Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group

Discussion of Design Considerations

March 1, 2012

Agenda

1. Introductions (5 Minutes)
2. HFS Response to Proposal Document Submitted During February 9th TAG Meeting (10 Minutes)
3. Discussion Regarding Questions Posed to TAG Members (30 Minutes)
4. New Inpatient Payment Simulation Model – Changes and Results (30 Minutes)
5. Preliminary OP Model – Preliminary Assumptions and Results (30 Minutes)
6. Wrap-Up (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

Discussion Regarding Questions Posed to TAG Members

- **Topic 1:** What methodology should be used to allocate remaining static payments not incorporated into claims-based payments to individual hospitals?
  - Should allocations be tied to level of uncompensated care, or percentage of Medicaid inpatient utilization?
  - If so, should the methodology consider the possibility of multiple thresholds that could be prioritized or combined?

- **Topic 2:** Several concerns have been raised regarding need to protect the viability of urban, high Medicaid hospitals through some form of enhanced funding. Historically, such hospitals have been categorized as safety net hospitals. By what objective criteria should such urban, high Medicaid hospitals be defined? Should criteria have multiple tiers – so as to recognize degrees of participation in the Medicaid program?

Preliminary Inpatient Simulation Results

Inpatient 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

- 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

Preliminary Inpatient Simulation Results

Inpatient Model Assumptions Continued

- Model includes following acute policy adjusters (in hierarchical order):

Acute Policy Adjustment	Adjustment Factor	Target Pay-to-Cost Ratio
MPA/MHVA Tier 1	1.5	125%
MPA/MHVA Tier 2	1.4	100%
Freestanding Children's	1.6	100%
CAH	1.8	100%
Normal Newborn/OB	1.6	92% (acute avg.)
Other Neonates	1.3	100%
Pediatric	1.1	92% (acute avg.)

- Preliminary Standardized Payment Rates (before Wage or Teaching Adjustments)

DRG Base Rate	Psych Per Diem	Rehab Per Diem	LTAC Base Rate
$4,225.36	$772.81	$540.61	$4,141.99

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Service Type	SFY 2009 Claims	SFY 2009 Medicaid Days	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
General Acute Hospitals	338,972	1,277,472	100%	92%
Psychiatric Providers/ Units	41,012	351,690	109%	92%
Rehabilitation Providers/ Units	2,889	48,721	86%	92%
LTAC Providers	2,677	65,933	87%	87%
Inpatient Total	**385,550**	**1,743,816**	**100%**	**92%**

Note: Proposed inpatient system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside. Costs include 100% of assessment paid by providers. Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios – General Acute Only

General Acute Service Category	Policy Adjuster	SFY 2009 Claims	SFY 2009 Medicaid Days	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
MPA/MHVA Tier 1	1.5	16,993	66,323	160%	122%
MPA/MHVA Tier 2	1.4	106,873	390,050	112%	101%
Freestanding Children's	1.6	5,202	37,771	99%	101%
CAH	1.8	5,504	12,941	79%	100%
Normal Newborn/OB	1.6	103,686	246,316	78%	90%
Other Neonates	1.3	5,927	89,989	111%	100%
Pediatric	1.1	21,587	77,150	96%	94%
Other Adult	N/A	73,200	356,932	93%	80%
General Acute Total		**338,972**	**1,277,472**	**100%**	**92%**

Note: Proposed inpatient system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside. Costs include 100% of assessment paid by providers. Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

Provider Category	Number of Providers	SFY 2009 Claims	SFY 2009 Medicaid Days	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
General Acute Providers (w/ DPUs)	127	355,144	1,434,353	100%	92%
Critical Access Hospitals	51	5,882	14,112	81%	101%
Freestanding Psychiatric Providers	8	8,654	126,285	153%	107%
Freestanding Rehabilitation Providers	4	1,236	24,268	99%	90%
LTAC Providers	6	2,677	65,933	87%	87%
Out-of-State Providers	36	11,957	78,865	82%	76%
Inpatient Total	**232**	**385,550**	**1,743,816**	**100%**	**92%**

Note: Proposed inpatient system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside. Costs include 100% of assessment paid by providers. Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Preliminary Inpatient Simulation Results

Estimated Pay-to-Cost Ratios

IHA Requested Breakouts	SFY 2009 Claims	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
Transplant DRGs	142	175%	114%
Trauma Level 1 providers (all claims)	95,856	103%	98%
Trauma Level 2 providers (all claims)	89,002	89%	86%

Note: Proposed inpatient system aggregate pay-to-cost ratio is lower than current system because of $311 million outpatient set-aside. Costs include 100% of assessment paid by providers. Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Outpatient: 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)

Preliminary Outpatient Simulation Results

Outpatient Claims Data Processing

- Preliminary outpatient model based on SFY 2009 outpatient hospital claims data and excludes non-institutional claims data
- Outpatient claim costs estimated for Medicaid cost reporting hospitals with Medicare cost report data
- Claims included in cost calculation processed under EAPG program version 3.7 using 3M's default settings
- SFY 2009 outpatient claims data extracts, including estimated cost and EAPG program output, have been provided to IHA for their review

Preliminary Outpatient Simulation Results

Outpatient Claims Data Issues

- MMIS "rolls-up" outpatient claim detail lines for each revenue code/HCPCs combination due to storage limitations; as such not all unique services dates were maintained
  - Original claim detail data extracted from HIPAA hub and matched to MMIS data so unique service dates could be identified (95% of MMIS claim lines matched to HIPAA hub)

- HCPCS not reported for every claim detail line (especially for drugs); HCPCS is required for valid EAPG assignment by EAPG program
  - Drug EAPGs estimated for claims with drug revenue codes missing HCPCs (9% of total model claim lines) based on claim cost, using crosswalk provided by 3M

- Many claim detail lines appear to contain outlier unit values
  - Model uses lesser of reported units or EAPG average unit per claim line (units adjusted for 6% of total model claim lines)

Preliminary Outpatient Simulation Results

Initial Outpatient Model Assumptions

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

- Initial preliminary outpatient model consists of :
  - $0 static payments in revised system
  - $0 assessment cost (100% of tax has been allocated to inpatient)
  - Excludes crossover claims, Cook/UI claims and claims without an assigned/valid EAPG

Preliminary Outpatient Simulation Results

Initial Outpatient Model Assumptions (Cont'd)

Determination of Outpatient Set-Aside Amount:			**Amount 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%
Target 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 Outpatient Simulation Results

Initial Outpatient Model Assumptions (Cont'd)

- EAPG Relative Weights
  - Used 3M's EAPG v. 3.6 national weights without adjusting for Illinois case mix (CMI adjustment is next step – v 3.7 weights to be available in April)
  - For new v. 3.7 EAPGs not included in v. 3.6 national weights, EAPG weights were calculated based on claim costs for EAPG
  - Next steps: adjust 3M national weights for case mix, and calculate Illinois-specific relative weights for correlation analysis

- Conversion Factors
  - Used standardized conversion factor, adjusted for hospital wage index:
    (Standardized Amount * Labor Portion * Wage Index) +
    (Standardized Amount * Non-Labor Portion)

Preliminary Outpatient Simulation Results

Initial Outpatient Model Assumptions (Cont'd)

- 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"
  - Used EAPG program default list of 29 packaged routine ancillary services to bundle payment
  - 34% of total model claim lines contained packaged ancillary flag
  - May need to consider adding low-cost drugs to packaged list

- Procedure Consolidation
  - EAPG program designates certain procedures as "consolidated" EAPGs if another key procedure is present in the claim
  - Used EAPG program default consolidation list to bundle payment
  - 13% of model significant procedure claim lines have procedure consolidation flag

Preliminary Outpatient Simulation Results

Initial Outpatient Model Assumptions (Cont'd)

- Discounting
  - Discounting modifies the payment for an additional procedure provided during the same visit, unless it is consolidated
  - Used all 4 discount types (Terminated Procedure, Multiple Significant Procedure, Repeat Ancillary and Bilateral)
  - Used following discount factors based on New York Medicaid and Medicare:

Discount Type	Proposed Discount Factor
Terminated Procedure	50%
Multiple Significant Procedure	50%
Repeat Ancillary	50%
Bilateral (percentage of single service)	150%

Preliminary Outpatient Simulation Results

EAPG Category Distribution

EAPG Category	SFY 2009 Total Claim Detail Lines	Packaged Claim Lines	Consolidated Claim Lines	SFY 2009 Covered Charges
01 - Per Diem	78	-	-	25,404
02 - Significant Procedure	507,378	-	65,102	630,121,319
03 - Medical Visit	1,407,464	-	303	795,112,185
04 - Ancillary	4,502,043	3,116,881	133,133	805,800,765
05 - Incidental	510,822	510,822	7,439	204,396,179
06 - Drug	1,654,255	-	63,292	251,035,138
07 - DME	7,319	-	261	9,384,499
08 - Unassigned (APG = 999)	792,252	-	22,349	400,255,063
21 - Physical Therapy & Rehabilitation	435,474	-	119,204	76,722,651
22 - Mental Health & Counseling	144,714	-	1,527	38,050,654
23 - Dental Procedure	6,592	-	1,810	2,864,102
24 - Radiologic Procedure	517,369	-	133,255	768,291,309
25 - Other Diagnostic Procedure	161,258	-	47,547	178,919,691
Grand Total	**10,647,018**	**3,627,703**	**595,222**	**4,160,978,958**

Preliminary Outpatient Simulation Results

Initial Estimated Pay-to-Cost Ratios

Provider Category	Number of Providers	SFY 2009 Claims	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
General Acute Providers (w/ DPUs)	128	9,548,542	101%	132%
Critical Access Hospitals	51	735,879	99%	69%
Freestanding Psychiatric Providers	8	37,961	237%	188%
Freestanding Rehabilitation Providers	4	28,195	103%	In Process
LTAC Providers	2	8,077	217%	106%
Out-of-State Providers	32	288,364	44%	156%
Outpatient Total	**225**	**10,647,018**	**99%**	**129%**

Note: Proposed outpatient system includes $311 million shift in funding from inpatient. Costs exclude assessments (100% of tax has been allocated to inpatient). Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Preliminary Combined Simulation Results

Initial Estimated Pay-to-Cost Ratios

Provider Category	Inpatient		Outpatient		Combined	
	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios	Current System Pay-to-Cost Ratios	Proposed System Pay-to-Cost Ratios
General Acute Providers (w/ DPUs)	100%	92%	101%	132%	100%	101%
Critical Access Hospitals	81%	101%	99%	69%	94%	79%
Freestanding Psychiatric Providers	153%	107%	237%	188%	156%	109%
Freestanding Rehabilitation Providers	99%	90%	103%	In Process	100%	In Process
LTAC Providers	87%	87%	217%	106%	90%	88%
Out-of-State Providers	82%	76%	44%	156%	75%	91%
Total	**100%**	**92%**	**99%**	**129%**	**100%**	**100%**

Note: Proposed combined system includes $311 million shift in funding from inpatient to outpatient. 100% of provider tax has been allocated to inpatient. Costs have been trended to SFY 2013 price levels. Claims based payments have not yet been trended forward to SFY 2011.

Wrap-Up

- Inpatient analysis
- Outpatient analysis
- Next Meeting