The Illinois Hospital Provider Community
&
The Illinois Medicaid Program

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 $1,506.93
  (Kidney and Urinary Tract Infection > 17, w/o Complications)
  \( \times 0.3747 \)
- Relative Weight Adjusted + $400.00
- Hospital Specific Final DRG Base Rate $1,906.93
- Add Capital
- 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

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

**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

DRG and Per Diem

- DRG: 80%
- Per Diem: 20%

PSYCH: 56%
CHILDRENS: 34%
REHAB: 4%
LTAC: 2%
Sole Community: 4%
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 Supplemental Payments 42%

Claims Based 58%
NON-CLAIMS-BASED SUPPLEMENTALS
Hospital Supplemental Reimbursement

- Annually Updated $112,850 with 5.7% of Total
- Static Non-Assessment Funded $347,430 with 17.6% of Total
- Static Assessment-Funded $1,509,380 with 76.6% of Total

Total Supplementals $1,969,660 with 100.0% of Total

Note: The chart indicates that the Hospital Supplemental Reimbursement is not very dynamic.
Inpatient Claims Based Payments, 46%

Outpatient Claims Based Payments, 12%

Inpatient Supplementals - HAP, 22%

Inpatient Supplementals - Non-HAP, 9%

Outpatient Supplementals - Non-HAP, 1%

Outpatient Supplementals - HAP, 10%
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

<table>
<thead>
<tr>
<th>Providers Qualified</th>
<th>Program Total Pay Amount</th>
<th>HAP Amount</th>
<th>Total Supplemental</th>
<th>Average Per Hospital</th>
<th>Re-Determine?</th>
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<tbody>
<tr>
<td>Total Of Supplemental (2011 Level)</td>
<td>221</td>
<td>$460,282</td>
<td>$1,509,376</td>
<td>$1,969,658</td>
<td>$8,912</td>
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### Outpatient Payments

<table>
<thead>
<tr>
<th>Description</th>
<th>Providers</th>
<th>Pay Amount</th>
<th>HAP Amount</th>
<th>Total Supplemental</th>
<th>Average Per Hospital</th>
<th>Re-Determine?</th>
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<tr>
<td>Outpatient Assistance Adjustment Payments - (OAAP)</td>
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<td>$23,063</td>
<td>$19,040</td>
<td>$42,102</td>
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<td>Pediatric Outpatient Adjustment Payments - (POAP)</td>
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<td>$19,937</td>
<td>$2,848 Frozen SFY 1996</td>
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<tr>
<td><strong>Hospital Assessment APL Across The boards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See values below</td>
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<tr>
<td><strong>(Outpatient)</strong></td>
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<td></td>
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</table>

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<th>Average Per Hospital</th>
<th>Re-Determine?</th>
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<td>Rural Adjustment Payments - (RAP)</td>
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<td>Tertiary Care Payment</td>
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<td>Pediatric Inpatient Adjustment Payments - (PIAP)</td>
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<td><strong>Critical Hospital Adjustment Payments (CHAP)</strong></td>
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<td><strong>Trauma Center Adjustment</strong></td>
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<td><strong>Rehab Hosp Adj</strong></td>
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<td><strong>Rural Chap</strong></td>
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<td>Safety Net Adjustment Payments (SNAP)</td>
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<td>County Trauma Center Adjustment</td>
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<td>Excellence In Academic Medicine (EAM)</td>
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<td>$27,600</td>
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<td>Hospital Access Payments</td>
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<td><strong>High volume (Inpatient)</strong></td>
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<td>$52,790</td>
<td>$52,790</td>
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<td><strong>Across the Board (Inpatient)</strong></td>
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<td>$404,200</td>
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<td><strong>Capital (Inpatient)</strong></td>
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<td>$114,313</td>
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<td><strong>Obstetrical Care (Inpatient)</strong></td>
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<td>$140,352</td>
<td>$140,352</td>
<td>$1,276</td>
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<tr>
<td><strong>Trauma Care (Inpatient)</strong></td>
<td>93</td>
<td>$242,615</td>
<td>$242,615</td>
<td>$2,609</td>
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<tr>
<td><strong>Tertiary Care Enhancement (Inpatient)</strong></td>
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<td>$29,824</td>
<td>$29,824</td>
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<td><strong>Medicare Crossovers (Inpatient)</strong></td>
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<td>$8,796</td>
<td>$8,796</td>
<td>$1,100</td>
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<tr>
<td><strong>Magnet Hospital (Inpatient)</strong></td>
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<td>$40,775</td>
<td>$3,707</td>
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<td>APL Across The boards (Outpatient)</td>
<td>204</td>
<td>$449,588</td>
<td>$449,588</td>
<td>$2,204</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 community
  Kick-off meeting with provider

- 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

Contact:
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Or
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