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- Service for specific hospital services, tied to specific Medicaid clients – but now out of date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Out of Date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

GRF Statics may be incorporated
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
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