MERCER

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CONNECTICUT HOSPITAL PAYMENT MODERNIZATION
TRANSITION TO APR-DRGS

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Agenda

- Welcome and introduction.
- Meeting format and frequency.
- 3M national weights.
- Derivation of “real acuity”.
- Indirect medical education.
- Outlier policy.
- Transfer policy.
- Behavioral health and rehab per diems.
- Questions and answers.

INTRODUCTION

MEETING FORMAT AND FREQUENCY

Meeting Format and Frequency

- Participants.
- Logistics.
- Frequency.

3M NATIONAL WEIGHTS

3M National Weights

- Request from hospitals via Connecticut Hospital Association (CHA).
- Mercer and the Connecticut Department of Social Services (DSS) are amenable to this change.
- Slightly less precise, but administratively simpler.
- Will use a single factor to normalize to 1.0.
- Leads to change (simplification) in outlier approach.

DERIVATION OF “REAL ACUITY”

Derivation of “Real Acuity”

- Suggested by hospitals/CHA that using Medicaid data is more accurate.
- For many calculations, the use of Medicaid data is more accurate, but not for this one. The adjustment factor we are solving for is a general and system-wide change in practice patterns.
- Medicaid membership increased almost 50% between 2008 and 2012, making the change in the covered population likely to overwhelm any attempt to estimate changes in practice patterns.
- The broadest and most consistent data set is from the entire state (1%).
- Second best data is for Medicare (0.7%).

Derivation of “Real Acuity” (cont’d)

- This calculation does not attempt to capture increases in the number of covered Medicaid beneficiaries (the All Patient Refined Diagnosis Related Group [APR-DRG] system will pay for every additional person who requires hospitalization).
- It does not attempt to capture the changing illness burden associated with adding new Medicaid populations or enrollees over time (the APR-DRG system is specifically designed to accurately pay for these types of changing profiles).
- Goal is to estimate the extent to which, for a stable group, practice pattern changes have an impact on the average acuity remaining in the inpatient setting.

INDIRECT MEDICAL EDUCATION

Indirect Medical Education (IME)

- The hospitals via CHA have requested the elimination of this factor for year one, but believe it should be revisited in future years.
- IME factor will not be included at this time.
- IME factor is less important now, given the revenue neutral approach to implementation.
- The concept and measurement of IME may become important as future policy frameworks are developed.

OUTLIER POLICY

Outlier Policy

- The hospitals, via CHA, have requested the elimination of an outlier policy for the first year, but believe this decision should be revisited in future years. There is concern regarding complexity.
- DSS and Mercer believe that an outlier policy is necessary for modernized and prospective payment.
- Outlier methods are not “less relevant” because of revenue neutrality — they are integral to modernized APR-DRG prospective payment and the goal of recognizing acuity more accurately.
- Financial modeling anticipated and always included outliers. Hewlett Packard (HP) is able to incorporate without problem.
- To the extent that hospitals agree that the risk of outliers can be assumed, however; the threshold can be set higher — so that fewer outliers are triggered, and fewer dollars fall into this category.
- Medicare and other payers utilize outlier payments and hospitals are likely familiar with those calculations.

TRANSFER POLICY

Transfer Policy

- The hospitals, via CHA, have requested the elimination of this policy, but believe this decision should be revisited in future years. There is concern regarding complexity.
- DSS and Mercer believe that a transfer policy is necessary for modernized and prospective payment.
- Transfer payments are not “less relevant” because of revenue neutrality — they are integral to payment modernization.
- Financial modeling anticipated and always considered transfers, HP is able to incorporate without problem.
- Without a transfer policy
  - With only one payment per case — likely to go to receiving hospital, disadvantaging transferring hospital
  - Making two full payments is not consistent with guiding principles.

BEHAVIORAL HEALTH AND REHAB PER DIEMS

Behavioral Health (BH) Per Diems

- BH criteria: DRG = 740-776
- Three per diem rate tiers: $975, $1,050, and $1,125.
- Rates will be the same for child and adult BH per diems to eliminate the current rate disparities.
- Each hospital will be assigned to a tier in order to approximate historical revenue levels for BH days.
- For hospitals with BH distinct part units (DPUs), tier assignment will also take into consideration BH costs as reported in their FY12 Medicare cost report.
- If a hospital's change in revenue is negative and its percentage of cost is less than 100%, then the hospital will be bumped up one tier unless it is already assigned to the highest tier.
- Hospitals without a DPU are assigned to tier one, rate of $975.

Rehabilitation Per Diems

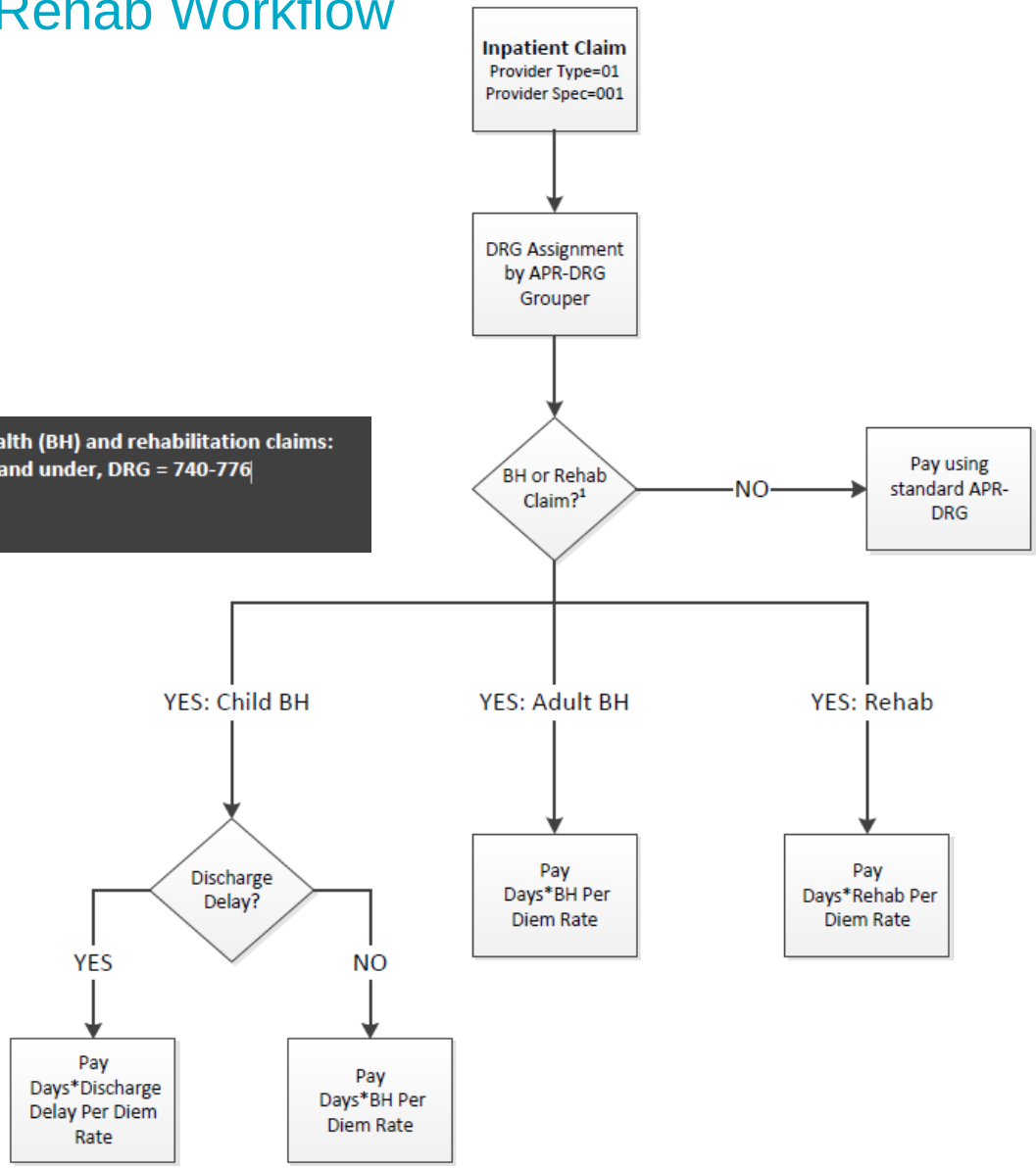
- Rehab criteria: DRG = 860
- One per diem rate of $1,370 for all rehab claims.
- This is based on 80% of the weighted average cost for the seven hospitals with a rehab DPU.
- Note: There were only 138 rehab claims in the 2012 data.

Behavioral Health (BH) and Rehab Per Diems

Inpatient BH and Rehab Workflow

[1]Criteria for identifying behavioral health (BH) and rehabilitation claims:

- **Child BH: client age 18 years and under, DRG = 740-776**
- **Adult BH: DRG = 740-776**
- **Rehabilitation: DRG = 860**



QUESTIONS AND ANSWERS

Resources

Connecticut Department of Social Services Reimbursement Modernization Website:

http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256

Connecticut Medical Assistance Program Website:

www.ctdssmap.com

Please address any additional questions in writing to:

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