ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Hospital Reimbursement Reform

Presentation to

House Human Services Appropriations Committee

February 28, 2013

Current Hospital Payment Structure

Payments are of two varieties:

Claims-based

- Inpatient and outpatient
- Service for specific hospital services, tied to specific Medicaid clients – but now out of date
- Total spending: $2.6 billion

Flat, static payments: not based on claims

GRF-based supplementals

- Total spending: $420 million ($85 million is updated annually)

Hospital assessment-related supplementals

- Current spending: $1.5 billion
- New hospital assessment 2012: $480 million - waiting for federal approval

Claims-Based Components Out of Date

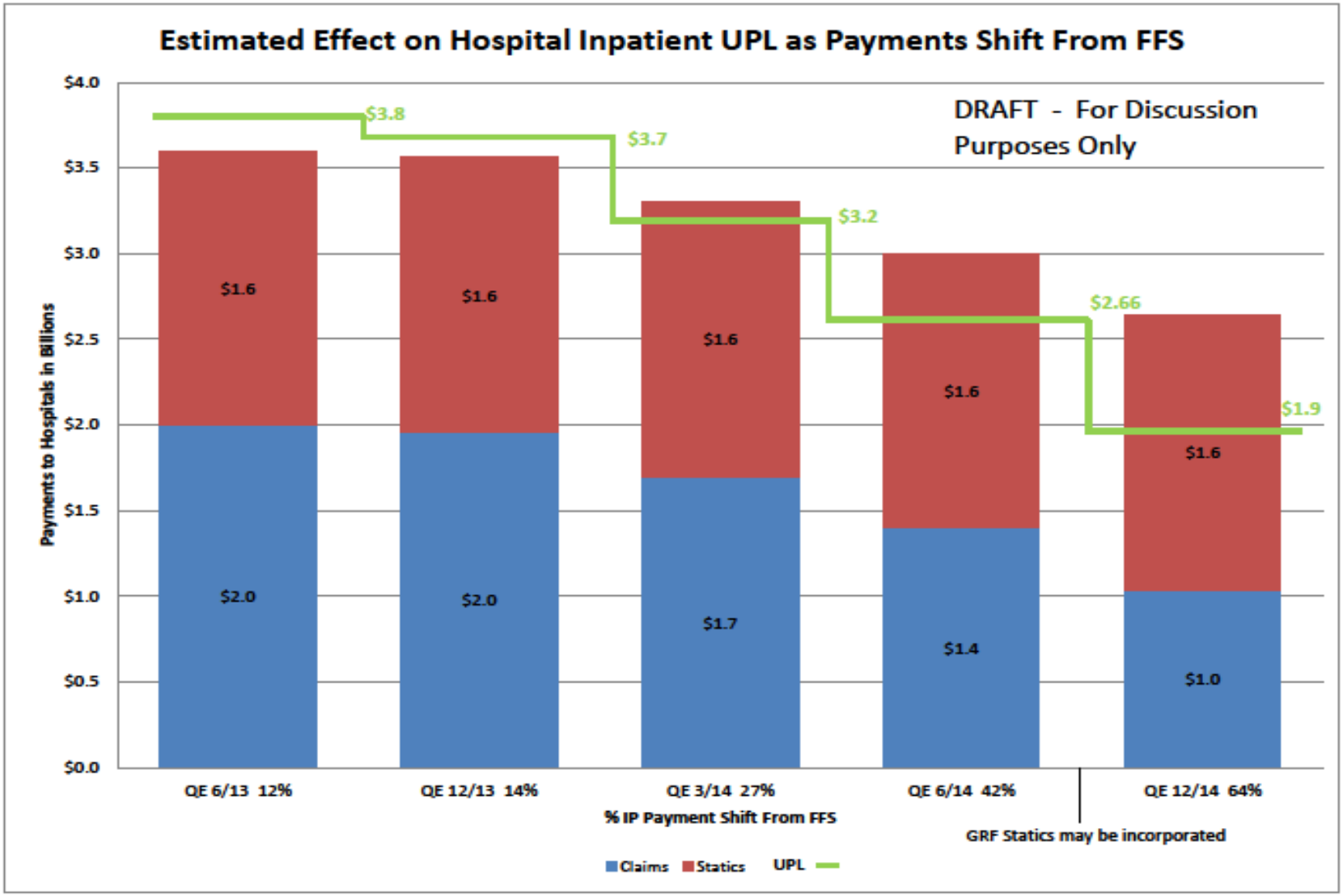
- Inpatient: DRG system - fixed rate for any patient with a particular condition
  - Modeled after Medicare system, not Medicaid
  - Established in 1991, based on 1989-90 cost reports, and last updated in 1995
  - Does not adequately address service acuity and reward for more complex cases
  - Software to maintain will no longer be available after 10/1/14
- Outpatient: Rate schedule with some bundling of procedures, home-grown by IHA and HFS jointly
  - Established in 1996 and last substantial update was 1998
  - Over-emphasizes inpatient services versus outpatient services
- System kept together by collection of "add-ons" for various hospitals
  - Static, flat payments came to account for 48% of Medicaid payments to hospitals
  - But hospital-related assessments in other states (and in Illinois, early on) are not necessarily paid out as static payments, but incorporated into rates

Reimbursement Reform Critical to Coordinated Care

- Current plan will enroll more than 50% of Medicaid clients in care coordination systems by 1/1/15 – mostly in managed care (MCO)
  - Hospital payments to be made by MCOs as part of capitated payments (i.e. fixed payments based on Per Member/Per Month)
- Will focus on appropriate care in appropriate settings – emphasis on outpatient rather than inpatient care
- Will focus on coordinated care for high-need clients – emphasis on acuity, quality, and care transitions, rather than quantity
- With Medicaid paying 48% of hospital payments as static payments, will run into problem of "Upper Payment Limit" (UPL)

How "Upper Payment Limits" Will Impact State Budget

- Federal rules impose an "Upper Payment Limit" or "UPL", calculated every October for following year -- based on what Medicare would pay for same patients, applied to Medicaid
- UPL applies only to payments paid directly to hospital by state Medicaid Program – including fee-for-service (claims-based) + static payments -- not payments by MCOs
- UPL is decreased as hospital payments shift to MCOs, e.g. if FFS payments drop by 50%, UPL will drop correspondingly
- But State must continue to pay static payments to hospitals, so any payments above UPL will not be matchable by federal government
- With care coordination roll-out plan, state will exceed UPL in FY14


Estimated Effect on Hospital Inpatient UPL as Payments Shift From FFS
DRAFT - For Discussion Purposes Only
Payments to Hospitals in Billions
$4.0
$3.5
$3.0
$2.5
$2.0
$1.5
$1.0
$0.5
$0.0
$3.8
$3.7
$3.2
$2.66
$1.9
$1.6
$1.6
$1.6
$1.6
$1.6
$2.0
$2.0
$1.7
$1.4
$1.0
QE 6/13 12%
QE 12/13 14%
QE 3/14 27%
QE 6/14 42%
QE 12/14 64%
% IP Payment Shift From FFS
GRF Statics may be incorporated
Claims
Statics
UPL

Reimbursement Reform Process

- March 28, 2011: kick-off meeting with hospitals; April 29, 2011: second large group meeting with expert panel discussion
- 12 Technical Advisory Group meetings to date
- Using technical consultant from Navigant with experience in other states and private insurance
- Have general consensus on new "grouper" methodologies
  - Inpatient: APR-DRG: "All Payer Refined=Diagnosis Related Groups"– 1,256 DRGs + 4 severity levels, instead of current 500 DRGs + 2 severity levels; variations of per diem for specialty care services
  - Outpatient: EAPG: "Enhanced Ambulatory Patient Groups" – 520 groupings instead of 18

SMART Act Provisions

- May, by rule, implement APR-DRG payment system for inpatient services on or after 7/1/13; shall begin testing APR-DRG system between 10/1/12 and 6/30/13
- May, by, rule implement EAPG for outpatient services on or after 1/1/14; shall begin testing EAPG system between 1/1/13 and 12/31/13
- Shall reduce hospital payments correspondingly if upper payment limits are exceeded (but this reduces “hospital pie” and revenues to state)
- May transition GRF-funded supplementals to claims-based system, beginning 7/1/14, over period of 2 years, and no more than 4 years after implementation date of new methodologies
- Payments to hospitals per hospital assessment scheduled to sunset 12/31/14

Key Outstanding Policy Issues

- How to improve the proportion of the outpatient base, within budget
- Types of policy adjusters to include as inflators to base rates, e.g. high Medicaid utilization, medical education expenses
- Accommodations to “safety net” hospitals for loss of revenues related to policies on hospital readmissions, care coordination, etc.
- Length of time needed for transition to new methodologies
- How to protect against coding improvements that could exceed total budget
- Whether and how to shift any GRF-funded supplementals after 7/1/14
- Whether and how to shift any assessment-related supplementals after 12/31/14
- How to protect state from risk of loss of federal funds if UPL is exceeded