MERCER

STATE OF CONNECTICUT HOSPITAL PAYMENT MODERNIZATION

Stakeholder Web Conference — September 3, 2014

Summary of Decisions and Follow-Up Items

Topic	Notes	Decisions and Follow-up Items
Meeting Format and Frequency	• The Connecticut Hospital Association (CHA) has a committee on Hospital Finance. • Subcommittee formed to interface with the Connecticut Department of Social Services (DSS) regarding transition to Diagnosis Related Groups (DRGs) and Ambulatory Payment Classifications. • CHA would like more frequent meetings with DSS and consultants prior to implementation. • DSS and consultants would like to ensure full information is available to all interested parties.	• DSS to schedule bi-weekly web conferences with CHA committee for Thursdays at 2:00 pm EST starting on September 18, 2014. • Frequency: Every two weeks. • Host/Facilitator: DSS/Mercer. • Invitees: CHA Committee, all hospitals. • Location: Web conference. • Purpose: Information sharing about transition to All Patient Refined (APR)-DRG methodology, including time for questions and answers. • Agenda: Mercer/DSS will set the agenda considering suggested topics and questions provided by invitees.
3M National Weights	• CHA requested a switch from Connecticut-specific weights to 3M national weights. • DSS and consultants believe this is a reasonable approach. • Outlier approach will change to fixed loss — similar to what Medicare uses.	• DSS has accepted CHA's request to use 3M national weights. • Outlier methodology changes to fixed loss approach. • See "CT HPM Issue Paper - 3M National Weights".

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Derivation of “Real Acuity”	• CHA requested the use of Medicaid-only data to calculate the estimate of real acuity increase. • Mercer's issue paper on documentation and coding improvements (DCI) was good in that it laid out the differences of opinion, but it did not resolve the differences. • Medicaid-only data show approximately 2% per year for real acuity increase. • Medicaid data fluctuate up and down year over year. • When membership is changing, it's not a stable data set. • CHA requested DSS revisit the 1% real acuity increase. • CHA requested DSS consider a recorded withhold of 5%, as opposed to an actual upfront withhold. • CHA requested DSS consider applying DCI adjustment/refund on a hospital-specific basis.	• Base rates will be adjusted for a DCI expected improvement of 5%; the concept of reserve is not intended to withhold funds, but to minimize any impact on cash flow. • DSS and project team have reviewed and confirmed the best estimate of real acuity increase estimate of 1%. • If warranted, any refund will be paid back to hospitals by mid-2016, but every effort will be made to shorten this timeline. It has been noted that the timing of this potential adjustment is approximately one year earlier than the current reconciliation, and the amount (estimated to be 0%, maximum 5%) is lower than current reconciliation for many hospitals. • DCI reserve/refunds cannot accurately be attributed hospital by hospital. • See revised issue paper "CT HPM Issue Paper - Coding Improvements".
Indirect Medical Education (IME)	• CHA requested the elimination of an IME factor for year one. • DSS anticipates IME will be valuable in the future.	• DSS has accepted CHA's request to eliminate IME for year one. • See "CT HPM Issue Paper - Indirect Medical Education (IME) Adjustment Factor".

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Outlier Policy	• CHA requested no outlier policy in year one. • CHA expressed concerns about sufficient resources flowing through the system throughout the year. • CHA would prefer the pool of money for outliers be smaller. • Agreement that outlier policy is desirable. • CHA wants to understand how outlier policy fits in with revenue neutrality for year one. • Agreement to model different scenarios of outlier policy with high threshold.	• Outlier policy is an important component of APR-DRG payment methodology. • Outlier policy will be modeled with varying levels including high thresholds and scenarios will be provided to CHA and hospitals. • See "CT HPM Issue Paper - Outlier Policy and Approach". • See "CT HPM Issue Paper - Revenue Neutrality" for additional analysis of the impact of outliers on revenue neutrality.
Transfer Policy	• CHA requested no transfer policy in year one. • Distinction between transfers within a hospital versus to another hospital. • More clarification is needed on various transfer scenarios. • Need to get admitting processes nailed down. • CHA wants to understand how transfer policy fits in with revenue neutrality for year one.	• Transfer policy is an important component of APR-DRG payment methodology. • Transfers from a medical admission to a Behavioral Health (BH) stay will not trigger transfer payment policy. • Transfer policy applies to claims with discharge status of: 02 and 05 — these are medical to medical transfers. • CHA will provide three hospital volunteers to work with DSS and CHN on medical/psych admits. • See "CT HPM Issue Paper - Transfer Payment Policy and Approach". • See "CT HPM Issue Paper - Revenue Neutrality" for additional analysis of the impact of transfers on revenue neutrality.

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BH and Rehab Per Diems	• There will be three per diem rates for BH claims. • Each hospital will be assigned to one of the three tiers to help hospitals maintain their revenue structure. • Child and adult BH services will be paid the same per diem.	DSS published the BH and rehab per diem rates on the DSS Reimbursement Modernization web site. http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256
Questions and Answers	Q: What is the timeline for when the normalized weight table will be available? A: Targeting October 2014. Q: Is January 1, 2015 a realistic implementation date? A: Yes. Q: How will hospice be handled? A: If a patient elects the hospice benefit, the claim would come in from the hospice agency. It would not be a claim for an acute hospital.	Please visit the DSS Reimbursement Modernization web site for links to meeting presentations, issue papers, FAQs, and other relevant information: http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256