 3/20/15).
[62] M.L. Smiley, M. Riba, M.M. Davis et al. *Primary Care Capacity in Michigan: How are Physicians Responding?, 2014 Michigan Physician Survey* (Ann Arbor, MI: Center for Healthcare Research & Transformation, Dec. 17, 2014). http://www.chrt.org/publication/primary-care-capacity-michigan-physicians-responding/
[63] Ibid.
[64] Center for Medicare and Medicaid Innovation, *Multi-Payer Advanced Primary Care Practice*, (N.d.): http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/ (accessed 3/20/15).
[65] N. McCall, S. Haber, M. Van Hasselt et al., *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First Annual Report* (Research Triangle Park, NC: RTI International, Jan. 2015): http://innovation.cms.gov/Files/reports/MAPCP-EvalRpt1.pdf (accessed 3/20/15).
[66] Michigan Primary Care Transformation Project.
[67] N. McCall, S. Haber, M. Van Hasselt et al., *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First Annual Report* (Research Triangle Park, NC: RTI International, Jan. 2015): http://innovation.cms.gov/Files/reports/MAPCP-EvalRpt1.pdf (accessed 3/20/15).

across 226,369 beneficiaries.[68] In September 2014, CMS announced that the demonstrations in Michigan and four other states, which were set to end after 2014, would be extended through 2016.[69]

Accountable Care Organizations

An accountable care organization (ACO) is a group of providers that is clinically and financially responsible for the care of a group of patients. ACOs are intended to encourage the coordination of care to decrease duplication of services. As part of the ACA, there are two ACO models being implemented by CMS for the Medicare population, the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model. Under both models, provider groups earn incentives if certain financial and quality goals are met. Under the Pioneer ACO, providers may also share in losses with greater potential for risk and reward than MSSP ACOs.

As of January 2015, 20 MSSP ACOs were serving Michigan residents.[70] There was one Pioneer ACO remaining in Michigan (called Michigan Pioneer ACO, affiliated with the Detroit Medical Center), down from three at the program's start in 2012. Nationwide, as of January 2015, there were 19 Pioneer ACOs, down from 32.[71] Pioneer ACOs dropped out of the program or shifted to participation in the MSSP program because of concerns about the risk involved and/or the methodology used to calculate savings in the Pioneer model.

Michigan's remaining Pioneer ACO has received nearly $10 million in earned shared savings over the first two performance years, 2012 and 2013. According to CMS, the Michigan Pioneer ACO slowed spending by 3.9 percent in year 1, and earned $4.02 million in shared savings. In the second performance year, the ACO slowed spending by 4.9 percent and earned $5.95 million in shared savings.[72,73,74]

In Michigan, two of the eight MSSP ACOs that began in 2012 earned shared savings payments in performance year one. Oakwood Accountable Care Organization, LLC (affiliated with Oakwood Healthcare) earned $8.57 million in shared savings in performance year 2012. Also in 2012, Southeast Michigan Accountable Care, Inc. (SEMAC) earned $12.09 million in shared savings.[75] SEMAC (affiliated with Dearborn-based United Outstanding Physicians) ranked fourth in the nation among MSSP ACOs for overall savings.[76,77]

[68] N. McCall, S. Haber, M. Van Hasselt et al., *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First Annual Report* (Research Triangle Park, NC: RTI International, Jan. 2015): http://innovation.cms.gov/Files/reports/MAPCP-EvalRpt1.pdf (accessed 3/20/15).
[69] Center for Medicare and Medicaid Innovation, *Multi-Payer Advanced Primary Care Practice*, (N.d.): http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/ (accessed 3/20/15).
[70] Center for Medicare and Medicaid Innovation, March 2015.
[71] Center for Medicare and Medicaid Innovation, March 2015: http://innovation.cms.gov/initiatives/map/index.html#model=pioneer-aco (accessed 3/20/15).
[72] Center for Medicare and Medicaid Innovation, *Medicare Pioneer ACO Model Performance Year 1 and Performance Year 2 Financial Results*, Oct. 2014: http://innovation.cms.gov/Files/x/PioneerACO-Fncl-PY1PY2.pdf
[73] Advisory Board, "First look: How the Pioneer ACO near you has performed," *The Daily Briefing*, Oct. 9, 2014: http://www.advisory.com/daily-briefing/2014/10/09/how-the-pioneer-aco-near-you-has-performed (accessed 3/20/15).
[74] Equivalent earned shared savings information for all MSSP ACOs in Michigan is not available.
[75] Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results*, (N.d.): https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt (accessed 3/20/15).
[76] J. Greene, "3 provider organizations awarded Medicare accountable-care organization contracts," *Crain's Detroit Business*, July 9, 2012: http://www.crainsdetroit.com/article/20120709/FREE/120709951/3-provider-organizations-awarded-medicare-accountable-care (accessed 3/20/15).
[77] J. Greene, "Many Michigan ACOs saving millions under Medicare's cost-saving plan," *Crain's Detroit Business*, Feb. 8, 2015: http://www.crainsdetroit.com/article/20150208/NEWS/302089981/many-michigan-acos-saving-millions-under-medicares-cost-saving-plan (accessed 3/20/15).

Bundled Payments for Care Improvement

A bundled (or episode-based) payment occurs when a payer and provider agree to group all the services related to a single illness or course of treatment into a single payment in hopes of encouraging care coordination and more efficient use of services. In January 2013, the CMS Innovation Center launched a three-year demonstration, the Bundled Payments for Care Improvement (BPCI) Initiative, to test four payment models using the bundled payment strategy.[78]

- **Model 1:** Tests retrospective payments for acute care hospital stays
- **Model 2:** Tests retrospective payments for acute and post-acute care
- **Model 3:** Tests retrospective payments for post-acute care
- **Model 4:** Tests prospective payments for acute hospital stays

The BPCI initiative is still ongoing, but a preliminary assessment of the effects of the initiative on a sample of participants during the first year showed some cost savings and quality improvements.[79] In Michigan, 41 provider organizations are testing Model 2, 109 are testing Model 3, and one is testing Model 4.[80] In addition to hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies may also participate in Model 3.

Future Changes for Providers

As the ACA passes its fifth year, more new approaches related to the delivery and financing of healthcare are on their way. Two notable changes that have been announced include expansion to the value based payment approaches and the state innovation models, both of which build on programs already in effect.

CMS Value-Based Payment and Alternative Payment Goals

In 2015, CMS announced two major goals related to expanding value-based payments and alternative payment models:[81]

- **Goal 1:** Tie 85 percent of traditional Medicare payments to quality or value by the end of 2016 and 90 percent by 2018.
- **Goal 2:** Grow the portion of traditional Medicare payments made through alternative payment models to 30 percent by the end of 2016 and 50 percent by 2018.

HHS concurrently announced the creation of the Health Care Payment Learning and Action Network to encourage private insurers, providers, consumers and others to also use alternative payment models.[82] The ACA's alternative payment and delivery models are playing a key role in this effort to reduce spending and enhance quality.

[78] Center for Medicare and Medicaid Innovation, *BPCI Initiative Episodes: Details on the Participating Health Care Facilities*, (N.d.): http://innovation.cms.gov/initiatives/Bundled-Payments/Participating-Health-Care-Facilities/index.html
[79] L. Dummit, G. Marrufo, J. Marshall et al., *CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report* (Falls Church, VA: The Lewin Group, Feb. 2015): http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf (accessed 3/20/15).
[80] Center for Medicaid and Medicare Innovation.
[81] U.S. Department of Health and Human Services, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," Jan. 26, 2015: http://www.hhs.gov/news/press/2015pres/01/20150126a.html (accessed 3/20/15).
[82] Ibid.

State Innovation Model

The Innovation Center has also created a grant program, known as the State Innovation Model (SIM), to encourage states to design and implement their own innovative, state-wide health care models. Michigan is one of 11 states awarded funds, $70 million over three-years, to implement its SIM model. The Michigan SIM has three broad objectives: 1) healthcare system transformation, 2) payment reform, and 3) population health improvement. [83] The state's SIM intends to accomplish these objectives through care coordination at several layers, building on the MiPCT model and expanding to community and regional coordination efforts. The SIM is also intended to target specific populations including infants, high-cost health care users, and individuals with multiple chronic diseases.[84]

Conclusion

The ACA is a complex law that intends to expand coverage, improve quality and control costs, with significant impacts on consumers, insurers and providers. Michigan consumers have new coverage options through the Healthy Michigan Plan and the Health Insurance Marketplace. Both these programs have exceeded enrollment expectations set by public and private groups. Michigan has one of the most competitive insurance marketplaces in the country, providing consumers across the state considerable choice of health plans and products. Similarly, providers across the state are testing new approaches to increasing value in health care while old approaches to reimbursement are changed substantially. In five years since its passage, it is clear that the ACA has had interconnected yet distinct impacts on consumers, insurers, and providers in the state.

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[83] Michigan Department of Community Health, *Reinventing Michigan's Health Care System: Blueprint for Health Innovation: Update and Next Steps* [PowerPoint slides], Feb. 26, 2015.
[84] Center for Medicare and Medicaid Innovation, *State Innovation Models Initiative: Model Test Awards Round Two*, (N.d.): http://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/ (accessed 3/20/15).