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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 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
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
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
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
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
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
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
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 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:

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>SFY 2011 Claims Data Reported Payments</th>
<th>Revised Model Rates Applied to SFY 2011 Claims Data</th>
<th>Estimated Payment Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DRG/Per Diem Payments</td>
<td>Outlier Payments (Net of DSH/MPA)</td>
<td>DRG/Per Diem Payments</td>
</tr>
<tr>
<td>Acute COS 20 Services</td>
<td>$1,261.2</td>
<td>$610.4</td>
<td>$1,543.2</td>
</tr>
<tr>
<td>Psychiatric COS 21 Services</td>
<td>$160.9</td>
<td>$0.0</td>
<td>$153.4</td>
</tr>
<tr>
<td>Rehabilitation COS 22 Services</td>
<td>$31.2</td>
<td>$0.1</td>
<td>$30.7</td>
</tr>
<tr>
<td>LTAC COS 20 Services</td>
<td>$46.1</td>
<td>$6.5</td>
<td>$37.3</td>
</tr>
<tr>
<td>Inpatient Total</td>
<td>$1,499.3</td>
<td>$617.0</td>
<td>$1,764.5</td>
</tr>
</tbody>
</table>
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
“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):

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

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

<table>
<thead>
<tr>
<th>LTAC Provider</th>
<th>LTAC Provider Estimated SFY 2013 Cost Per Day (Without Assessment Cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,215.06</td>
</tr>
<tr>
<td>2</td>
<td>$1,314.28</td>
</tr>
<tr>
<td>3</td>
<td>$1,405.08</td>
</tr>
<tr>
<td>4</td>
<td>$1,698.18</td>
</tr>
<tr>
<td>5</td>
<td>$2,034.24</td>
</tr>
<tr>
<td>6</td>
<td>$2,162.64</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td><strong>$1,309.28</strong></td>
</tr>
</tbody>
</table>
Alternative Inpatient Model Update
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