Illinois Department of Healthcare and Family Services

Inpatient and Outpatient Payment Reform

Project Overview and Design Framework

April 29, 2011

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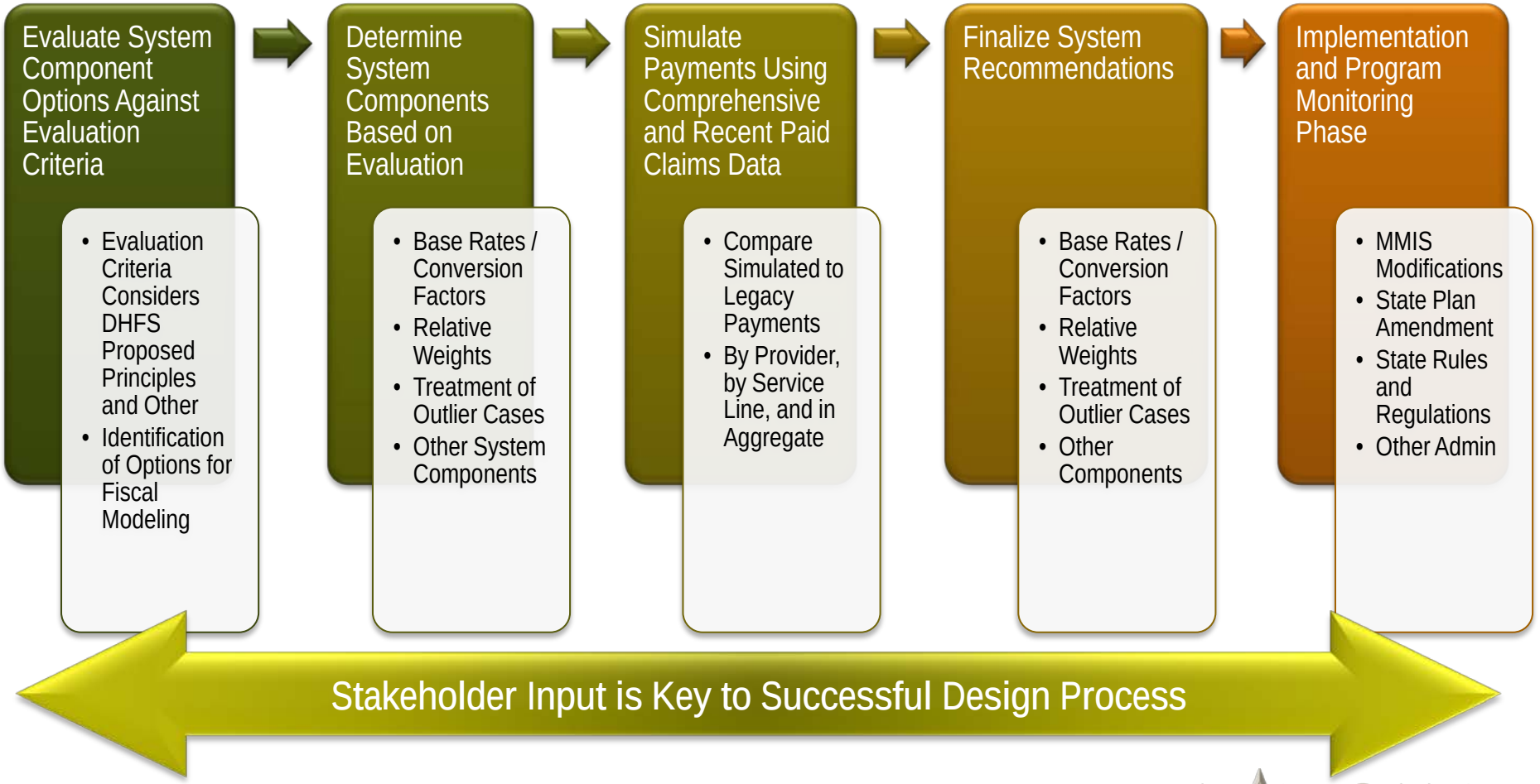
Project Overview

Overview of Design Framework



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Evaluation of Options – Evaluation Criteria

Baseline Evaluation Criteria

- Based on HFS Proposed Principles
- Additional Granularity to Broader Criteria
  - ➢ Payment Predictability
  - ➢ Facilitate Updates
  - ➢ Consistency with Maintaining Standards of Access to Quality Services

Consideration of Forward Compatibility

- Future Integrated Care Models
- Future Enhancements to Bundling
- Value-based Purchasing, Payment for Quality Outcomes
- Shared Savings Models
- Identification of Potentially Preventable Readmissions and Complications

Federal Requirements

- Anticipated Regulations Defining Section 30(A) Standards
- Upper Payment Limits
- DSH Payment Limits
- Other

Baseline Assumptions for Conceptual Design

- Fully Prospective Basis – No Cost Settlement
  - ➢ Maximize Use of Per Case or Per Discharge Payment Method - Consider Use of Per Diems or Other Methods Only if Per Discharge Payment Results in Unacceptable Predictability
  - ➢ Per Procedure Level for Outpatient Services, When Possible, with Packaging or Bundling
- Solutions Must Be Forward Compatible with Anticipated Direction of Healthcare Reform

Baseline Assumptions for Conceptual Design

- Appropriate Balance Between Inpatient and Outpatient Services
  - ➢ Avoid Creating Incentives for Payment Levels to Inappropriately Influence Place of Service - Correct Service in the Correct Setting
- Maintain Opportunities for Federal Participation in Program Funding
- Consistency with Sound Payment Principles - Medicaid ≠ Medicare (But We Can Learn from Medicare's Experience)
- Assume Constant Funding Levels for Conceptual Design Process

Inpatient Payment Reform - Design Considerations and Options

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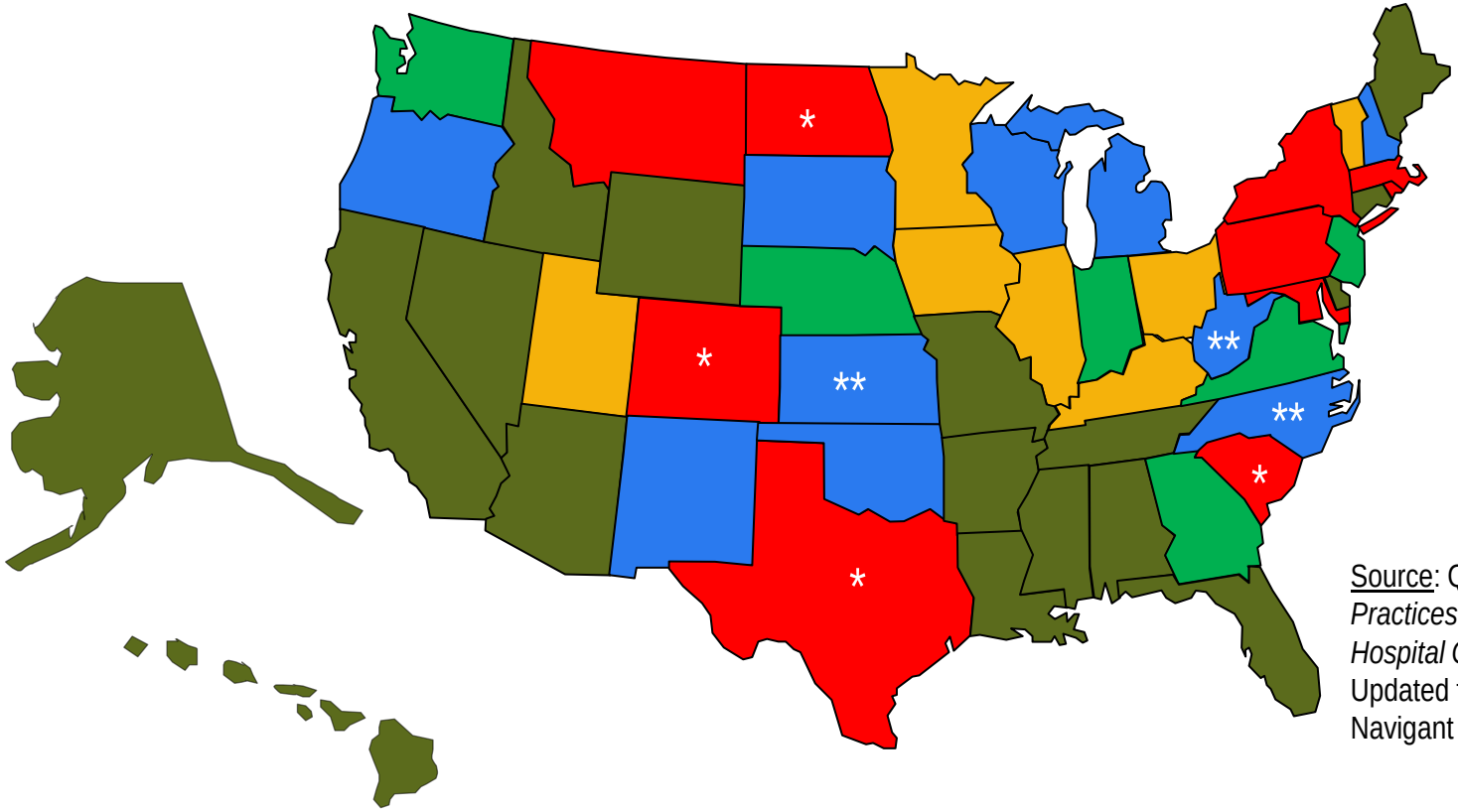
Inpatient Payment Models

What Are Other State Medicaid Programs Doing?

- APR-DRGs (* Indicates Moving To)
- MS-DRGs (** Indicates Moving To)
- CMS DRGs
- AP or Tricare DRGs
- Other Per Stay/Per Diem/Cost Reimbursement/Other



Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010, Updated for Information Obtained by Navigant and CHCS.

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Inpatient Options – DRG Algorithms, or "Groupers"

Description	MS-DRGs V.28 (CMS - Maintained by 3M)	APR-DRGs V.28 (3M and NACHRI)	APS-DRGs V.28 (Ingenix)
Intended Population	Medicare (age 65+ or under age 65 with disability)	All patient (based on the Nationwide Inpatient Sample)	All patient (based on the Nationwide Inpatient Sample)
Overall approach and treatment of complications and comorbidities (CCs)	Intended for use in Medicare Population. Includes 335 base DRGs, initially separated by severity into "no CC", "with CC" or "with major CC". Low volume DRGs were then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. The is no CC or major CC list; instead, severity depends on the number and interaction of CCs.	Structure based on MS-DRGs but adapted to be suitable for an all-patient population. Includes 407 base DRGs, each with three severity levels. Same CC and major CC list as MS-DRGs.
Number of DRGs	746	1,258	1,223
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four levels of severity (total 112)	9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)

Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010.

Inpatient Options – DRG Algorithms, or "Groupers"

Description	MS-DRGs V.28 (CMS - Maintained by 3M)	APR-DRGs V.28 (3M and NACHRI)	APS-DRGs V.28 (Ingenix)
Psychiatric DRGs	9 DRGs; most stays group to "psychoses"	24 DRGs, each with four levels of severity (total 96)	10 base DRGs, each with three levels of severity (total 30)
Payment Use by Medicaid	MI, NH, NM, OK, OR, SD, TX, WI	CO, MA, MD, MT, ND, NY, PA, RI, SC, TX	None
Payment use by other payers	Commercial plan use	BCBSMA, BCBSTN	Commercial plan use
Other users	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state "report cards"	Hospitals, AHRQ, various state "report cards"
Uses in measuring hospital quality	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital-acquired conditions.	Used as risk adjustor in measuring mortality, readmissions, complications	Used as risk adjustor in measuring mortality and readmissions and to reduce payment for hospital-acquired conditions

Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010.

MS-DRG Grouper

- **Consideration of MS-DRGs for Medicaid Payment:**
  - Designed for Classification of Medicare Patients…

> "The MS-DRGs were specifically designed for purposes of Medicare hospital inpatient services payment… We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, we encourage those who want to use MS-DRGs for patient populations other than Medicare [to] make the relevant refinements to our system so it better serves the needs of those patients."

Source: CMS, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule," *Federal Register* 72:162 (Aug. 22, 2007): 47158

APR-DRG Grouper

Benefits of Migrating to APR-DRGs

- Enhanced Homogeneity of Classifications
- Enhances Recognition of Resources Necessary for High Severity Patients
- Facilitates Superior Measurement of Resource Requirements
- Enhances Recognition of Acuity Related to Specialty Hospitals, Including Children's and Teaching Hospitals
- Will Facilitate Measurement of Potentially Preventable Readmissions and Complications
- Reduced Occurrence of Outlier Cases

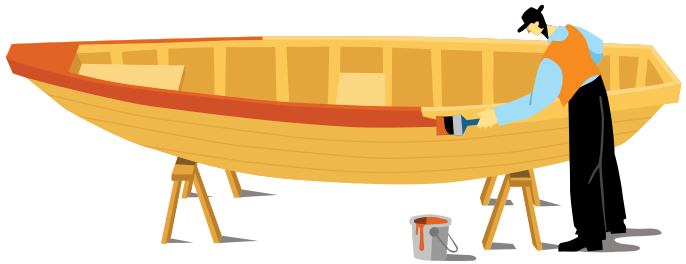
Inpatient Options – Other Design Considerations

- Basis and Method for Determining Relative Weights
- Establishing Weights for Low-Volume Classifications
- Basis and Method for Determining Base Rates / Conversion Factors
- Potential Adjustments to Base Rates / Conversion Factors for Unique Characteristics or Differences
- Outlier (and Inlier) Policies, Including Targeted Outlier Percentages
- Payment for Specialty Services, Including Psychiatric, Rehabilitation and Drug and Alcohol Services
- Payment for Transfer Cases, Including Post Acute Transfer Policies
- Payment Policies for Hospital Acquired Conditions and / or Never Events
- Measuring Preventable Readmissions and Complications

Inpatient Options – Implementation Considerations

- Fiscal Impacts from Change, and Potential Need for Transitional Corridor / Phase-In Period
- Method for Achieving Targeted Expenditures / Budget Neutrality
- Frequency and Methods for Updating and Rebasing Rates
- Monitoring and Managing Shifts in Acuity or Case Mix Resulting from Improved Coding Efforts, Including Potential Adjustments to Weights
- ICD-10 Transition

Outpatient Payment Reform - Design Considerations and Options



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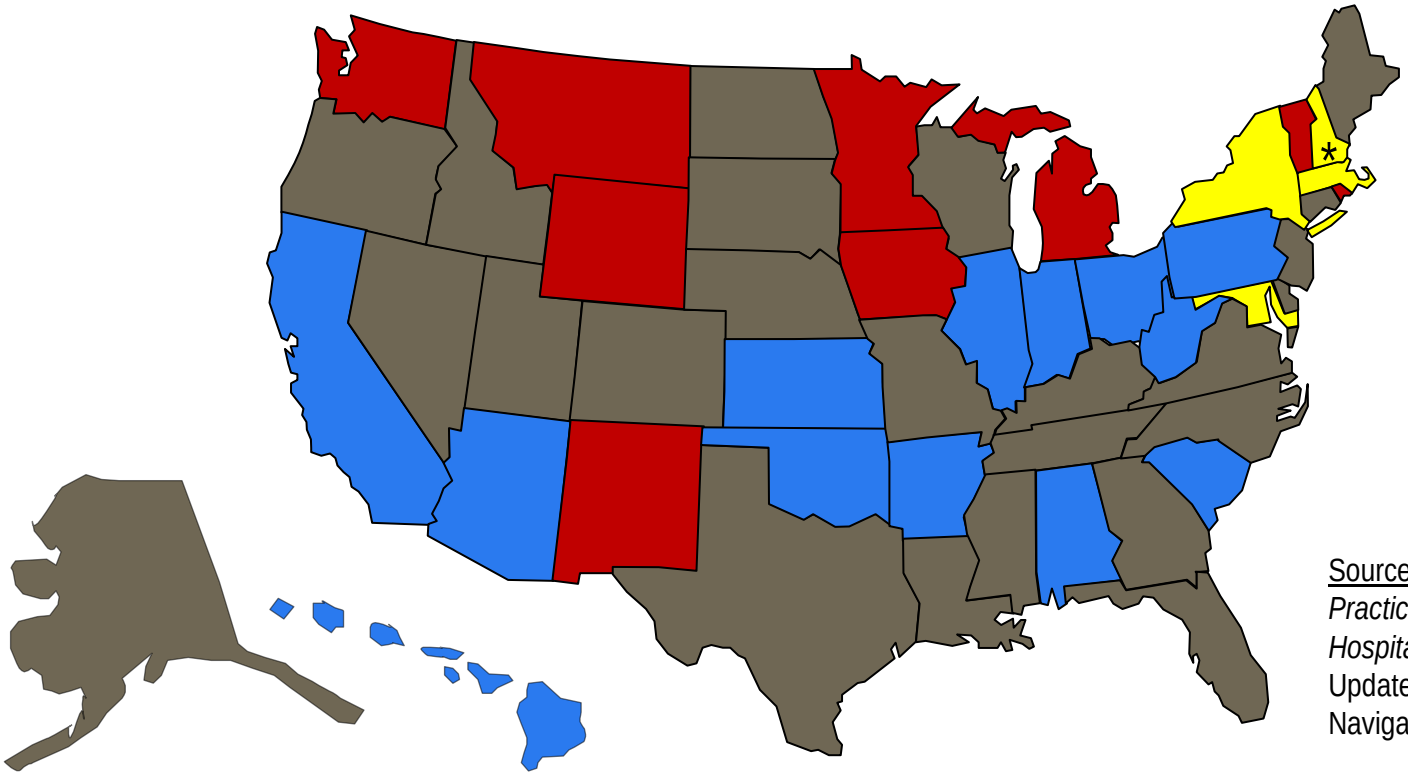
Outpatient Payment Models

What Are Other State Medicaid Programs Doing?

- Ambulatory Patient Groups (APGs) (* Indicates Moving Toward)
- Ambulatory Payment Classification (APC) Groups
- Primarily Other Fee Schedule
- Primarily Cost Reimbursement



Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010, Updated for Information Obtained by Navigant and CHCS.

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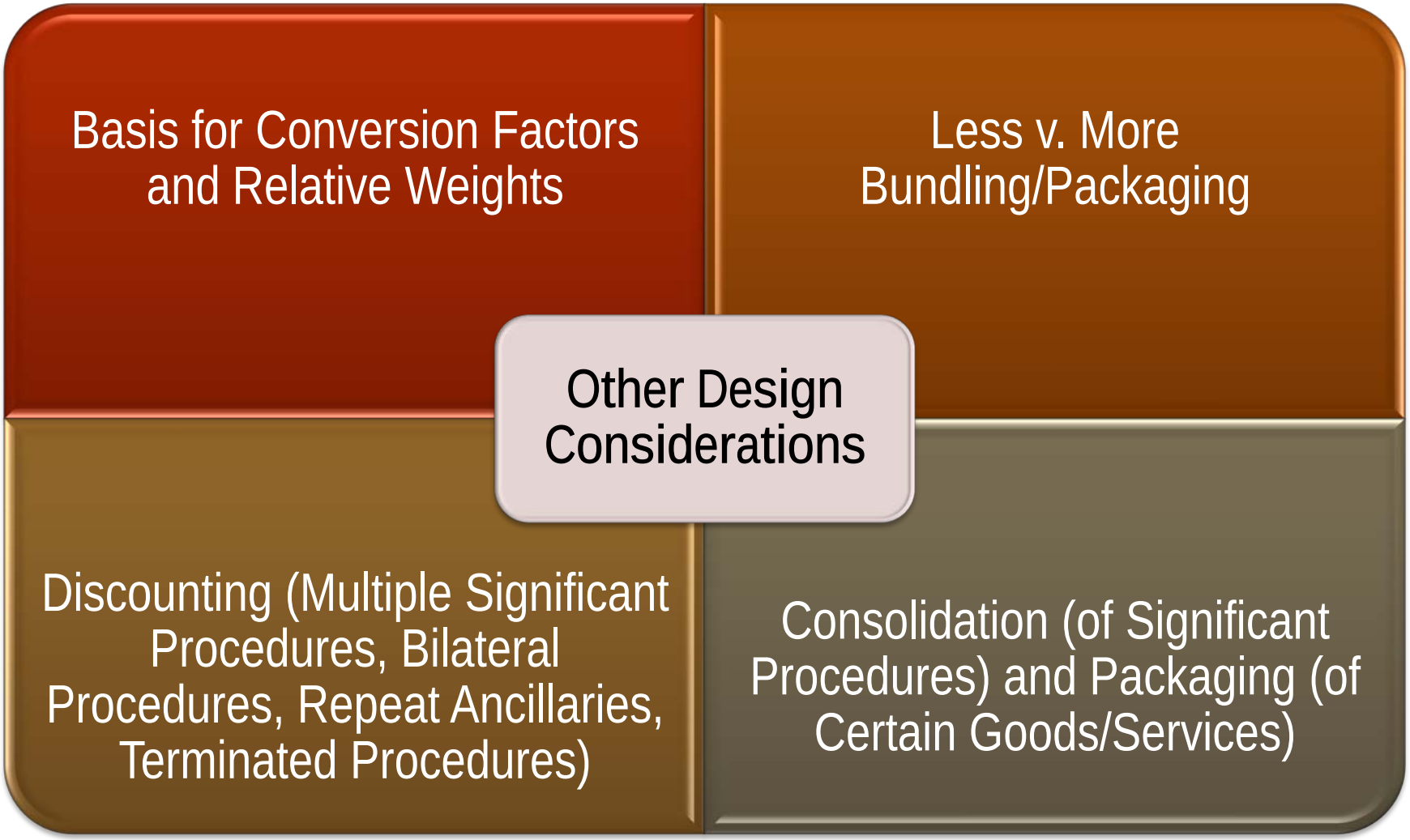
Outpatient Options – Payment Models

Description	APGs	Full APCs	APC Fee Schedule	APLs
Example	New York	Montana	Rhode Island	Illinois
General Approach	Group to EAPG, then pay rate by EAPG	Group to APC, then pay rate by APC	Group to APC, then pay rate by APC	Group to APLs, and pay for APL with highest rate
Multiple groups payable for same visit	Yes	Yes	Yes	No
Approach to packaging (bundling)	Most	Some	Least	All Bundled
Payment for lab services	By EAPG (23 groups)	Lab fee schedule	Lab fee schedule	Bundled

Outpatient Options – Payment Models

Description	APGs	Full APCs	APC Fee Schedule	APLs
Example	New York	Montana	Rhode Island	Illinois
Total Groups	496	836	836	
Purchasing Clarity (Clinical Meaningfulness)	Best	Limited	Very Limited	Limited
Relative Weights	No national weights	Medicare	Medicare	N/A
National Correct Coding Initiative	Included	Included	Excluded	N/A
Overall spending	Reflects EAPG conversion factor	Reflects APC conversion factor	Reflects APC conversion factor	Reflects highest APL assignment

Outpatient "Bundled" Models - Considerations



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Discussion,
Questions and Answers

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