Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group

Discussion of Design Considerations

December 19, 2011

Agenda

- Introductions
- Inpatient Specialty Services Payment Methodologies
- Potential System Rebalancing
- Coordinated Care Initiative
- Static Payments
- Next Steps
- 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
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

Preliminary Inpatient Simulation - Assumptions

- Statewide standardized base rate established to achieve existing funding levels (subject to future decisions regarding potential rebalancing) – aggregate funding pool includes all current supplemental and assessment payments
- Each facility's base rate is equal to the statewide standardized base rate adjusted for geographic wage and teaching program differences
- Costs include 100 percent of assessment amounts
- Relative weights – adopted National weights and Illinois-specific lengths-of-stay
- Medicare outlier policy, with $22,385 fixed stop loss, and 80% marginal cost percentage
- Medicare transfer-out policy (not post-acute transfer policy)
- Optional adjusters yet to be determined
- Documentation and coding adjusters yet to be determined
- Specialty services – will incorporate alternative payment methods in future models
- CAH – included in DRG model as a baseline for evaluating future adjustments to payment policy

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)
    - Day adjustments that incrementally decrease during the patient stay (119% on first day down to 92% on 22nd day and beyond)

Inpatient Specialty Services Payment Methodologies

Psychiatric Providers / Distinct Part Units Proposed Pricing Formulas

- Proposed Claim Payment:
  (Psychiatric Per Diem Rate) x (Days Adjustment) x (APR-DRG Relative Weight)

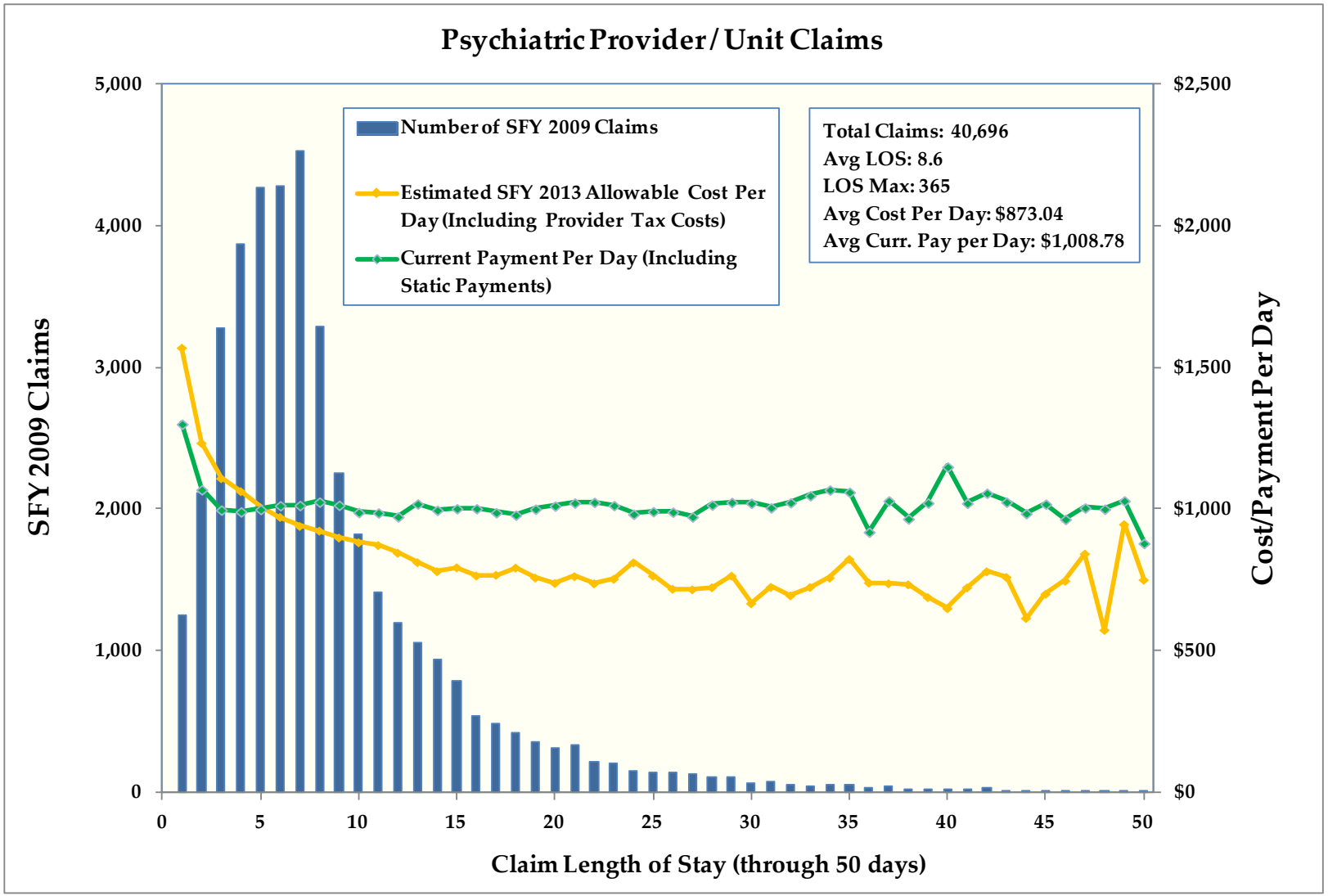
- Proposed Psychiatric Per Diem Rate:
  [(Standardized amount x Labor Portion x Wage Index) +
  (Standardized Amount x Non-Labor Portion)] * (Teaching Factor) * (Rural Status)

- Proposed Days Adjustments (per Medicare IPF-PPS):

Length of Stay	Adjustment	Length of Stay	Adjustment	Length of Stay	Adjustment	Length of Stay	Adjustment	Length of Stay	Adjustment
1	1.19	6	1.02	11	0.99	16	0.97	21	0.95
2	1.12	7	1.01	12	0.99	17	0.97	22	0.92
3	1.08	8	1.01	13	0.99	18	0.96	Beyond 22	0.92
4	1.05	9	1.00	14	0.99	19	0.95		
5	1.04	10	1.00	15	0.98	20	0.95		

Inpatient Specialty Services Payment Methodologies

Excludes Cook County / U of I claims, Medicare crossover claims and claims with ungroupable/invalid APR-DRGs



Note: 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.

Inpatient Specialty Services Payment Methodologies

Rehabilitation Providers / Distinct Part Unit Proposed Approach

- HFS considered a Medicare-style rehabilitation payment system but determined major components were not feasible or appropriate for Medicaid services:
  - CMS IRF-PPS uses a rehabilitation-specific patient classification system (CMGs) which assigns classifications based on assessment data not available for Medicaid patients
  - CMS IRF-PPS reimburses on a per discharge basis; payment does not recognize the patient length of stay

- 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

Rehabilitation Providers / Distinct Part Units Proposed Pricing Formulas

- Proposed Claim Payment:
  (Rehabilitation Per Diem Rate) x (Days) x (APR-DRG Relative Weight)

- Proposed Rehabilitation Per Diem Rate:
  [(Standardized amount x Labor Portion x Wage Index) +
  (Standardized Amount x Non-Labor Portion)] * (Teaching Factor) * (Rural Status)

Inpatient Specialty Services Payment Methodologies

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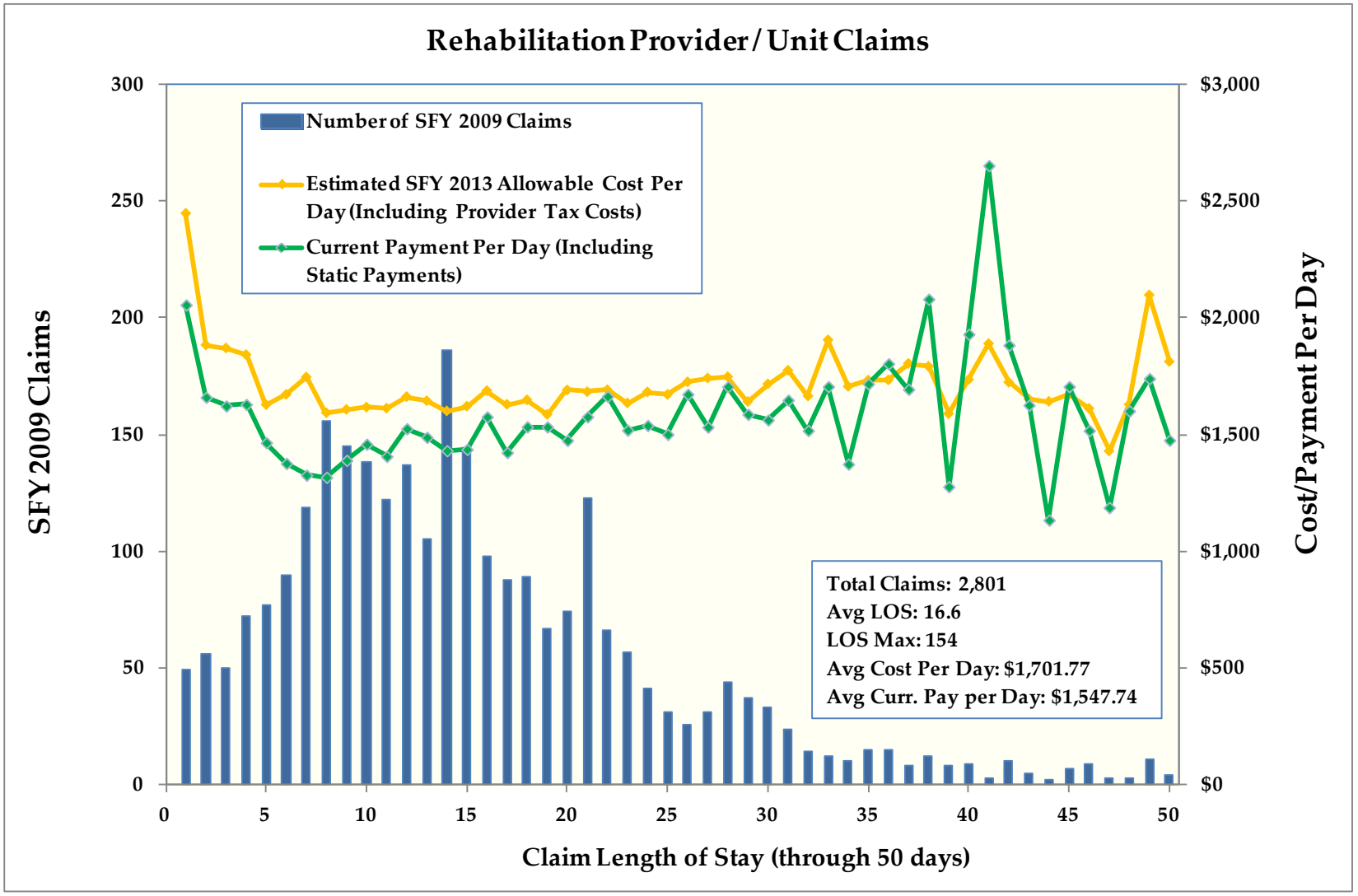

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Inpatient Specialty Services Payment Methodologies

LTAC Proposed Approach

- HFS is currently considering a Medicare-style LTAC payment system, which mimics the acute DRG system with LTAC-specific payment rates

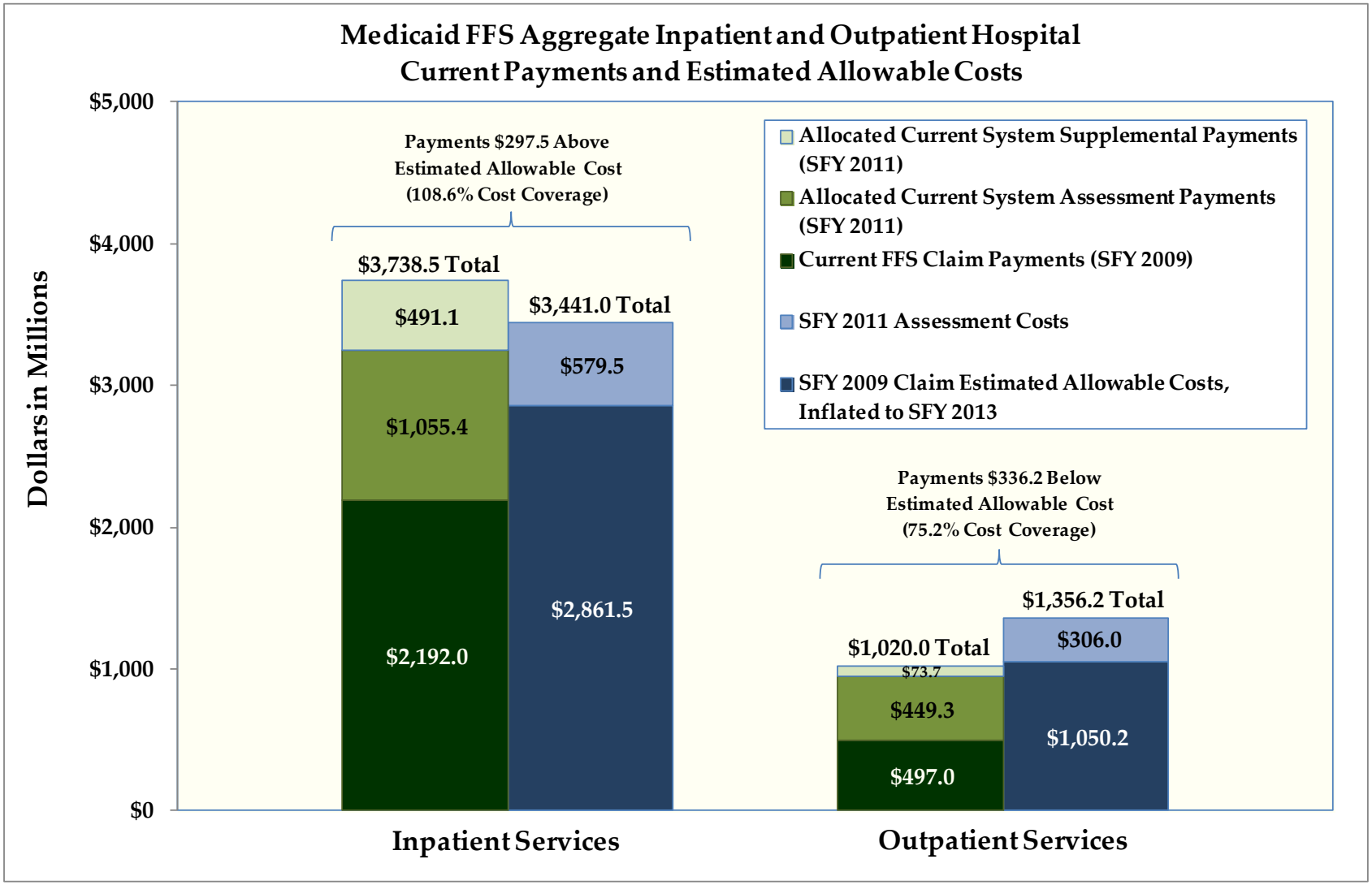
- Elements of the CMS LTCH-PPS under consideration:
  - DRG-based system, using APR-DRGs and national weights
  - LTAC-specific standardized DRG base rates, adjusted for wage index
  - High cost outlier payments
  - Short-stay outliers
  - No medical education payments (direct or indirect)

Potential System Rebalancing

- The current Medicaid FFS hospital inpatient and outpatient payment systems appear to be unbalanced relative to estimated allowable costs:
  - Inpatient hospital payments are greater than outpatient hospital payments relative to estimated allowable costs
  - Inpatient hospital payments relative to cost differ between general acute, psychiatric, rehabilitation and LTAC providers
  - Inpatient hospital payments relative to cost for normal newborn and obstetric services are lower than for other acute service categories

Potential System Rebalancing

Excludes Cook County / U of I claims, Medicare crossover claims and claims with ungroupable/invalid APR-DRGs



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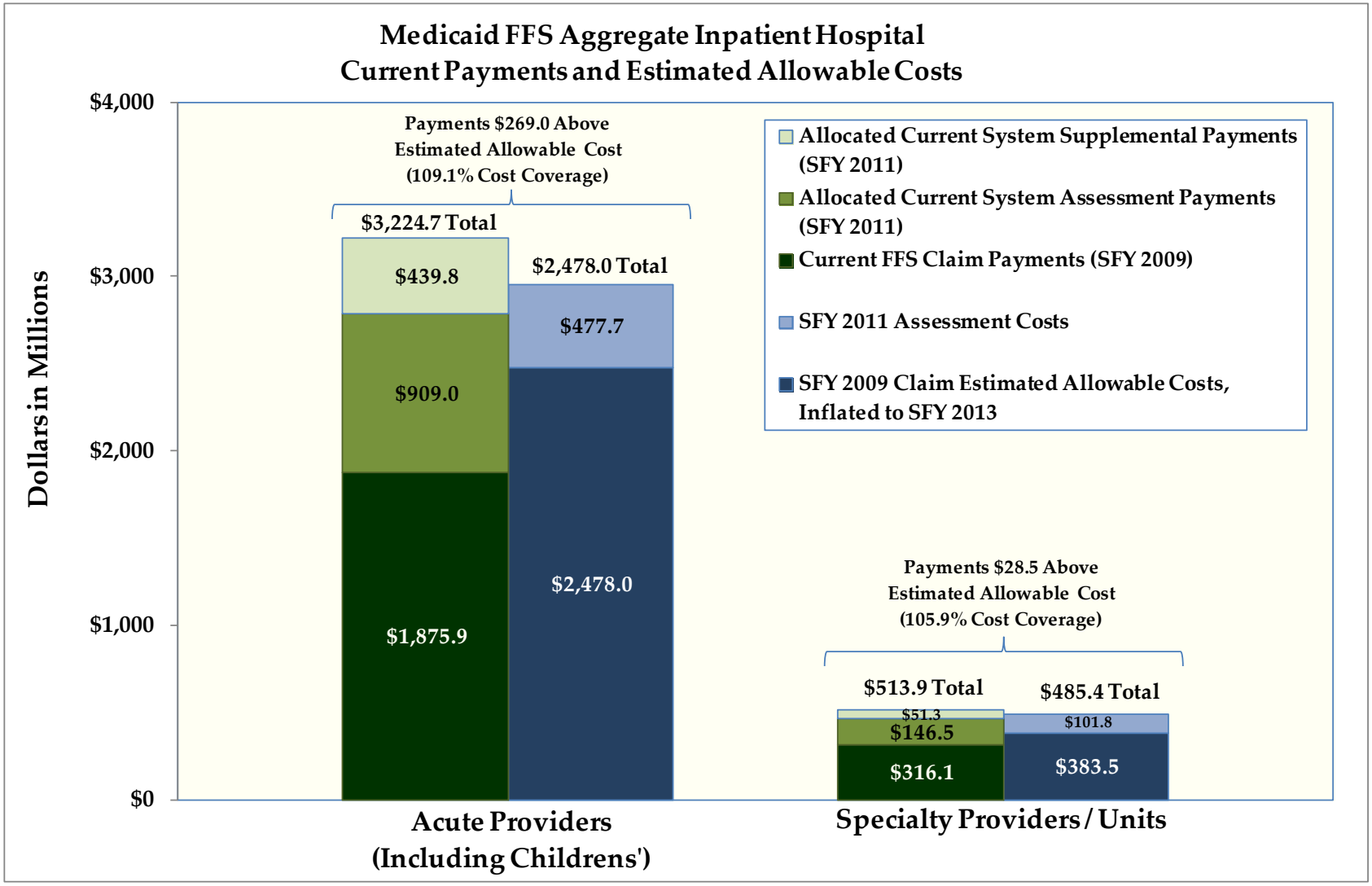

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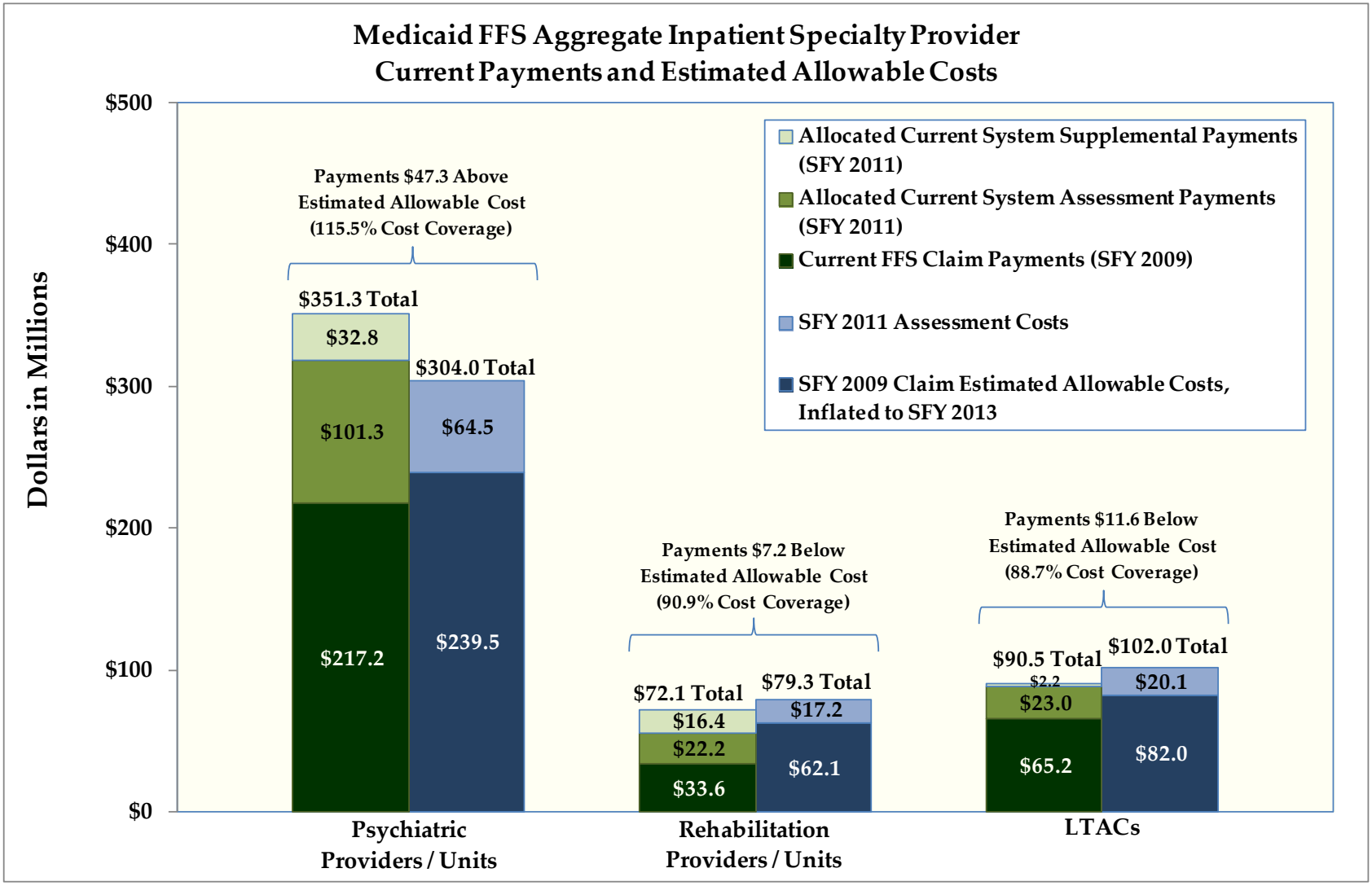

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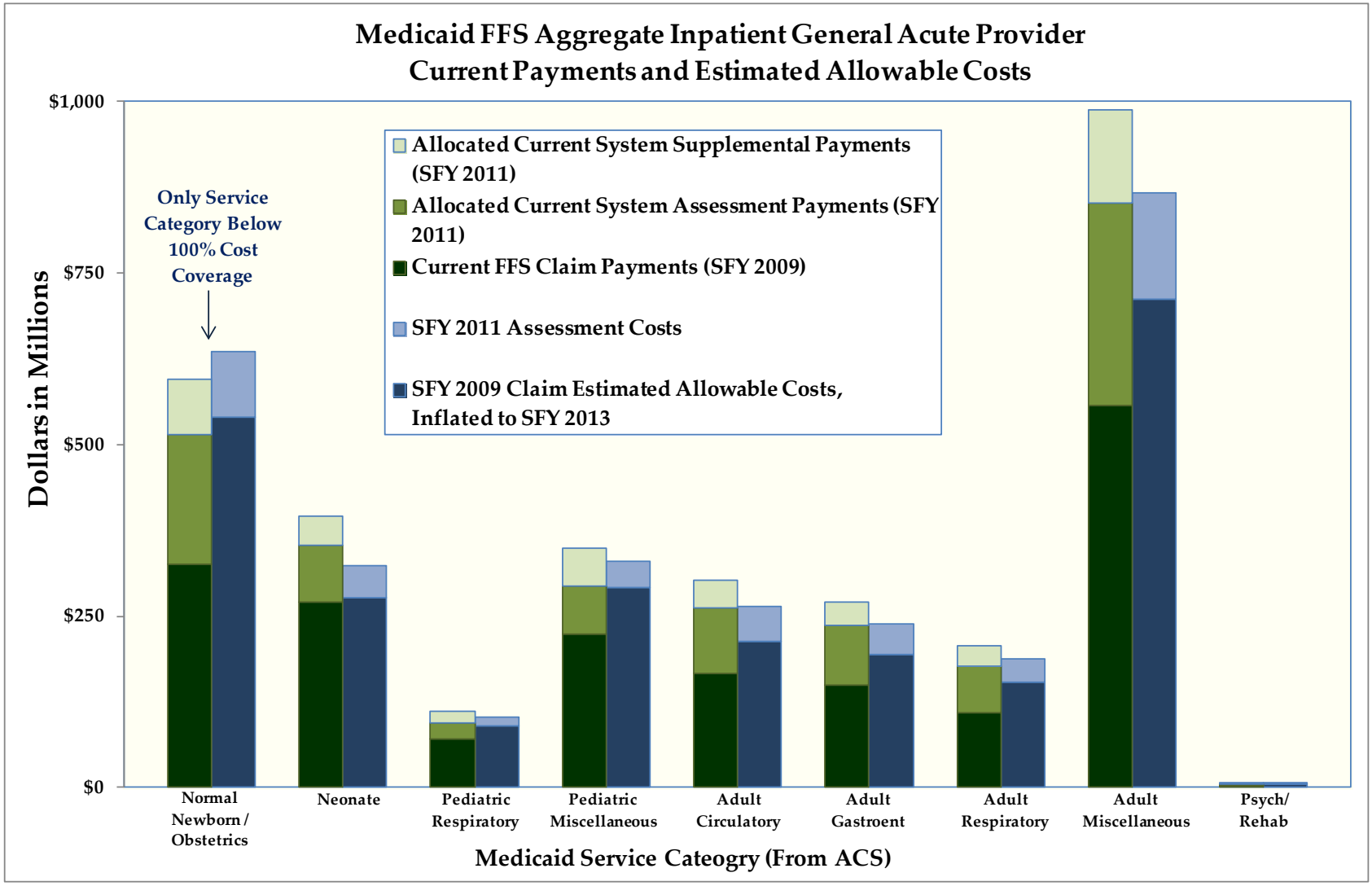

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Potential System Rebalancing

System Rebalancing Options:

- Assumption is that aggregate funding pool for inpatient and outpatient combined will not change
- Shift funding towards outpatient hospital services
- Shift funding towards normal newborn/obstetrics services
- Shift funding towards specialty services

December 19, 2011 TAG FY 2011 Static Payments

Handout 1

	Base	FY 11	Revised		Proposed
	Count	Amounts	Reallocation	Count	Amounts
Grand total	**225**	**1,553,642,571**	0.507	**210**	**766,259,212**
Grand total less stimulus/sunset payments	**225**	**1,460,636,181**	0.475	**167**	**766,259,212**
Non-assessment subtotal	**218**	**385,837,690**	1.000	-	-
Sunsetting payments	**12**	**1,496,774**	1.000	-	-
Stimulus subtotal	**9**	**14,607,748**	1.000	-	-
One-time stimulus subtotal	**204**	**93,006,390**	1.000	-	-
Assessment subtotal	**210**	**1,058,693,969**	0.276	**210**	**766,259,212**
Non-assessment static payments					
DHA	30	151,291,687	1.000	-	-
Trauma	36	41,235,135	1.000	-	-
Rehab	4	10,022,067	1.000	-	-
RCHAP	88	15,876,836	1.000	-	-
PIAP	15	10,797,867	1.000	-	-
SNAP	122	85,287,042	1.000	-	-
Tertiary	136	33,230,075	1.000	-	-
PAP	6	4,353,771	1.000	-	-
RAP IP	48	583,663	1.000	-	-
County trauma	63	8,967,488	1.000	-	-
EAM	10	24,192,059	1.000	-	-
Payments sunsetting on 06/30/2012					
SNAP	7	929,535	1.000	-	-
RHA	1	125,000	1.000	-	-
DHA	4	442,239	1.000	-	-
Stimulus static payments					
DHA	4	6,600,610	1.000	-	-
SNAP	5	8,007,138	1.000	-	-
One-time stimulus static payments			1.000		
Perinatal level III	14	8,687,175	1.000	-	-
Level 1 trauma center	23	8,020,892	1.000	-	-
Medicaid per diem base	204	52,436,548	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	208	376,279,707	0.450	208	206,953,839
Enhanced PIAP	12	13,693,775	-	12	13,693,775
Psych Rehab MIUR	7	13,132,230	-	7	13,132,230
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	19	26,123,127	-	19	26,123,127