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ISSUE PAPER — AMBULATORY PAYMENT CLASSIFICATION POLICY CHANGES

State of Connecticut Hospital Payment Modernization

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Overview

To support the modernization of hospital payments in the State of Connecticut, the Connecticut Department of Social Services (DSS) implemented ambulatory payment classification (APC) reimbursement methodology using a combination of the current Medicaid Management Information System and the APC grouper software to process outpatient hospital claims.

Policy changes made by DSS that could impact the APC project, or were a result of the APC project, were identified and appropriately addressed in the data modeling and analysis.

Discussion

Key policy changes are typically communicated to providers via provider bulletins issued by DSS. In preparation for the APC implementation, in January 2014, DSS issued provider bulletin 2014-06 "Revenue Center Codes (RCCs) Requiring a Valid CPT or HCPCS Procedure Code on Outpatient Claims", which required outpatient claims to include valid procedure codes for dates of service on or after May 1, 2014. This policy change was necessary to support data modeling at the procedure code level and ultimately to ensure that claims would be processed correctly by the grouper upon implementation. Outpatient claims data with dates of services from May 1, 2014 through December 31, 2014 paid through April 10, 2015 were used to develop the APC conversion factor.

Policy changes were categorized into two types:

1. Existing policy changes implemented after the first date of service in the claims data being used for analysis (May 1, 2014) and prior to implementation of APCs.
2. New policy changes that became effective on the APC implementation date of July 1, 2016.

Provider Bulletins

To help with the identification of policy changes, select provider bulletins that were issued after provider bulletin 2014-06 were reviewed. A summary of the provider bulletins reviewed and considered for potential impact on the APC project is provided in the following table. For those bulletins where an APC impact has been identified (in **bold** below), further explanation is provided within this paper.

Provider Bulletins Considered for the APC Project

Number	Bulletin Name	APC Impact?
2014-23	Timely Completion of Medical Records in the Hospital Setting	No
2014-27	Outpatient Border Hospital Rates	No
2014-32	Partial Day Billing for Behavioral Health Intermediate Levels of Care	No
2014-37	Billing Requirements for Urgent and Emergent Care	No
2014-60	**Reimbursement for Practitioner Services Rendered in the Facility Setting**	**Yes**
2014-74	**Tobacco Cessation Group Counseling at Hospital Outpatient Settings**	**Yes**
2014-86	Changes to Connecticut Medicaid Preferred Drug List	No
2014-88	Billing for Emergency Department Services	No
2014-96	Consolidated Laboratory Fee Schedule Update	No
2014-99	Autism Spectrum Disorder (ASD) Evaluation and Treatment Services	No
2015-20	**Establishment of Fixed Fees for Certain Outpatient Procedures**	**Yes**
2015-25	Digital Breast Tomosynthesis	No
2015-37	Tobacco Cessation Group Counseling Services	No
2015-46	Revised Billing Instructions for Outpatient Claims	No
2016-06	**Hospital Based Practitioners — Outpatient Services**	**Yes**
2016-25	**Update Regarding Outpatient Hospital Modernization — Outpatient Prospective Payment System (OPPS)**	**Yes**
2016-34	**Guidelines for Observation for Medical and Behavioral Health Services**	**Yes**
2016-35	**Outpatient Hospital Modernization — Behavioral Health Services**	**Yes**

In a letter to providers dated August 26, 2015, DSS communicated an additional policy change to the payment rate for RCC 901, electroconvulsive therapy services, which was also identified as having an impact to the APC project.

Existing Policy Changes

The following existing policy changes were identified to have an impact to the APC project. The impact to the APC project is described in more detail below:

1. Reimbursement for Practitioner Services Rendered in the Facility Setting (2014-60)
2. Tobacco Cessation Group Counseling at Hospital OP Setting (2014-74)
3. Establishment of Fixed Fees for Certain Outpatient Procedures (2015-20)
4. Outpatient Reimbursement for RCC 901 (provider letter)

Reimbursement for Practitioner Services Rendered in the Facility Setting

As of October 1, 2014, DSS adjusted reimbursement for practitioners based on the facility type code. This policy change impacts professional services and the physician services analysis that was performed as part of the APC project. The physician services analysis involved shadow pricing professional claims using the appropriate physician fee schedules. The physician services analysis utilized the updated fee schedules identified in this policy change.

Tobacco Cessation Group Counseling at Hospital Outpatient Settings

As of October 1, 2014, DSS began paying for tobacco cessation group counseling as a new covered service. These services had limited representation in the data set. Analysis was completed to ensure the financial impact was understood and our review concluded that these services were excluded from APC and there was no impact.

Establishment of Fixed Fees for Certain Outpatient Procedures

As of April 1, 2015, DSS changed its pricing to use fixed fees for certain outpatient procedures. The claims data utilized for the development of the APC conversion factor were for dates of service prior to this policy change and were adjusted to reflect the new fees.

A summary of the criteria used to adjust allowed amounts in the data modeling is provided in the table below:

Data Modeling Adjustments for New Fixed Fees

Service	Criteria	Adjusted Allowed Amount
Chest X-Ray	CPT 71010, 71015, 71020, 71021, 71022, 71030, 71035	$ 28.90
Screening Mammography	CPT 77052, 77057, G0202	$ 117.91
Unlisted procedure, dental alveolar structures	CPT 41899*	$ 2,000.00

**Maximum units allowed for this code is one.*

Outpatient Reimbursement for RCC 901

Effective July 1, 2015, DSS changed the fee paid for RCC 901, electroconvulsive therapy services, from $105.46 to $446.29. For RCC 901, the updated fee of $446.29 was used as the adjusted allowed amount for the purposes of data modeling.

New Policy Changes

The following new policy changes were a result of the APC implementation. The impact to the APC project is described in more detail below:

1. Hospital Based Practitioners — Outpatient Services (2016-06)
2. Update Regarding Outpatient Hospital Modernization — OPPS (2016-25)
3. Guidelines for Observation for Medical and Behavioral Health Services (2016-34)
4. Outpatient Hospital Modernization — Behavioral Health Services (2016-35)

Hospital Based Practitioners — Outpatient Services

Effective July 1, 2016, hospitals will be reimbursed outside of the OPPS for outpatient professional fees. The analytical dataset includes bundled professional services and was adjusted for estimated professional claims from unbundling. See the Professional Services Issue Paper for details on this topic.

Update Regarding Outpatient Hospital Modernization — OPPS (Pharmacy Services with Status Indicators "G" and "K" and Diagnostic Mammograms)

Effective July 1, 2016, DSS modernized outpatient hospital reimbursement to a prospective payment model that includes the APC methodology. Provider bulletin 2016-25 addresses broad topics related to outpatient hospital payment modernization, such as updates to the regulations and the provider manual, as well as the role of the Connecticut Medical Assistance Program (CMAP) Addendum B, which is used to document the payment methodology for procedure codes outpatient providers can submit for reimbursement.

Highlighted below are two policy changes which are documented in CMAP Addendum B and were also included in the May 26, 2016 APC presentation for the hospitals:

- Pharmacy Services with status indicators "G" and "K" — on July 1, 2016, DSS began reimbursing pharmacy services with status indicators "G" and "K" based on the Medicare fee schedule, which overall provides a lower reimbursement level than what was paid previously. An adjustment was made to the APC target to account for this policy change.
- Diagnostic Mammograms — on July 1, 2016, DSS began reimbursing diagnostic mammograms (RCC 401) based on a fixed fee instead of a ratio of cost to charges. Due to the timing of this decision and the estimated overall small impact of this change, no adjustments were made to the analytical dataset or APC target.

Guidelines for Observation for Medical and Behavioral Health Services

Effective July 1, 2016, DSS will follow Medicare guidelines for observation services. Modeling the impact of this policy change was beyond the scope of the data analysis and no adjustments were made to the analytical dataset or APC target.

Outpatient Hospital Modernization — Behavioral Health Services

Effective July 1, 2016, outpatient behavioral health services will be modernized, but will not be paid, using the APC methodology. Changes to the payment methodology for routine behavioral health services were determined to have an impact on the APC target, and an adjustment was made to the APC target to account for this policy change.

Conclusion

The impact of existing and new policy changes on the transition to APCs has been evaluated and addressed to help ensure the data used for analysis and modeling has been adjusted as appropriate.