Illinois Department of Healthcare and Family Services

Hospital Rate Reform Initiative

Technical Advisory Group

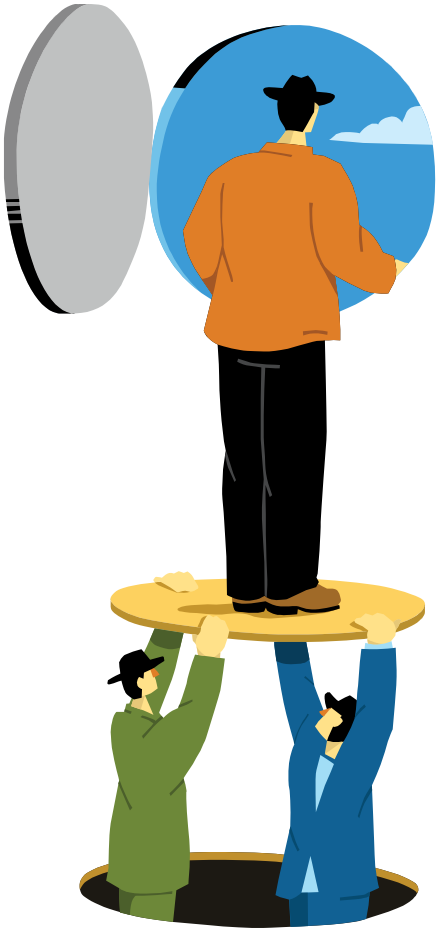
January 29, 2013

NAVIGANT

Meeting Agenda

Agenda
Revised Inpatient Model with Policy Adjusters
Shadow Pricing Models
TAG Requested Analyses
Alternative Inpatient Model Update
Coding Improvement / Transition Period
Questions and Discussion

Revised Inpatient Model with Policy Adjusters



NAVIGANT

Revised Inpatient Model With Policy Adjusters

Revised Model assumptions

- Effective July 1, 2013, HFS will replace its current Medicaid FFS inpatient CMS DRG version 12 and per diem payment methodology with a new APR-DRG-based payment system
  - At implementation, the new APR-DRG system will not replace static payments, MPA/MHVA payments or LTAC add-on payments

- Based on review of the "Baseline" model and input from the TAG, HFS is evaluating a revised model with:
  - Policy adjusters that increase payments for key Medicaid services
  - "Flat" per diem rate for specialty services (psychiatric, rehabilitation and LTAC services) that removes the acuity and graduated day adjustments from the pricing formula

Revised Inpatient Model With Policy Adjusters

Revised Model assumptions (continued)

- Revised model uses SFY 2009 claim-based payments net of DSH, MPA/MHVA, and LTAC add-on payments as basis for APR-DRG system funding pool
  - Used SFY 2009 data to facilitate data reconciliation with IHA
  - Claim reported payments used for DRG funding pool do not reflect SMART Act reductions
  - LTAC per diem payments under current system simulated for a provider paid under DRGs in SFY 2009
  - Static payments excluded from DRG funding pool

- Modeled rates are designed to make each category of service budget neutral to current system claim DRG / per diem payments
  - COS 20 – Acute
  - COS 21 – Psychiatric
  - COS 22 – Rehabilitation
  - COS 20 – LTAC

Revised Inpatient Model With Policy Adjusters

Acute services

- For COS 20 acute services, revised model components include:
  - APR-DRG version 29 3M national relative weights re-center scaled to 1.0 for Illinois Medicaid case mix
  - Statewide standardized base rate of $4,193.48, with labor portion adjusted for FFY 2012 Medicare IPPS wage index
  - Medicare outlier policy, with $22,385 fixed stop loss, and 80% marginal cost percentage
  - Medicare standard transfer-out policy (without post-acute transfer policy) – prorated payment for cases with length of stay less than APR-DRG average
  - No direct or indirect medical education payments

Revised Inpatient Model With Policy Adjusters

Acute services

- Baseline model (without policy adjusters) projected a $35.7 million decrease in payments (6.6% reduction) for newborn and obstetrical services combined
  - HFS and the TAG recognize that newborn and obstetrical services are critical to the Medicaid program and have a high Medicaid market share
  - TAG requested that HFS evaluate a policy adjuster for these services
- To maintain access to these services, HFS, with support of the TAG, is considering a policy adjuster that would maintain current system funding levels for newborn and obstetrical services combined

Revised Inpatient Model With Policy Adjusters

Acute services (continued)

- Policy adjuster of 15% applied to DRG base payments for newborn/OB services as follows:
  - Normal newborn DRGs: identified based on APR-DRGs 626 and 640
  - Neonate DRGs: identified based on non-normal newborn DRGs in MDC 15 (Newborns and other neonates with condition originating in perinatal period)
  - Obstetric DRGs: identified based on MDC 14 (Pregnancy, childbirth and the puerperium)

- Acute pediatric services were also evaluated, but because these services already had a projected payment increase, no policy adjuster was applied in the model

Revised Inpatient Model With Policy Adjusters

Psychiatric services

- For COS 21 psychiatric services, revised model components include:
  - Psychiatric-specific standardized per diem rate of $366.45, adjusted for FFY 2012 Medicare IPF-PPS wage index and rural status
  - Removed relative weight and graduated day adjustments

- Baseline model (without policy adjusters) projected a $19.6 million decrease in payments (23.0% reduction) for pediatric psychiatric services
  - Policy adjuster of 30% applied to per diem payments for psychiatric pediatric services to maintain current funding levels

Revised Inpatient Model With Policy Adjusters

Rehabilitation services

- For COS 22 rehabilitation services, revised model components include:
  - Rehabilitation-specific standardized per diem rate of $597.93, adjusted for FFY 2012 Medicare IRF-PPS wage index and rural status
  - Removed relative weight adjustments

- Baseline model (without policy adjusters) projected a $1.3 million decrease in payments (20.3% reduction) for pediatric psychiatric services
  - Policy adjuster of 30% applied to per diem payments for rehabilitation pediatric services to maintain current funding levels

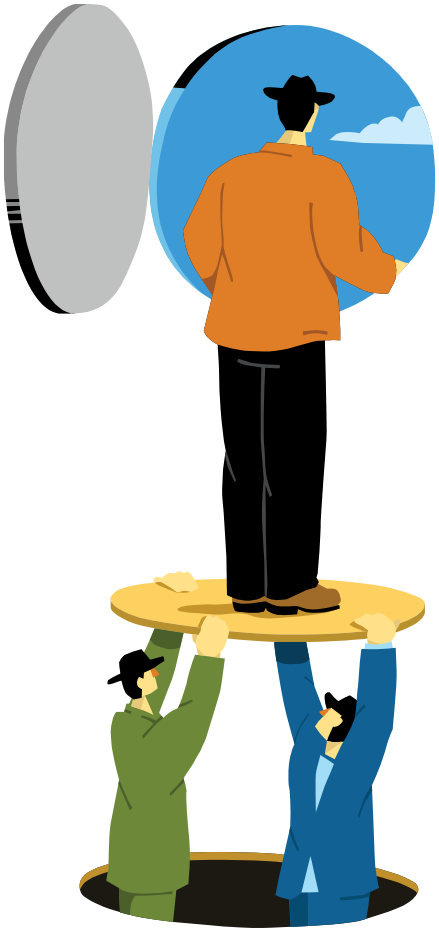
Revised Inpatient Model With Policy Adjusters

LTAC services

- For COS 20 LTAC services, revised model components include:
  - LTAC-specific standardized per diem rate of $593.79, adjusted for FFY 2012 Medicare IPPS wage index
  - Removed relative weight adjustments

- Since virtually all LTAC claims were adult, no pediatric policy adjuster was applied in the model

Shadow Pricing Models



NAVIGANT

Shadow Pricing Models

Shadow Pricing Assumptions – Partial SFY 2013 Claim Data

- To evaluate the new system using the most recent claims data available (and as required by the SMART Act), HFS has re-priced 92,093 SFY 2013 FFS claims under the Revised Model payment rates and methodology
  - Claims with an admission dates starting July 1, 2012 and discharges dates on or before December 14, 2012

- SFY 2013 claim reported payments reflect 3.5% SMART Act reductions
  - For comparison purposes, 3.5% SMART Act reductions applied to simulated new system payments
  - Simulated new system payments were compared to reported claim payments net of DSH, MPA/MHVA and LTAC add-ons

Shadow Pricing Models

Shadow Pricing Assumptions – Full SFY 2011 Claims Data

- To evaluate the new system using the most fully mature and complete state fiscal year of claims data available, HFS has re-priced SFY 2011 FFS claims under the Revised Model payment rates and methodology

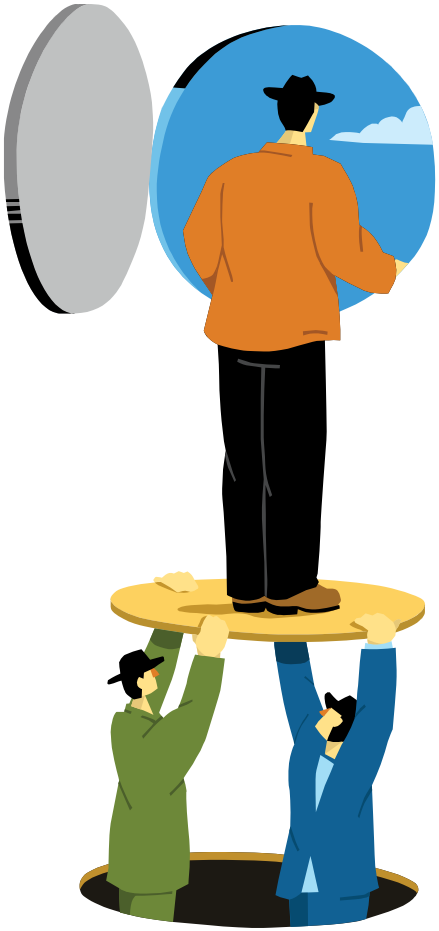
- SMART Act reductions had not yet occurred in SFY 2011
  - As such, for comparison purposes, 3.5% SMART Act reductions were not applied to simulated new system payments
  - Simulated new system payments were compared to reported claim payments net of DSH, MPA/MHVA and LTAC add-ons

Shadow Pricing Assumptions – SFY 2011 Claims (Continued)

» Revised Model rates applied to SFY 2011 FFS claims data resulted in simulated new system payments that are lower than current system payments:

Category of Service	SFY 2011 Claims Data Reported Payments			Revised Model Rates Applied to SFY 2011 Claims Data			Estimated Payment Change
	DRG/Per Diem Payments	Outlier Payments	Total Claim Payments (Net of DSH/MPA)	DRG/Per Diem Payments	Outlier Payments	Total Claim Payments (Net of DSH/MPA)	
Acute COS 20 Services	$1,261.2	$610.4	$1,871.6	$1,543.2	$249.1	$1,792.2	-$79.4
Psychiatric COS 21 Services	$160.9	$0.0	$160.9	$153.4	$0.0	$153.4	-$7.5
Rehabilitation COS 22 Services	$31.2	$0.1	$31.3	$30.7	$0.0	$30.7	-$0.6
LTAC COS 20 Services	$46.1	$6.5	$52.5	$37.3	$0.0	$37.3	-$15.2
Inpatient Total	$1,499.3	$617.0	$2,116.3	$1,764.5	$249.1	$2,013.6	-$102.7

Requested TAG Analyses



NAVIGANT

Requested TAG Analyses

Requested analyses from prior TAG meeting

- Consider model version that maintains current system outlier payment levels
- Evaluate model results for transplant services
- Evaluate model results for teaching hospitals
- Evaluate model results for providers with high capital expenditures
- Consider cost-based LTAC payment rates

Requested TAG Analyses

"Current Outlier Level" Approach

» Alternative model requested to maintain outlier payments at current levels for acute services ($471.4 million for SFY 2009 acute COS 20 claims):

Alternative Model Version	Outlier Payments (Using SFY 2009 Claims)	Outlier Payment % of Total DRG Payments	Modeled Outlier Fixed Loss Threshold	Modeled Outlier Marginal Cost Factor	Percent of Acute COS 20 Claims with Simulated Outlier Payment
Current System	$471.4 million	27.2%	$28,981 (SFY 2009 average)	0.80	5.7%
Revised Model with Policy Adjusters	$251.4 million	14.5%	$22,385	0.80	2.3%
Alternative Baseline Model 1	$471.4 million	27.2%	$6,475	0.80	10.9%
Alternative Baseline Model 2	$471.4 million	27.2%	$8,537	0.90	8.0%
Alternative Baseline Model 3	$471.4 million	27.2%	$22,385	1.457	2.4%

Requested TAG Analyses

Transplant Service Evaluation

- Current inpatient methodology pays 60% of charges for transplants (except for kidneys, which are paid under DRGs)

- Policy Adjuster Model using SFY 2009 data simulates a per discharge DRG payment plus outlier for transfer cases
  - 27.1% modeled pay-to-charge ratio for transplants (using inflated charges) under new system compared to 21.8% for acute services overall

Requested TAG Analyses

Medical Education Evaluation

- Current inpatient methodology does not include separate claim-based direct or indirect medical education payments; IME factor used to reduce outlier payments when calculating claim costs

- In the Revised Model (using SFY 2009 data), the 10 in-state general acute teaching hospitals with the highest FFY 2013 Medicare intern-to-bed ratio have a projected a $26.0 million combined payment increase (6.5% change) for acute services
  - 8 hospitals with a projected gain, 2 with a projected loss

- In the Revised Model (using SFY 2009 data), the 10 in-state general teaching hospitals with the highest Medicaid direct medical education costs (based on SFY 2009 claims) have a projected $23.3 million combined payment increase (3.9% change) for acute services
  - 6 hospitals with a projected gain, 4 with a projected loss

Requested TAG Analyses

Capital Cost Evaluation

- Current inpatient methodology includes a capital per discharge add-on payment (not acuity or length of stay adjusted)

- In the Revised Model (using SFY 2009 data), the 10 in-state general acute hospitals with the highest Medicaid capital costs (based on SFY 2009 claims) have a projected $28.4 million combined payment increase (4.8% change) for acute services
  - 6 hospitals with a projected gain, 4 with a projected loss

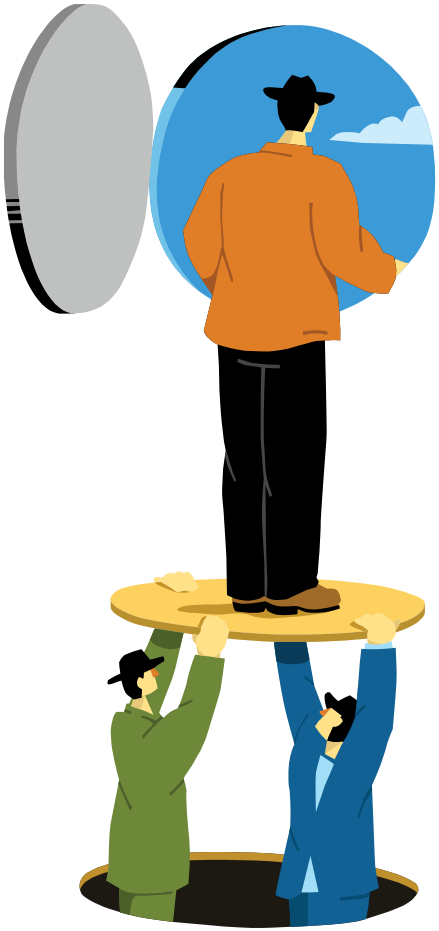
Requested TAG Analyses

LTAC Cost-Based Rate Evaluation

» LTAC provider cost per day distribution using SFY 2009 claims data (current LTAC per diem rate is $604):

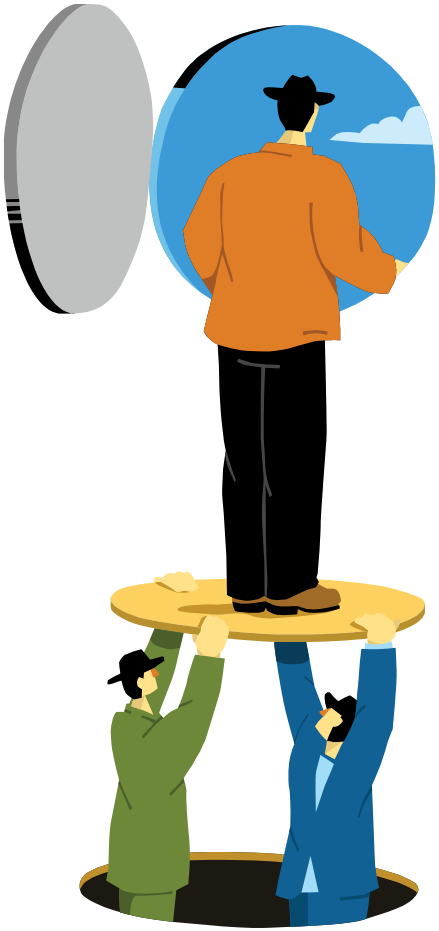
LTAC Provider	LTAC Provider Estimated SFY 2013 Cost Per Day (Without Assessment Cost)
1	$ 1,215.06
2	$ 1,314.28
3	$ 1,405.08
4	$ 1,698.18
5	$ 2,034.24
6	$ 2,162.64
Weighted Average	$1,309.28

Alternative Inpatient Model Update



NAVIGANT

Transitional Corridor



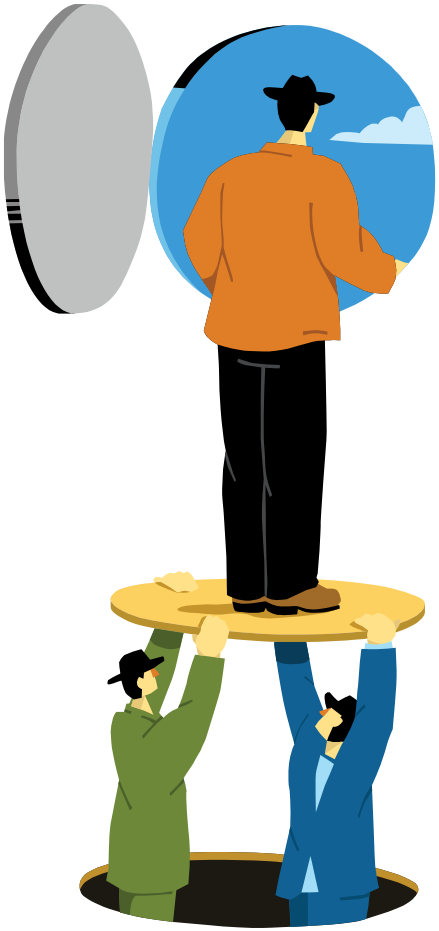
NAVIGANT

Transitional Corridor

Example Transitional Corridor Period

- Payments are made through DRG methodology
- Transition is created through adjustment to hospital base rates
- Prospectively limit individual hospital's estimated payment change percentage to:
  - +/- 5% in year 1
  - +/- 10% in year 2
  - +/- 15% in year 3
  - Rebase using claims paid under APR-DRGs and coded under ICD-10 in year 4
- Will allow hospitals time to adjust, improve efficiency, and reduce cost growth
- Actual transition period may differ from example

Questions and Discussion



NAVIGANT