

FREQUENTLY ASKED QUESTIONS — TRANSITION TO AMBULATORY PAYMENT CLASSIFICATION (APC)

State of Connecticut Hospital Payment Modernization

June 17, 2016

Policy Topics

1. What is the implementation date for the APC payment methodology?

July 1, 2016.

2. What version of the APC grouper will be used at implementation?

3M CMS OCE/APC v17.1 (April 2016) will be in production for the July 1, 2016 implementation. While the Connecticut Department of Social Services (DSS) recognizes that the July 2016 update (version 17.2) is available, it is too close to the implementation date to incorporate these changes at this time. DSS will work with Hewlett Packard Enterprise (HPE) to schedule the updates needed for version 17.2.

3. Is there Connecticut-specific APC grouper software available?

HPE has contacted 3M Health Information Systems (HIS) regarding offering the Connecticut Medicaid APC initiative within the 3M software. 3M HIS has requested that all hospitals interested in this feature please contact their 3M Client Relationship Executive.

4. Will DSS stay current with Medicare and update the system every January and also implement any quarterly coding changes?

Yes, DSS plans to stay current with Medicare and update the system with the January and quarterly updates that are consistent with Connecticut Medical Assistance Program's (CMAP) regulations and policy. The specific timing of when the updates will be applied has not yet been finalized and will be dependent on factors such as the release date for the Medicare files. The APC System Updates [issue paper](#) will be revised to reflect this approach.

5. Is the implementation of APCs intended to be budget neutral? Will a cost trend factor to adjust from the base data period of 2014 be applied?

The implementation is based on budget-neutral modeling approaches, and is based on the 2014 data set. Due to the complexity of outpatient payment, and varying levels of data completeness and accuracy, the calculation of hospital-specific revenue neutrality was not deemed to be accurate enough to consider. No cost inflation assumptions have been included in the calculation of the conversion factor.

6. Will DSS monitor and evaluate the new system to determine if it maintains budget neutrality for the State?

Yes, DSS will monitor payments on an ongoing basis.

7. How often will the conversion factor change?

There is not a conversion factor update schedule at this time.

8. Will a statewide conversion factor be used?

Yes, most hospitals will be paid based on a statewide conversion factor but there may be some exceptions to this policy. A separate conversion factor has been developed for Connecticut Children's Medical Center.

9. Will there be a phase-in of the conversion factor from hospital-specific to statewide?

The APC project will have a uniform implementation date of the statewide conversion factor on July 1, 2016. A phase-in process is not planned.

10. Will the conversion factor be wage adjusted?

Yes, Medicare wage indices **prior** to reclassification will be applied to the statewide conversion factor.

11. Why are the reclassified Medicare wage indices not used?

It was determined that the original wage indices would be more appropriate for the conversion factor calculation.

12. Why are wage indices applied when Connecticut is a small area state?

The project has a guiding principle to follow Medicare as closely as possible and methods show a variation in wages by geography.

13. Will DSS provide a CMAP specific Addendum B?

Yes, DSS has published [CMAP Addendum B](#) and an associated [issue paper](#).

14. Will behavioral health (BH) services be excluded from the APC methodology?

Yes, revenue center codes (RCCs) 90x, 91x, and 953 will all be excluded from the APC methodology. Please see the APC Policy Exclusions and Behavioral Health Services [issue papers](#) for additional information.

15. Will BH services continue to be paid using the BH revenue center code rates?

Two behavioral health (BH) services (Electroshock Treatment and Tobacco Cessation Group Counseling) will continue to pay using the BH RCC. Another subset of BH services will continue to use the existing BH RCC rates but pay based on procedure codes. For example, Group Therapy, Partial Hospitalization Program, and the Intensive Outpatient Program. Please see the APC Policy Exclusions and Behavioral Health Services [issue papers](#) for a complete list of services. All other BH services payments will be based on existing procedure code rates found on the BH Clinic fee schedule. A policy transmittal providing more guidance on billing for BH services will be forthcoming.

16. What fee schedules will be used for BH services?

The majority of BH outpatient services will be paid according to the fees on the BH Clinic-Outpatient fee schedule. Specific rate types have been designated for Outpatient Mental Health, Outpatient Enhanced Care Clinic and Outpatient Chronic Disease. The Electroshock Treatment and Tobacco Cessation Group Counseling will use the Outpatient Hospital fee schedule.

17. Will other services be excluded from the APC methodology?

Yes, please see the APC Policy Exclusions [issue paper](#) for additional information.

18. How will lab services be paid?

The approach to payment of lab services is similar to Medicare's payment methodology, differing only when coverage is different. That is, in most cases the APC status indicator will dictate the payment method. This includes the newest status indicator value of Q4, which designates whether services are packaged or paid for based on the lab fee schedule used to price lab services provided to non-patients. Please see [CMAP Addendum B](#) and the associated [issue paper](#) for specific lab code information.

19. How will outpatient professional services be reimbursed?

Those professional services delivered by a hospital-based provider and eligible for separate reimbursement are reimbursed based on the physician fee schedule. The current physician fee schedules can be accessed and downloaded from the CMAP website, www.ctdssmap.com. For exceptions to this policy and additional information, see provider bulletin PB 2016-06.

20. Will providers need to enroll with Medicaid to be eligible for payment?

Yes, providers who are not already enrolled will need to enroll with Medicaid in order to be eligible for payment. Due to the change in billing requirements for professional services, it is expected that providers will be actively enrolling prior to APC implementation. Additional information can be found in provider bulletin PB 2016-06.

21. Can emergency room practices bill directly — not through the hospital?

Yes, emergency room practices that are enrolled Medicaid providers can bill directly effective for dates of service July 1, 2016.

22. Which professionals should not bill directly on the professional claim form?

The detailed changes to professional billing related to outpatient services can be found in provider bulletin PB 2016-06.

23. Can the hospital practitioner groups bill for outpatient professional BH services?

Most outpatient BH services in the hospital setting are considering an all-inclusive service and therefore the professional fees should not be submitted separately. The exceptions to this are outlined in provider bulletin PB 2016-16.

24. How will pharmacy services with status indicator of "G" or "K" be reimbursed?

Pharmacy services with status indicator of "G" or "K" will be paid using the Medicare payment rate reflected in [CMAP Addendum B](#).

25. Is DSS following Medicare's bundling policy for status indicator = "N"?

DSS is following Medicare's bundling process and policy. The few exceptions where a procedure code assigned a status indicator = "N" that is not bundled are related to services excluded from APCs such as BH and vaccines or services not covered by DSS.

26. Where are the Medicaid policies for status indicators J1, Q1, Q2, Q3, S, T and V that state why the APCs identified on Addendum B are not reimbursed by Medicaid?

The policies for APCs that are identified by Medicare in Addendum B, but not reimbursed by Medicaid, will be found in the updated Outpatient State Regulations: Sec. 17b-262-973, Services Not Covered and Sec. 17b-262-970, Services Covered and Limitations. Please note there are some specific procedure codes not payable in Medicaid but the service is covered and must be billed under a different procedure code.

27. Will the policy for observation services be changing?

Yes, as noted in the APC Policy Changes [issue paper](#), new criteria will be used for observation services. DSS will be following Medicare's billing guidelines for observation and will be issuing a provider bulletin regarding the new criteria.

28. How will outliers be handled?

Please see the Outpatient Outliers [issue paper](#).

29. How would a hospital calculate its specific claim payments?

Hospitals should use the CMAP Addendum B Payment Type to determine if the procedure code is eligible for an APC payment. For procedure codes that have a payment type of APC, hospitals can use the APC grouper software they currently use for Medicare to obtain the key APC data elements such as APC group, relative weight and discount factors. This information along with the wage adjusted conversion factor will allow the hospital to calculate the APC payment.

30. Is there an APC payment example?

Yes, Attachment A of the Outpatient Outliers [issue paper](#) provides an APC payment example. Additional examples are provided in HPE's provider training.

Data Topics

1. What time period of data was used for conversion factor development?

The base data used for the conversion factor calculation was outpatient claims with dates of service from May 1, 2014 through December 31, 2014, paid through April 10, 2015.

2. Was the data or analysis annualized?

No.

3. Are Medicare crossover claims included in the analytical data set?

No.

4. How was third party liability (TPL) handled in the analytical data set?

The analytical data set includes claims where Medicaid was not primary. For these (and all claims), "Medicaid Allowed", not the final payment amount, was used for the Fiscal Impact Model. As the APC system goes into effect, the TPL adjudication approach will continue unchanged — except the Medicaid allowed will be based on APC methods.

5. Was the base data adjusted for policy changes?

Yes, please see the APC Policy Changes [issue paper](#).

6. Does the APC conversion factor calculation include an adjustment for disproportionate share hospitals?

No.

7. Does the APC conversion factor calculation include an adjustment for graduate medical education?

No.

8. Was the Hospital Tax used in the development of the APC conversion factor?

No.

9. What cost to charge ratios were used for determining the current payment amounts in the Fiscal Impact Model?

The Medicaid allowed amount from the analytical data set was used in the determination of current payment amounts. Claims from May 1, 2014 through June 30, 2014 are based on percent of charges from the federal fiscal year 2011 (FFY11) cost report and claims from July 1, 2014 through December 31, 2014 are based on percent of charges from the FFY12 cost report.

10. What cost to charge ratios were used for determining outlier payments in the conversion factor calculation?

For each hospital an overall outpatient cost-to-charge ratio was calculated using information from the Medicare cost report with a fiscal year ending in 2014. The charge and cost data was obtained from Worksheet D, Part V.

11. Will cost to charge ratios be used in the future payment system?

The new system uses fixed fees and only utilizes cost-to-charge ratios for outliers. Cost-to-charge ratios will be updated annually.

12. Is there an issue paper explaining how the estimated impact of unbundling professional claims was calculated?

Yes, please see the Professional Services [issue paper](#).

13. What year Addendum B was used for the APC claim detail file?

The 2014 grouper and Addendum B were used in order to match to the claims data time period.

14. Which grouper was used for the data analysis?

The 2014 3M APC Medicare grouper was used. In addition, results from the 2013 grouper were evaluated to help inform and improve the data analysis.

15. Why wasn't the current grouper version used?

The 2014 grouper was used in order to match to the claims data time period. Using a grouper version that does not match the time frame of the data set could potentially increase the error rate because a more recent grouper version reflects coding guidelines not available when the 2014 claims were billed.

16. What analysis has been performed to understand the changes from the base period of 2014?

No specific analysis has been performed, billing practices and groupers need to change in tandem. However, the conversion factor based on the 2014 data set remains relevant as Medicare's updates are intended to be revenue neutral.

17. Given Medicare's APC grouper updates are intended to be revenue neutral for the Medicare population, has any analysis been performed to determine the impact for the Medicaid population?

No specific analysis has been performed to determine the impact for the Medicaid population. Due to differences in the Medicare and Medicaid populations, it is likely that the impact of grouper updates would not be perfectly revenue neutral for the Medicaid population.

18. Was there any impact related to composite APCs?

Our review of the claims data confirmed that composite APCs were assigned to claims. The composite APCs were assigned based on 2014 data and the 2014 version of the grouper software and values.

19. What adjustments were made to the APC Payable Target?

Adjustments were made for estimated professional claims from unbundling, changes in routine BH services and changes in pharmacy claims with status indicator "K".

20. Will DSS provide a fiscal impact analysis by RCC or other category of service?

An analysis by RCC was not planned because of the shift away from payment based on RCCs to payment based on procedure codes. The fiscal impact model considers all APC Payable services in aggregate.

21. Why was some data excluded from the conversion factor calculation? Will the exclusion of this data impact the payment of claims under the APC system?

For the purposes of the conversion factor calculation, a clean and reliable data set is needed for analysis. The analytical data set does not need to include all claims because it is used to calibrate the conversion factor. The focus is on accuracy and good claims — not accounting for every claim. The exclusion of this data from the analytical dataset will not impact claims payment under the APC system.

22. Can the hospitals get detailed claim files containing the data used in the APC conversion factor calculation?

Yes, detailed claims files containing the hospital-specific outpatient APC data used to calculate the conversion factor were provided to each hospital. Revised claims files based on changes to the APC Table as described in the Pharmacy RCC 636 [issue paper](#) will be provided to each hospital.

23. Can the hospitals get the Patient Account Number or Medicaid Recipient ID fields for the APC claim detail file?

Yes, upon request, DSS will provide hospitals with a supplemental file that contains Patient Account Number, Medicaid Recipient ID and ICN that can be linked to the detailed claim file.

Additional Resources

Connecticut Department of Social Services Reimbursement Modernization:

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

Connecticut Hospital Outpatient Payment Modernization Issue Papers:

<http://www.ct.gov/dss/cwp/view.asp?a=4598&q=571050>

Connecticut Medical Assistance Program:

www.ctdssmap.com

CMAP Addendum B:

<https://www.ctdssmap.com/CTPortal/Hospital%20Modernization/tabId/143/Default.aspx>