

Illinois Department of Healthcare and Family Services

Hospital Rate Reform Initiative

Technical Advisory Group

December 18, 2012



NAVIGANT

Meeting Agenda



Agenda

SMART Act Overview

Inpatient Baseline Model A

Baseline Model A Shadow Pricing

Inpatient Model B With Fully Loaded Rates

Alternative Inpatient Model Update

Coding and Documentation Improvement Adjustment

Transition Period

Questions and Discussion

SMART Act Overview





Critical SMART Act Dates - Inpatient:

- » 10/1/2012: Begin APR-DRG Shadow Pricing
- » 4/1/2013: Finalize APR-DRG system administrative rules
- » 7/1/2013: APR-DRG system implementation
- » 7/1/2014: Begin process for GRF static transition
- » 12/31/2014: Current assessments sunset; begin consideration of potential changes to provider assessment



Public Act 097-0689 Sec. 14-11(a) - Hospital payment reform:

» APR DRG Implementation:

- › “The Department may, by rule, implement the All Patient Refined Diagnosis Related Groups (APR DRG) payment system for inpatient services provided on or after July 1, 2013, in a manner consistent with the actions authorized in this Section.”
- › HFS assumes GRF static and assessment payments are to be excluded from APR-DRG system at implementation



Public Act 097-0689 Sec. 14-11(b) - Hospital payment reform:

» APR DRG Shadow-Pricing:

- › “On or before October 1, 2012 and through June 30, 2013, the Department shall begin testing the APR-DRG system. During the testing period the Department shall process and price inpatient services using the APR-DRG system; however, actual payments for those inpatient services shall be made using the current reimbursement system.”
- › HFS has tested initial claim dataset with first service dates from 7/1/2012 adjudicated through 10/19/2012 for evaluation purposes



Public Act 097-0689 Sec. 14-11(b) - Hospital payment reform:

» Technical Advisory Group:

- › “During the testing period, the Department, in collaboration with the statewide representative of hospitals, shall provide information and technical assistance to hospitals to encourage and facilitate their transition to the APR-DRG system.”
- › HFS will continue to meet with the TAG to provide shadow pricing results and facilitate discussion about the APR-DRG system implementation



Public Act 097-0689 Sec. 14-11(d) - Hospital payment reform:

» Technical Advisory Group (Continued):

- › “The Department in consultation with the current hospital technical advisory group shall review the test claims for inpatient and outpatient services at least monthly, including the estimated impact on hospitals, and, in developing the rules, policies, and procedures to implement the new payment systems, shall consider at least the following issues” (summarized from SMART Act language):

- | | |
|---|---|
| (1) National relative weights | (5) Transition funding pools to preserve access to care and financial stability |
| (2) Updated outlier payment methodology | (6) Whether GRF static payments should be used as part of the base payment system |
| (3) Policy adjusters to high Medicaid utilization providers | |
| (4) Inpatient specialty service payments using acuity-adjusted per diem rates | |



Public Act 097-0689 Sec. 14-11(h) - Hospital payment reform:

» Supplemental payments transition:

- › “Beginning July 1, 2014, the Department may transition current General Revenue funded supplemental payments into the claims based system over a period of no less than 2 years from the implementation date of the new payment systems and no more than 4 years from the implementation date of the new payment systems, provided however that the Department may adopt, by rule, supplemental payments to help ensure access to care in a geographic area or to help ensure access to specialty services.”
- › HFS will discuss with TAG options for transitioning supplemental payments into the APR-DRG system starting SFY 2015



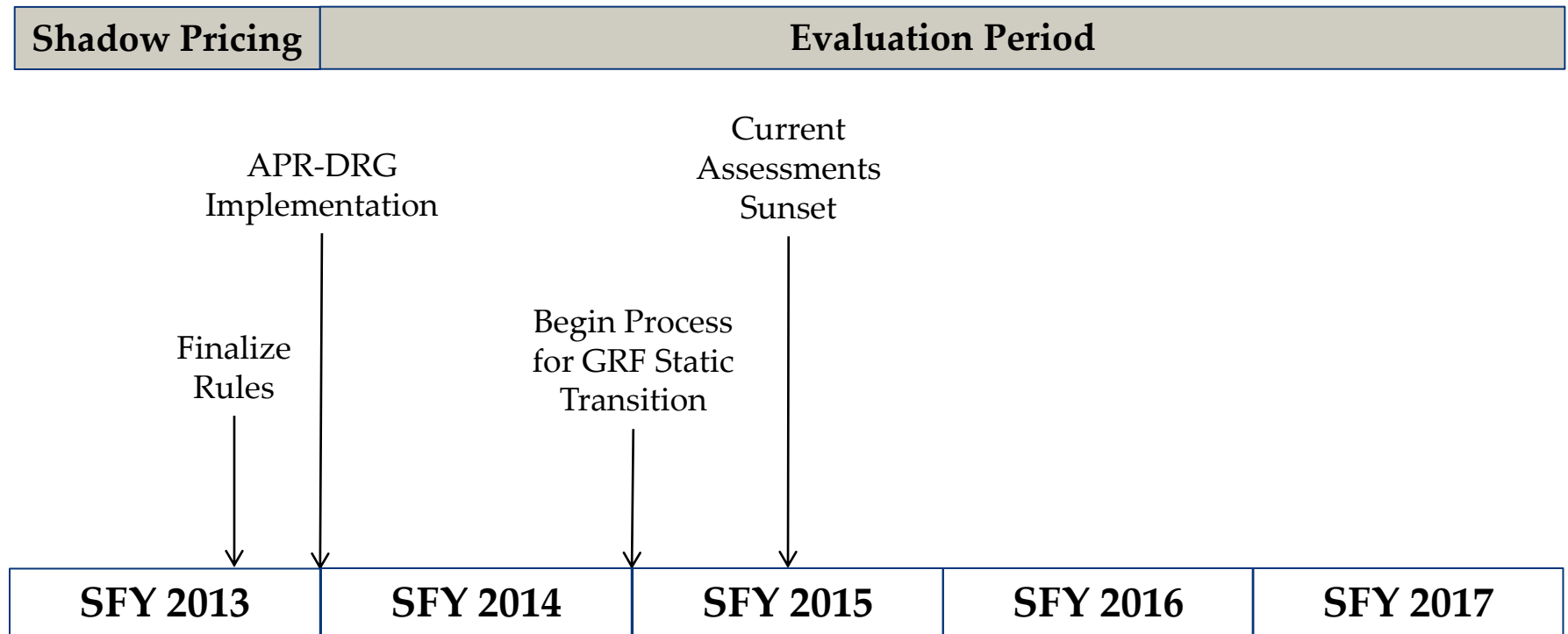
Public Act 097-0689 Sec. 14-11(g) - Hospital payment reform:

» **Assessment payments transition:**

- › “The payments to hospitals financed by the current hospital assessment, authorized under Article V-A of this Code, are scheduled to sunset on June 30, 2014. The continuation of or revisions to the hospital assessment program shall take into consideration the impact on hospitals and access to care as a result of the changes to the hospital payment system.”
- › HFS assumes actual sunset date will be December 31, 2014 and will discuss with TAG options for potential provider assessment changes starting CY 2015



SMART Act Timeline - Inpatient



Inpatient Baseline Model A





Baseline Model A assumptions

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

- » To evaluate impact of simply switching to the APR-DRG grouper, HFS has created a Baseline Model A
 - › For evaluation purposes only – does not represent a recommendation
 - › Baseline model does not contain policy adjustors and distributes funding based on case mix



Baseline Model A assumptions (continued)

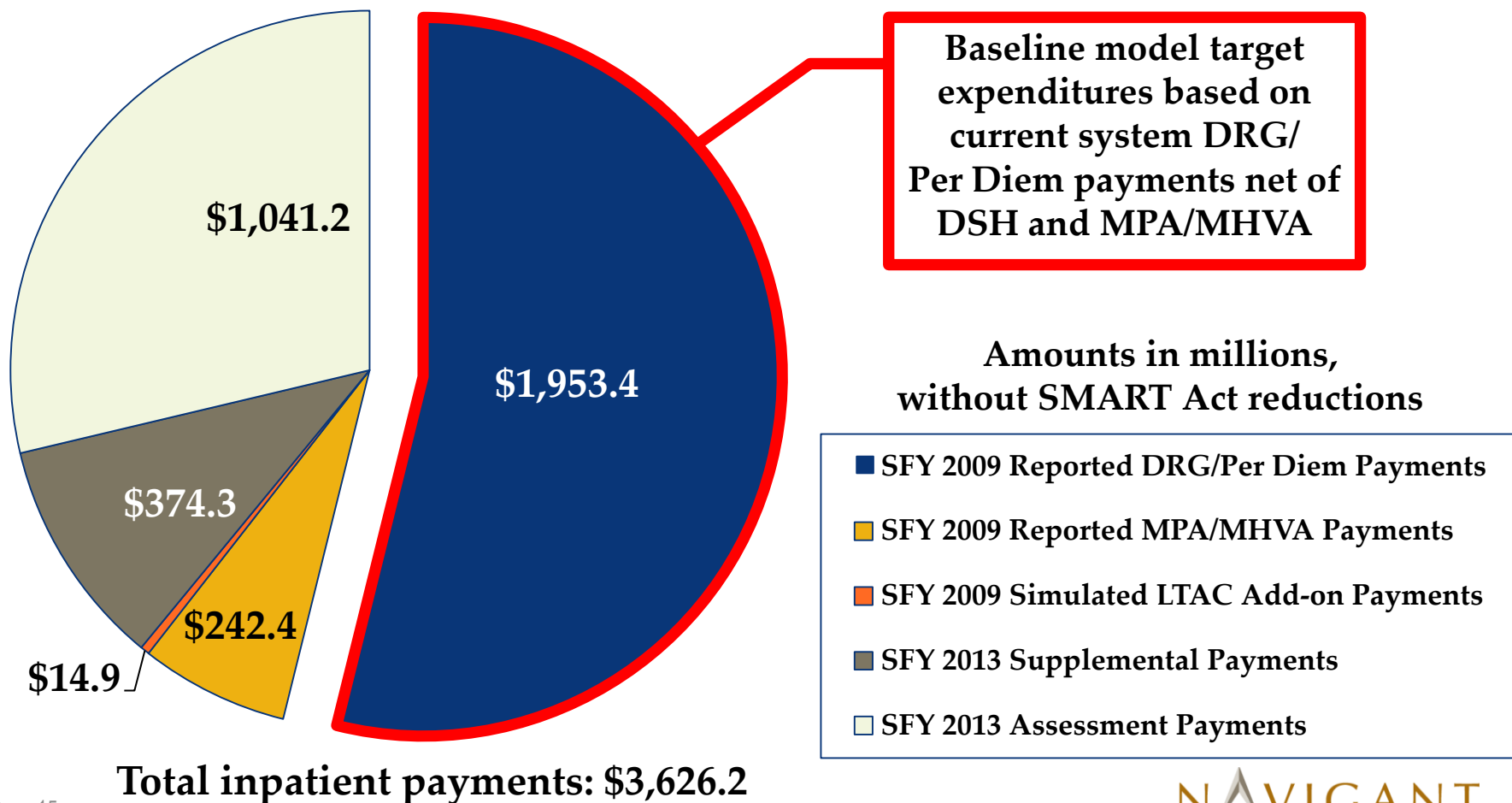
- » Baseline model uses SFY 2009 claim-based payments net of DSH, MPA/MHVA, and LTAC add-on payments as basis for APR-DRG system funding pool
 - › Used SFY 2009 data to facilitate data reconciliation with IHA
 - › Claim reported payments used for DRG funding pool do not reflect SMART Act reductions
 - › 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

Inpatient Baseline Model A



Baseline Model A funding pool (inpatient services combined)





Baseline model assumptions – acute services

- » Model components for acute services:
 - › APR-DRG version 29 3M national relative weights re-centered to 1.0 for Illinois Medicaid case mix
 - › Statewide standardized base rate of **\$4,349.30**, with labor portion adjusted for 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
 - › No provider or service-related policy adjustors



Baseline model assumptions – specialty services

- » COS 21 - Psychiatric services:
 - › Psychiatric-specific standardized per diem rate of **\$515.94**, adjusted for wage index and rural status
 - › 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)
- » COS 22 - Rehabilitation services:
 - › Rehabilitation-specific standardized per diem rate of **\$319.21**, adjusted for wage index and rural status
 - › Relative weight adjustments for rehabilitation APR-DRGs (4 total classifications)
- » COS 20 - LTAC providers:
 - › LTAC-specific standardized per diem rate of **\$157.44**, adjusted for wage index
 - › Relative weight adjustments by APR-DRG (all classifications)

Inpatient Baseline Model A



Baseline Model Summary - Preliminary

Provider Type	Number of Providers	SFY 2009 Claims	APR-DRG Case Mix	Current System Base Claim Payments	Model A Base Claim Payments	Estimated Payment Change	Estimated Payment Change Percentage
General Acute Providers – Safety Net (w/ DPU's)	19	91,826	0.812	\$275.2	\$336.3	\$61.2	22.2%
General Acute Providers – Other (w/ DPU's)	106	256,930	1.013	\$1,334.4	\$1,294.4	-\$40.1	-3.0%
Freestanding Children's Providers	2	6,388	1.685	\$100.4	\$95.1	-\$5.2	-5.2%
Freestanding Psychiatric Providers	8	8,654	0.674	\$64.3	\$46.9	-\$17.4	-27.1%
Freestanding Rehabilitation Providers	4	1,236	1.878	\$16.9	\$16.0	-\$0.8	-5.0%
LTAC Providers	6	2,677	2.597	\$41.4	\$42.1	\$0.7	1.6%
Critical Access Hospitals	51	5,882	0.684	\$11.5	\$15.3	\$3.8	33.3%
Out-of-State Providers	36	11,957	1.733	\$109.4	\$107.3	-\$2.1	-2.0%
Inpatient Total	232	385,550	1.000	\$1,953.4	\$1,953.4	\$0.0	0.0%



Baseline model A next steps

- » Identify appropriate policy adjustors – could be actual or placeholder
 - › OB/normal newborn
 - › Neonatal
 - › Pediatric
 - › High Medicaid utilization providers

- » Determine need for transitional phase-in

- » Develop model version using SFY 2011 claims, version 30 APR-DRGs and FFY 2013 Medicare factors

- » Adjust payments to reflect impact of SMART Act

Baseline Model A Shadow Pricing





Shadow Pricing Assumptions

- » To test the APR-DRG system, HFS has re-priced 30,086 SFY 2013 FFS claims under Baseline Model A payment rates and methodology
 - › Claims with an admission dates starting July 1, 2012 and discharges dates on or before October 19, 2012

- » SFY 2013 claim reported payments reflect 3.5% SMART Act reductions
 - › For comparison purposes, 3.5% SMART Act reductions applied re-priced APR-DRG payments
 - › Re-priced APR-DRG payments compared to reported claim payments net of DSH, MPA/MHVA and LTAC add-ons



Shadow Pricing Assumptions (continued)

- » SFY 2013 claims were coded by providers for payment under CMS DRGs (providers will not be paid under APR-re-priced payments until SFY 2014)

- » When making neonatal APR-DRG assignments HFS defaulted to the birth weight range indicated by diagnosis code if the birth weight was not reported
 - › Under this approach, there were 25 claims with ungroupable DRG
 - › If birth weight was required, there would have been 5,979 ungroupable DRG cases

Baseline Model A Shadow Pricing



Inpatient Shadow Pricing Summary - Preliminary

Provider Type	Number of Providers	SFY 2013 Claims	APR-DRG Case Mix	Current System Base Claim Payments	Model A System Base Claim Payments	Estimated Payment Change	Estimated Payment Change Percentage
General Acute Providers – Safety Net (w/ DPU's)	19	12,006	0.824	\$34.4	\$43.4	\$9.0	26.3%
General Acute Providers – Other (w/ DPU's)	106	16,017	0.605	\$48.1	\$41.0	-\$7.1	-14.8%
Freestanding Children's Providers	2	626	1.431	\$5.9	\$4.6	-\$1.2	-20.8%
Freestanding Psychiatric Providers	8	136	0.730	\$0.9	\$0.5	-\$0.4	-47.2%
Freestanding Rehabilitation Providers	3	94	1.835	\$0.6	\$0.8	\$0.1	16.7%
LTAC Providers	5	386	1.827	\$2.1	\$2.2	\$0.1	5.3%
Critical Access Hospitals	25	213	0.367	\$0.2	\$0.3	\$0.1	24.7%
Out-of-State Providers	30	608	1.200	\$2.6	\$3.0	\$0.3	12.9%
Inpatient Total	198	30,086	0.740	\$94.9	\$95.8	\$0.9	1.0%

Inpatient Model B With Fully Loaded Rates





Fully Loaded Rate Model assumptions

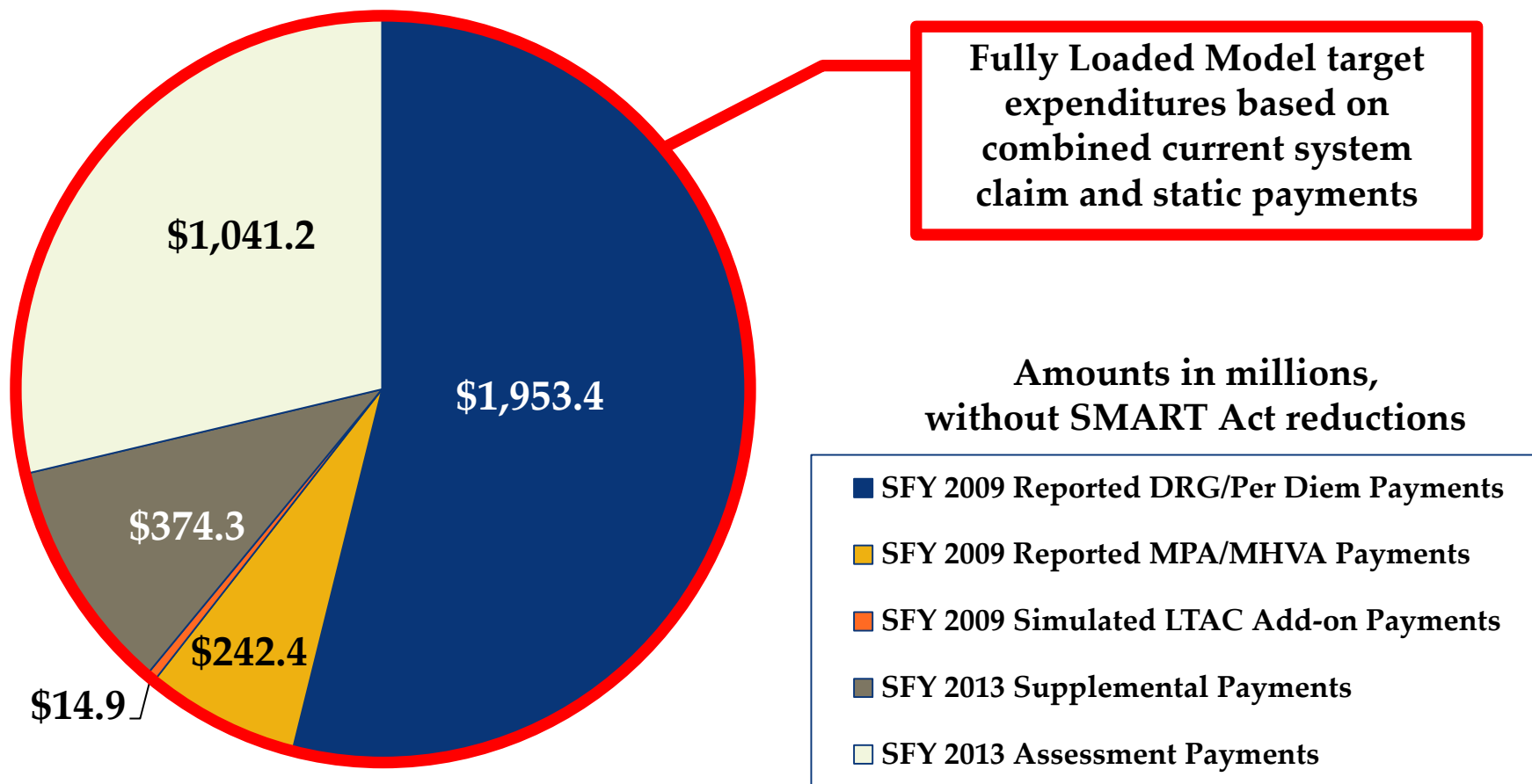
- » To evaluate impact of transitioning all static payments to the APR-DRG grouper, HFS has created an alternative Model B
 - › Model B does not contain policy adjustors and distributes funding based on case mix
 - › For evaluation purposes only – does not represent a recommendation

- » Fully Loaded Model B uses combined SFY 2009 claim-based payments (net of DSH) and SFY 2013 static payments as basis for APR-DRG system funding pool
 - › Payments do not reflect 3.5% SMART Act reductions

Inpatient Model B With Fully Loaded Rates



Fully Loaded Rate Model funding pool



Total inpatient payments: \$3,626.2

Inpatient Model B With Fully Loaded Rates



Fully Loaded Model assumptions – by service

- » Same pricing methodology as Baseline Model
- » Modeled rates are designed to make each category of service budget neutral to combined current system claim payments and allocated static payments
 - › COS 20 – Acute services: standardized DRG base rate of **\$8,712.01**, adjusted for wage index
 - › COS 21 - Psychiatric services: standardized per diem rate of **\$1,179.24**, adjusted for wage index and rural status
 - › COS 22 - Rehabilitation services: standardized per diem rate **\$751.19**, adjusted for wage index and rural status
 - › COS 20 - LTAC providers: standardized per diem payments rate of **\$375.00**, adjusted for wage index

Inpatient Model B With Fully Loaded Rates



Model B Summary - Preliminary

Provider Type	Number of Providers	SFY 2009 Claims	APR-DRG Case Mix	Current System Claim and Static Payments	Model B System Claim Payments	Estimated Payment Change	Estimated Payment Change Percentage
General Acute Providers – Safety Net (w/ DPU)	19	91,826	0.812	\$734.5	\$672.7	-\$61.7	-8.4%
General Acute Providers – Other (w/ DPU)	106	256,930	1.013	\$2,274.0	\$2,357.3	\$83.4	3.7%
Freestanding Children's Providers	2	6,388	1.685	\$178.2	\$134.1	-\$44.1	-24.8%
Freestanding Psychiatric Providers	8	8,654	0.674	\$130.5	\$107.2	-\$23.3	-17.8%
Freestanding Rehabilitation Providers	4	1,236	1.878	\$45.9	\$37.7	-\$8.2	-17.8%
LTAC Providers	6	2,677	2.597	\$97.9	\$100.0	\$2.0	2.1%
Critical Access Hospitals	51	5,882	0.684	\$26.5	\$30.6	\$4.2	15.7%
Out-of-State Providers	36	11,957	1.733	\$138.9	\$186.6	\$47.8	34.4%
Inpatient Total	232	385,550	1.000	\$3,626.2	\$3,626.2	\$0.0	0.0%

Alternative Inpatient Model Update



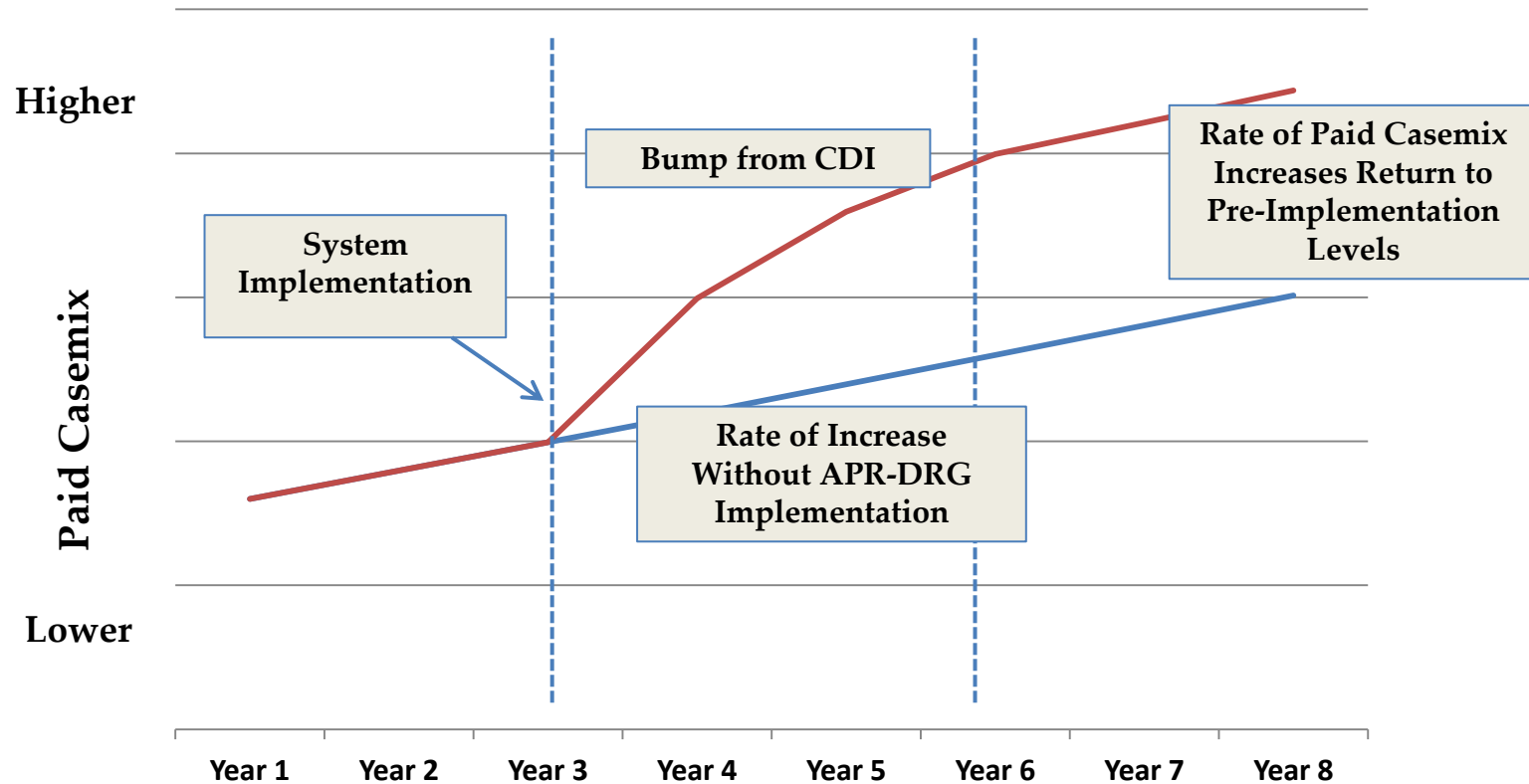
Coding Documentation and Improvement Adjustment



Coding and Documentation Improvement Adjustment



Illustration of Potential Impacts to Paid Casemix from Coding and Documentation Improvement





Why do we need an adjustment?

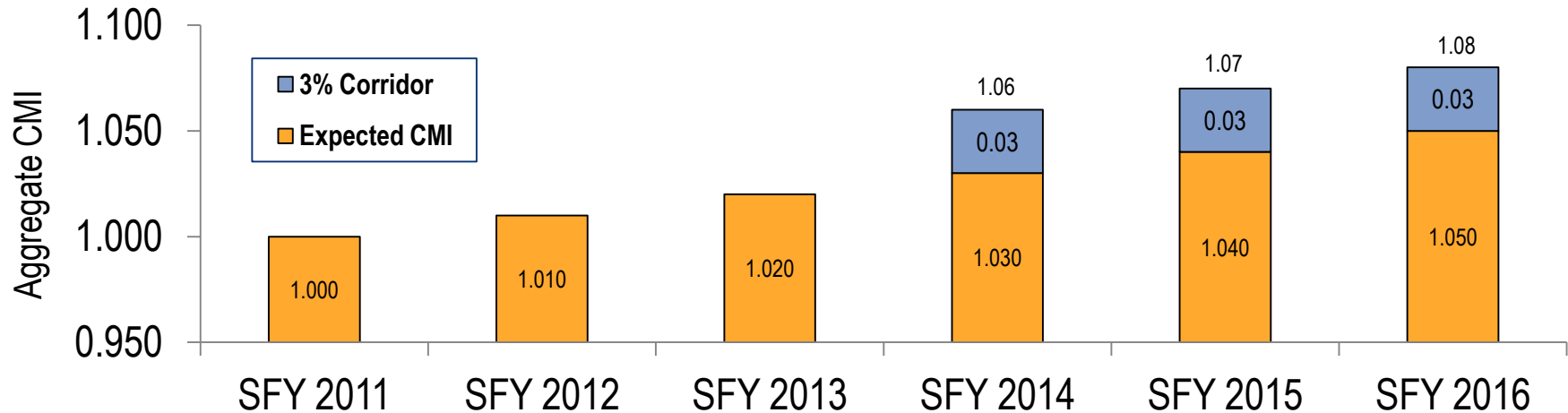
- » Coding and documentation improvements are a necessary and appropriate response by providers to the requirements under the APR-DRG model.
- » Because the same level of coding rigor was not required for payment purposes under the legacy per diem model, we assume that case mix in our simulation models is understated.
- » We expect that case mix will increase in future periods, beyond actual increases in patient acuity.
- » Increases cannot be predicted with precision – and may be significant.



Examples of Actual Case Mix Increases from DRG Grouper Change

- » In October 2007, CMS in its Medicare Inpatient Prospective Payment System (IPPS) replaced its CMS-DRG grouper with the MS-DRG grouper
 - › CMS subsequently estimated that the extent of case mix increase from coding improvements above real case mix for FFY 2008-2009 was **5.8%**
 - › Medicare inpatient Documentation and Coding Adjustment preemptively reduces rates; **2.0%** FFY 2012 and **1.9%** in FFY 2013
- » In July 2010, the Pennsylvania Department of Public Welfare (DPW) in its Medicaid IPPS replaced its CMS-DRG grouper with the APR-DRG grouper
 - › DPW subsequently estimated that total case mix increases for SFY 2011 was **12.1%**

Coding and Documentation Improvement Adjustment



Example Adjustment Parameters

1. State adjusts rates for SFY 2014 to reflect 3% reduction in Relative Weights/Casemix
2. Analyze first year under APR-DRGs. If actual CMI in SFY 2014 is less than “expected”, State adjusts rates upward in following year to compensate for 3% reduction.
3. If actual CMI in SFY 2014 is greater than “expected”, but falls within the “corridor”, State adjusts rates upward in the following year to compensate for amount of 3% reduction not used up by casemix increases.
4. If actual CMI in SFY 2014 is greater than combined “expected” and “corridor”, State adjusts rates in the following year downward to compensate for additional cost to the state resulting from casemix increases.
5. State can make similar adjustments for SFY 2015 and subsequent years, if necessary.

Transition Period





Example Transition 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

