STATE OF CONNECTICUT HOSPITAL REIMBURSEMENT MODERNIZATION

Transition to an All Patient Refined-Diagnosis Related Group Payment System (APR-DRG)

Current Inpatient Reimbursement Method

Hospital-specific Case Rate:

- interChange cannot process case rate payments. Instead, claims are paid at a hospital-specific, interim per-diem rate.
- The case rate is same for every claim, regardless of diagnosis or length of stay.
- Pass-through payments are paid at actual cost which includes: Capital, Hospital Based Physicians, and Graduate Medical Education.

- Settlement process occurs after year end. The process reconciles per diem rates to case rates and actual pass-through.

- Child behavioral health claims, stand-alone psychiatric hospitals, and children's hospitals (CCMC) are paid separate per diem rates and are not affected by the case rate settlement process.

Current Inpatient Reimbursement Method

Inpatient stays are reimbursed at a hospital specific case rate which is **not linked** to services provided or case acuity

Incentivizes hospitals to take less complex cases and avoid higher acuity cases with long anticipated lengths of stay

Incentivizes hospitals to discharge patients as quickly as possible

Provides no incentive to control pass through costs

No penalty for readmissions

Case rates **are not** compatible with modern reimbursement methodologies or delivery of care models

Legislative Authority

In 2013, the Legislature amended hospital statutes giving necessary authority to implement an APR-DRG system.

Connecticut General Statutes 17b-239
as amended by Public Act 13-247

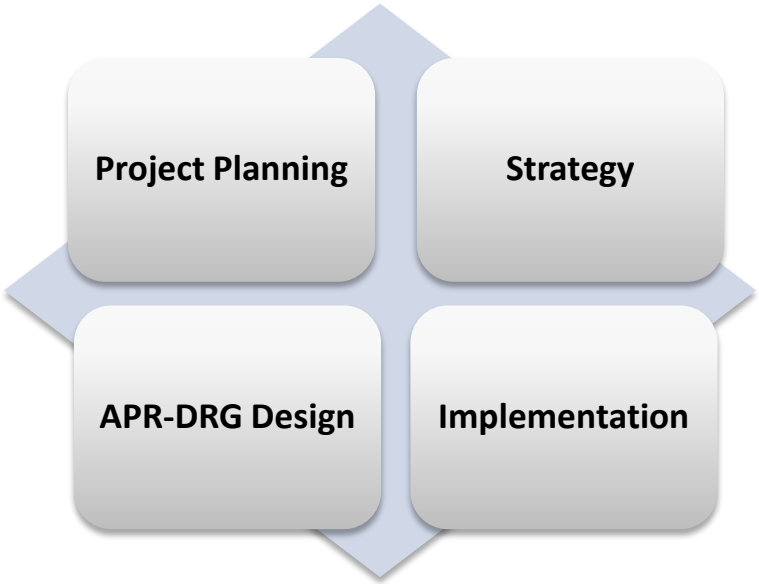
(2) **On or after July 1, 2013, Medicaid rates paid to acute care and children's hospitals shall be based on diagnosis-related groups established and periodically rebased by the Commissioner of Social Services** … The Commissioner of Social Services shall annually **determine inpatient rates for each hospital by multiplying diagnostic-related group relative weights by a base rate**. Within available appropriations, the commissioner may, in his or her discretion, make additional payments to hospitals based on criteria to be determined by the commissioner. Nothing contained in this section shall authorize Medicaid payment by the state to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

How to undertake a hospital modernization reimbursement effort while considering multiple stakeholder interests?

(…plus 19 other hospitals.)

Collaboration

The Department of Social Services' Division of Health Services works in partnership with stakeholders and consultants to create and implement a new method of hospital reimbursement. Plan of action includes:



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CERTIFIED PUBLIC ACCOUNTANTS

MERCER

Stakeholder Participation & Project Transparency

Technical Advisory Group

Participants:

- DSS
- Consultants
- Connecticut Hospital Association
- Hospital Representatives
- OPM

Goal:

- Active participation in the design
- Feedback
- Share Ideas
- Minimize unintended consequences
- Transparency

Result: Gridlock - Platform for BIG POLICY issues - Agenda creep

Stakeholder Participation & Project Transparency - Redux

Revised Approach:

Design, Share, Feedback, Adjust

3 In-Person Presentations (with Q&A)

- Introductory
- Basic Design
- Design Details

Bi-weekly Conference Webinars

- All hospitals are invited to participate
- Review agenda items and issue papers

Stakeholder Participation & Project Transparency

Developed Hospital Reimbursement Modernization Website

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

- Automatic list-serve e-mail updates when content is updated

Update State Regulations

- Fiscal Note
- Draft to OPM and the Governor's Office
- Public Notice

Medicaid State Plan Amendment

- Public Notice
- Attachment 4.19A
- SPA 15-001

Stakeholder Participation & Project Transparency

The Department posts "Issue Papers" on the project webpage, to frame critical project decision points.

Hospital Payment Modernization (HPM) Issue Papers

2014

CT HPM Issue Paper - 3M National Weights - *Revision Date: August 12, 2014*

CT HPM Issue Paper - Coding Improvements - *Revision Date: October 9, 2014*

CT HPM Issue Paper - Indirect Medical Education (IME) Adjustment Factor - *Revision Date: August 19, 2014*

CT HPM Issue Paper - Outlier Policy and Approach - *Revision Date: August 19, 2014*

CT HPM Issue Paper - Revenue Neutrality - *Revision Date: October 9, 2014*

CT HPM Issue Paper - Transfer Payment Policy and Approach- *Revision Date: August 19, 2014*

Why Diagnosis-Related Groups (DRGs)?

The DRG system was developed by Yale University and first implemented in New Jersey in 1980.

Benefits of a DRG System:

- Greater administrative simplification for hospital providers and DSS by following established Medicare reimbursement policies and procedures.
- Greater accuracy and predictability in matching reimbursement to relative cost and complexity.
- Greater ability to partner with Medicare and other payers in developing innovative payment strategies designed to reward *quality* as opposed to *quantity* of care.
- Eliminates the need for settlements, and creates budgetary ease for both DSS and hospitals.
- The DRG method is ICD-10 compliant. (99.75% precision from ICD-9 to ICD-10)

What is a Diagnosis Related Group (DRG)?

- Each group contains patients with **similar patterns** of resource utilization. (staffing patterns, supplies, etc.)
- Groups are based on primary and secondary diagnoses, surgical procedures, age (pediatric vs. adult), and newborn birth-weight.
- Connecticut will be implementing All Patient Refined-DRG (APR-DRG) which is designed for public and commercial organizations.
- **Higher acuity results in a higher payment**.

What is an APR-DRG?

- The Department chose APR-DRGs because the method is **most appropriate** for Medicaid populations.
- Our intent was to mirror Medicare but the Medicare grouper is not appropriate since it does not focus on pediatrics, newborns, or pregnant women.
- There are **over 300** APR-DRG groups and each contains four levels of Severity of Illness (SOI)
- APR-DRG is **patient-centered** as payment within a group is determined by severity of illness and risk of mortality.

How are APR-DRG payments calculated?

DRG Payment = Base Rate x DRG Weight

- In **year 1**, Base Rates are calculated on a hospital-specific basis and are revenue neutral for the hospital
- In **years 2 through 5**, the base rates will be melded together to eventually establish a state-wide base rate or peer group base rates
- DRG weights will be based on **national APR-DRG weights** rather than a Connecticut specific weight
- Weights will be updated every 1 to 2 years
- The more acute the case, the higher level of hospital resources used, therefore **the higher the weight and the higher the payment**

Examples of APR-DRG Weights

DRG	SOI*	DRG	DRG Description	Weight	ALOS
55	1	055-1	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	0.6365	1.76
55	2	055-2	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	0.8726	2.66
55	3	055-3	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	1.3717	3.68
55	4	055-4	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	3.3854	8.82
56	1	056-1	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR	0.6594	1.79
56	2	056-2	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR	0.9378	2.68
56	3	056-3	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR	1.472	4.32
56	4	056-4	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR	3.7182	10.56
57	1	057-1	CONCUSSION, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	0.6401	1.29
57	2	057-2	CONCUSSION, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	0.8432	1.86
57	3	057-3	CONCUSSION, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	1.2448	3.24
57	4	057-4	CONCUSSION, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	3.1443	7.46

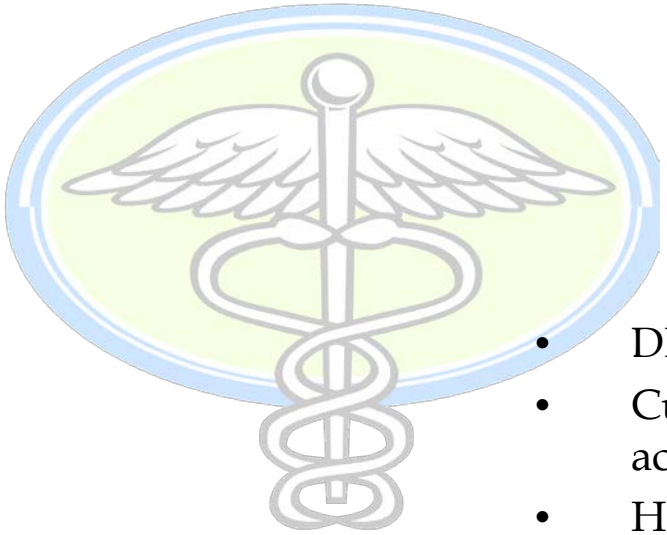
*Severity of Illness

Other Considerations: Coding

- The current system **does not** incentivize proper coding as every claim is paid at the hospital's case rate.
- For APR-DRGs to work as intended, **claims must be properly coded** with complete and accurate diagnoses and surgical procedure codes.
- **Coding is expected to improve** leading to higher weighted DRGs and higher payment.
- Calculated base rates were reduced to account for expected changes in acuity – real increase and increase due to better coding.

Other Considerations: Behavioral Health – Per Diem (no DRG)

- Assigned DRG of 740 – 776 but paid at one of three per diem rates ($975, $1,050, $1,125)
- To eliminate current rate disparities, rates will be the same for child and adult
- Each hospital is assigned a tier that approximates historical revenue levels for BH days



Other Considerations: Physician Services within a Hospital

- DRGs are not designed to include a physician component.
- Current rates do include hospital based physicians based on actual cost.
- Hospital based physicians will need to enroll and bill from the physician fee schedule.

Questions?