MERCER

STATE OF CONNECTICUT HOSPITAL PAYMENT MODERNIZATION

Stakeholder Web Conference Summary — September 18, 2014

Summary of Decisions and Follow-up Items

Topic	Notes	Decisions and Follow-up Items
Welcome and Introduction	• The Connecticut Department of Social Services (DSS) has posted several documents on the DSS web site, including presentation slides and issue papers. • There is an auto-notification feature where users may sign up for email alerts when new information is added.	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
Derivation of "Real Acuity" and Coding Improvements	• There is a difference of opinion about the real acuity factor: 1% versus 2%. • The Connecticut Hospital Association (CHA) suggested the documentation and coding improvements (DCI) adjustment be netted against the market basket inflation factor of 3.2%. • CHA suggested the DCI adjustment be made over time — as opposed to all in the first year. • CHA suggested the DCI adjustment be applied on a hospital specific basis. • There are three separate estimates: — Changes in coding improvements. — Changes in practice patterns. — Changes in acuity and population. • The DCI adjustment is intended to isolate the changes due to coding improvements only.	• DSS and project team have reviewed and confirmed that the statewide all payer-all hospital target is best measure of underlying case-mix index (CMI) practice pattern increases. • The model does not build in inflation — it targets revenue neutrality. • The documentation and coding improvement factor is a one-time adjustment applicable to year one.

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Outliers	• Case mix varies significantly at the hospital specific level. • CHA would prefer a smaller pool of dollars for outliers. • CHA requested the outlier policy not be hospital specific — take the same percentage from all hospitals. • The current system doesn't have an outlier policy and CHA suggested funding the outlier policy with new revenues.	• Outlier policy will be modeled with varying levels including high thresholds and scenarios will be provided to CHA and hospitals. • See revised issue paper "CT HPM Issue Paper - Hospital Revenue Neutrality".
Transfers	• The transfer policy is only applicable for medical to medical admissions.	• CHA sent four names of potential volunteers to work with DSS on the prior authorization process for medical to behavioral health admissions.
Three Day Rule	• The three day payment window (Three Day Rule) requires that hospitals bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g. therapeutic) with the claim for an inpatient (IP) stay when services are furnished to a beneficiary in the three days preceding an IP admission.	• In order to satisfy revenue neutrality in year one, DSS intends to implement the "Three Day Rule" in a post and pay in 2015 and begin denying claims by January 1, 2016 to coincide with the transition of outpatient services to Ambulatory Payment Classifications.

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All Patient Refined Diagnosis Related Groups (APR-DRG) List	• CHA requested the list of APR-DRGs be provided to the hospitals. • Is there a crosswalk from MS-DRGs to APR-DRGs? • The normalizing factor will be ready in a week or two. • Why normalize to one? Why not use the national weights without a normalization factor? • Normalization to one allows for rate comparisons and trues up the off-the-shelf product to Connecticut Medicaid. • CHA doesn't see the benefit of normalizing to one.	• The APR-DRG list is on the DSS Reimbursement Modernization web site: http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256 • A crosswalk from MS-DRGs to APR-DRGs is not likely to be helpful, as they are not linearly related. • The project team plans to normalize off-the-shelf weights to 1.0 for the Medicaid population. If all hospitals agree that this is not desirable, team asked for a written request to skip normalization step.
Phase-In	• Agreement that phase-in discussions are important. • CHA proposed the following schedule for phase-in: — Year 1: 100% hospital-specific rates. — Year 2: 75% hospital-specific/25% statewide. — Year 3: 50% hospital-specific/50% statewide. — Year 4: 25% hospital-specific/75% statewide. — Year 5: 100% statewide rates.	• Phase-in discussions are planned for early in 2015.
Timeline	• CHA would like to have at least 30 days to review rates before implementation.	• Rates will be presented in late October or early November, 2014 for implementation on January 1, 2015.

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Questions and Answers	**Q:** Please provide documentation of the target in the revenue neutral pro forma calculation. (Show how the $21M is derived.) **A:** Documentation of the revenue neutral target is provided in "Revenue Neutral Base Rate Calculation Documentation of Target 20141001.pdf". **Q:** Should hospitals expect to begin direct billing IP physicians on January 1, 2015? **A:** Yes. Hospitals are expected to begin direct billing on 1500s for IP physician services on January 1, 2015. HP has scheduled provider training on this topic. **Q:** What is the impact on revenue neutrality for emergency department physician services that come through on the IP claim? **A:** DSS is working on a response to this question. **Q:** What is the impact on revenue neutrality for capital costs that are currently paid on a pass through? **A:** The hospital-specific revenue neutral rates will implicitly include capital at 2012 levels. DSS and the project team see capital as an important policy to formalize and rationalize in the context of prospective payment as the phase in process is developed early in 2015.	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