Illinois Department of Healthcare and Family Services

Inpatient and Outpatient Payment Reform

Project Overview and Design Framework

April 29, 2011
Overview of Design Framework

Evaluate System Component Options Against Evaluation Criteria
- Evaluation Criteria Considers DHFS Proposed Principles and Other
- Identification of Options for Fiscal Modeling

Determine System Components Based on Evaluation
- Base Rates / Conversion Factors
- Relative Weights
- Treatment of Outlier Cases
- Other System Components

Simulate Payments Using Comprehensive and Recent Paid Claims Data
- Compare Simulated to Legacy Payments
- By Provider, by Service Line, and in Aggregate

Finalize System Recommendations
- Base Rates / Conversion Factors
- Relative Weights
- Treatment of Outlier Cases
- Other Components

Implementation and Program Monitoring Phase
- MMIS Modifications
- State Plan Amendment
- State Rules and Regulations
- Other Admin

Stakeholder Input is Key to Successful Design Process
### 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
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.
### Description

<table>
<thead>
<tr>
<th>Description</th>
<th>MS-DRGs V.28 (CMS - Maintained by 3M)</th>
<th>APR-DRGs V.28 (3M and NACHRI)</th>
<th>APS-DRGs V.28 (Ingenix)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Population</td>
<td>Medicare (age 65+ or under age 65 with disability)</td>
<td>All patient (based on the Nationwide Inpatient Sample)</td>
<td>All patient (based on the Nationwide Inpatient Sample)</td>
</tr>
<tr>
<td>Overall approach and treatment of complications and comorbidities (CCs)</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Number of DRGs</td>
<td>746</td>
<td>1,258</td>
<td>1,223</td>
</tr>
<tr>
<td>Newborn DRGs</td>
<td>7 DRGs, no use of birth weight</td>
<td>28 base DRGs, each with four levels of severity (total 112)</td>
<td>9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)</td>
</tr>
</tbody>
</table>

**Source:** Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care.* CHCS: November 2010.
## Inpatient Options – DRG Algorithms, or “Groupers”

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

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.”

Benefits of Migrating to APR-DRGs

- Enhanced Homogeneity of Classifications
- Facilitates Superior Measurement of Resource Requirements
- Will Facilitate Measurement of Potentially Preventable Readmissions and Complications
- Enhanced Recognition of Resources Necessary for High Severity Patients
- Enhances Recognition of Acuity Related to Specialty Hospitals, Including Children’s and Teaching Hospitals
- 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
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
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.
### Outpatient Options – Payment Models

<table>
<thead>
<tr>
<th>Description</th>
<th>APGs</th>
<th>Full APCs</th>
<th>APC Fee Schedule</th>
<th>APLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>New York</td>
<td>Montana</td>
<td>Rhode Island</td>
<td>Illinois</td>
</tr>
<tr>
<td>General Approach</td>
<td>Group to EAPG, then pay rate by EAPG</td>
<td>Group to APC, then pay rate by APC</td>
<td>Group to APC, then pay rate by APC</td>
<td>Group to APLs, and pay for APL with highest rate</td>
</tr>
<tr>
<td>Multiple groups payable for same visit</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Approach to packaging (bundling)</td>
<td>Most</td>
<td>Some</td>
<td>Least</td>
<td>All Bundled</td>
</tr>
<tr>
<td>Payment for lab services</td>
<td>By EAPG (23 groups)</td>
<td>Lab fee schedule</td>
<td>Lab fee schedule</td>
<td>Bundled</td>
</tr>
</tbody>
</table>
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<td>Example</td>
<td>New York</td>
<td>Montana</td>
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<td>Illinois</td>
</tr>
<tr>
<td>Total Groups</td>
<td>496</td>
<td>836</td>
<td>836</td>
<td></td>
</tr>
<tr>
<td>Purchasing Clarity (Clinical Meaningfulness)</td>
<td>Best</td>
<td>Limited</td>
<td>Very Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Relative Weights</td>
<td>No national weights</td>
<td>Medicare</td>
<td>Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>National Correct Coding Initiative</td>
<td>Included</td>
<td>Included</td>
<td>Excluded</td>
<td>N/A</td>
</tr>
<tr>
<td>Overall spending</td>
<td>Reflects EAPG conversion factor</td>
<td>Reflects APC conversion factor</td>
<td>Reflects APC conversion factor</td>
<td>Reflects highest APL assignment</td>
</tr>
</tbody>
</table>
Outpatient “Bundled” Models - Considerations

Basis for Conversion Factors and Relative Weights

Less v. More Bundling/Packaging

Discounting (Multiple Significant Procedures, Bilateral Procedures, Repeat Ancillaries, Terminated Procedures)

Consolidation (of Significant Procedures) and Packaging (of Certain Goods/Services)

Other Design Considerations
Discussion, Questions and Answers