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STATE OF CONNECTICUT HOSPITAL PAYMENT MODERNIZATION ISSUE PAPER — HOSPITAL REVENUE NEUTRALITY

Issue Description:	The Connecticut Department of Social Services (DSS) has selected a goal of hospital-specific revenue neutrality for the initial implementation of All Patient Refined Diagnosis Related Groups (APR-DRG) payments. The State of Connecticut (State) acute care hospital reimbursement is currently based on a hospital-specific target cost per discharge, as well as pass-through amounts calculated during a retrospective reconciliation process. As the State transitions to APR-DRG payments starting on January 1, 2015, how will hospital-specific revenue neutrality be addressed?
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Revision Date:	November 3, 2014
Status:	Revised Draft

Overview

The initial implementation of the APR-DRG payment system is intended to be revenue neutral by hospital. Revenue neutrality will be based on 2012 hospital-specific reconciliation data. This issue paper identifies how the various components of the 2012 reconciliation process will be handled under the APR-DRG system.

Definition and Context

In this case “revenue neutrality” means:

1. A new, more accurate payment system will be developed based on an analytical data set.
2. The new payment system will generate the same revenue to each hospital as the current system, assuming the same utilization of services as contained in the analytical data set, subject to the approaches defined in the remainder of this paper.
3. By design, the revenue neutral system is *not* likely to generate the same payments as the prior system when utilization patterns change, however, because it more accurately recognizes current acuity.
   A. If the first year utilization were exactly the same as the base year, revenue would remain the same.
   B. If the first year utilization is almost identical, but with one higher acuity admission — revenue will increase accordingly (and be higher than the current method would generate).
   C. If the first year utilization is almost identical, but with one lower acuity admission — revenue will decrease accordingly (and be lower than the current method would generate).

Current Payment Methodology

The current State acute hospital inpatient (IP) reimbursement methodology pays a hospital-specific per diem rate which is retrospectively reconciled to a hospital-specific per discharge target rate, plus a pass-through of other costs.

The basics of the current reconciliation formula include:

- The lower of: 1) program discharges x target amount per discharge; or 2) total program IP operating costs (excluding capital-related costs, provider-based physician costs, and medical education costs).

Plus:
- Capital-related costs for Medicaid IP routine and ancillary services.
- Program provider-based physician costs.
- Organ acquisition costs (kidney, liver, and heart).
- Medicare Severity DRG payments for heart and liver transplants (with offset of standard discharge payment).
- Costs for burn units certified by the American Burn Association.
- Direct graduate medical education (GME) payments.

Offset by:
- Indemnity payments — other party payors.
- Health care acquired condition (HCAC) payment adjustment.

In addition, under the current system there are various supplemental payments (for example, disproportionate share payments) made to hospitals which have been paid outside the reconciliation process, and will remain outside the APR-DRG system.

APR-DRG Payment Methodology

The new payment methodology is intended to establish prospective payment, and seeks to eliminate or limit the need for retrospective reconciliation. The table below addresses each of the items from the current reconciliation process with respect to its inclusion or exclusion from the new target amount:

Item from 2012 Reconciliation	Include in Target?	Notes
Lower of: 1) target amount; or 2) IP operating costs (excluding capital, provider-based physicians, and medical education)	Yes	2012 behavioral health and rehabilitation will be separately identified.
Capital-related costs for Medicaid IP routine and ancillary services	Yes	Capital costs based on 2012 reconciliation amounts. These costs will be inflated to estimate 2015 cost levels.
Program provider-based physician costs	No	Transitioning to direct billing under the professional fee schedules.

Item from 2012 Reconciliation	Include in Target?	Notes
Organ acquisition costs (kidney, heart, and liver)	No	Organ acquisition costs will be handled outside of the APR-DRG system.
Heart and liver transplants	Yes	Transplants will be paid via APR-DRG.
Costs for burn units certified by the American Burn Association	Yes	Burn admissions will be paid via APR-DRG.
Direct GME Payments	No	GME will be handled as a separate calculation and payment.
Indemnity payments — other party payors	No	Third party liability recoveries will be removed at the time of claims adjudication.
HCAC payment adjustment	No	Claims will be reduced for HCAC at the time of claims adjudication.

In addition, the target will include payments for child behavioral health (less the hospital based physician portion of those payments).

The process above results in total hospital revenue neutral target payments, which include IP claims that will be paid under an APR-DRG method and adult and child behavioral health and rehabilitation under a per diem method.

Total hospital target payments will be comprised of four separate categories:
1. Adult behavioral health claims.
2. Child behavioral health claims.
3. Rehabilitation claims.
4. APR-DRG claims.

Please see the file “Revenue Neutral Pro Forma Calc 20141009 DRAFT.pdf” for a sample calculation of the revenue neutral rate.

Follow-up Questions

In a meeting with hospitals and the Connecticut Hospital Association (CHA), questions arose around the interactions of the policies for outliers and transfers with the goal of revenue neutrality. Specifically, there were concerns that these policies could mathematically reduce the base rate, and that future year revenue neutrality will not be maintained if, for example, the number or ratio of outliers is not consistent with the data year.

Restating from above, for this project “revenue neutrality” means:
1. A new, more accurate payment system will be developed based on an analytical data set.
2. The new payment system will generate the same revenue to each hospital as the current system, assuming the same utilization of services as contained in the analytical data set, subject to the approaches defined in the remainder of this paper.
3. By design, the revenue neutral system is *not* likely to generate the same payments as the prior system when utilization patterns change, however, because it more accurately recognizes current acuity.

The discussion below attempts to add clarity on these topics:

Outliers

1. The outlier system pays more (and more accurately) for hospitals that experience the higher costs of the most difficult cases. This policy recognizes that acuity, and reduces disincentives to providing services that are associated with higher odds of outlier cases occurring (for example, immature neonates, trauma cases, etc.).
   A. If the first year utilization were exactly the same as the base year, revenue would remain as modeled (revenue neutral).
   B. If the first year utilization is almost identical, but with additional outlier admissions — revenue will increase accordingly (and be higher than the current method would provide). Payment will be more accurate because the costs associated with the first year's utilization will be higher as well.
   C. If the first year utilization is almost identical, but with fewer outlier admissions — revenue will decrease (and be lower than the current method would provide), based on lower total acuity. Payment will be more accurate because the costs associated with the first year's utilization will be lower as well.

See the attached examples.

Transfers

1. For transfer cases, a full course of treatment is typically not provided, thus these cases generate lower cost cases than the average within a DRG. Thus, within a DRG reimbursement system, transfer cases receive a prorated payment to reflect these lower costs. The discussion with the hospitals on this topic was more focused on the definition of transfers than on the transfer payment policy. Two different kinds of transfers were identified:
   A. Medical to Behavioral Health.
   B. Medical to Medical (more acute facility).

DSS has determined that the Medical to Behavioral Health transfers will be treated as two separate payment events — an APR-DRG payment being made for the first event and per diem payment being made for the second event. These situations will be considered as two admissions and not trigger the "transfer payment policy".

The transfer policy for the Medical to Medical transfer represented by discharge status of 02 and 05 (for which the DRG does not already represent a transfer case) and represents a very small portion of total costs, solves a difficult problem of paying the transferring hospital far too much, or nothing at all, and has the effect of increasing the base rate (relative to paying both facilities using a high cost APR-DRG weight). If DSS paid the full APR-DRG payment to both facilities, there would be an incentive for hospitals to increase the number of transfers. If DSS did not pay anything to the transferring facility, there could be an incentive to retain cases that would be better handled in a different facility.

The hospital from which the member is transferred will be reimbursed a per diem, based upon the DRG base payment divided by the DRG average length of stay. The resulting amount is multiplied by the sum of one plus the actual length of stay, not to exceed the total DRG base payment.

The hospital to which the member is transferred shall be reimbursed the full APR-DRG payment without any reduction due to the transfer.

Additional Follow-up Question on Outliers

In a subsequent teleconference with hospitals and the CHA, an additional request was made to consider implementing the outlier adjustment to hospital-specific base rates using an "all hospital average" approach.

Considerations

Although mathematically possible, the project team sees this idea as problematic:

1. A hospital with few outlier cases would have its base rate reduced more based on the "average expected outliers" than on its own data. As such, revenue neutrality as defined by the analytical data set would not be met as the hospital would receive less than its target. If this hospital generally has "fewer than average" outliers, future year funding would be systematically lower as well.
2. A hospital with many outlier cases would have its base rate reduced less based on the "average expected outliers" than on its own data. As such, revenue neutrality as defined by the analytical data set would not be met as the hospital would receive more than its target. If this hospital generally has "more than average" outliers, future year funding would be systematically higher as well.
3. As a result, this approach would transfer payment from those hospitals with few outlier cases to those with many — and violate the concept of hospital specific revenue neutrality. A likely result is that the smaller and more rural hospitals would see reduced revenues, and the bigger, more urban, higher acuity hospitals would see increased revenues.

DSS and the project team understand that the hospitals do not receive special consideration for outliers on a case by case basis under the current payment approach, and that there are concerns with possible changes in the levels and distribution of outliers in future years. However, adjusting all hospitals by the same amount or ratio for outliers will violate the integrity of the revenue neutrality proposition — both in the analytical data set and model, and in future payment years.

The project team continues to recommend modeling various thresholds for outliers, and using a high threshold if desired.

Additional Follow-up Question on Transfers

In a subsequent letter from the CHA, an additional request was made to consider implementing the transfer adjustment to hospital-specific base rates using an "all hospital average" approach.

Considerations

Although mathematically possible, the project team sees this idea as problematic as well:

1. A hospital that transfers very few cases would have its base rate increased more based on the "average expected transfers" than on its own data. As such, revenue neutrality as defined by the analytical data set would not be met as the hospital would receive more than its target. If this hospital generally transfers "fewer than average" cases, future year funding would be systematically higher as well.

2. A hospital that transfers many cases would have its base rate increased less based on the "average expected transfers" than on its own data. As such, revenue neutrality as defined by the analytical data set would not be met as the hospital would receive less than its target. If this hospital generally transfers "more than average" cases, future year funding would be systematically lower as well.
3. As a result, this approach would transfer payment from those hospitals with many transfer cases to those with few — and violate the concept of hospital specific revenue neutrality. A likely result is that the smaller and more rural hospitals would see reduced revenues, and the bigger, more urban, higher acuity hospitals would see increased revenues.

DSS and Mercer understand that the hospitals do not receive special consideration for transfers on a case by case basis under the current payment approach. However, adjusting all hospitals by the same amount or ratio for transfers will violate the integrity of the revenue neutrality proposition — both in the analytical data set and model, and in future payment years.

The project team continues to recommend the proposed transfer approach, represented by discharge status of 02 and 05 based on the guiding principles of the project and the desire for hospital-specific revenue neutrality. The impact of the transfer policy is expected to be small and will be modeled in the financial impact analysis.

Additional Follow-up Question on Capital

In a subsequent letter from the CHA, an additional request was made to consider applying inflation to the 2012 capital payments included in the analytical data set.

Considerations

This suggested approach adds a new level of estimation to the process, and changes the definition of revenue neutrality subtly. This approach to revenue neutrality has the conceptual appeal of making the change in method more clearly apply to the year of implementation, but it does require more assumptions and estimates than the original approach. It adds additional hospital funding through the use of assumed inflation rates on hospital capital allocation levels under the previous method.

Decision

DSS considers this proposed refinement in method to be consistent with the guiding principle of revenue neutrality (from any change in payment method) by adding additional specificity regarding the inflation in capital funding which likely would have affected the previous method in 2015. Mercer has been asked to develop an estimation process to derive 2015 expected levels of capital and to consider the data provided by CHA. This issue paper has been revised to incorporate this change in definition.

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Payment Comparison with and without Outlier Claim

Example 1 — Reimbursement Methodology Includes an Outlier Policy

Outlier claims highlighted in red

Base Year Claim Set with Outlier Claim Present and Same Claim Set Paid with DRGs

DRG	Claim Cost	DRG WT	Outl Thresh	DRG Paid	Outl Payment	All DRG System Payments
A	12,000	2.1667		11,280.14		11,280.14
A	14,000	2.1667		11,280.14		11,280.14
B	15,000	2.2778		11,858.60		11,858.60
B	10,000	2.2778		11,858.60		11,858.60
B	16,000	2.2778		11,858.60		11,858.60
C	10,000	1.7778		9,255.50		9,255.50
C	10,000	1.7778		9,255.50		9,255.50
C	12,000	1.7778		9,255.50		9,255.50
C	55,000	1.7778	40,000	9,255.50	11,250	20,505.50
D	2,500	0.4611		2,400.64		2,400.64
D	3,000	0.4611		2,400.64		2,400.64
D	2,800	0.4611		2,400.64		2,400.64
Total	162,300	19.6611		102,360.00	11,250	113,610.00
Avg Cost	13,525.00					
Current rate at 70% of cost	9,467.50					
Total Paid	113,610.00			102,360.00	11,250	113,610.00
Cost Coverage	70.00%					70.00%

Future Claim Set without Outlier Claim Present

DRG	Claim Cost	DRG WT	Outl Thresh	DRG Paid	Outl Payment	All DRG System Payments
A	12,000	2.1667		11,280.14		11,280.14
A	14,000	2.1667		11,280.14		11,280.14
B	15,000	2.2778		11,858.60		11,858.60
B	10,000	2.2778		11,858.60		11,858.60
B	16,000	2.2778		11,858.60		11,858.60
C	10,000	1.7778		9,255.50		9,255.50
C	10,000	1.7778		9,255.50		9,255.50
C	12,000	1.7778		9,255.50		9,255.50
				-		-
D	2,500	0.4611		2,400.64		2,400.64
D	3,000	0.4611		2,400.64		2,400.64
D	2,800	0.4611		2,400.64		2,400.64
Total	107,300	17.8833		93,104.50		93,104.50
				86.77%		

Future Claim Set with an Additional Outlier Claim

DRG	Claim Cost	DRG WT	Outl Thresh	DRG Paid	Outl Payment	All DRG System Payments
A	12,000	2.1667		11,280.14		11,280.14
A	14,000	2.1667		11,280.14		11,280.14
B	15,000	2.2778		11,858.60		11,858.60
B	10,000	2.2778		11,858.60		11,858.60
B	16,000	2.2778		11,858.60		11,858.60
C	10,000	1.7778		9,255.50		9,255.50
C	10,000	1.7778		9,255.50		9,255.50
C	12,000	1.7778		9,255.50		9,255.50
C	55,000	1.7778	40,000	9,255.50	11,250	20,505.50
C	55,000	1.7778	40,000	9,255.50	11,250	20,505.50
D	2,500	0.4611		2,400.64		2,400.64
D	3,000	0.4611		2,400.64		2,400.64
D	2,800	0.4611		2,400.64		2,400.64
	217,300	21.4389		111,615.50		134,115.50
						61.72%

DRG Rate Determination

Total Paid	113,610.00
Outlier Carve-Out	11,250.00
Inliers	102,360.00
Total Weight	19.6611
Rate	5,206.22

Example 2 — Reimbursement Methodology Does Not Include an Outlier Policy

Outlier claims highlighted in red

Base Year Claim Set with Outlier Claim Present and Same Claim Set Paid with DRGs

DRG	Claim Cost	DRG WT	DRG Paid
A	12,000	2.1667	12,519.89
A	14,000	2.1667	12,519.89
B	15,000	2.2778	13,161.94
B	10,000	2.2778	13,161.94
B	16,000	2.2778	13,161.94
C	10,000	1.7778	10,272.73
C	10,000	1.7778	10,272.73
C	12,000	1.7778	10,272.73
C	55,000	1.7778	10,272.73
D	2,500	0.4611	2,664.49
D	3,000	0.4611	2,664.49
D	2,800	0.4611	2,664.49
Total	162,300	19.6611	113,610.00
Avg Cost	13,525.00		
Discharge rate at 70%	9,467.50		
Total Paid	113,610.00		

DRG Rate Determination

Total Paid	113,610.00
Outlier Carve-Out	-
Inliers	113,610.00
Total Weight	19.6611
Rate	5,778.41

Cost Coverage	70.00%	70.00%	

Future Claim Set without Outlier Claim Present

DRG	Claim Cost	DRG WT	DRG Paid
A	12,000	2.1667	12,519.89
A	14,000	2.1667	12,519.89
B	15,000	2.2778	13,161.94
B	10,000	2.2778	13,161.94
B	16,000	2.2778	13,161.94
C	10,000	1.7778	10,272.73
C	10,000	1.7778	10,272.73
C	12,000	1.7778	10,272.73
D	2,500	0.4611	2,664.49
D	3,000	0.4611	2,664.49
D	2,800	0.4611	2,664.49
Total	107,300	17.8833	103,337.27
			96.31%

Future Claim Set with an Additional Outlier Claim

DRG	Claim Cost	DRG WT	DRG Paid
A	12,000	2.1667	12,519.89
A	14,000	2.1667	12,519.89
B	15,000	2.2778	13,161.94
B	10,000	2.2778	13,161.94
B	16,000	2.2778	13,161.94
C	10,000	1.7778	10,272.73
C	10,000	1.7778	10,272.73
C	12,000	1.7778	10,272.73
C	55,000	1.7778	10,272.73
C	55,000	1.7778	10,272.73
D	2,500	0.4611	2,664.49
D	3,000	0.4611	2,664.49
D	2,800	0.4611	2,664.49
Total	217,300	21.4389	123,882.73
			57.01%

Summary

Outlier policies help to mitigate risk if outlier cases occur. As seen in the examples above, if a hospital has an outlier in the base year claim set but fewer outliers in future years, their cost coverage increases regardless if there is or is not an outlier payment methodology in place. If additional outlier cases occur in future years, cost coverage will decrease regardless. However, with an outlier payment methodolgy in place, this redcution in cost coverage is mitigated.