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

Stakeholder Input is Key to Successful Design & Maintenance Process

July 15, 2011 & beyond

Jan 2013
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?
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/hospitalraterereform/
Project Overview

Overview of Design Framework

Identify System Component Options, and Evaluate Against Evaluation Criteria
- Evaluation 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
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 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
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