Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group

Discussion of Design Considerations

September 22, 2011

Agenda

- Introductions (5 min)
- DHFS Assumptions and Context for Design Process (10 Min)
- Status of Cost Validation Process (5 Min)
- Status data integrity cross checks with Illinois Hospital Association (15 Min)
- Inpatient Methodology Conceptual Design Proposal (45 Min)
- Results of Initial Payment Simulation Models (20 Min)
  - Approach to preliminary inpatient simulations
- Next steps (10 – 20 Min)
  - Finish Detailed Costing
  - Other ideas
- Next meeting

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

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

Context for Design Process

- DHFS' guiding principles as stated
- DHFS' available funding is finite (budget neutral)
- Decisions related to distribution of funding must make services utilized by Medicaid beneficiaries a priority

- Assumed hospital goals are *mission* and *margin*
  - Medicaid rates matter most for services where Medicaid represents a significant market share
  - Planning for change – negative or positive – is a significant issue for hospitals
  - Hospital decisions to promote, expand and build for service provision reflect margins by service

Performance & Outcomes

- As a payer, the Medicaid program has an expectation of purchasing high quality healthcare for its clients
- Performance & Outcome standards provide an opportunity for providers to shine through comparative measurement against agreed upon standards
- Creative interaction with the clients to avert future adverse – expensive medical outcomes (Post Discharge Follow-ups)
  - E.g., A need to promote linkage to proper follow-up care (services)

- *When challenged by a goal, high performers tend to raise the bar.*

Status of Cost Validation Process

- 162 providers requested cost alignment files from DHFS
- 119 hospitals submitted responses
- 79 hospitals suggested changes to cost center alignments
- 70 hospitals suggested changes to revenue code mapping
- Navigant is currently in the process of identifying necessary changes to “standard costing assumptions” to reflect suggestions, and building provider-specific adjustments into cost calculations

Discussion of Preliminary Inpatient Methodology Design Options

Note that at this time, no final decisions have been made or proposed by the Department of Healthcare and Family Services. The analyses on the following slides have been prepared and are solely the responsibility of Navigant. These analyses have been prepared for discussion purposes only, and do not reflect recommendations by Navigant.

Evaluating the Options

Evaluation Criteria	
Access	Does the option promote access to care?
Quality	Does the option promote and reward high value, quality-driven healthcare services?
Efficiency	Is the option aligned with incentives for providing efficient care?
Resource Recognition	Does the option match payments with resource and service acuity differences?
Compliance	Is the option consistent with the Department's need to maintain compliance with State and Federal requirements?
Predictability	Does the option provide predictable and transparent payments for providers and the State?

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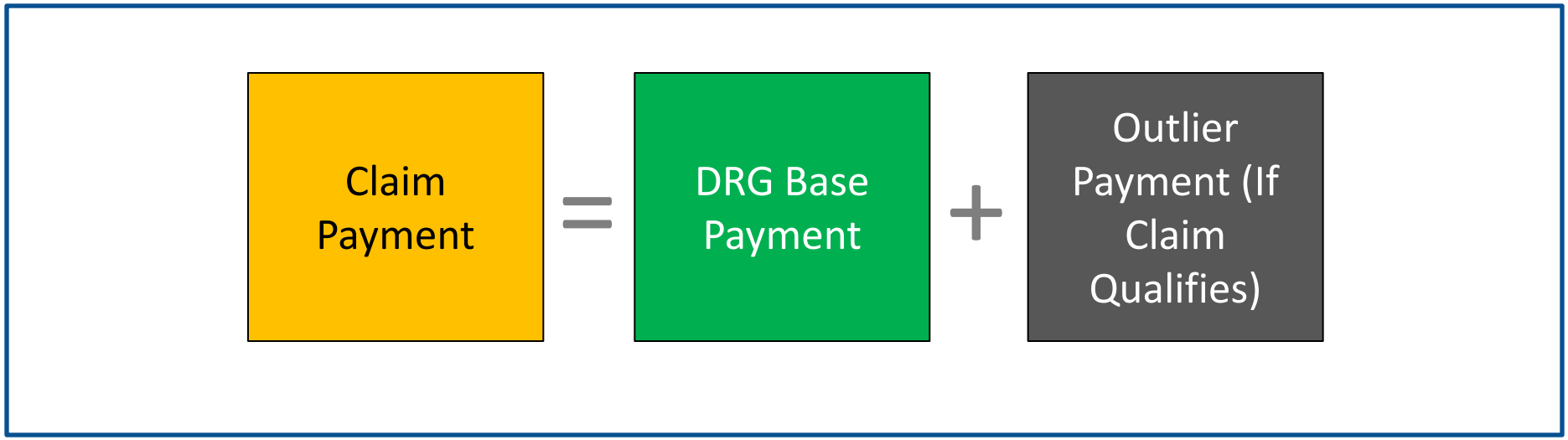
Evaluating the Options

Evaluation Criteria	
Transparency	Does the option enhance transparency, and contribute to an overall methodology that is easy to understand and replicate?
Adaptability	Does the option promote adaptability for future changes in utilization and the need for regular updates?
Facility Sensitivity	Does the option recognize unique and critical differences in hospital characteristics?
Policy	Is the option consistent with State and Federal policy priorities?
Forward Compatibility	Is the option flexible enough to support payment structures in anticipated future service models?

Inpatient Conceptual Design



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Inpatient Conceptual Design

(1) Note that if optional adjustment factors are applied, the system must remain budget neutral.

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Inpatient Conceptual Design

- A standardized base rate can be determined in a number of ways, and considering a number of factors
  - Medical education program differences
  - Geographic wage differences
  - Other differences

- We propose establishing an Illinois Medicaid-Specific Standardized Rate ("IMSSR"), with hospital-specific adjustments
  - The facility-specific wage index, based on the Medicare wage index
  - Medical education

(2) Standardized base rate could be established separately for operating and capital components.

Inpatient Conceptual Design

- The IMSSR will also be adjusted for budget neutrality, including all payments except for DSH (including all supplemental programs)

- The IMSSR will also be trended forward using the appropriate CMS hospital market basket index related to the time periods

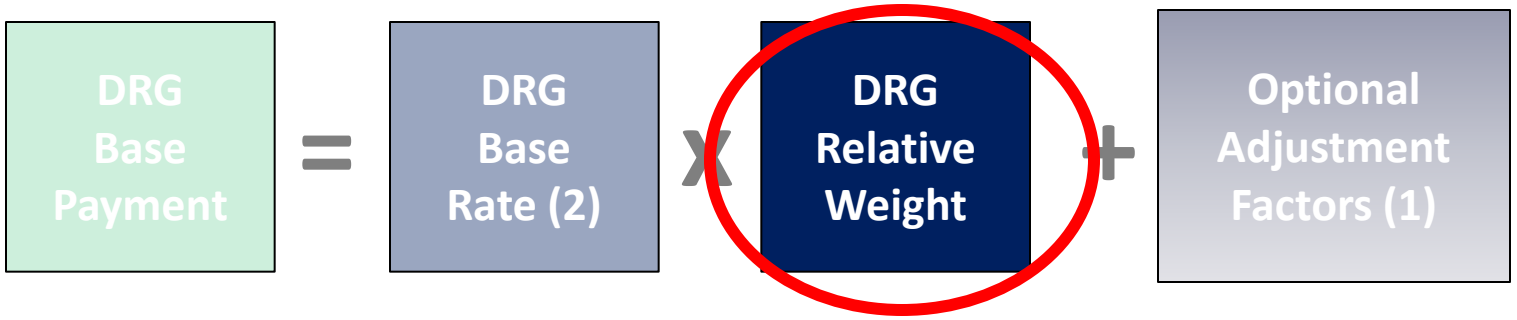
Inpatient Conceptual Design

- The IMSSR will be calculated based on the statewide weighted average cost per discharge
  - Using 2009 paid claims data on file with DHFS
  - Estimating cost at line level using information from matching period cost reports prepared and submitted by the hospitals (the process from last meeting)
  - Adjusting cost for acuity (case mix) based on the same 2009 claims data
  - Adjusting for geographic wage and medical education cost differences
  - Excludes the costs of specialty services that will be paid outside of the standard DRG model, including psychiatric, rehabilitation and long-term acute care services

Inpatient Conceptual Design

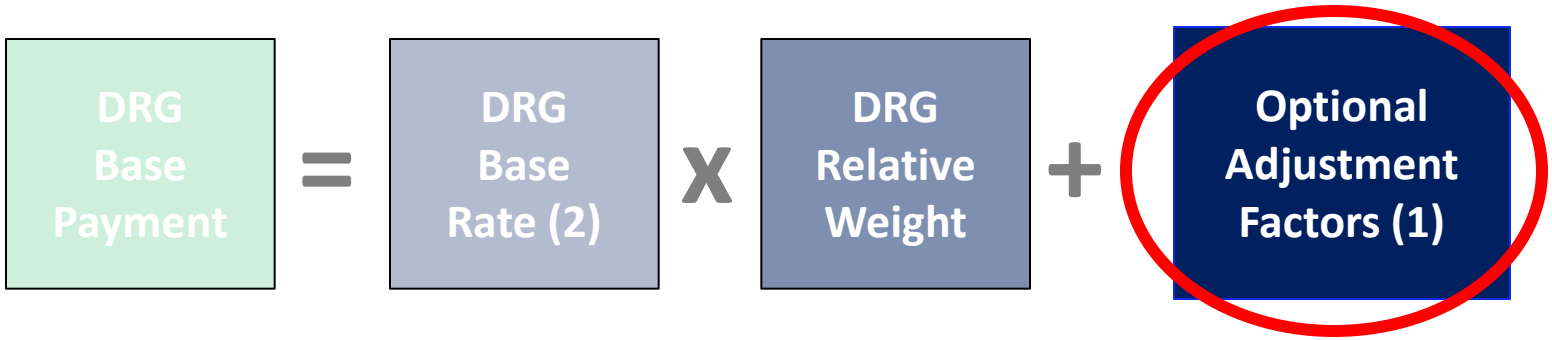
- We propose calculating Illinois Medicaid-specific weights
  - Calculate based on average cost per discharge for DRG, divided by the average cost per discharge of all DRGs combined
  - Using 2008 & 2009 paid claims data on file with DHFS
  - Estimating cost at line level using information from matching period cost reports prepared and submitted by the hospitals (the process from last meeting)
  - Adjusting for geographic wage and medical education cost differences
  - Excludes the costs of specialty services that will be paid outside of the standard DRG model, including psychiatric, rehabilitation and long-term acute care services

Inpatient Conceptual Design



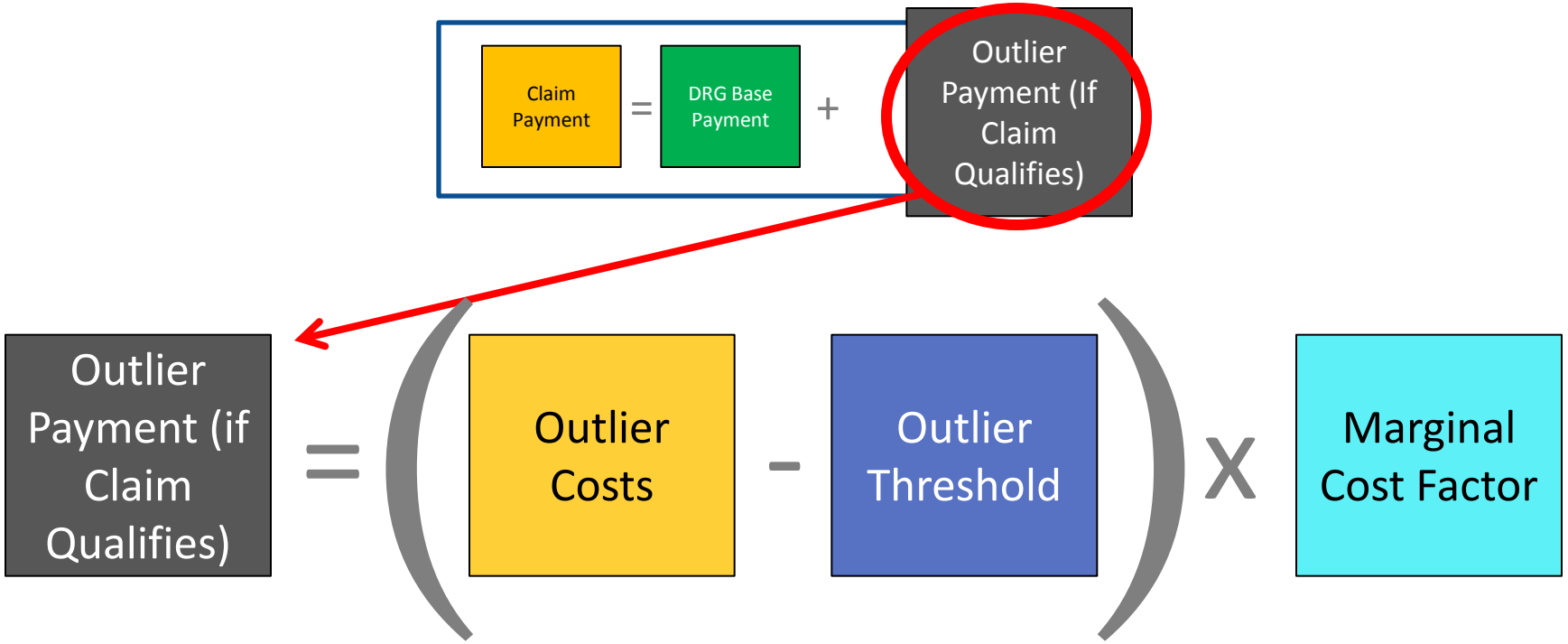
- Will trim outlier claims based on +/- 3 standard deviations from mean value before calculating weights
- Will test for relative weight "stability" using a "Z" test, which calculates for minimum sample size required to meet sampling parameters, given population standard deviation
  - Testing parameters require 90% confidence, +/- 10% precision
  - Must have minimum 10 claims to be considered "stable"
- Will supplement "low volume" or "unstable" classifications with national relative weights developed by 3M
  - Will require adjusting the 3M weights to scale, relative to Illinois-specific weights

Inpatient Conceptual Design



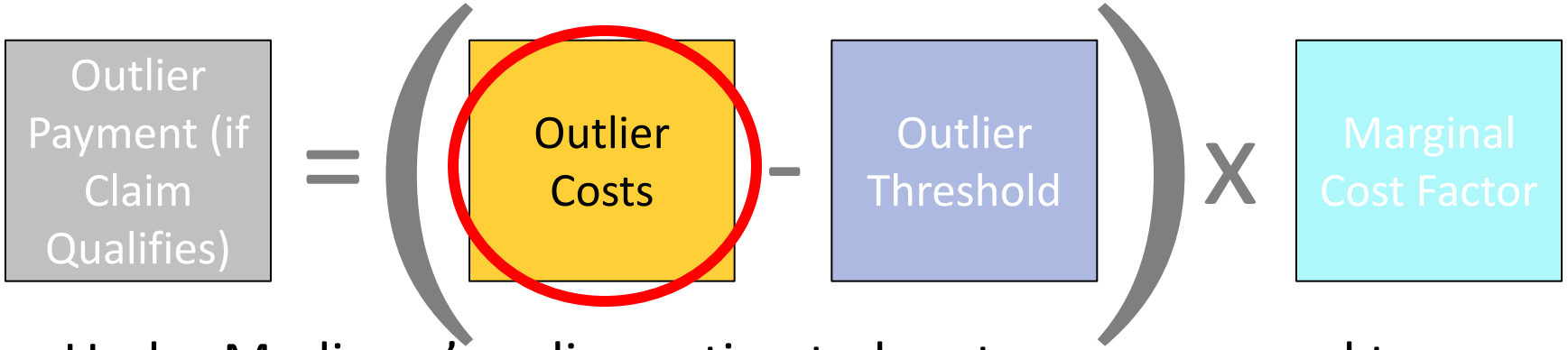
- There a number of optional factors that could be applied to adjust final payments, although, with all adjustments, system will remain budget neutral
- To be established to achieve policy objectives, consistent with DHFS "Guiding Principles"
- Possible policy objectives
  - Performance/outcome initiatives
  - Targeted primary Medicaid mission services

Inpatient Conceptual Design



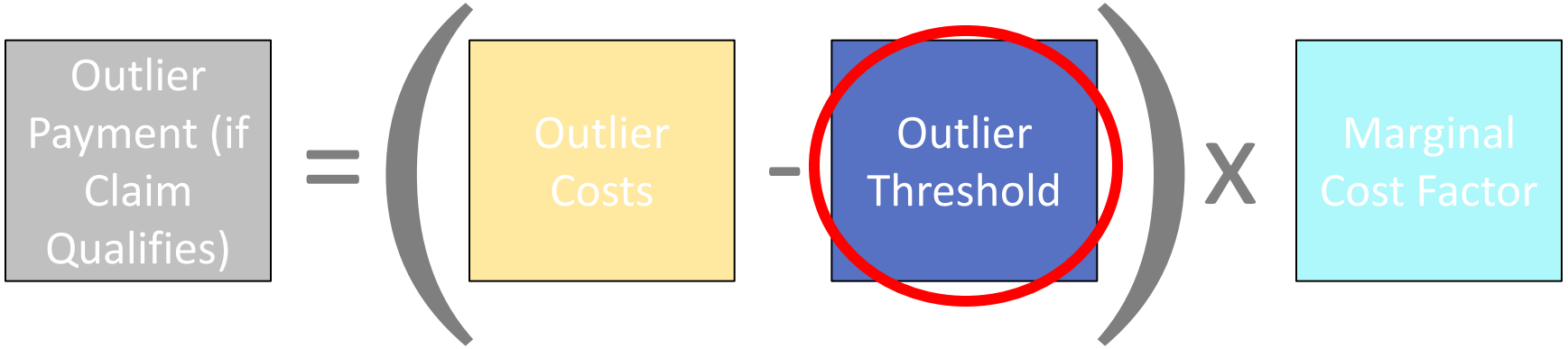
- We propose following Medicare's approach to making payments for high-cost outlier claims
- We will also consider establishing an "inlier" policy, for claims with very low costs

Inpatient Conceptual Design



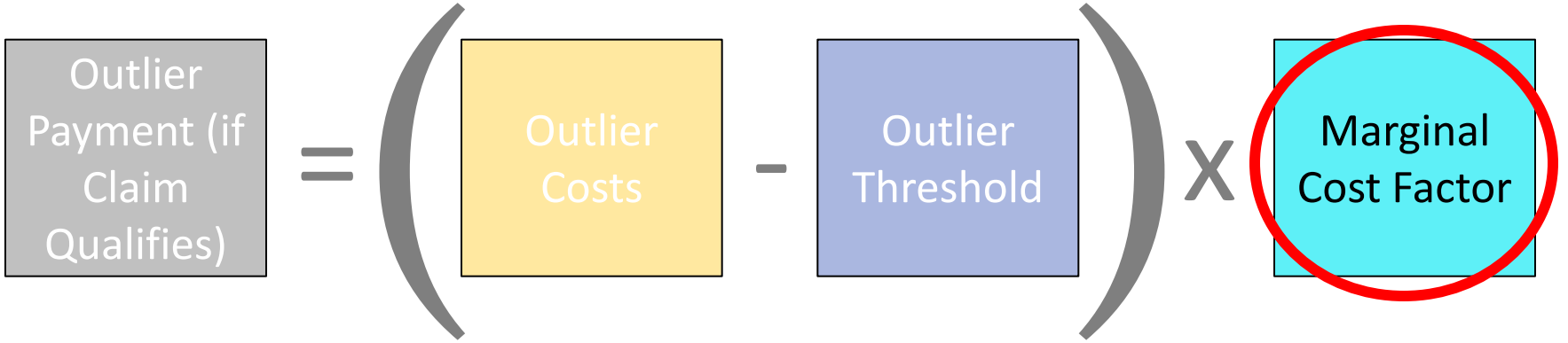
- Under Medicare's policy, estimated costs are compared to a predetermined outlier threshold. If estimated costs exceed the threshold, the claim qualifies for an outlier payment.
- We propose adopting Medicare's policy for estimating the cost of each claim
  - Adopt Medicare's outlier CCR for each hospital, as published by CMS, for the Medicare effective date immediately preceding the Medicaid rate year
  - Estimate cost by multiplying the claims allowed charges times the published Medicare outlier CCR

Inpatient Conceptual Design



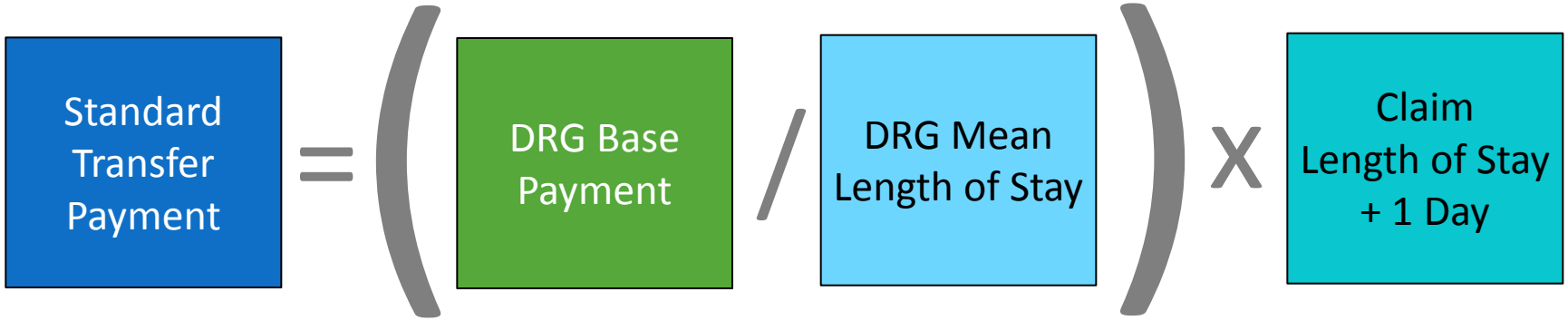
- The outlier threshold will be the sum of the DRG Base Payment and a fixed stop-loss amount
  - We propose adopting Medicare's fixed stop-loss amount, which is currently published to be $22,385, and adjusted for Medicare geographic wage differences for each hospital
  - May adjust the fixed stop-loss amount to the extent necessary to achieve targeted payment levels for outliers (between 5% and 10% of total DRG payments)

Inpatient Conceptual Design



- The outlier payment is calculated by multiplying the amount of estimated costs that exceed the outlier threshold by the marginal cost factor
  - We propose adopting Medicare's marginal cost factor, of 80%
  - May adjust the marginal cost factor to the extent necessary to achieve targeted payment levels for outliers (between 5% and 10% of total DRG payments)

Inpatient Conceptual Design



- We propose adopting Medicare's standard transfer payment policy for transfer-out claims
- Transfer-out payment will be eligible for an outlier payment
- The receiving hospital (final discharging hospital) will receive a full DRG payment
- We do not propose to adopt Medicare's post-acute transfer policy

Other Considerations – Specialty Care

Options for Psychiatric Services

- Replicate Medicare model – per diem based on MS-DRG assignment, with various adjustments
- Facility-specific cost per diem
- Statewide average, acuity adjusted per diem with optional length of stay step downs
- Peer group, acuity adjusted per diem with optional length of stay step downs

* For preliminary simulation, assumed payments and method did not change

Secondary Considerations

- For Medicare model, need to calculate APR-DRG weights, replicating Medicare's approach, or x-walk MS-DRG assignments to APR-DRG assignments
- Consider replicating Medicare adjustments if Medicare model is adopted
- For non-Medicare per diem, adjustments for geographic wage differences and medical education differences
- Separate policy depending on designation as a Distinct Part Unit
- Impact of possible transition to proper step down placement, community, LTC, etc..

Other Considerations – Specialty Care

Options for Rehabilitation Services

- Replicate Medicare model – per discharge based on Medicare Case-Mix Group (CMG) assignment, with various adjustments
- Facility-specific cost per diem
- Statewide average, acuity adjusted per diem with optional length of stay step downs
- Peer group, acuity adjusted per diem with optional length of stay step downs

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Secondary Considerations

- For Medicare model, need to x-walk CMG assignments to APR-DRG assignments
- Consider replicating Medicare adjustments if Medicare model is adopted
- For non-Medicare per diem, adjustments for geographic wage differences and medical education differences
- Separate policy depending on designation as a Distinct Part Unit
- Impact of possible transition to proper step down placement, community, LTC, etc..

Other Considerations – Specialty Care

Options for Long-Term Acute Care Services

- Replicate Medicare model – per discharge based on MS-DRG assignment with different relative weights, with various adjustments
- Facility-specific cost per diem
- Statewide average, acuity adjusted per diem with optional length of stay step downs
- Peer group, acuity adjusted per diem with optional length of stay step downs
- Pay according to current nursing facility payment methodology, with adjustments

* For preliminary simulation, assumed payments and method did not change

Secondary Considerations

- For Medicare model, need either adopt MS-DRGs, or x-walk MS-DRG assignments to APR-DRG assignments
- Consider adopting Medicare weights
- Consider replicating Medicare adjustments if Medicare model is adopted
- For non-Medicare model, consider adjustments for geographic wage differences and medical education differences

Other Design Considerations

Consideration	Discussion
Payments for Designated Critical Access Hospitals (Federally recognized class)	• TBD • For purposes of preliminary simulation, we assumed payments and methods did not change
Coding and Documentation Adjustment	• Determine real case-mix rate of increase by analyzing historical trends, and establish adjustment factor for increases that exceed a factor of that trend • No adjustment incorporated into preliminary simulation
Frequency of rebasing and updating	• TBD

Preliminary Simulation Model
Inpatient Hospital Services

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Preliminary Inpatient Simulation - Assumptions

- Statewide standardized base rate, with adjustments for geographic wage and teaching program differences – cost basis determined using hospital-specific aggregate CCR
- Costs include 100 percent of assessment amounts
- Base rates adjusted to targeted funding level using budget neutrality adjustment – funding pool includes all supplemental and assessment payments, which have been allocated to individual claims based on relative charges
- Relative weights – adopted National weights and Illinois-specific lengths-of-stay
- Medicare outlier policy, with $23,385 fixed stop loss, and 80% marginal cost percentage
- Medicare transfer-out policy (not post-acute transfer policy)
- No policy adjusters – anticipate incorporating policy adjusters in future models
- No documentation and coding adjuster – anticipate incorporating adjuster in future models
- Specialty services – psychiatric, rehabilitation and LTAC kept constant – will incorporate alternative payment methods in future models
- CAH – included in DRG model as a baseline for evaluating future adjustments to payment policy

Preliminary Inpatient Simulation - Results

Description	Results	Comments
Legacy system payments	$ 3.997 Billion	
Simulated system payments	$ 3.997 Billion	Budget Neutral
DRG Base Standardized Amount	$ 8,274	Statewide standardized amount with facility-specific adjustments for wage and teaching program differences
Relative Weights	APR-DRG National Weights	Adjusted to average of 1.0, based on 2009 claims data
Documentation and Coding Adjustment	None	
Policy Adjustors	None	Will add based on DHFS policy priorities
High cost outlier parameters	Fixed Stop-Loss = $22,385 Marginal Cost Percentage = 80%	
Low cost outlier parameters	None	Options open for discussion
Outlier payments as % of total	4.5%	As a percentage of total DRG payments

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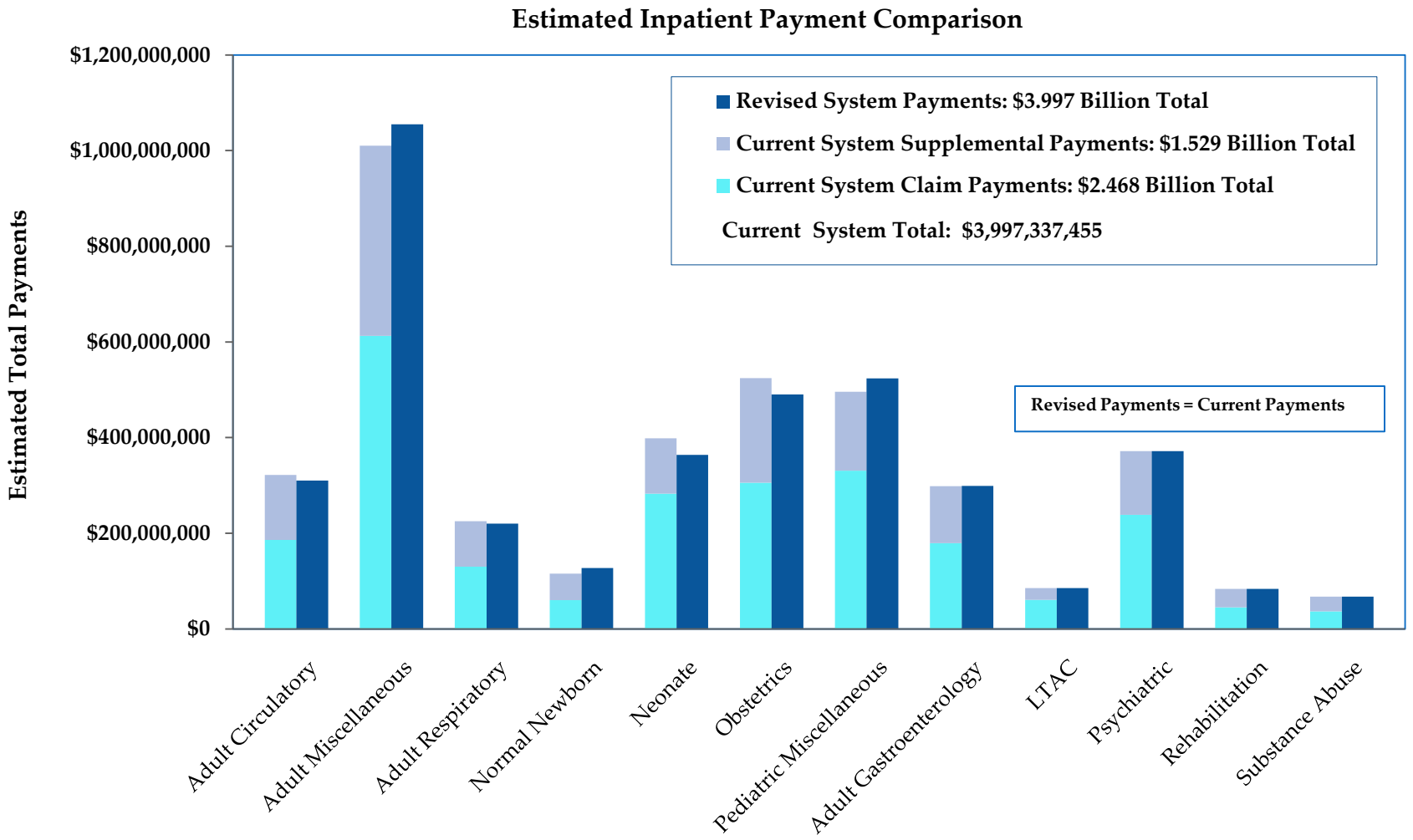
Preliminary Inpatient Simulation - Results



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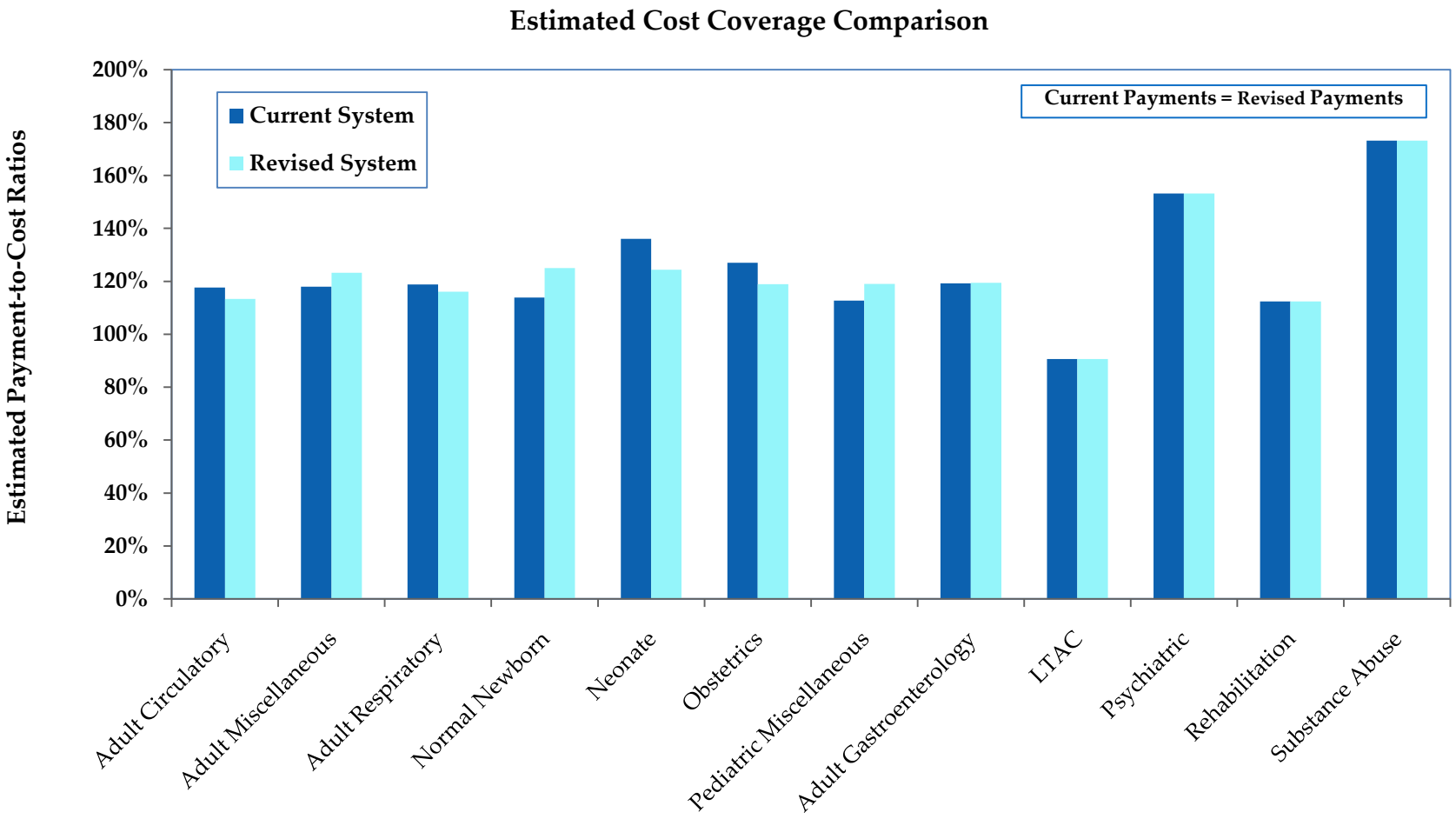
Preliminary Inpatient Simulation - Results



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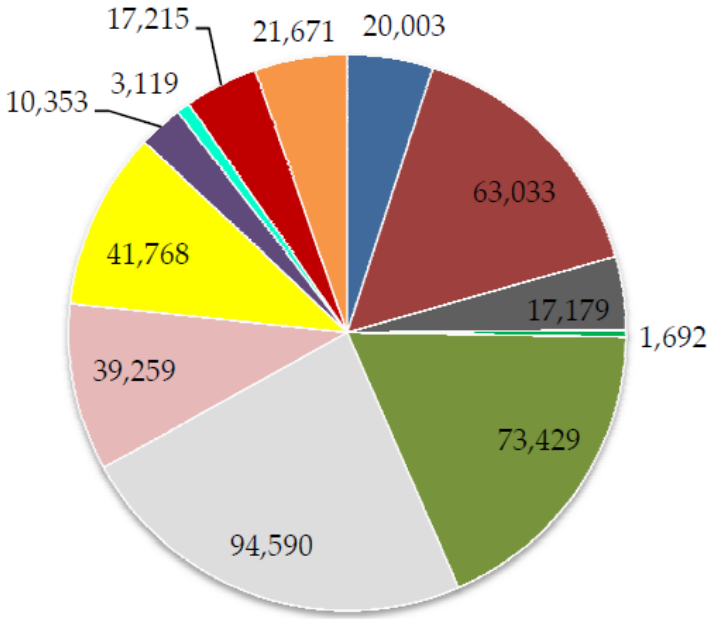
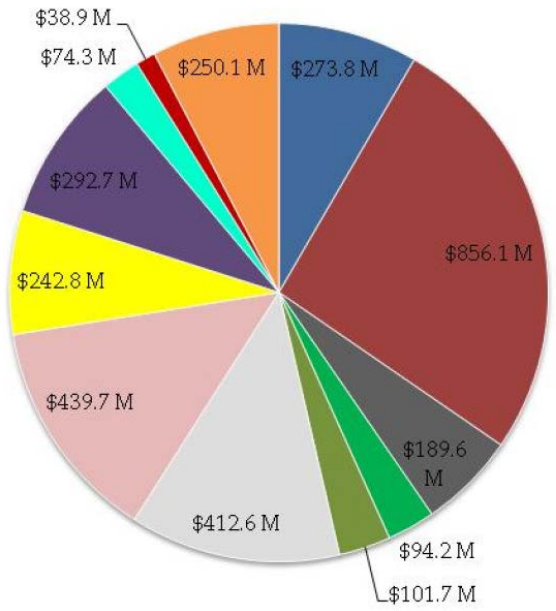
Preliminary Inpatient Simulation - Results

Number of Claims
(Total 403,311)



SFY 2013 Estimated Cost
(Total $3.266 Billion)



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