

Illinois Hospital Rate Reform Questions and Answers Updated: February 29, 2012

QUESTION: Can the Department model a disproportionate share payment directly into its simulations? I think the sooner this is done the better as, otherwise, certain payment levels portrayed in handouts will be artificially high and provide for unrealistic expectations.

ANSWER: It is HFS' intent to keep federally-defined disproportionate share hospital (DSH) adjustment payments separate from payments to be made under the new IPPS. However, it is the department's intention to include a class of DSH-like payments (currently made as Medicaid percentage adjustment (MPA) and Medicaid high volume adjustment (MHVA)) into the reimbursement structure.

QUESTION: I fully understand the Department's attempt to minimize taxpayer risk associated with this complicated re-design and, thus, it's desire to implement a 5% set aside. However, as noted yesterday, it would seem using historical data to model for "expected" CMI might provide a misleading result in these case as this new, dynamic model will bear little resemblance to its predecessor. Specifically, if we expect a movement of inpatient services to the outpatient setting, can we correct for that in establishing the "expected" CMI? For instance, if, after implementation of this new system, 10% of inpatient services are expected to migrate to the outpatient setting, can the Department assume these particular services were in the bottom quartile (or bottom half if need be) of your modeling data set and adjust the "expected" CMI accordingly?

ANSWER: HFS does not expect that rebalancing payments between inpatient and outpatient hospital settings will have a significant impact on whether patients are cared for in an inpatient or outpatient setting. It is HFS' expectation that providers (physicians and hospitals) are making decisions regarding inpatient or outpatient service settings based on a patient's clinical and social needs – and not based on how much they will be paid.

Further, given that approximately 42 percent of current payments are now made in some form of static supplemental or assessment payment, HFS believes that moving a significant portion of those static dollars into both inpatient and outpatient claims-based payments will have the effect of increasing claim-based payments on both sides, thereby mitigating potentially adverse incentives that may have existed historically.

QUESTION: Can the Department model a simulation where all targeted supplemental payments and all hospital assessment payments remain in their current form?

ANSWER: It is HFS' intent to incorporate all or a significant portion of the static supplemental payments into the new IPPS model. At this time, HFS does not intend to prepare payment simulation models with all static supplemental payments excluded.

QUESTION: Will there be a separate capital payment or will that all be part of the base rate?

ANSWER: At this point, we are not recommending a separate capital payment amount. Funding associated with historical capital-related payments will be incorporated into the total funding pool for purposes of establishing DRG base rates, and as such, the resulting DRG base rates will be inclusive of both operating and capital components.

CONCERN: LTACHs have a significant number of Medicare exhaust claims. This can be tricky with a DRG but no issue with a per diem. We recommend to start the Medicaid APR-DRG calculation at the time Medicaid becomes prime to prevent complication between the two.

RESPONSE: Currently, if their Medicare Part A benefits exhaust during an inpatient claim, we require the hospital to bill two claims for the inpatient stay. One Medicare claim and one Medicaid claim. The Medicaid claim requires a manual override and must be submitted to the billing consultant.

QUESTION: Will non-cost reporting hospitals remain a flat per diem and at the same rate? We shouldn't shift any money to non-cost reporting hospitals. I assume they are not in the calculations. Could HFS confirm?

ANSWER: Non-cost reporting hospitals are excluded from the current design process, and payments associated with non-cost reporting hospitals are currently not considered in the funding pool for purposes of designing the new IPPS. However, HFS has yet to determine if they will be subject to payment under the new IPPS.

QUESTION: Navigant create a comparison of 2009 transplants by type showing 2009 payments and estimated payments under 1,2,3 from Jan 18th scenarios?

ANSWER: HFS intends to analyze the fiscal impacts on transplant services as part of the IPPS design process. HFS understands that transplants are high cost specialty services, and the need to maintain access to these services for Medicaid beneficiaries.

CONCERN: Since our reform efforts address a reimbursement methodology for all psychiatric providers and a reimbursement methodology for all rehabilitation providers, we suggest any related data be reported in a consolidated manner for all psychiatric providers and a consolidated manner for all rehabilitation providers. Data related to psychiatric units and rehabilitation units should not be consolidated with general acute care hospital data, but should be consolidated with data for free-standing psychiatric providers and free-standing rehabilitation providers accordingly.

RESPONSE: The Department believes that the costs associated with psychiatric and rehabilitation providers can vary significantly depending on whether or not they are a freestanding facility, or a distinct part unit within a hospital that is not a freestanding psychiatric or rehabilitation facility. As such, the Department prefers to show these types of providers separately.

CONCERN: We have found that 80% or more of the Medicare cases are coded to one DRG for psychosis. We suggest HFS determine if a similar correlation will be found under the APR-DRG system. If so, we suggest that any impact of coding issues under APR-DRGs for psychiatric services does not warrant a case-mix set-aside for psychiatric, as payments would not be materially impacted by case-mix changes.

RESPONSE: The Department agrees that the potential for increases in case mix may be less significant for certain provider types, such as psychiatric providers. As such, when developing the transitional strategy for coding and documentation improvements, the Department will consider these differences, and consider establishing a policy that will monitor and adjust payments separately for such provider types.

CONCERN: Psychiatric providers are predominantly a provider of inpatient services and do not have the outpatient business to shift funds too. For psychiatric providers, such a shift of funds results in a material reduction in reimbursement and not a rebalancing of reimbursement. Psychiatric providers should be exempt from any rebalancing of funds from inpatient to outpatient services.

RESPONSE: It is the Departments objective to direct payments to make them more balanced relative to the estimated costs of the services. This may impact providers differently, increasing payments to some and decreasing payments to others. As such, it will not be possible for the Department to maintain current payment levels for all providers.

QUESTION: There are some static payments scheduled to sunset as of 6/30/2012. If those payments have been placed into the analysis for rate reform as of 2013 is there action being pursued by HFS to continue those payments beyond the sunset date?

ANSWER: It is HFS' intent to establish rates under the new IPPS at the same funding levels that were in place for inpatient and outpatient hospital services in SFY 2011. To the extent that supplemental payments that are designated to sunset in 2013 are part of the funding in SFY 2011, they will be a part of the aggregate pool of funding to be used to establish the new reimbursement methodologies.

CONCERN: My understanding from earlier meetings was that any policy adjusters would occur at the end of the rate reform analysis not in the middle. The rationale for the adjusters at the January 18 meeting was that these (OB, neonate and peds) were key services to the Medicaid program and that it was important that those services be at a reasonable percent of cost. There are other services that are just as important (such as psych) on a regional level in terms of access that are not "policy adjusted". It is very difficult to assess the impact of the proposed rate reform on a market or individual institutional level until all of the pieces have been put in place (inpatient, outpatient, etc..). Until there is an understanding of the proposed payment system versus the legacy payment system, in total, we should not be introducing policy adjusters.

RESPONSE: It is HFS' intention to be transparent in the new IPPS design phase. As such, it was HFS' intent to share with the TAG the analytical results of the payment simulation modeling as it stood as of January 18th. The analysis shared at that meeting also included results by type of hospital using a number of hospital groupings to give members of the TAG the same information that HFS had at that time for purposes of evaluating the potential impacts of all policy adjustors, and at the same time, explained to the TAG that, based on the results shared at that meeting, that it would be necessary to look at additional policy adjustors. Specifically, HFS said that it was it had yet to analyze and consider other adjustor, and that the evaluation of potential policy adjustors would be ongoing. Also note that at the October 28th meeting, we shared similar results without the effect of any policy adjustors.

Regarding psychiatric services, while no final decision has yet been made, it is HFS' current intent to "balance" payments to psychiatric services in the same way as other major categories of service (rehabilitation and general acute) based on estimated costs. HFS will also consider policy adjustments within the psychiatric category.

We appreciate your comment – HFS is committed to a transparent process, and also believes that in order to benefit from the TAG process, it is best to share as much information as possible with the TAG, even if that analysis is preliminary.

CONCERN: While we are on the subject of policy adjustors, there should be consideration beyond the MHVA adjustment for key services in markets (both inpatient and outpatient) that are provided. In my circumstance psych and chemotherapy come to mind. We provide the chemo for virtually all the Medicaid population in our region. That is very expensive and perhaps there should be a policy adjuster for key outpatient services as well.

RESPONSE: As described above, HFS is considering other policy adjustors. As part of that process, HFS will consider psychiatric and chemotherapy services as part of that process.

CONCERN: I am very concerned about the slide on Page 21 because the payment reform being proposed does not recognize the significant burden of uninsured that the safety net hospitals bear. If the proposed payment system is implemented on 7/13 there will still be a significant number of uninsured for a period of time before the impact of the ACA is fully realized and to see the reduction in Pay to Cost that high Medicaid hospitals would incur is very concerning.

RESPONSE: HFS appreciates your concerns. It is HFS' intent to evaluate a number of potential policy adjustors as part of the design process. High uninsured volume and safety net characteristics will be included as part of those considerations. It is HFS' intent to provide federally-defined disproportionate share hospital (DSH) adjustment payments separate from payments to be made under the new IPPS. However, it is the department's intention to include a class of DSH-like payments (currently made as Medicaid percentage adjustment (MPA) and Medicaid high volume adjustment (MHVA)) into the reimbursement structure.