Illinois Medicaid Hospital Reimbursement Reform

Technical Advisory Group
Kick-off Meeting
July 15, 2011

Agenda

- Introduction of Members
- Why are we here?
- Outline of Goals
- Discussion of cost report review work to date
  - Why its important?
  - Planned usage of data
- Discussion on work plan
  - Project overview
  - Discussion on decision points
- Next steps
- Next meeting

Technical Advisory Group

(Provider Community Representation List)

- Children's Memorial Hospital
  - **Prem Tuteja**, Director, Third Party Reimbursement
- Swedish Covenant Hospital
  - ***Gary M. Krugel***, Senior Vice President of Operations and CFO
- Southern Illinois Healthcare
  - **Michael Kasser,** Vice President/CFO/Treasurer
- Memorial Health Systems
  - **Bob Urbance,** Director – Reimbursement
- Carle Foundation Hospital
  - **Theresa O'Banion**, Manager-Budget & Reimbursement
- Franklin Hospital (Illinois Critical Access Hospitals)
  - **Hervey Davis**, CEO
- Mercy Hospital and Medical Center
  - **Thomas J. Garvey**, Chief Financial Officer
- Hospital Sisters Health System
  - **Richard A. Walbert**, Vice President of Finance
- Touchette Regional Hospital
  - **Michael McManus**, Chief Operating Officer
- Resurrection Health Care
  - **John Orsini,** Executive VP & CFO
- University of Illinois Hospital
  - **Patrick O'Leary,** Director of Hospital Finance
- Sinai Health System
  - **Chuck Weiss,** Executive VP & CFO
- Cook County Health & Hospital System
  - **Randall Mark,** Director of Intergovernmental Affairs & Policy
- Provena Health System
  - **Gary Gasbarra**, Regional Chief Financial Officer
- Advocate Healthcare System
  - **Jim Skogsbergh,**
- Universal Health Systems
  - **Dan Mullins,** Vice President of Reimbursement, Behavioral Health Division

Technical Advisory Group

(Technical Advisors to Hospital Systems)

- **Illinois Hospital Association**
  - **Steve Perlin,** Group Vice President, Finance
  - **Jo Ann Spoor,** Director, Finance
- **Illinois Academic Hospital Providers & multiple hospital provider systems**
  - **Matthew W. Werner** - M. Werner Consulting - Designated Technical Consultant
- **Multiple hospital provider systems**
  - **J. Andrew Kane** - Kane consulting - Designated Technical Consultant

Technical Advisory Group

(Technical Advisors to HFS)

- **Illinois Department of Healthcare and Family Services**
  - **Joe Holler, Deputy Administrator of Finance (Co-Chairs)**
  - **Frank Kopel, Deputy Administrator of Medical Programs (Co-Chairs)**
  - **Theresa Eagleson, Administrator of Medical Programs**
- **Navigant Consulting**
  - **James Pettersson,** Managing Director
  - **Ben Mori**

Objectives & Guidelines for the Group

- As the "Medicaid single State agency" HFS is ultimately responsible for the final system
- The group is gathered to act in a technical advisory capacity to the HFS
- Members should reach out to their peers to gather feedback from others and to share meeting issues and discussion points
- Members are encouraged to provide objective advice to the group as it relates to the complete Medicaid system
- All parties, both HFS and the provider community, must commit to remaining transparent and open during the process, bringing all issues to the group for discussion

Your Role

& beyond

Why are we here ?

Hospital Rate Reimbursement System Deficiencies

- Based on old data: 1989-90 cost reports
- DRGs are based on Medicare system from 1992, not Medicaid
- 42% of payments ($1.9 billion) are static , non-claims based
- Over-emphasizes inpatient services versus outpatient services
- Does not adequately address service acuity and reward for more complex cases
- Does not pay for performance or value
- Is not responsive to advances in medical technology and healthcare delivery models
- Current coding grouper not compatible with ICD-10 (Eff. 10-2013)
  - Current system will be functionally disabled by Oct. 2013
- Is incompatible with Illinois Medicaid reform: care coordination for 50% of clients

Changing State Environment

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

Changing Federal Environment

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

What are the goals of the state?

And tasks for the group?

Federal Compliance

GOALS

- Implement a new technical grouping system, that is ICD-10 ready and more precise in the recognition of acuity.
  - Both Inpatient and Outpatient
- Provide a rate structure that promotes proper delivery of healthcare in the proper setting.
  - Where appropriate and feasible promote more care in less institutionalized and costly settings.
- Promote more predictable and transparent pricing /reimbursement for providers.
  - Providers must be able to more accurately predict the level of compensation for services rendered.
- Implement a system that recognizes, and rewards, quality health outcomes and efficiency.
  - Rate structures and policies that promote creative /efficient healthcare delivery models.
- Create a system that establishes a sound financial basis for the changing environment.
  - Creates a basis for smoother transitions to more coordinated care models.
- Dynamic and flexible enough to be responsive to changing federal and state goals.
  - Regular updates and adjustments

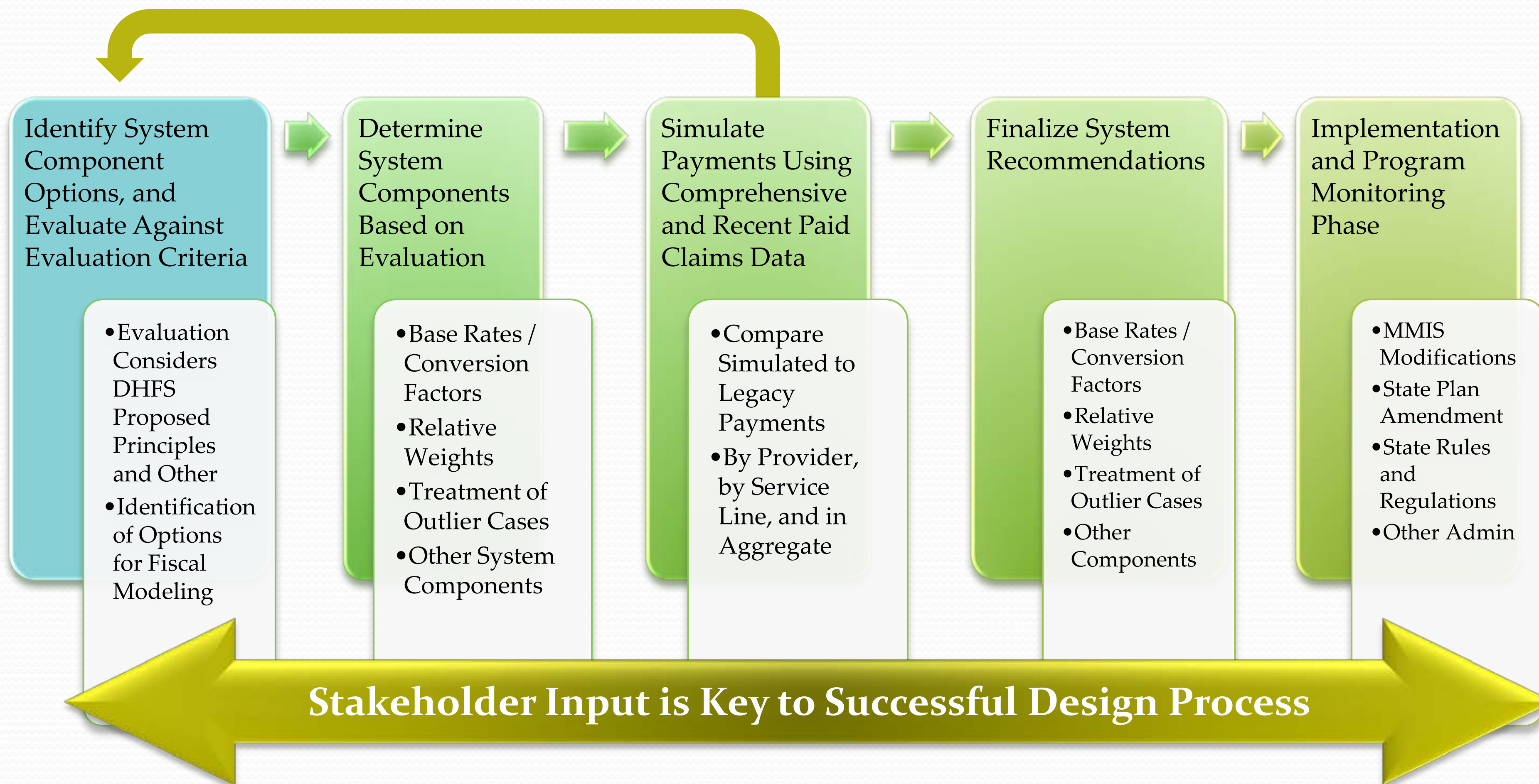
The WEBINARS

- HFS & Navigant have hosted two webinars to begin to solicit input from providers on a key component
- And to review some baseline assumptions.
- WHY?

- All information related to this initiative including a recording of the webinar is available at http://hfs.illinois.gov/hospitalratereform/

Project Overview

Overview of Design Framework



Evaluating the proposed model(s)

- Transparent methodologies that are easy to understand and replicate
- Promotes high value, quality-driven healthcare services
- Compliant with federal regulations
- Adaptable to changes in utilization and need for regular updates
- Enhance payment predictability for providers and the State
- Incentives to provide efficient care in the most appropriate settings
- Maintain appropriate access to high quality services
- Consistency with state and federal policy priorities
- Recognize resources and aligns payments to the to the services provided, including differences in acuity
- Consistency with supporting payment structures under future coordinated care models, including potential enhanced bundling models

Key Decision Points - Inpatient

APR-DRG Relative Weights

- Illinois-specific, or adopt 3M national values or borrow from other state?
- If Illinois-specific, cost based vs. charge based
- Adjustments for measurable differences, including differences resulting from, geographic wage variation or medical education programs
- Method for calculating
- Method for determining stability – minimum "N" size
- Approach for lower volume DRG classifications

Key Decision Points - Inpatient

APR-DRG Base Rates

- Statewide standardized amount, peer group or provider-specific
- If statewide or peer group, adjustments for measurable differences, such as geographic wage differences or differences in costs associated with medical education programs
- Treatment or recognition of different components - Operating, Capital and Medical Education
- Recognition of measurable and objective differences in provider service delivery requirements

Key Decision Points - Inpatient

Specialty Service Payment Rates

- Potential separate payment policies for psychiatric, rehabilitation, detoxification and LTAC services
- Per discharge or per diem payment rates
- Statewide standardized amount or provider-specific
- Potential adjustments for service intensity and/or length of stay

Key Decision Points - Inpatient

Other Inpatient Payment Policies

- Outlier (and Inlier) policies, including targeted outlier percentages, determination of thresholds, fixed stop loss amounts and marginal cost factors
- Payment for transfer cases, including post acute transfer policies
- Payment policies for Hospital Acquired Conditions and/or Never Events
- Measuring Preventable Readmissions and Complications

Key Decision Points - Outpatient

EAPG Relative Weights

- Illinois-specific or borrow from 3M or other state?
- Cost based vs. charge based
- Adjustments for measurable differences, including differences resulting from, geographic wage variation or medical education programs
- Use of "singleton"[1] claims with only one significant procedure or all claims
- Method for determining stability
- Approach for low volume EAPGs

(1) Singleton = Claim with only one significant procedure as opposed to multiple significant procedures

Key Decision Points - Outpatient

EAPG Conversion Factors

- Illinois-specific or Medicare-based
- Statewide standardized amount, peer group-specific or provider-specific
- If statewide or peer group, adjustments for measurable differences, such as geographic wage differences or differences in costs associated with medical education programs
- Recognition of rate components - Operating, Capital or Medical Education components
- Recognition of measurable and objective differences in provider service delivery requirements

Key Decision Points - Outpatient

Other Outpatient Payment Policies

- "Carve out" services currently excluded from APL system
  - Ex…Non-institutional services
- Ancillary packaging - bundled with main significant procedure(s)
- Procedure consolidation - bundled with main significant procedure(s)
- Procedure discounting