The Illinois Hospital Provider Community
&
The Illinois Medicaid Program

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

A Partnership For Reimbursement Reform

March 28, 2010

Past, Present & Future

Where are we now?

General Statistics

(Dates of service)

- 256 cost reporting providers
  - 184 General Acute Care Providers
  - 15 Children's Specialty Providers
  - 9 Psych Specialty Providers
  - 5 Rehab Specialty Providers
  - 4 Long Term Acute Care Providers
  - 39 Out of State providers

- 403,400 Average Annual Hospital Admissions
  - 407,000 -> 2010*
  - 407,700 -> 2009
  - 398,200 -> 2008
  - 400,700 -> 2007

- 1,862,425 Average Annual Hospital Days of Care
  - 1,866,700 -> 2010 *
  - 1,894,500 -> 2009
  - 1,847,700 -> 2008
  - 1,840,800 -> 2007

- 2,706,625 Average Annual Hospital Based Outpatient Encounters
  - 2,997,500 -> 2010*
  - 2,763,000 -> 2009
  - 2,582,000 -> 2008
  - 2,484,000 -> 2007

*Represents services, billed and received by the department at this time
Data excludes all Medicare / Medicaid Duals, and MCO encounter services

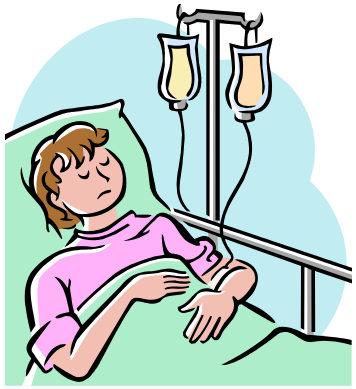
IS IT A CLASSIC ?

OR A CLUNKER ?

NEEDS CONSTANT CARE, PARTS REPLACED & EXPENSIVE TO DRIVE

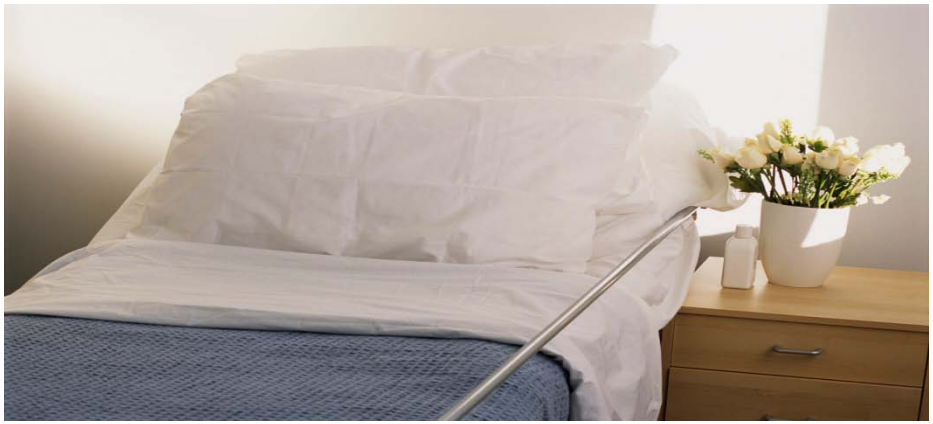
IT'S ALL IN YOUR...

PERSPECTIVE



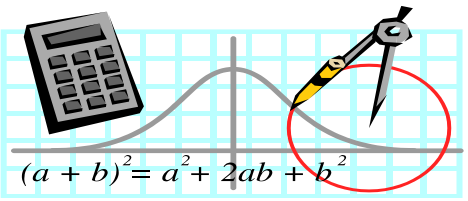
INPATIENT

- CURRENT SYSTEM -



Two Methods of Reimbursing Hospitals for Inpatient Services

- Reimbursement generally only after a patient is discharged from an inpatient setting
  - Diagnosis related groups (DRGs)
    - Diagnoses are grouped into major diagnostic categories
    - The more severe or labor intensive the diagnosis group, the higher the payment
    - Hospitals are reimbursed a fixed payment per stay
  - Per Diem
    - Hospitals reimbursed on a per diem basis receive a fixed payment for each day of inpatient service provided, regardless of diagnosis



How Does a DRG System Work?

- Basic principle: single base rate, with adjustment for geography
- Adjust base rate for the severity of care
- Payment made per occurrence (discharge), not on the length of stay (per diem)
- Intended to address the intensity of an average inpatient stay

History of the Current DRG System

- Sept 1, 1991: Establishment of an inpatient hospital reimbursement system based on Medicare's DRG Prospective Payment system (DRG-PPS), Medicare's weights and rates

- Rates were adjusted on Oct. 1, 1992

- In 1995, legislative freeze on hospital rate updates; all rates and weights in effect on June 30, 1995 remained in effect thereafter

- The base reimbursement system has remained unchanged since that time, with the exception of modifications for growth in outlier rates

Example of a DRG-PPS Priced Claim

• Hospital Specific Base Rate	$4,021.70
• DRG Assigned 321 – Relative Weight (Kidney and Urinary Tract Infection > 17, w/o Complications)	X 0.3747
• Relative Weight Adjusted Hospital Specific Final DRG Base Rate	$1,506.93
• Add Capital	+ $400.00
• **Total**	**$1,906.93**

Current System – Adjustments and Add-Ons

- Disproportionate Share Adjustments, Medicaid Percentage Adjustments & Medicaid High Volume Adjustments
  - Annually determined and rebased
  - Paid for each day of stay

- Outlier payments – recognizing those cases that significantly exceed norms
  - Current charges are multiplied by the 1989/1990 charge ratio
  - Supplemental payments and add-ons are not taken into account

Outlier calculation comparison:

Current CCRs to outdated CCRs

Example for discussion purposes

Data component	Values	*Notes*
Charges Submitted on the claim	$500,000	
		Avg. 1989 / 90 CCR
Hospital Cost to Charge Ratio	0.70	*(Unchanged since 1995)*
Calculated Cost of Care (Frozen CCRs)	$350,000	
Resulting Outlier Payment	$248,000	
Current Charge Ratio	0.35	*2008 Cost Reports (Avg.)*
Calculated Cost of Care (Current CCRs)	$175,000	
Resulting Outlier Payment	$108,000	
Difference	**$140,000**	

No add-ons are included in outlier calculation

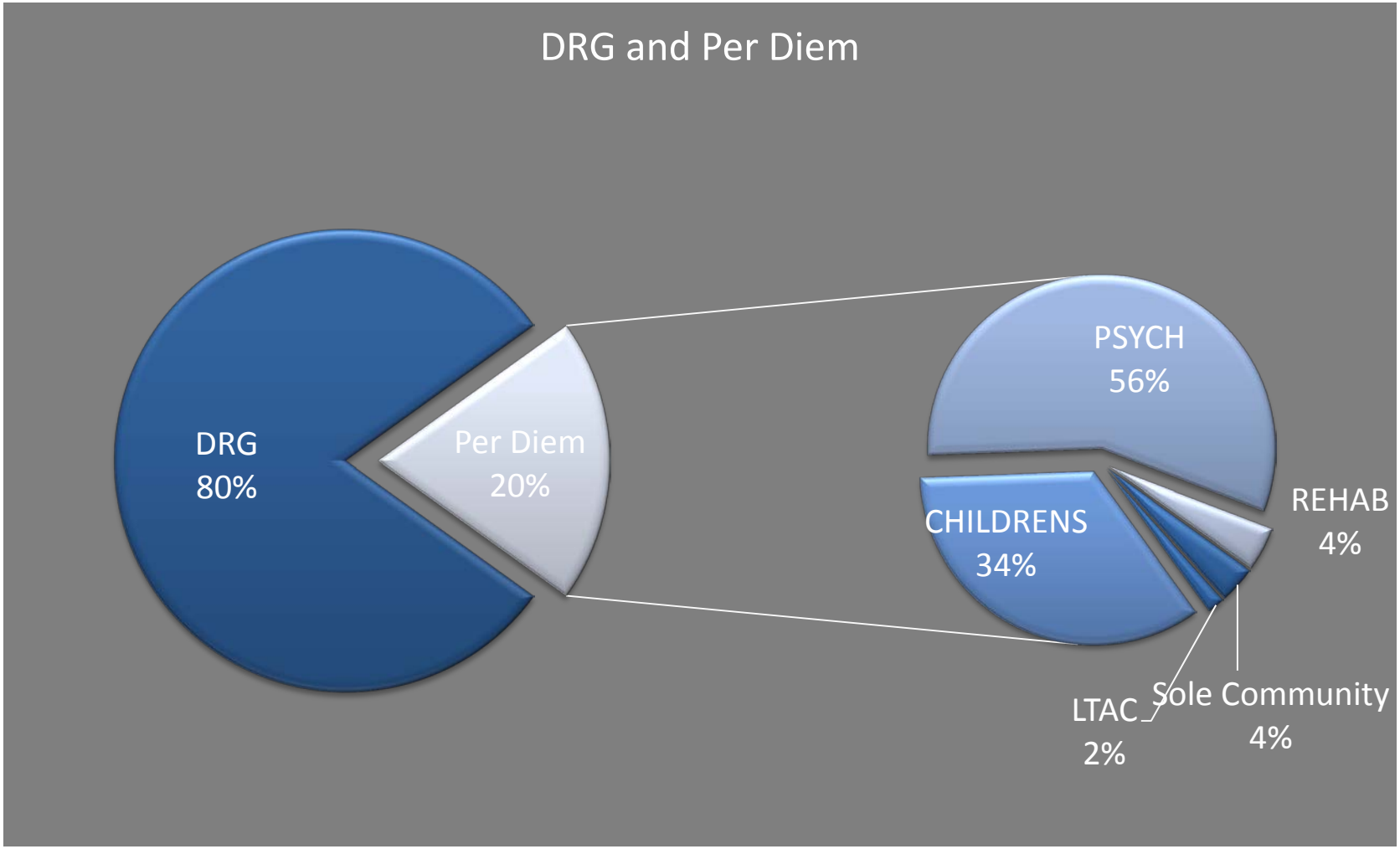
PER DIEM RATES

Current Per Diem Reimbursement

- Certain hospitals and specialty care services are reimbursed on a per diem basis, instead of DRG
  - Psychiatric, rehabilitation, pediatric specialty care (children's hospitals)
  - General acute care providers with an average length of stay greater than 25 days (Long Term Acute Care Hospitals – LTACHs)
  - Sole community providers
- Per diem rates are based on cost reports from 1989 & 1990, adjusted forward

Inpatient Admissions Breakdown

5 year average



Shortcomings of Current Inpatient Reimbursement System

- DRG system is out of date in terms of its reflection of service intensity
- DRGs based on Medicare population, rather than services more closely aligned with Medicaid population
- Per diem rates do not encourage efficient inpatient stays, nor reflect the complexity of care

At this point,
we've only covered
46% of the total
reimbursement

OUTPATIENT

Hospital Based Outpatient Services

- Last revised in 1998

- The hospital community and the department worked together to analyze and create the current Ambulatory Procedures Listing (APL) methodology

- These are bundled payment rates for such services as surgery, diagnosis, emergency room, psychiatric care, and others

Shortcomings of Current Outpatient Reimbursement System

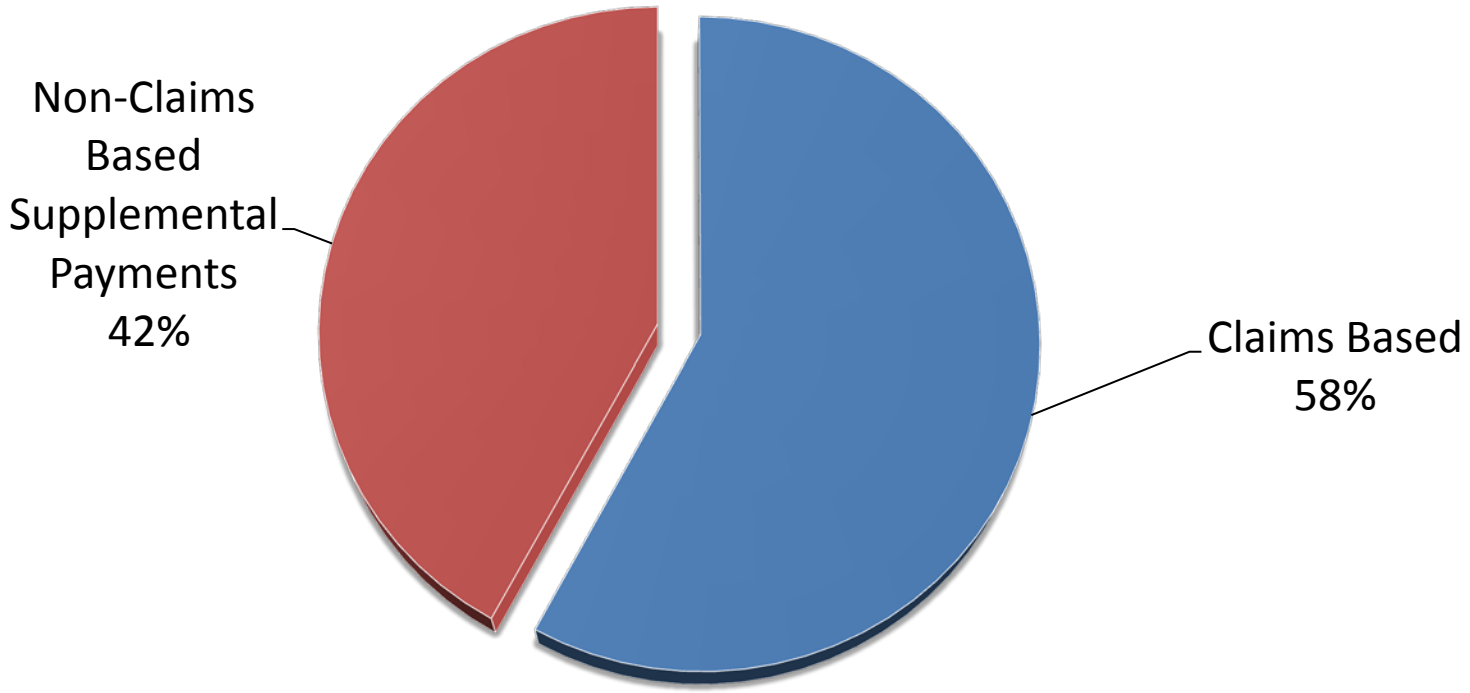
- Current outpatient policies do not provide incentives for appropriate levels of use of the outpatient setting

- Likely to incentivize short-term inpatient admissions over using the outpatient setting

That was another 12% of the total reimbursement

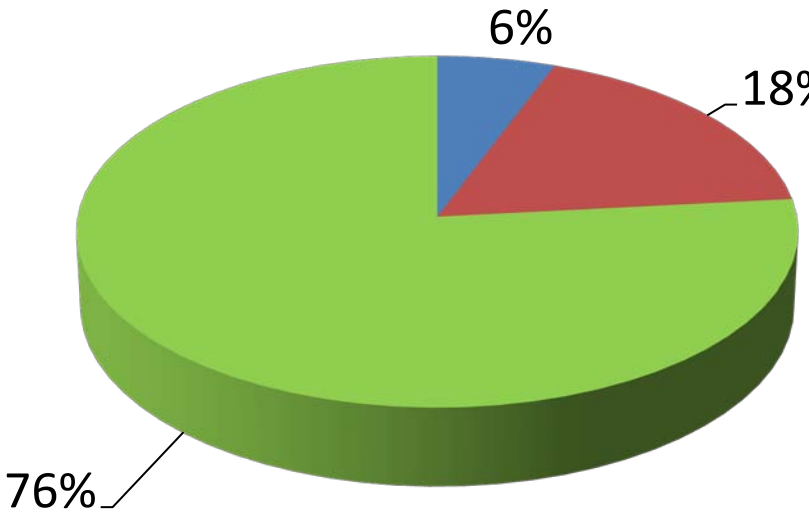
Only 58% of reimbursement is claims based

Hospital Reimbursement Distribution



NON-CLAIMS-BASED SUPPLEMENTALS

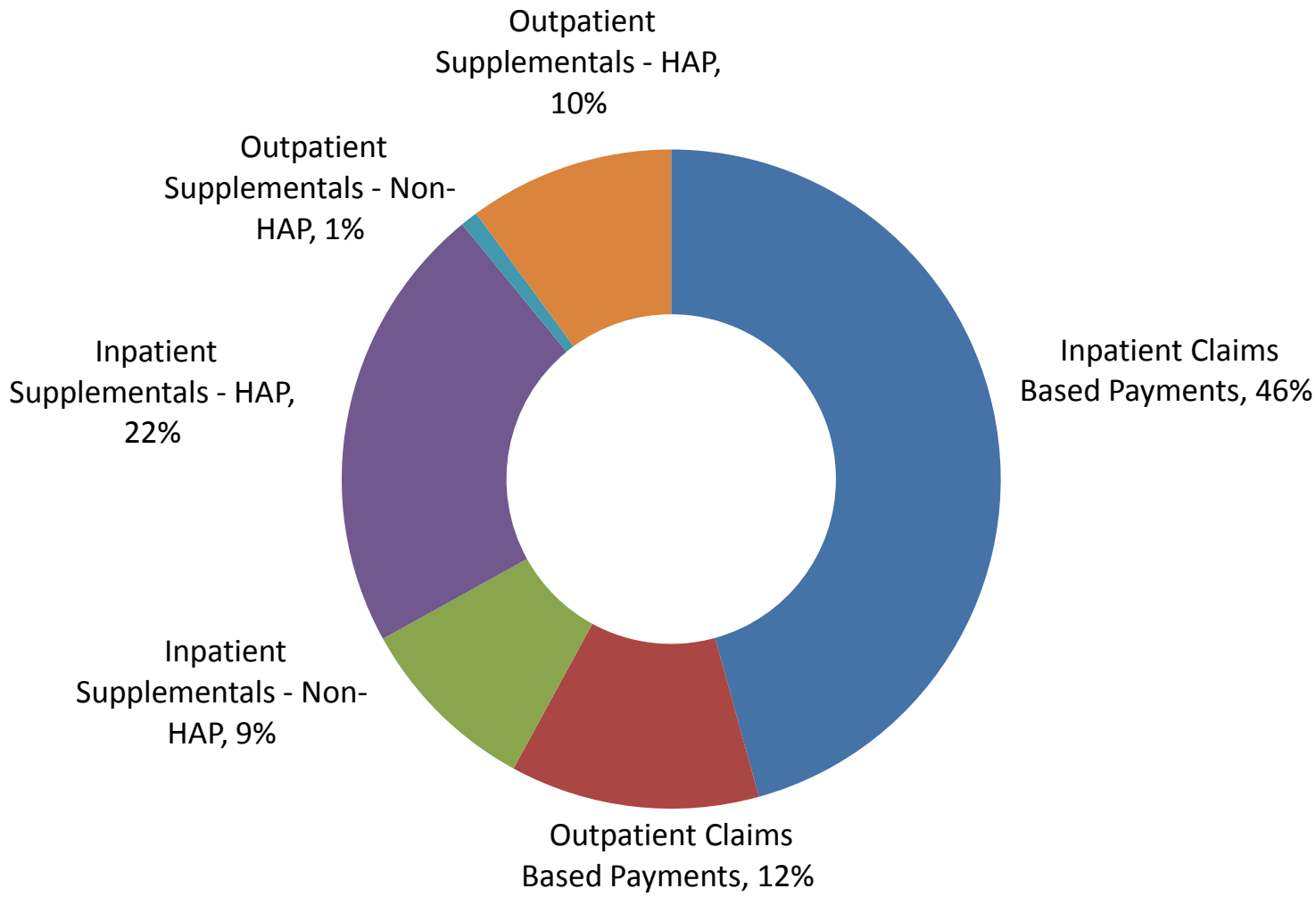
Hospital Supplemental Reimbursement



NOT VERY DYNAMIC

		Millions	% of Total
Annually Updated	$	112.85	5.7%
Static Non-Assessment Funded	$	347.43	17.6%
Static Assessment-Funded	$	1,509.38	76.6%
Total Supplementals	**$**	**1,969.66**	**100.0%**

Hospital Reimbursement Distribution In Detail



Shortcomings of Static Payments

- Reflect historical, not current, service levels
- Do not address changes in service needs
- Do not incentivize performance
- Increasingly out of line with federal payment approaches

Non-Claims Paid Static Payments

	Providers Qualified	Program Total Pay Amount	HAP Amount	Total Supplemental	Average Per Hospital	Re-Determine?
Total Of Supplemental (2011 Level)	**221**	**$460,282**	**$1,509,376**	**$1,969,658**	**$8,912**	
		Outpatient Payments				
Outpatient Assistance Adjustment Payments - (OAAP)	14	$23,063	$19,040	$42,102	$3,007	Frozen SFY 2005
Pediatric Outpatient Adjustment Payments - (POAP)	7	$19,937	$0	$19,937	$2,848	Frozen SFY 1996
Hospital Assessment APL Across The boards (Outpatient)			*See values below*			
		Inpatient Payments				
Rural Adjustment Payments - (RAP)	53	$7,000	$0	$7,000	$132	Annual Update
Psychiatric Adjustment Payments - (PAP)	6	$4,354	$0	$4,354	$726	Frozen SFY 2001
Tertiary Care Payment	137	$33,231	$0	$33,231	$243	Frozen CY 1998
Pediatric Inpatient Adjustment Payments - (PIAP)	15	$10,798	$0	$10,798	$720	Frozen SFY 1996
Critical Hospital Adjustment Payments (CHAP)	**144**	**$228,240**	**$379**	**$228,619**	**$1,588**	**Mixed**
Trauma Center Adjustment	*36*	$41,235	$0	$41,235	*$1,145*	*Annual Update*
Rehab Hosp Adj	*4*	$11,522	$0	$11,522	*$2,881*	*Annual Update*
Direct Hosp Adj	*30*	$159,606	$379	$159,985	*$5,333*	*Frozen 1998*
Rural Chap	*88*	$15,877	$0	$15,877	*$180*	*Annual Update*
Safety Net Adjustment Payments (SNAP)	123	$96,441	$6,704	$103,146	$839	SFY 2000
County Trauma Center Adjustment	64	$9,619	$0	$9,619	$150	Annual Update
Excellence In Academic Medicine (EAM)	11	$27,600	$0	$27,600	$2,509	Annual Update
Hospital Access Payments	213		$1,483,253	$1,483,253	$6,964	Frozen SFY 2005
High volume (Inpatient)	*14*		*$52,790*	*$52,790*	*$3,771*	
Across the Board (Inpatient)	*230*		*$404,200*	*$404,200*	*$1,757*	
Capital (Inpatient)	*95*		*$114,313*	*$114,313*	*$1,203*	
Obstetrical Care (Inpatient)	*110*		*$140,352*	*$140,352*	*$1,276*	
Trauma Care (Inpatient)	*93*		*$242,615*	*$242,615*	*$2,609*	
Tertiary Care Enhancement (Inpatient)	*120*		*$29,824*	*$29,824*	*$249*	
Medicare Crossovers (Inpatient)	*8*		*$8,796*	*$8,796*	*$1,100*	
Magnet Hospital (Inpatient)	*11*		*$40,775*	*$40,775*	*$3,707*	
APL Across The boards (Outpatient)	*204*		*$449,588*	*$449,588*	*$2,204*	

It hasn't moved (been updated) for a while !

So When Does a Classic Become a Clunker?

1965 Mustang

In 1965 the price of

Dozen Eggs	**-**	**$0.53**
Gallon of Milk	**-**	**$0.95**
Gallon of Gas	**-**	**$0.31**
Miles per Gallon	**-**	**12- 15**

Prices Today

Dozen Eggs	**-**	**$1.25**
Gallon of Milk	**-**	**$2.89**
Gallon of Gas	**-**	**$3.89 or higher**
Miles per Gallon	**-**	**12-15**

Comfortable but inefficient and non-responsive

IT MAY BE TIME TO TRADE-IN THE CLASSIC CLUNKER !

THE GOAL FOR THE FUTURE !

EFFICIENCY AND SERVICE

Hospital Upper Payment Limits - Impact

- P.A. 096-1501 (Medicaid reform law) requires that by January 1, 2015, at least 50 percent of Medicaid beneficiaries must be participating in a risk-based care coordination program

- Federal law under Title XIX establishes the maximum level of reimbursement for hospitals, expressed as the Upper Payment Limit (UPL)

- The UPL calculation applies to payments paid directly to hospitals by the State, not to payments made by coordinated care entities

- Illinois' payment structure needs to be revised to ensure that all State payments to hospitals are under the UPL ceiling and matched by the federal government

Overall System Shortcomings - Review

- Based on old data
- DRGs are based on a non-Medicaid population
- Over-emphasis on inpatient services versus outpatient services
- Does not adequately address service acuity
- Does not pay for performance or value
- Not responsive to advances in medical technology and healthcare delivery models
- Current coding grouper not compatible with ICD-10 (Eff. 10-2013)

Changing State Environment

- Movement to coordinated care
- Focus on providing appropriate care and setting to clients, at the right time
- Greater emphasis on accountability, including risk element to payment
- Budgeting for results requires better measurement and benchmarks
- Focus on more efficient care to high-cost clients
- Better coordination of care across all provider types

Changing Federal Environment

- Federal partners raising concerns about the efficiency of Illinois' current rate system
- Federal health care reform advocating reimbursement approaches that emphasize value-based healthcare purchasing
- Increased emphasis on electronic records and meaningful use data
- Increased focus on accountability

Moving toward a system that aligns payments with services and outcomes


The Proposed
Principles of a New
System

Proposed Principles for Rate Reform

- **Transparent:** Easy to understand for payer (state), provider (hospital) and public
- **Promoting Quality:** Promotes high value, quality-driven healthcare services
- **Compliant:** Is compliant with federal regulations
- **Dynamic:** Adaptable to the changing healthcare landscape, utilization changes and updated regularly

Proposed Principles for Rate Reform (cont..)

- **Service-Based:** Payments are tied to the services provided
- **Efficient:** Encourages care in the appropriate setting
- **Responsive:** Supports state and federal policy priorities
- **Acuity-Sensitive:** Aligns reimbursement with care provided

Timing issues to consider

- October 1, 2013 – ICD-10
  - The current Medicare based DRG system will not support the use of ICD-10 coding

- January 1, 2014
  - Affordable Care Act mandate new populations

- January 1, 2015
  - P.A. 96-1501: at least 50% of recipients in a risk- based coordination of care program – or more

Where do we go from here?

An estimated time line for implementation:

• March 28, 2011	Kick-off meeting with provider community
• April 29, 2011	Second large group meeting, with expert panel discussion
• Spring/Summer 2011	Technical advisory group discussions
• Fall 2011	Load new system in test mode and begin “shadow period”

The next meeting is scheduled for:

- Friday, April 29th, 2011
- Chicago/Springfield Locations:

  To Be Announced
- Time : 1:00 – 3:00pm

THANK YOU FOR YOUR ATTENDANCE & PARTICIPATION

Questions or Comments

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