MERCER
MAKE TOMORROW, TODAY

ISSUE PAPER — PROFESSIONAL SERVICES

State of Connecticut Hospital Payment Modernization

Lead:	James Matthisen
Contributors:	Janet Flynn, Mike Krein, Sarah Yahna
Revision Date:	April 7, 2016
Status:	Draft

Overview

Moving to Ambulatory Payment Classifications (APCs) for outpatient hospital requires that some services currently "bundled" (into one payment to the hospital) will transform into two payments — one for the hospital, and another for the physician or professional performing the service. In order to accurately set the APC conversion factor, it is important to estimate the universe of payments comprising the APC system. Payments for services no longer considered outpatient hospital need to be estimated and removed from the derivation of the conversion factor.

Discussion

Because payments are not split into hospital versus professional in our data sets, it is impossible to use them to directly calculate the current costs of the professional services that will move outside of the hospital payment system. Our method instead attempts to find the professional services and derive the expected payments associated with these services under existing professional fee schedules. These estimated payments for previously bundled professional services were subtracted from the total hospital payments to generate the target amount representing ***all claims which were submitted as outpatient during the data period, and which would be expected to remain as outpatient claims in the modernized system.***

Base Data

The following base data was used for the identification of bundled professional services:

- Outpatient institutional claims data.
- Dates of service from May 1, 2014 through December 31, 2014.
- Revenue center codes (RCCs) 456, 51x, 28x, 33x, 41x, 48x, 72x, 76x, and 95x.
- Relevant procedure codes found on the detail lines of the above RCCs.

Fee Schedule Sources and Criteria

The current provider fee schedules were used for the professional services shadow pricing analysis:

- https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx

Fee Selection Process

The process for shadow pricing the institutional claims data at the professional fee schedule included the following steps using the base data identified above:

1. Using the billing provider ID, attending provider ID, attending provider type and specialty, age of the client and primary diagnosis, certain procedure codes from these claims were flagged as being eligible for:
   A. Husky Health Primary Care rates
   B. Obstetrics fee
   C. Pediatric fee
   D. 90% of the physician fee
   E. Person-Centered Medical Home (PCMH) increment
2. Data was grouped by each of the above flags, RCC, provider type, provider specialty and procedure code.
3. Fees from the State of Connecticut Department of Social Services fee schedules were then attached to each record based on procedure code. In instances where multiple rate types were identified for a given procedure code, the fees and associated flags were manually reviewed to determine which fee schedule and rate type to assign. For RCCs 28x, 33x, 41x, 48x, 72x, 76x, and 95x many of the procedure codes represented the technical component of the service. In these instances, the procedures that were not found on the designated fee schedules were not shadow priced.
4. After fees were assigned, it was determined if the fee for a given procedure code should be 90% of the physician fee schedule or if the procedure code would be eligible for an enhanced PCMH fee increment. If a procedure code was determined to be both 90% of the physician fee and eligible for the enhanced PCMH fee increment, the PCMH increment was calculated from the 90% adjusted fee.
5. Total dollars were estimated by multiplying the procedure code counts by the assigned fee. This analysis was completed and summarized by RCC.

Conclusion

The following table provides a summary of the estimated professional claims from unbundling that were used to adjust the APC target for the conversion factor calculation. These amounts represent the additional professional billing for services formerly included in outpatient hospital reimbursement.

RCC	Shadow Price Amount
456	$2,556,674
51x	$5,721,974
28x, 33x, 41x, 48x, 72x, 76x, and 95x	$4,612,572