Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group

Discussion of Design Considerations

January 18, 2012

Agenda

- Introductions
- Inpatient Specialty Services Payment Methodologies
- APR-DRG Relative Weight Comparison
- Potential System Rebalancing
- Preliminary Payment Simulation Model Results
- Transitional Strategy for Expected Coding and Documentation Improvements
- Next Steps

Technical Advisory Group

- Children's Memorial Hospital
  - **Prem Tuteja**, Director, Third Party Reimbursement
- Swedish Covenant Hospital
  - **Gary M. Krugel**, Senior Vice President of Operations and CFO
- Southern Illinois Healthcare
  - **Michael Kasser,** Vice President/CFO/Treasurer
- Memorial Health Systems
  - **Bob Urbance,** Director – Reimbursement
- Carle Foundation Hospital
  - **Theresa O'Banion**, Manager-Budget & Reimbursement
- Franklin Hospital (Illinois Critical Access Hospitals)
  - **Hervey Davis**, CEO
- Mercy Hospital and Medical Center
  - **Thomas J. Garvey**, Chief Financial Officer
- Hospital Sister Health System
  - **Richard A. Walbert**, Vice President of Finance

- Touchette Regional Hospital
  - **Michael McManus**, Chief Operating Officer
- Resurrection Health Care
  - **John Orsini,** Executive VP & CFO
- University of Illinois Hospital
  - **Patrick O'Leary,** Director of Hospital Finance
- Sinai Health System
  - **Chuck Weiss,** Executive VP & CFO
- Cook County Health & Hospital System
  - **Randall Mark,** Director of Intergovernmental Affairs & Policy
- Provena Health System
  - **Gary Gasbarra**, Regional Chief Financial Officer
- Advocate Healthcare System
  - **Steve Pyrcioch,** Director of Reimbursement
- Universal Health Systems
  - **Dan Mullins,** Vice President of Reimbursement, Behavioral Health Division

Technical Advisors to Hospital Systems

Illinois Hospital Association

Steve Perlin, Group Vice President, Finance
Jo Ann Spoor, Director, Finance
Joe Holler

Illinois Academic Hospital Providers & multiple hospital provider systems

Matthew W. Werner - M. Werner Consulting - Designated Technical Consultant

Multiple hospital provider systems

J. Andrew Kane - Kane consulting - Designated Technical Consultant

Inpatient Specialty Services Payment Methodologies

New Inpatient Specialty Services Payment Systems

- HFS is considering the continuation of reimbursement for inpatient specialty services (psychiatric, rehabilitation and long-term acute care) using a separate methodology from the acute DRG payment system
- HFS is considering the identification of specialty services to continue to be based on provider type as opposed to DRG classification
- For each of the specialty service types, HFS is considering adopting elements (but not all) of Medicare's payment parameters

Inpatient Specialty Services Payment Methodologies

Psychiatric Providers / Distinct Part Unit Proposed Approach

- HFS is currently considering a Medicare-style psychiatric payment system
- Elements of the CMS IPF-PPS under consideration:
  - Psychiatric-specific standardized per diem payments rates, adjusted for wage index, teaching programs and rural status
  - Claim payments made on per diem basis with the following adjustments:
    - Relative weight adjustments for psychiatric and substance abuse APR-DRGs (72 total classifications which consider comorbidities)
    - Day adjustments that incrementally decrease during the patient stay (119% on first day down to 92% on 22nd day and beyond)
- Elements of the CMS IPF-PPS not currently under consideration:
  - Patient age adjustments (ages 45+)
  - Patient comorbidity adjustments
  - Emergency room adjustments

Inpatient Specialty Services Payment Methodologies

Rehabilitation Providers / Distinct Part Unit Proposed Approach

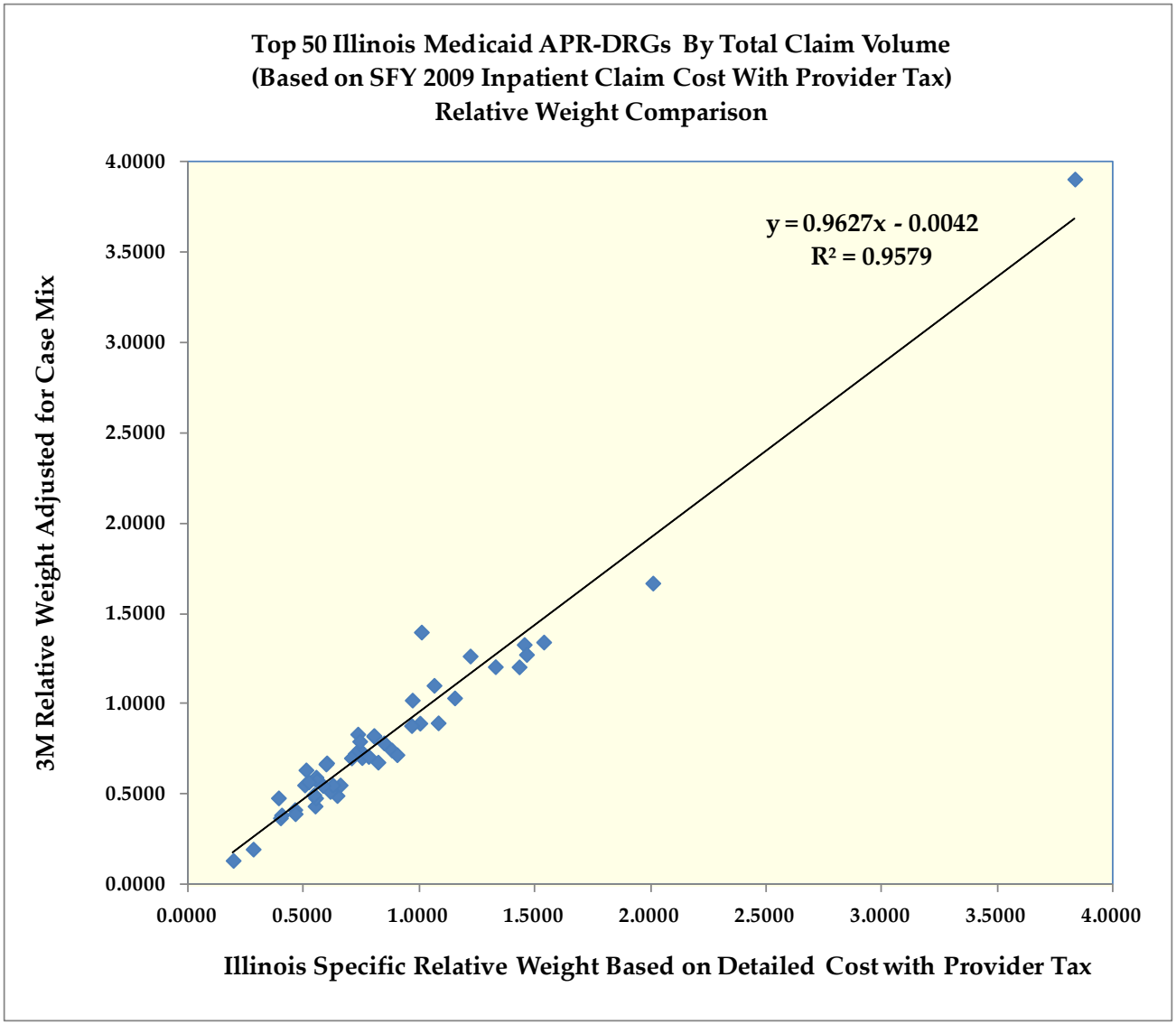
- HFS is currently considering a rehabilitation payment system similar to the proposed psychiatric per diem payment system, without incremental day adjustments:
  - Rehabilitation-specific standardized per diem payments rates, adjusted for wage index, teaching programs and rural status
  - Relative weight adjustments for rehabilitation APR-DRGs (4 total classifications)

Inpatient Specialty Services Payment Methodologies

LTAC Proposed Approach

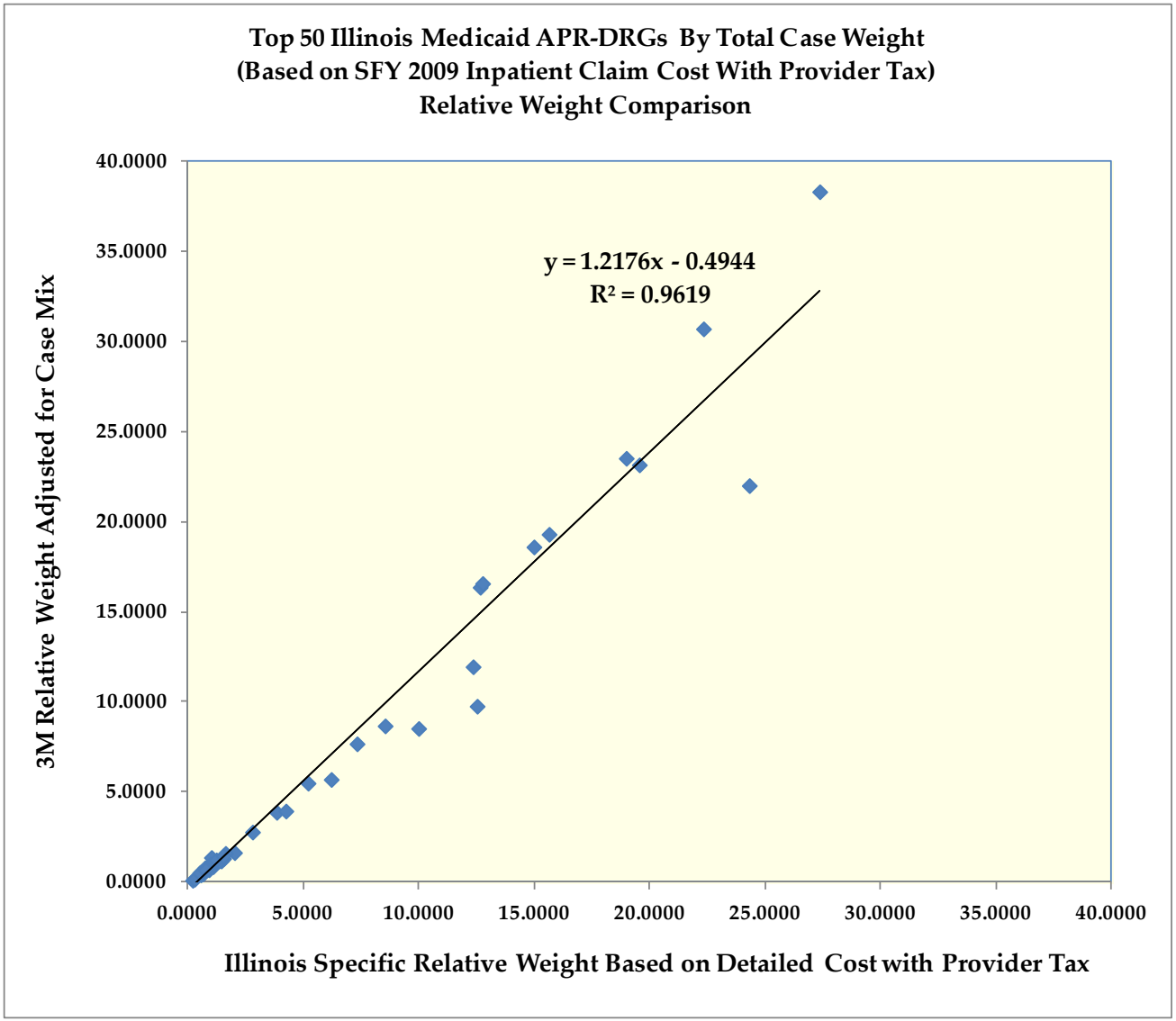
- HFS is currently considering a Medicare-style LTAC payment system, which mimics the acute DRG system with LTAC-specific payment rates
- Elements of the CMS LTCH-PPS under consideration:
  - DRG-based system, using APR-DRGs and national weights
  - LTAC-specific standardized DRG base rates, adjusted for wage index
  - High cost outlier payments
  - Short-stay outliers
  - No medical education payments (direct or indirect)

APR-DRG Relative Weight Comparison



Excludes Crossover Claims / Cook County & University of Illinois Claims / Psych, Rehab and Detox DRGs

APR-DRG Relative Weight Comparison

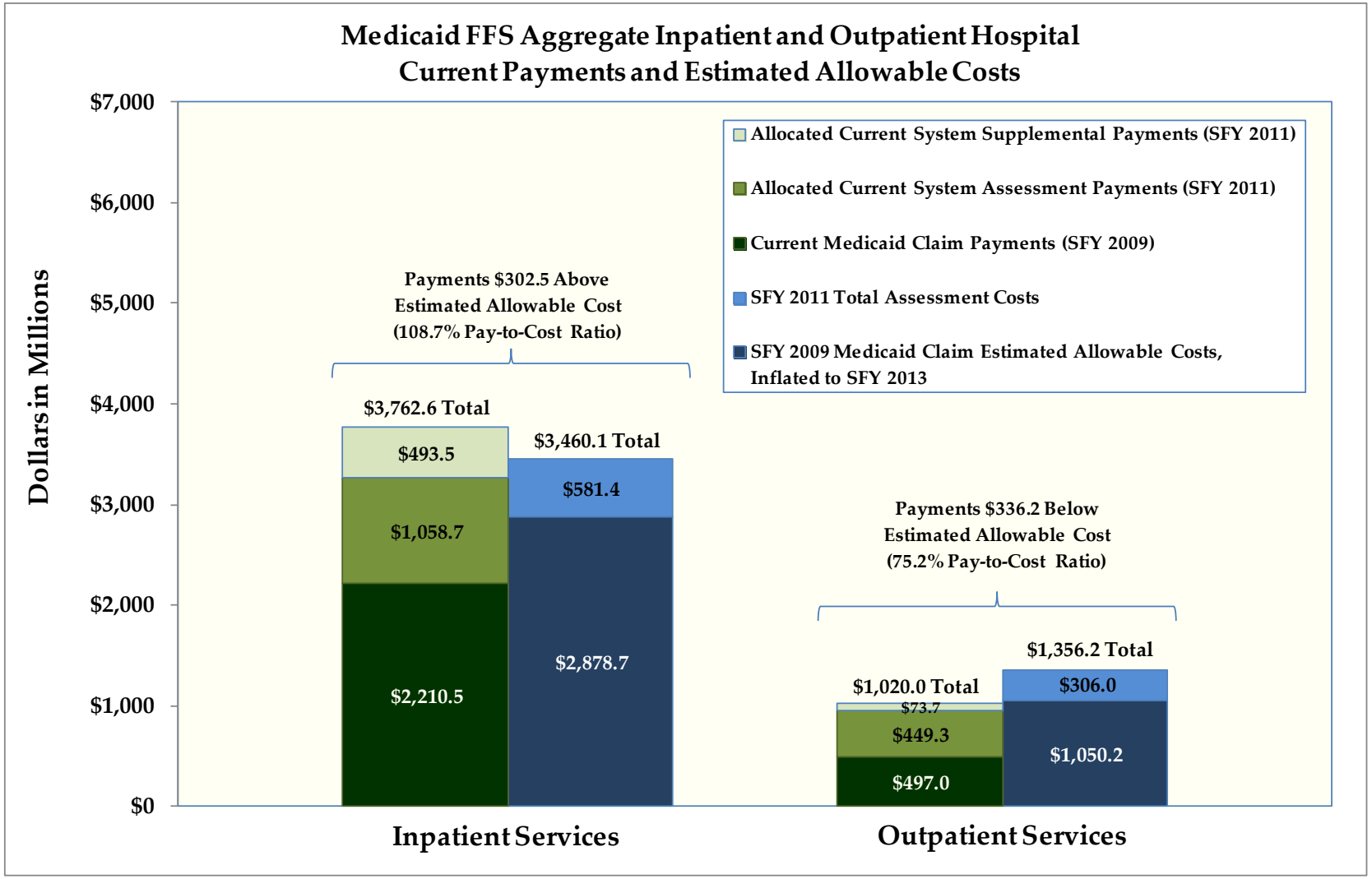


Excludes Crossover Claims / Cook County & University of Illinois Claims / Psych, Rehab and Detox DRGs

Potential System Rebalancing

*Summary Version 1: **Excludes** Medicare Crossover claims, Total Assessment Cost Allocated Between Inpatient and Outpatient*

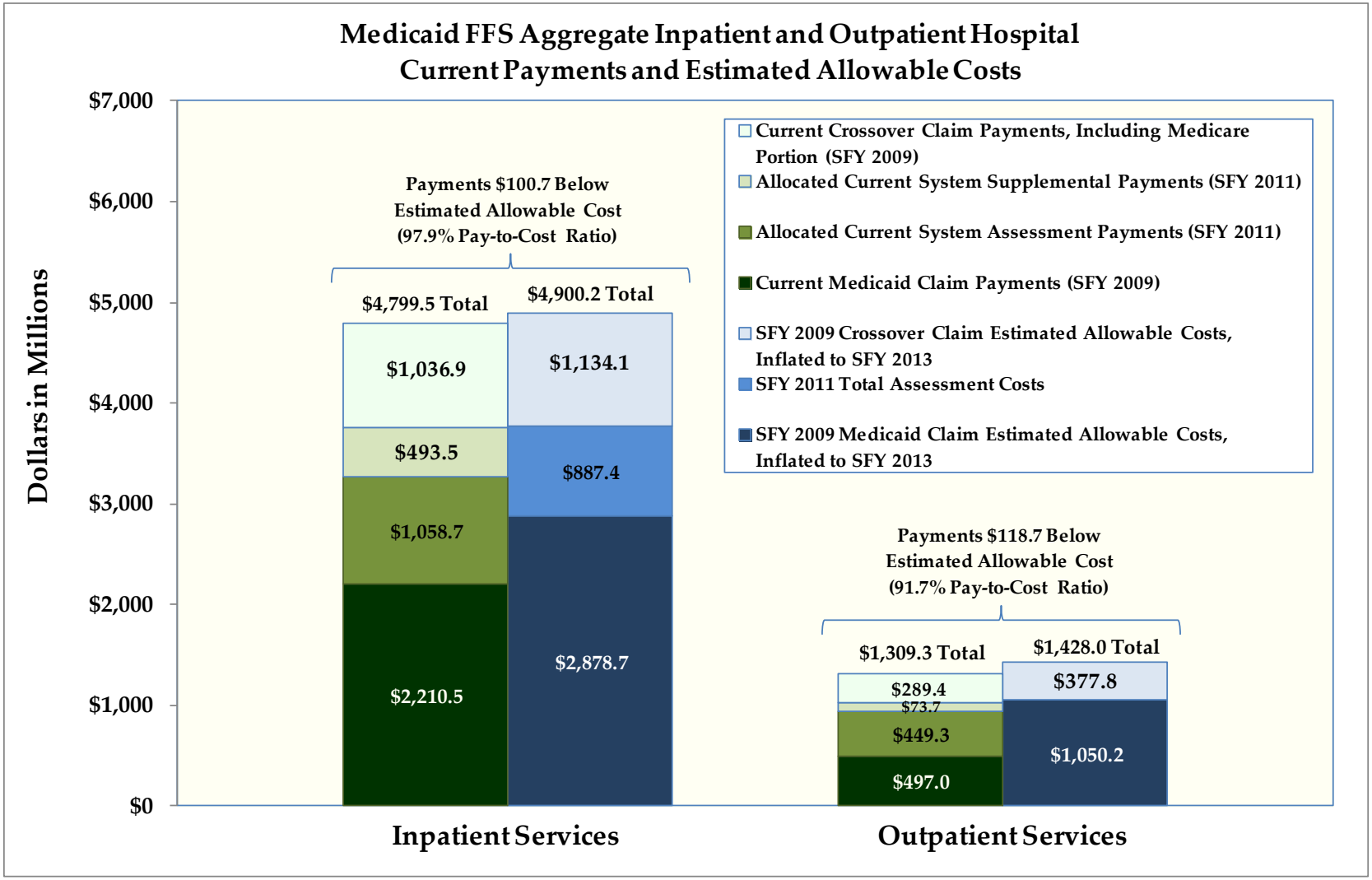
Excludes Cook County / U of I claims



Note: Estimated claims allowable costs are based on Medicare cost reporting rules, and therefore exclude amounts considered by Medicare to be "unallowable" for purposes of determining the costs of inpatient hospital services, such as certain costs associated with provider-based physicians, CRNAs and medical schools. However, total assessment costs shown in this chart extends beyond what is allowable under Medicare cost reporting rules.

Potential System Rebalancing

*Summary Version 2: **Includes** Medicare Crossover claims, Total Assessment Cost Allocated to Inpatient*

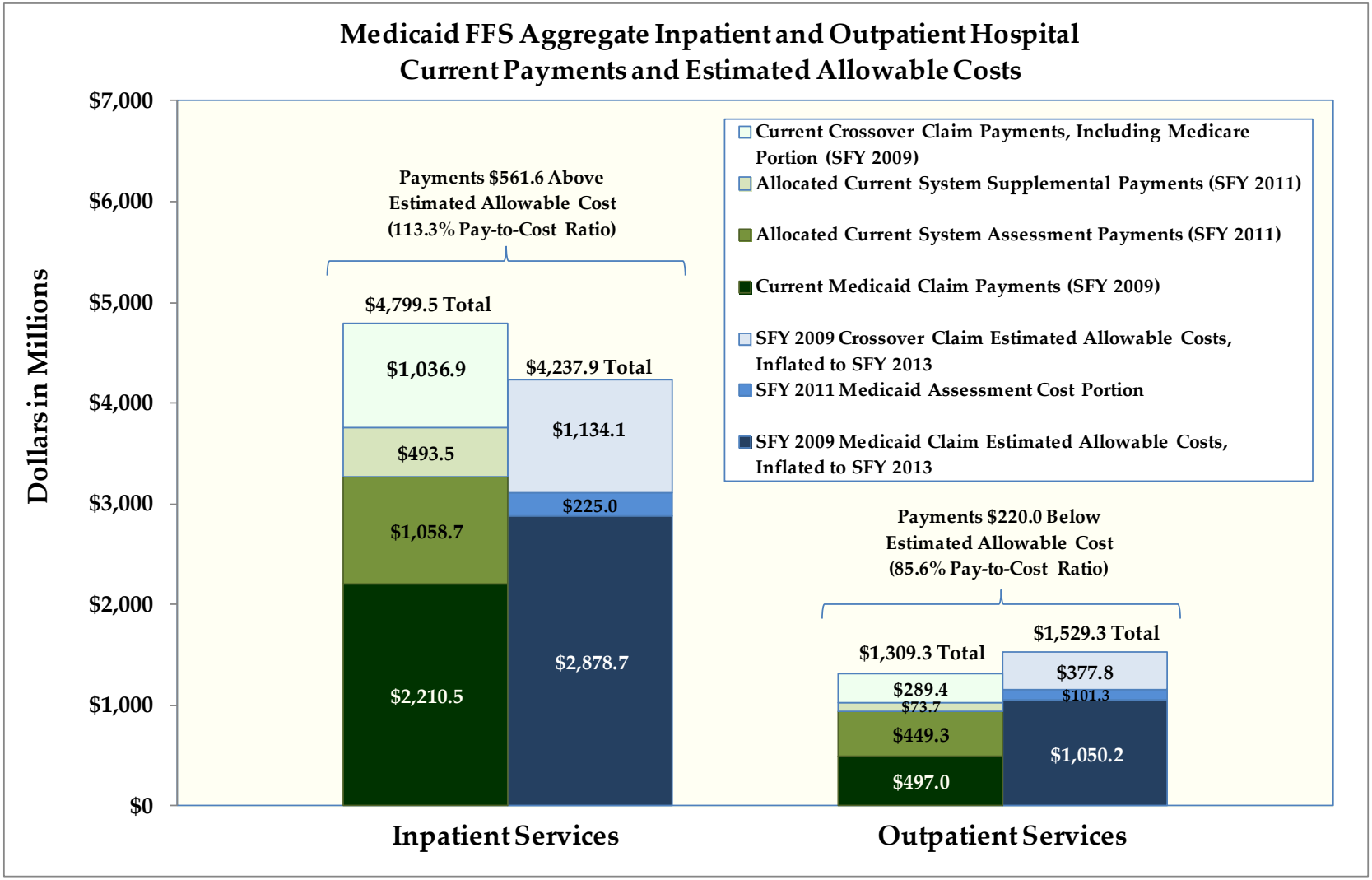


Excludes Cook County / U of I claims

Note: Estimated claims allowable costs are based on Medicare cost reporting rules, and therefore exclude amounts considered by Medicare to be "unallowable" for purposes of determining the costs of inpatient hospital services, such as certain costs associated with provider-based physicians, CRNAs and medical schools. However, total assessment costs shown in this chart extends beyond what is allowable under Medicare cost reporting rules

Potential System Rebalancing

*Summary Version 3: **Includes** Medicare Crossover claims, Medicaid Assessment Cost Portion Allocated to Inpatient and Outpatient*



Excludes Cook County / U of I claims

Note: Claims estimated allowable costs are based on Medicare cost reporting rules, and therefore exclude amounts considered by Medicare to be "unallowable" for purposes of determining the costs of inpatient hospital services, such as certain costs associated with provider-based physicians, CRNAs and medical schools.

Potential System Rebalancing

Determination of Outpatient Set-Aside Amount (Based on Summary Version 3):

		Amounts In Millions
Total current system inpatient payments	*A*	$ 4,799.5
Total current system outpatient payments	*B*	1,309.3
Total	*C=A+B*	$ 6,108.8
Total current system inpatient estimated allowable costs, including only Medicaid portion of tax	*D*	$ 4,237.9
Total current system outpatient estimated allowable costs, including only Medicaid portion of tax	*E*	1,529.3
Total	*F=D+E*	$ 5,767.2
Pay-to-cost ratio, including only Medicaid portion of tax	*G=C/F*	105.9%
Adjusted inpatient expenditures	*H=D*G*	$ 4,488.9
Amount to shift to outpatient (set-aside)	*I=A-H*	**$ 310.6**

Note: Claims estimated allowable costs are based on Medicare cost reporting rules, and therefore exclude amounts considered by Medicare to be "unallowable" for purposes of determining the costs of inpatient hospital services, such as certain costs associated with provider-based physicians, CRNAs and medical schools.

Preliminary Inpatient Simulation Results

Assumptions

- 3 payment simulation model options

- Each inpatient model version includes:
  - HFS' proposed modifications to assessment payments (without supplemental payments)
  - 3M national relative weights adjusted for Illinois case mix
  - Statewide standardized base rates and per diem rates
  - Medicare outlier policy, with $22,385 fixed stop loss, and 80% marginal cost percentage
  - Medicare transfer-out policy (not post-acute transfer policy)
  - Estimated costs with 100% of assessment cost
  - Shifting of funds under new system between acute, psychiatric and rehabilitation to achieve consistent aggregate pay-to-cost ratios for each service type – potential policy adjusters for specific types of services
  - LTAC funds kept budget neutral to current system

Preliminary Inpatient Simulation Results

Model Differences

Model Version	Target Expenditures	Policy Adjusters
1	SFY 2009 reported claim payments (excluding DSH) plus SFY 2011 assessment and supplemental payments, without trending	None
2	Same as Version 1, less $311 million set aside for outpatient	None
3	Same as Version 1, less $311 million set aside for outpatient	Made to achieve > 100% pay-to-cost ratio for: •OB/Normal Newborn – 1.75 factor •Neonate – 1.35 factor •Other Pediatric – 1.35 factor

Preliminary Inpatient Simulation Results

Model Differences

Model Version	Preliminary Standardized Payment Rates (Before Wage Index or Teaching Adjustments)			
	DRG Base Rate	Psych Per Diem	Rehab Per Diem	LTAC Base Rate
1	$6,153.12	$862.94	$603.61	$4,141.99
2	$5,369.40	$772.81	$540.61	$4,141.99
3	$4,340.56	$772.81	$540.61	$4,141.99

These analyses have been prepared for discussion purposes only. They do not reflect recommendations by Navigant. No final decisions have been made or proposed by DHFS.

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Service Type	Current System	Version 1 (no outpatient set-aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
General Acute Hospitals	99.7%	100.2%	91.7%	91.7%
Psychiatric Providers/ Units	108.9%	100.2%	91.7%	91.7%
Rehabilitation Providers/ Units	86.1%	100.2%	91.7%	91.7%
LTAC Providers	87.5%	87.5%	87.5%	87.5%
Inpatient Total	**99.9%**	**99.9%**	**91.6%**	**91.6%**

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Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

General Acute Service Category	Current System	Version 1 (no outpatient set-aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
Normal Newborn / Obstetrics	85.0%	87.2%	79.5%	101.5%
Neonate	115.6%	107.4%	99.4%	104.4%
Other Pediatric	100.8%	103.5%	95.2%	100.4%
Other Adult	102.1%	103.1%	94.2%	82.9%
General Acute Total	**99.7%**	**100.2%**	**91.7%**	**91.7%**

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Provider Category	Number of Providers	Current System	Version 1 (no outpatient set-aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
General Acute Providers	125	99.6%	101.2%	92.6%	92.5%
Freestanding Children's Providers	2	106.5%	92.0%	86.2%	89.4%
Critical Access Hospitals	51	81.4%	85.4%	77.2%	76.3%
Freestanding Psychiatric Providers	8	152.8%	116.0%	106.5%	106.5%
Freestanding Rehabilitation Providers	4	99.4%	98.4%	90.5%	90.5%
LTAC Providers	6	87.5%	87.5%	87.5%	87.5%
Out-of-State Providers	36	82.2%	84.7%	76.5%	75.5%
Inpatient Total	**232**	**99.9%**	**99.9%**	**91.6%**	**91.6%**

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Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

SFY 2009 Medicaid FFS Days Range (Excluding Crossovers)	Number of Providers	Current System	Version 1 (no set-outpatient aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
0 - 4,999	170	87.8%	85.7%	78.2%	77.2%
10,000 - 19,999	39	95.6%	96.6%	88.1%	88.7%
20,000 - 39,999	15	120.5%	114.2%	104.4%	104.9%
40,000 +	8	101.6%	107.3%	99.7%	99.7%
Inpatient Total	**232**	**99.9%**	**99.9%**	**91.6%**	**91.6%**

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Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

FYE 2010 Medicaid FFS Utilization (Excluding Crossovers)	Number of Providers	Current System	Version 1 (no outpatient set-aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
< 20%	161	82.9%	89.5%	82.2%	82.2%
20-39.9%	49	102.6%	107.5%	98.4%	98.6%
40-60%	16	133.3%	107.4%	98.1%	97.3%
60% +	6	128.4%	103.5%	98.9%	99.2%
Inpatient Total	**232**	**99.9%**	**99.9%**	**91.6%**	**91.6%**

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Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Total Beds	Number of Providers	Current System	Version 1 (no outpatient set-aside, no policy adjusters)	Version 2 ($311 mm outpatient set-aside, no policy adjusters)	Version 3 ($311 mm outpatient set-aside, with policy adjusters)
<100	98	97.4%	84.1%	77.0%	78.6%
100-199	58	107.4%	98.2%	89.2%	87.9%
200-299	42	103.6%	103.5%	95.3%	96.1%
300-399	16	86.4%	87.5%	79.9%	80.6%
400-499	4	119.6%	105.9%	96.1%	93.6%
500 +	14	93.9%	105.9%	97.6%	97.2%
Inpatient Total	**232**	**99.9%**	**99.9%**	**91.6%**	**91.6%**

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Proposed Transitional Strategy for Expected Coding and Documentation Improvement

Why do we need a strategy?

- ***Coding and documentation improvements are necessary**, and as such are expected to be made by providers as an **appropriate response** to the coding requirements under the APR-DRG model.*
- *Because the same level of coding rigor was not required for payment purposes under the legacy CMS-DRG model, HFS expects that **case mix will increase** as a result of improvements to claim coding once the system is implemented – **beyond actual increases in acuity**.*
- *As such, HFS expects that actual payments, in the aggregate, will exceed payments that have been estimated as part of the simulation modeling process.*
- *To maintain budget neutrality (SFY 2011 funding), it will be necessary establish a **transitional strategy**.*

Proposed Transitional Strategy for Expected Coding and Documentation Improvement

Data Collection and Coding -

Data Element	Under CMS-DRGs	Under APR-DRGs
Principle Diagnosis	Drives DRG assignment	Drives DRG assignment and may impact SOI
Other Diagnoses	Key diagnoses impact	Every diagnosis may impact
Patient age	Some impact	Significant impact
Birth weight	No impact	Significant impact
"Simple" procedures	No impact	Impacts in some cases
Coding	Inclusion of key diagnoses and procedures can ensure correct CMS-DRG assignment without being a "complete representation" of all care the patient received	Any diagnosis and procedure and/or combinations of diagnoses and procedures can impact APR-DRG assignment – Coding should be "all inclusive"

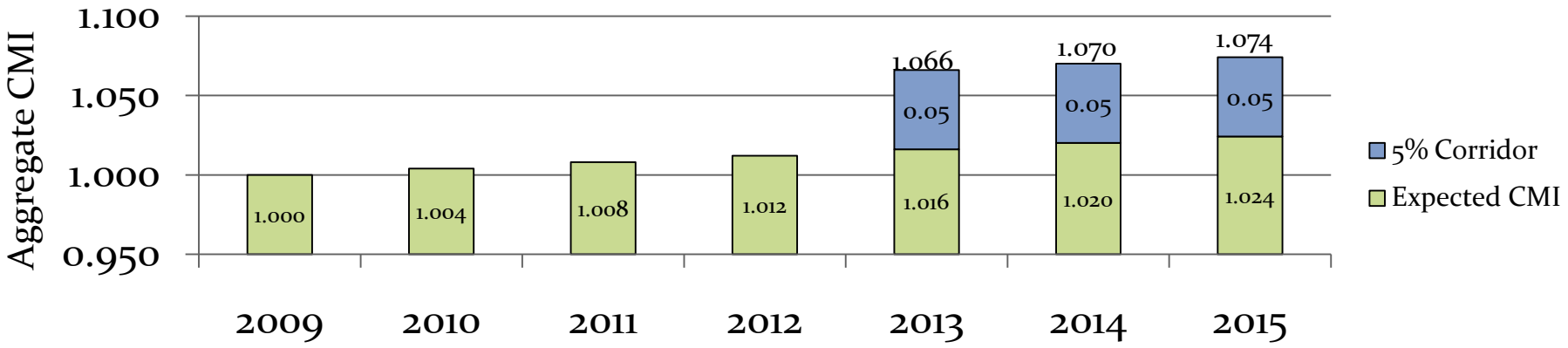
Proposed Transitional Strategy for Expected Coding and Documentation Improvement

Patient Record	Version 1 Coding	Version 2 Coding
DX 1 – V3000 – Live newborn	Include	Include
DX 2 – 745.4 – Ventricle septal defect	Include	Include
DX 3 – V290 – Observation	**Exclude**	Include
DX 4 – 745.5 – Ostium secoundum type arial septal defect	**Exclude**	Include
DX 5 – 774.6 – Unspecified fetal and neonatal jaundice	**Exclude**	Include
Same legacy CMS-DRG Assignment - 389, Full Term Neonate w/Major Problems		
Different APR-DRG Assignments – 640 - Neonate Birthwt > 2499G, Normal Newborn or Neonate w Other Problem	**SOI = 2** **RW = .2005**	**SOI = 3** **RW = .5795**

Proposed Transitional Strategy for Expected Coding and Documentation Improvement

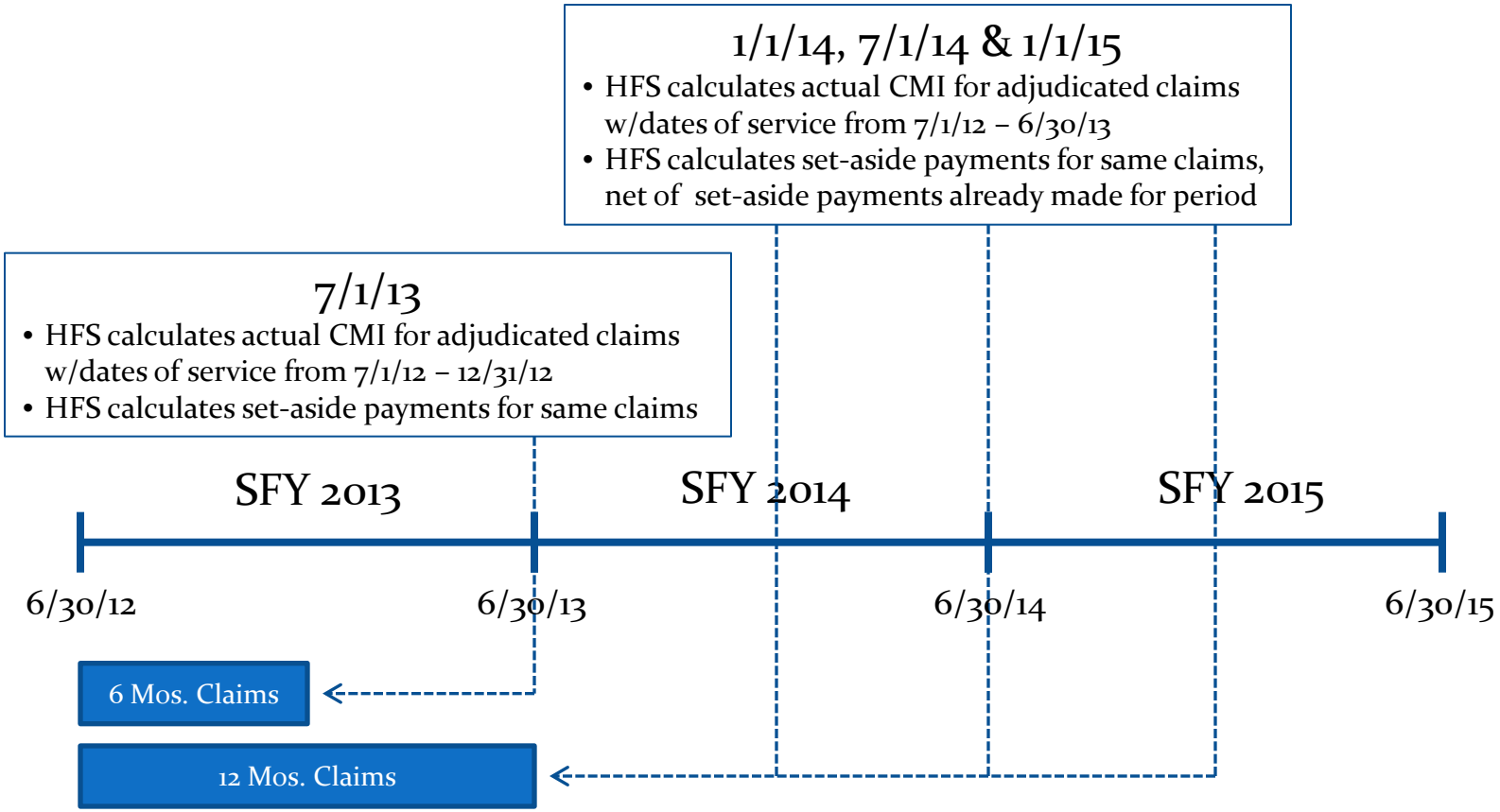
Proposed Approach - To be applied at the aggregate level – not at the individual hospital level -
1. Determine "expected" CMI for 2013, 2014 and 2015 based on actual rates of CMI increase in historical paid claims data (SFY 2006-2010).
2. Adjust payment simulation model (which is based on SFY 2009 claims data) to reflect "expected" increases in CMI for 2011. Simulated payments are increased.
3. Establish a set-aside amount of 5% by adjusting base rates in 2011 payment simulation model so that total projected payments are 5% less than targeted amounts (after all other targeted policy adjustors are applied). 5% set-aside applies to all inpatient services.
4. After payment system goes live, HFS periodically reviews actual CMI (every 6 mos).
5. If actual CMI is lower than "expected" CMI, HFS makes set-aside payments to each hospital – payments to be 5% of actual claim payments for period reviewed for each hospital.
6. If actual CMI is greater than "expected" by less than 5%, HFS makes reduced set-aside payments to each hospital – payments to be proportionally determined based on proportion of 5% "corridor" that is not absorbed by CMI increases.
7. HFS may adjust relative weights prospectively or retrospectively, depending on significance of case-mix changes.

Proposed Transitional Strategy for Expected Coding and Documentation Improvement



Proposed Adjustment Parameters	
1.	If actual CMI in 2013 is less than "expected", HFS returns total set-aside amount. Expected is based on actual CMI increases of .4% from 2006 to 2010.
2.	If actual CMI in 2013 is greater than "expected", but falls within the "corridor", HFS returns the ratable portion of set-aside amount that has not been absorbed through the aggregate CMI increase. HFS may prospectively adjust relative weights downward.
3.	If actual CMI in 2013 is greater than combined "expected" and "corridor", HFS retains all set-aside amount because amount has been fully absorbed through aggregate CMI increases. HFS may adjust relative weights downward retrospectively and prospectively.
4.	HFS will make similar adjustments for 2014, 2015 and subsequent years, if necessary.

Proposed Transitional Strategy for Expected Coding and Documentation Improvement



Subsequent Periods

Same process is repeated in subsequent years. HFS may adjust relative weights prospectively and/or retrospectively, depending on significance of increases or decreases.

Next Steps

- Inpatient analysis
- Outpatient analysis
- Next Meeting

SCENARIO 2

	Base		Revised		
	Count	Amounts	Reallocation	Count	Amounts
Grand total	**227**	**1,545,072,285**	0.503	**211**	**767,146,336**
Grand total less stimulus/sunset payments	**227**	**1,430,955,832**	0.464	**168**	**767,146,336**
Non-assessment subtotal	**219**	**388,721,065**	1.000	**-**	**-**
Sunsetting payments	**7**	**6,360,901**	1.000	**-**	**-**
Stimulus subtotal	**9**	**14,607,748**	1.000	**-**	**-**
One-time stimulus subtotal	**205**	**93,147,804**	1.000	**-**	**-**
Assessment subtotal	**211**	**1,042,234,766**	0.264	**211**	**767,146,336**
Non-assessment static payments					
DHA (Note 1)	30	151,291,687	1.000	-	-
Trauma	36	41,235,135	1.000	-	-
Rehab (Note 2)	4	10,022,067	1.000	-	-
RCHAP	88	15,876,836	1.000	-	-
PIAP	15	10,797,867	1.000	-	-
SNAP (Note 3)	122	85,287,042	1.000	-	-
Tertiary	137	33,230,921	1.000	-	-
PAP	6	4,353,771	1.000	-	-
RAP IP	48	583,663	1.000	-	-
County trauma	63	11,850,018	1.000	-	-
EAM	10	24,192,059	1.000	-	-
Payments sunsetting on 06/30/2012					
SNAP (Note 3)	4	3,147,268	1.000	-	-
RHA (Note 2)	1	1,500,000	1.000	-	-
DHA (Note 1)	2	1,713,633	1.000	-	-
Stimulus static payments					
DHA (Note 1)	4	6,600,610	1.000	-	-
SNAP (Note 3)	5	8,007,138	1.000	-	-
One-time stimulus static payments					
Perinatal level III	14	8,687,175	1.000	-	-
Level 1 trauma center	23	8,020,892	1.000	-	-
Medicaid per diem base	205	52,577,962	1.000	-	-
Medicaid per diem DSH bonus	58	23,861,775	1.000	-	-
Assessment static payments					
High Volume Payment	14	52,790,050	-	14	52,790,050
Total Base Payment Increase	209	377,335,313	0.380	209	233,947,894
Enhanced PIAP	12	13,693,775	-	12	13,693,775
Psych Rehab MIUR	8	13,148,426	-	8	13,148,426
Capital	95	114,312,514	1.000	-	-
Rural OB	41	28,468,500	-	41	28,468,500
Perinatal	69	111,883,500	-	69	111,883,500
Increase for all Trauma Hospitals	53	149,681,961	-	53	149,681,961
Trauma	38	88,925,600	-	38	88,925,600
Pediatric Trauma	2	4,006,985	-	2	4,006,985
Tertiary	120	29,824,450	-	120	29,824,450
Crossover	8	8,796,375	1.000	-	-
Magnet	11	40,775,196	-	11	40,775,196
Isolated Payment in CHAP and SNAP	8	8,592,122	1.000	-	-

(Note 1) Total static DHA for SFY 2011 = $159,605,930 ($151,291,687 + $1,713,633 + $6,600,610)
(Note 2) Total static Rehab for SFY 2011 = $11,522,067 ($10,022,067 + $1,500,000)
(Note 3) Total static SNAP for SFY 2011 = $159,605,930 ($85,287,042 + $3,147,268 + $8,007,138)