Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group

Discussion of Design Considerations

February 9, 2012

Agenda

- Introductions (5 minutes)
- Follow-up from January 18th Meeting (15 minutes)
- Payment Simulation – Revised Inpatient Model Results (30 minutes)
- Establishing Benchmark Funding Levels – SFY 2011 Payment Estimates (20 minutes)
- Proposed Transitional Strategy for Expected Coding and Documentation Improvement (10 minutes)
- Outpatient Payment Reform – EAPG Model (30 minutes)
- Implementation Schedule (5 minutes)
- Next Steps (5 minutes)

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, Vice President, Finance

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

Follow up from January 18th Meeting

- **Technical Documentation for APR-DRG Patient Classification System**
  - Navigant's APR-DRG technical documentation is copyrighted by 3M
  - 3M has indicated that Navigant may not share our copyrighted documentation with the providers
  - 3M will make the technical documentation available to the IHA and its members – providers may contact the IHA to obtain a password, and then will be able to access on 3M website
- **Reconciliation of Pay-to-Cost Analyses Presented at Previous Meetings**
  - Changes in aggregate payments and costs due to:
    - Removal of Cook County/University of Illinois
    - Revised costing approach
    - Inclusion of inpatient ungroupable DRG claims
- **Questions Received After January 18th Meeting**
  - Thank you for the questions – will post responses on HFS' website
- **3M National Relative Weight Correlation Analysis Excluded Provider Assessment Costs**

Follow up from January 18th Meeting

- **Reconciliation of January 18th Pay-to-Cost Analyses to 2012 Upper Payment Limit Analyses**
  - Different year of claims data used - 2012 UPL was based on SFY 2008 claims data -
  - Significant differences in supplemental payments
    - 2012 UPL uses 2012 supplemental payments
    - 2011 funding analysis uses 2011 supplemental payments
    - 2011 supplemental payments were $103 million greater than in 2012
  - 2012 UPL inpatient gap is created by increasing utilization based on historical trends – without utilization increases, 2012 payments would exceed costs (because supplemental payments are static)
  - Gap related to Medicare crossover claims has decreased by approximately $249 million – due in part to allocation of provider tax costs

Preliminary Inpatient Simulation Results

Model Assumptions

- Revised inpatient model includes:
  - HFS' proposed incorporation of all but $767 million of static payments into the payment rates
  - 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 Assumptions Continued

- Benchmark inpatient expenditures based on SFY 2009 reported claim payments (excluding DSH, without trending) plus SFY 2011 assessment and supplemental payments, less $311 million set aside for outpatient

- Policy Adjusters made to achieve 100% pay-to-cost ratio for:
  - MPA/MHVA Hospitals – 1.48 factor
  - CAHs – 1.95 factor
  - OB/Normal Newborn – 2.00 factor
  - Neonate – 1.40 factor
  - Other Pediatric – 1.33 factor

Applied to non-MPA/MHVA/CAHs

Preliminary Standardized Payment Rates (Before Wage Index or Teaching Adjustments)			
DRG Base Rate	Psych Per Diem	Rehab Per Diem	LTAC Base Rate
$3,931.34	$772.81	$540.61	$4,141.99

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Service Type	Current System	Proposed System With Outpatient Set-Aside and Policy Adjusters
General Acute Hospitals	99.7%	91.7%
Psychiatric Providers/ Units	108.9%	91.7%
Rehabilitation Providers/ Units	86.1%	91.7%
LTAC Providers	87.5%	87.5%
Inpatient Total	**99.9%**	**91.6%**

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

General Acute Service Category	Current System	Policy Adjuster	Proposed System With Outpatient Set-Aside and Policy Adjusters
MPA/MVHA Hospitals	115.3%	1.48	100.5%
Critical Access Hospitals	81.4%	1.95	101.4%
Normal Newborn / Obstetrics	78.1%	2.00	100.3%
Neonate	110.7%	1.40	100.1%
Other Pediatric	95.7%	1.33	100.3%
Other Adult	92.9%	1.00	76.5%
General Acute Total	**99.7%**		**91.7%**

Excludes MPA/ MHVA/ CAHs

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Provider Category	Number of Providers	Current System	Proposed System With Outpatient Set-Aside and Policy Adjusters
General Acute Providers	125	99.6%	92.2%
Freestanding Children's Providers	2	106.5%	89.4%
Critical Access Hospitals	51	81.4%	101.4%
Freestanding Psychiatric Providers	8	152.8%	106.5%
Freestanding Rehabilitation Providers	4	99.4%	90.5%
LTAC Providers	6	87.5%	87.5%
Out-of-State Providers	36	82.2%	75.8%
Inpatient Total	**232**	**99.9%**	**91.6%**

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

SFY 2009 Medicaid FFS Days Range (Excluding Crossovers)	Number of Providers	Current System	Proposed System With Outpatient Set-Aside and Policy Adjusters
0 - 4,999	170	87.8%	77.5%
10,000 - 19,999	39	95.6%	89.2%
20,000 - 39,999	15	120.5%	106.4%
40,000 +	8	101.6%	97.7%
Inpatient Total	**232**	**99.9%**	**91.6%**

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

FYE 2010 Medicaid FFS Utilization (Excluding Crossovers)	Number of Providers	Current System	Proposed System With Outpatient Set-Aside and Policy Adjusters
< 20%	161	82.9%	80.9%
20-39.9%	49	102.6%	98.7%
40-60%	16	133.3%	100.7%
60% +	6	128.4%	99.3%
Inpatient Total	**232**	**99.9%**	**91.6%**

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Total Beds	Number of Providers	Current System	Proposed System With Outpatient Set-Aside and Policy Adjusters
<100	98	97.4%	81.1%
100-199	58	107.4%	90.0%
200-299	42	103.6%	97.1%
300-399	16	86.4%	78.7%
400-499	4	119.6%	91.0%
500 +	14	93.9%	94.6%
Inpatient Total	**232**	**99.9%**	**91.6%**

Note: Proposed system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside

Benchmarking Funding Levels – SFY 2011 Payment Estimates

- In current model, SFY 2011 inpatient hospital funding levels estimated by combining SFY 2009 inpatient claim reported payments (without trending) and SFY 2011 assessment/supplemental payments
- HFS recognizes that claim payments have increased since SFY 2009 due to increases in hospital case mix, outlier payments, utilization, and the new LTAC per diem add-on payment
- HFS has committed to trending the payments forward from the SFY 2009 claims data period to SFY 2011 for purposes of the system design process

Benchmarking Funding Levels – SFY 2011 Payment Estimates (Cont'd)

- **Proposed Acute Services SFY 2011 Funding Level Adjustments:**
  - Increase current system DRG base payments using SFY 2011 case mix index trend factor (without trending per diem base payments, capital payments or other add-ons)

    SFY 2009 DRG Base Amt x Case Mix Index Trend Factor

  - Recalculate current system cost outlier payments using SFY 2011 charges trend factor (without trending current day outlier payments)

    SFY 2009 Covered Charges x Charges Trend Factor x IME Adjusted CCR

  - Revise ratio used to allocate supplemental/assessment payments and provider tax costs to each clam using SFY 2011 utilization trend factor

    SFY 2009 Claim Covered Charges /
    (SFY 2009 Provider Total Inpatient Covered Charges * Utilization Trend Factor)

Benchmarking Funding Levels – SFY 2011 Payment Estimates (Cont'd)

- Proposed SFY 2009-2011 trend factors based on average annual aggregate changes in the claims data from SFY 2007 through SFY 2010, extrapolated over 2 years
- SFY 2011 claims data not yet fully mature and would skew trending
- Proposed trend factors:

Trend Factor	Average Annual Increase	Proposed SFY 2009 – SFY 2011 Trend Factor
Case Mix Index Trend Factor	0.79%	1.0159
Charges Trend Factor	7.78%	1.1617
Utilization Trend Factor	0.74%	1.0149

Proposed Transitional Strategy for Expected Coding and Documentation Improvement

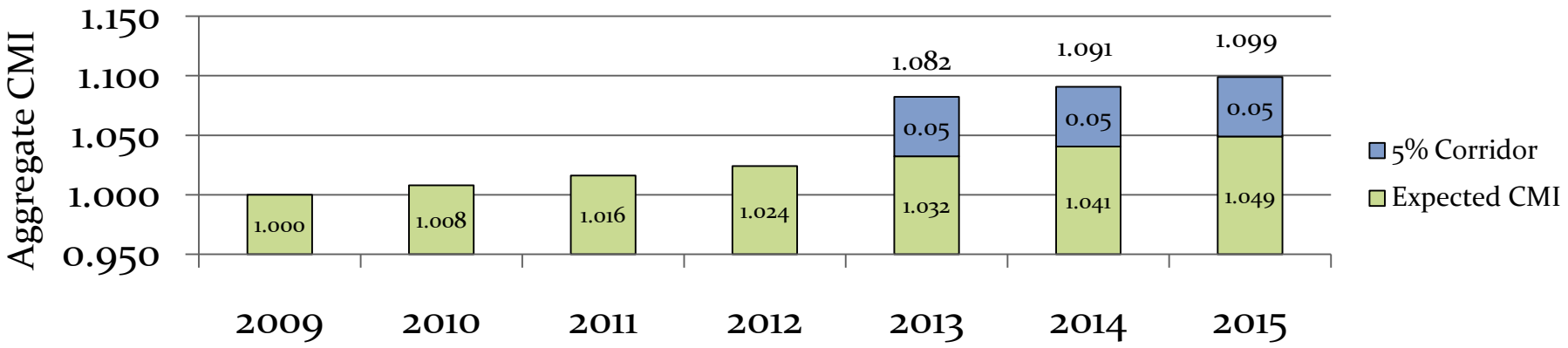
Why do we need a strategy?

- ***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

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 .8% from 2007 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.

Outpatient – APLs vs. EAPGs

System Component	Illinois APLs	EAPGs v. 3.7
Classification system (identified at claim detail level/CPT code level)	18 Ambulatory Procedures Listing	543 Enhanced Ambulatory Patient Groups
Claim payment basis	Payment made for highest ranking procedure in each claim without consideration of the resources expended on bundled services	Payments made for each multiple unrelated significant procedures in claim with consideration of the resources expended on bundled services
Bundling basis	All services bundled except for highest ranking APL (regardless of significance)	Bundling targeted to routine ancillary services and related procedures

EAPG classifications

EAPG program assigns each outpatient service to one of three main EAPG types:

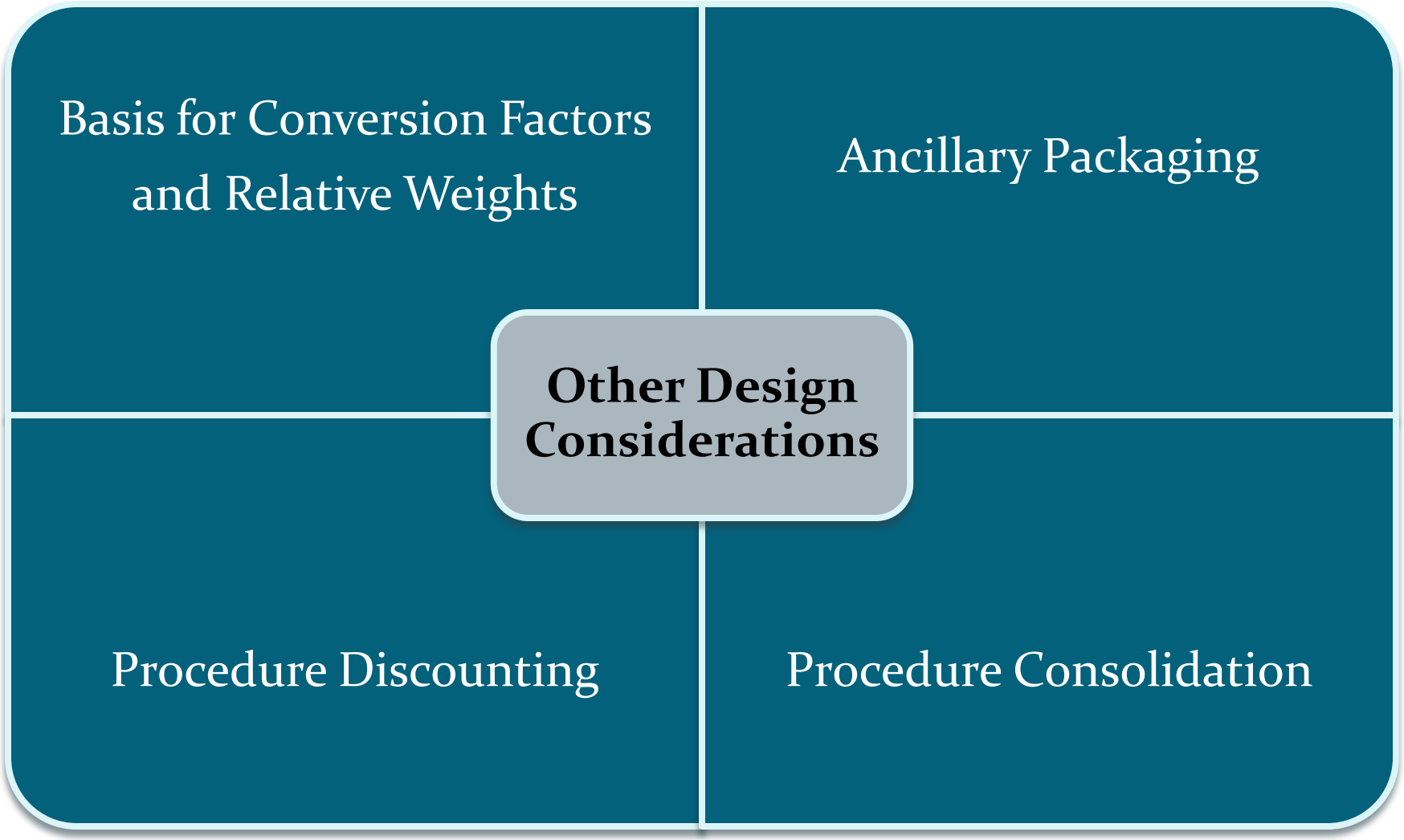
- Significant Procedures: Main procedure that constitutes the reason for the visit and requires the most resources
  - EAPG program distinguishes between related and unrelated
- Medical Visits: Medical treatments and therapies
  - Only assigned if a significant procedure is not performed during the patient visit
- Ancillary Tests and Procedures: Ancillary tests that assist in patient diagnosis or treatment
  - EAPG program distinguishes between routine and non-routine

Example EAPG Payment

Claim with significant procedures and routine ancillary services:

CPT	APL	EAPG	EAPG Type	EAPG Payment Method
31545	1C - Surgical – Low (Highest Ranking APL)	063 - Level II Endoscopy of Upper Air	Significant Procedure	Full payment
31515	1D - Surgical - Very Low	062- Level I Endoscopy of Upper Air	Related Procedure	Consolidated (no payment)
42405	1D - Surgical - Very Low	252 - Level I Facial and ENT	Unrelated Procedure	Discounted (partial payment)
88331	N/A	390 - Level I Pathology	Routine Ancillary	Packaged (no payment)
82435	N/A	402 - Basic Chemistry Tests	Routine Ancillary	Packaged (no payment)
93000	N/A	413 - Cardiogram	Routine Ancillary	Packaged (no payment)
00322	N/A	380 - Anesthesia	Routine Ancillary	Packaged (no payment)

Outpatient EAPG Methodology Options



Basis for Conversion Factors and Relative Weights

- EAPG Relative Weights
  - Department is considering using 3M's national weights, adjusted for Illinois case mix
  - Will calculate Illinois-specific relative weights and do correlation analysis – similar to inpatient
- Conversion Factors
  - Department is considering using a standardized conversion factor, adjusted for hospital wage index
  - (Standardized Amount * Labor Portion * Wage Index) + (Standardized Amount * Non-Labor Portion)

Ancillary Packaging

- EAPG program recognizes routine ancillary services provided in conjunction with a significant procedure or medical visit by designating these services as “packaged ancillary”

- Routine ancillary services are “packaged” and do not receive separate payment
  - However, the cost of packaged ancillary services are included the EAPG relative weight calculations and are therefore reflected in the significant procedure payment

- EAPG program contains a default list of 29 packaged ancillary services that can be customized

Procedure Consolidation

- When multiple procedures occur during an outpatient visit, some procedures of the same type may require significantly less resources
  - EAPG program designates certain procedures as “consolidated” EAPGs if another key procedure is present in the claim

- Consolidated procedures are “bundled” and do not receive separate payment

- EAPG program contains a procedure consolidation list based on clinical judgment that shows for each EAPG the other EAPGs that are an integral part of the procedure

Procedure Discounting

- Discounting modifies the payment for an additional procedure provided during the same visit, unless it is consolidated

- EAPG program identifies the following discount types:
  - *Terminated Procedure Discounting*
  - *Multiple Significant Procedure Discounting:* multiple occurrences of certain types of surgical or diagnostic procedures for the same day
  - *Repeat Ancillary Discounting:* Repeat Ancillary, Drug, and DME EAPGs
  - *Bilateral Discounting:* bilateral procedures performed on both sides of the body during the same session or on the same day

Procedure Discounting Continued

- While EAPG program identifies discounting type, it does not assign a discounting factor – HFS must determine factor

- Example outpatient discounting factors:

Discount Type	Medicare Discount Factor (APCs)	New York Medicaid Discount Factor (EAPGs)
Terminated Procedure	50%	50%
Multiple Significant Procedure	50%	50%
Repeat Ancillary	N/A	50%
Bilateral (percentage of single service)	150%	150%

Implementation Schedule

- July 1, 2012: Begin “shadow pricing” under new inpatient and outpatient systems; claims still paid under current system
- July 1, 2012 through June 30, 2013: Evaluate system performance based on analyses of “shadow pricing” results
- July 1, 2013: Proposed revised payment system implementation date for inpatient and outpatient

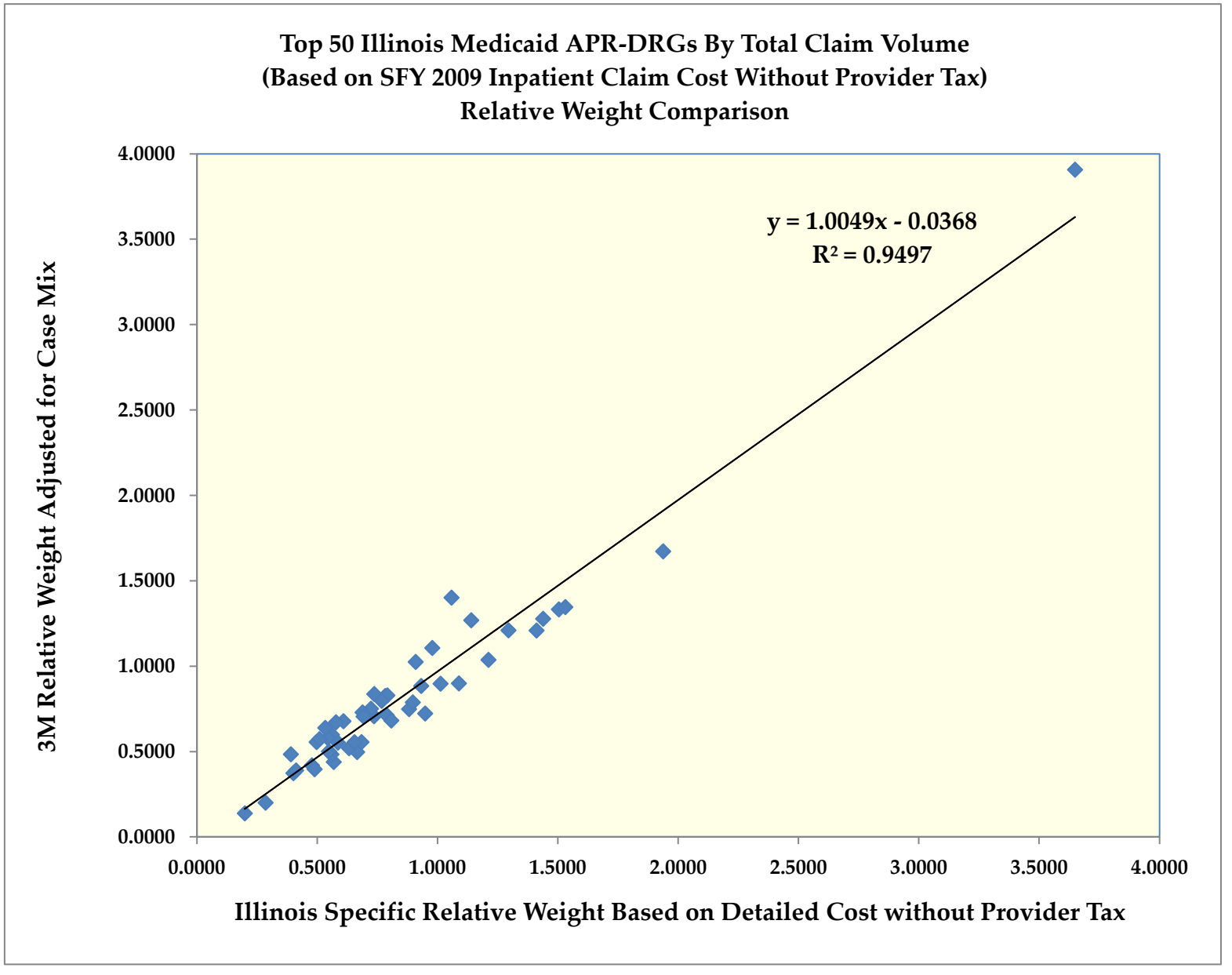
Next Steps

- Inpatient analysis
- Outpatient analysis
- Next Meeting

Illinois Hospital Rate Reform
Hospital Estimated Costs and Payments Reconciliation
From Previous TAG Meetings

TAG	Inpatient		Outpatient		Differences in Data and Other Assumptions for Analyses				
	Total Estimated Payments (In Millions)	Total Estimated Costs (In Millions)	Total Estimated Payments (In Millions)	Total Estimated Costs (In Millions)	Include Cook & UI Claims?	Approximate Number of Ungroupable Inpatient Claims Excluded	Method Used for Estimating Cost	Method for Recognizing Provider Tax Costs	Other Adjustments
09/22/11	3,997.3	3,266.5	1,114.4	1,500.4	Yes	2,100	**Inpatient** - Aggregate CCRs **Outpatient** - Detailed CCRs without adjustments from provider cost review	Provider tax costs estimated by adding 100% of the 2011 tax for providers with A-8 adjustments and adding the non-Medicaid portion of 2011 tax for providers without an A-8 adjustment	NA
10/28/11	4,010.9	3,729.7	1,063.7	1,464.7	Yes	500	**Inpatient** and **Outpatient** estimated using detailed CCRs with adjustments from provider cost review	Refined provider tax costs estimates by removing Medicaid portion of 2009 tax for providers without an A-8 adjustment, and then adding 100% of 2011 tax for all providers	Outpatient managed care claims and outpatient 72-hour rule costs removed from outpatient amounts
12/19/11	3,738.5	3,441.0	1,020.0	1,356.2	No	400	**Inpatient** and **Outpatient** estimated using detailed CCRs **with additional adjustments** from provider cost review	Refinements to outpatient provider tax cost allocations	No additional changes from previous version
01/18/12	3,762.6	3,460.1	1,020.0	1,356.2	No	0	No changes from previous version	No changes from previous version	No additional changes from previous version

State of Illinois Department of Healthcare and Family Services
Hospital Rate Reform Initiative
APR-DRG Relative Weight Comparison
Excludes Cook County / University of Illinois Claims / Psych, Rehab and Detox DRGs



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