Medicaid Reimbursement for D & TC’s

John W. Gahan Jr.
Department of Health
Topics

- Indigent Care Pool
- Electronic Health Record
- Medicaid Reimbursement
  ◦ FQHC’s
  ◦ Other Clinics
  ◦ Appeals
- Meaningful Use
- Primary Medical Home
- General Billing
- 2010 AHCF–1
- Questions and Answers
Introduction

- Section 2807-l and 2807-p of the Public Health Law provide for up to $55.5M ($52.5M for Regular and $3M for Supplemental) to eligible Diagnostic and Treatment Centers (D&T Cs).

- For CY 2011, the State decreased $55.5M by 2% and a total State share of Indigent Care Pool (ICP) became $54.39M ($51.45M for Regular and $2.94M for Supplemental).

- On July 29, 2011, Centers for Medicare and Medicaid Services (CMS) approved the extension of the New York Medicaid section 1115 demonstration (Partnership Plan), effective 8/1/2011, which allows the State to claim a federal match on the State funds provided through ICP by including mental health clinics in the ICP.
Total amount of ICP for CY 2011 has increased to $77,052,500.

<table>
<thead>
<tr>
<th><strong>2011 Indigent Care Pool Amounts</strong></th>
<th>Regular Indigent Care</th>
<th>Supplemental Indigent Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State share for 1/1/11-12/31/11</td>
<td>$51,450,000</td>
<td>$2,940,000</td>
<td>$54,390,000</td>
</tr>
<tr>
<td>FFP* for the period 8/1/11-12/31/11</td>
<td>$21,437,500</td>
<td>$1,225,000</td>
<td>$22,662,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$72,887,500</strong></td>
<td><strong>$4,165,000</strong></td>
<td><strong>$77,052,500</strong></td>
</tr>
<tr>
<td>Estimate for OMH facilities (1)</td>
<td>$3,683,912</td>
<td>$0</td>
<td>$3,683,912</td>
</tr>
<tr>
<td>Available for Article 28 D&amp;TCs</td>
<td>$69,203,588</td>
<td>$4,165,000</td>
<td>$73,368,588</td>
</tr>
</tbody>
</table>

* FFP : Federal Financial Participation
(1) Subject to revision – current estimate
Eligibility – Regular ICP

- Article 28 D&TC clinics

- Voluntary not-for-profit or Public (including HHCs)

- Comprehensive Primary Care Providers (Group 11,12,13 only)

- Must submit base year AHCF-1 cost report with all required documents (i.e. CEO & CPA certification, Audited F/S)

- Must provide services to uninsured individuals to account for at least 5% of the total threshold visits. (At least 5% Self-pay/Free visits out of total threshold visits.)

- Operational Loss (Medicaid rate × Self-pay/Free visits) must be larger than Revenue from Self-pay/Free visits
Eligibility – Supplemental IC

- New facilities must be eligible to receive a budgeted Medicaid Rate before April 1
- Expanded facilities must receive CON approval before April 1
- Must complete and submit a supplemental application form by established due date (BPACR posts a letter with supplemental application form to the Health Commerce System (HCS) website
- Must provide services to uninsured individuals to account for at least 5% of the total threshold visits
- Award amounts are determined on an annual basis, but paid prorated for the number of months operational
Calculation

- Period: Calendar Year (Jan. 1 – Dec. 31)
- Data: 2 year Prior AHCF-1 annual cost report.
  i.e. For the 2011 Indigent Care calculation, data from 2009 AHCF-1 cost reports are used.

Example - Exhibit I-D data from AHCF-1 cost report

<table>
<thead>
<tr>
<th>Description</th>
<th>Visits</th>
<th>Net Patient Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured/Self-Pay</td>
<td>1,665</td>
<td>$30,875</td>
</tr>
<tr>
<td>Free</td>
<td>7,252</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total Threshold Visits</td>
<td>13,113</td>
<td>-</td>
</tr>
</tbody>
</table>

| Medicaid Rate*         | $65.65 |

*Medicaid Rate: APG average payment, or FQHC PPS rate
% Eligible Visits:
  ◦ (Self-Pay visits + Free visits) / Total Threshold visits = (1,665 + 7,252) / 13,113 = 68.00%

Operating Loss:
  ◦ (Self-Pay visits + Free visits) × Medicaid Rate – Net Patient Revenue from Self-Pay and Free visits = (1,665 + 7,252) × $65.65 - $30,875 - $10,000 = $544,526

Nominal Loss:
  ◦ 1\textsuperscript{st} 15% @ 50% = $544,526 × .15 / .68 × 50% = $60,058
  ◦ 2\textsuperscript{nd} 15% @ 75% = $544,526 × .15 / .68 × 75% = $90,087
  ◦ 3\textsuperscript{rd} 15% @ 100% = $544,526 × (.68 - .15 - .15) / .68 × 100% = $304,294
  ◦ Total Nominal Loss = $60,058 + $90,087 + $304,294 = $454,439

Indigent Care Award:
  ◦ Total Nominal Loss / Total Statewide Nominal Loss × Indigent Care Pool Amounts
Indigent Care Process

- Post the Initial calculation to the HCS web site to allow providers 30 days to report any error. HCS account holders will receive email notification.

- Post a Supplemental Application form in the HCS and provide at least 30 days to apply for it.

- Finalize the Regular Indigent Care calculation with any error correction submitted during 30 days hotline period.

- Finalize the Supplemental Indigent Care calculation with submitted Applications.

- Post the Final Regular and Supplemental IC awards to the HCS.

- Start a Pool Distribution process.
Electronic Health Record System (EHRS)

- Introduction
- Eligibility
- Calculation
Authorization:
- Section 364-j-2 of the Social Services Law
- State Plan Amendment (SPA) #08-40 and #09-31

Supplemental payment of $7,388,000 for the period 10/1/08-12/31/08 and 10/1/09-12/31/09
- Made to eligible covered providers as medical assistance payments for services provided to Medicaid beneficiaries to reflect additional costs associated with the development, training, maintenance, and support of electronic health record systems (EHRS).
Eligibility

- **Facility Requirements:**
  1. Article 28 D&TC clinics
  2. Voluntary not-for-profit
     a. Qualify for Indigent Care Program, or
     b. Indicate on the cost reports submitted to the State that they received funding under section 333 of the Federal Public Health Services Act for health care for the homeless, or
     c. Operate approved programs under the state Prenatal Care Assistance Program (PCAP), or
     d. Licensed free standing Family Planning clinics.
Eligibility (cont.)

- **EHRS Requirements:**
  
  a. Must be capable of and used for exchanging health information with other computer systems according to national standards.
  
  b. Must be certified by the Certification Commission for Health Information Technology.
  
  c. Must be capable of and used for supporting electronic prescribing.
  
  d. Must be capable of and used for providing relevant clinical information to the clinician to assist with decision making.
Eligibility (cont.)

> **Data Requirements –**

a. Must submit a EHRS Survey with proper documentation by established due date. (November 2008)

b. Must submit base year AHCF-1 cost report with all required documents (CEO & CPA certification and Audited F/S).

c. Medicaid visits must be at least 25% of total threshold visits, or Medicaid visits and Uninsured visits* must be at least 30% of total threshold visits.

*Uninsured visits = Self-Pay visits + Free visits
Each qualified provider shall receive a supplemental payment equal to such provider’s proportional share of the total funds allocated, based upon the ratio of its visits from Medicaid recipients during the base year to the total number of Medicaid visits to all such qualified providers during the base year. The base year will be two years prior to the rate year.

For example:

- Medicaid visits = 50,000
- Total Statewide Medicaid visits of all EHRS qualified providers = 1,800,000
- EHRS Supplemental Pool Amount =$7,388,000
- EHRS Award Amount = $7,388,000 × 50,000 / 1,800,000 = $205,222
Medicaid Reimbursement

FQHC’S
Other DTC’s
Appeals
FQHC’s are Federally Qualified Health Centers.

There are 3 types: FQHC(Section 330 grant), Look-a-Likes and Rural Health Centers.

FQHC’s need approval to become an FQHC by Centers for Medicare and Medicaid Services (CMS).

Providers should provide NYS DOH with documentation from Health Resources and Services Administration (HRSA) for approval of the FQHC designated sites. Acceptable documentation is Notice of Grant Award (NGA) and HRSA Electronic Handbook (EHB). This requirement also includes SBHC/FQHC’s.
Medicaid Reimbursement – FQHC’S (cont.)

- PHL 2807 (8) provides State statute for reimbursement by Medicaid

- FQHC’s PPS rates (Rate code 4013) are calculated every 10/1.

- FQHC’s PPS rates are calculated based on the 1999 and 2000 reported costs.
  - Operating costs portion is multiplied by the Medicare Economic Index (MEI) factor every year October 1.
  - Capital costs portion remains on the 1999/2000 base. If a provider submits a capital appeal, then the capital portion of the rate will be revised based on Part 86-4.16 (d).

- Part 86-4.16(d)
  - Documented increases in the overall operating costs of a facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved by the Commissioner through the Certificate of Need (CON) process may be the basis for application for revision of a certified rate.
Group Psychotherapy rate (Rate code 4011) and Off-Site Visit rate (Rate code 4012), which remain unchanged since 6/1/08. (Part 86-4.9 (g) and (i))

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate code 4011</th>
<th>Rate code 4012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upstate Region</td>
<td>$31.54</td>
<td>$55.81</td>
</tr>
<tr>
<td>Downstate Region</td>
<td>$35.16</td>
<td>$62.48</td>
</tr>
</tbody>
</table>

FQHC’s may participate in the APG reimbursement methodology.
- FQHCs must declare their intention by completing, signing and returning the authorization by November 1 to be effective the following January 1 to participate in APG reimbursement. The authorization form can be found at the following APG’s web site.
  - [http://www.health.state.ny.us/health_care/medicaid/rates/apg/#fqhc](http://www.health.state.ny.us/health_care/medicaid/rates/apg/#fqhc)
Medicaid Reimbursement – FQHC’S (cont.)

➢ Hold Harmless for FQHC’s which opt into APGs
  ◦ FQHC’s that opt into APGs will be eligible to receive the difference between total APG reimbursement and the aggregate amount that would have otherwise been paid under the PPS rate, if latter is higher.

➢ Managed Care wrap around (Rate code 1609)
  ◦ Calculated by Bureau of Managed Care Finance.
    • Contact Name: Nick Cioffi
    • Phone Number: (518) 474 – 5050
Medicaid Reimbursement – Other Clinics

Authorizing Statute:

- Article 2807 (2-a) of the Public Health Law
  - Required a new Medicaid payment methodology based on Ambulatory Patient Groups that would apply to most ambulatory care services provided by free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers effective 9/1/09.

Part 86-8: Outpatient Services: Ambulatory Patient Group

- This Subpart shall govern Medicaid rates of payments for ambulatory care services provided in the following categories of facilities for the following periods:
  - Ambulatory services provided by diagnostic and treatment centers on and after September 1, 2009
  - Ambulatory surgery services provided by free-standing ambulatory surgery centers on and after September 1, 2009
Medicaid Reimbursement – Other Clinics (cont.)

- APG Timeline

<table>
<thead>
<tr>
<th>Start Date</th>
<th>9/1/2009</th>
<th>12/1/2009</th>
<th>1/1/2011</th>
<th>1/1/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>APG%</td>
<td>25% APG / 75% Blend</td>
<td>50% APG / 50% Blend</td>
<td>75% APG / 25% Blend</td>
<td>100% APG</td>
</tr>
</tbody>
</table>

- Questions regarding:
  - DOH Article 28 APG Policy, Rates & Weights,
  - Carve Outs
  - Payment Rules, or Implementation Issues

- Contact:
  NYS Department of Health
  Office of Health Insurance Programs
  Division of Financial Planning and Policy
  - email address: apg@health.state.ny.us
  - Phone: (518) 473-2160
  - APG web site: http://www.health.state.ny.us/health_care/medicaid/rates/apg/
Appeals

- All appeals for the revision of Medicaid rates should be addressed to:

  John W. Gahan Jr.
  Director
  Bureau of Primary & Acute Care reimbursement
  Room 1043, Corning Tower, Empire State Plaza
  Albany, NY 12237

- Title 10: Section 86-8.5: APG’s
- Title 10: Section 86-4.16(d): Capital related

  The commissioner shall consider only those applications for prospective revisions of certified or approved rates which are in writing.
Appeals (cont.)

- Capital Related: (APG Reimbursement)

**Applicable to all D & T Cs except Ambulatory Surgery centers**

- Must receive a certificate of need (CON) approval.
- Must submit anticipated utilization expressed in terms of threshold visits and/or procedures.
- Must submit the relevant final certified costs of construction approved by the department.
- Any modified rate certified or approved pursuant to this capital appeal shall be effective on the date the new service or program is implemented or, in the case of capital renovation, expansion or replacement, on the date the project is completed and in use.
Appeals (cont.)

Applicable to FQHCs for their PPS rate revision appeals.

- Capital expenditures that have been approved by DOH through the CON process
- A documented increase in operating costs per visit resulting from changes approved by DOH through CON process. (Scope of Services)
- Decreases in operating costs per visit resulting from deletion of services approved by DOH through the CON process. (Scope of Services)
- A documented increase in operating costs per visit resulting from a change in regulatory requirements or the implementation of additional or expanded programs, staff or services specifically mandated by DOH
- A change in magnitude, intensity or character of services which results in an increased cost per visit
- A change in applicable technologies and medical practices which result in an increased cost per visit
Primary Care Medical Home

History
Goals
NY Programs
New Developments
Primary Care Medical Home Brief History

- Primary care underinvestment (Medicaid)
- Existing and future challenges in primary care capacity
- Institutional settings create challenges in continuity, coordination, access
- National and state interest in ‘patient centered medical homes’
  - Accelerated by multi-payer pilots, NCQA recognition program, analysis of avoidable costs (inpatient, ER, specialty, high cost radiology, etc.)
Goals of Medical Home

- Better coordination of care between physicians (primary care and specialists)
- Improved access to physician/practice
  - Including e-communication
- Patient education and engagement in prevention and care for chronic conditions
- Safety associated with electronic prescribing
- Patient reminder systems, registries, tracking (results, referrals)
- Capacity to measure and improve quality
Programs in New York

- **Statewide Medicaid PCMH Incentive Program (2010)**
  - FFS and MMC
  - All primary care providers
  - National Committee for Quality Assurance (NCQA) recognition at any level

- **Multipayer PCMH Programs**
  - Adirondack Demonstration (2010)
    - Incorporates MAPCP (CMS/Medicare), Medicaid, Empire Plan (state employees), and 6 other payers
  - Hudson Valley (THINC)
  - Rochester
  - Western New York
What Happened?

- Payments for Medicaid and ADK began in 2010
- Went from ~ 400 NCQA recognized providers in 2009 to ~ 3800 recognized providers as of last quarter
  - Significantly higher than any other state
  - ~60% are level 3 recognized
- Almost 900,000 Medicaid members receive primary care in medical home
  - ~1/3 of all enrollees
New Developments

- Meaningful Use and PCMH alignment
- New standards from NCQA (2011)
  - Harder
- Joint Commission Standards
- Health Homes
  - Medical (and non-medical) ‘neighborhood’ of care for complex, co-morbid populations
- MRT 70….one million and CHPlus
- ACOs and New Payment Models
- Federal investments
  - FQHCs and PCMH
  - Medicaid Partnership Plan Waiver
    - Hospital-Medical Home Demonstration
Further information

- Medicaid Update: December 2009

- Contact:
  Foster Gesten M.D.
  Medical Director
  Office of Health Insurance Programs
  (518) 486-6265
Meaningful Use

- Medicaid EHR Incentive Payments are available for certain hospitals (acute care, cancer, and children’s hospitals) as well as Medicaid practitioners (physicians, dentists, nurse practitioners, certified nurse-midwives, and physician assistants who practice in an FQHC or RHC that is itself led by a PA).

- Eligible professionals may receive as much as $63,750 over six years of participation in the program. Providers may voluntarily reassign the incentive payment to an entity such as an employer or other entity that has a contractual or billing relationship with the provider. This reassignment also transfers any tax liability to the assignee.

- To be eligible, providers must demonstrate a minimum of 30% Medicaid patient volume (among other criteria); Family Health Plus is included as Medicaid but Child Health Plus is not. Providers who practice predominately at an FQHC or RHC (including look-alikes and certain tribal clinics) can qualify by demonstrating a minimum of 30% “needy patient” volume, where “needy” is defined as Medicaid (including FHP), Child Health Plus, uncompensated care, and sliding scale.
Registration for the incentive program is expected to begin in the fourth quarter of 2011. Providers have 90 days after the end of the payment year (calendar year for professionals, federal fiscal year for hospitals) to attest to activities conducted in the payment year and receive the incentive for that year.

Additional information:
- DOH website: [http://nyhealth.gov/health_care/medicaid/program/medicaid_ehr_incentive_prog/](http://nyhealth.gov/health_care/medicaid/program/medicaid_ehr_incentive_prog/)
- August 2011 Medicaid Update.
- New York Medicaid EHR Incentive Program Support Team by email at hit@health.state.ny.us or by phone at (800) 278-3960.
General Billing

Questions
General Billing - Questions

Q: Do FQHC’s need to wait until the MCO pays the claim?
   ◦ A: No. After discussions with OMIG it was decided the FQHC could submit the wrap claim while waiting for MCO payment. If denied, the FQHC can rescind the wrap claim

Q: Will Medicaid follow CMS requiring FQHC’s to register individually and bill using unique identifier?
   ◦ A: No. However for crossover claims to process, the billing NPI must be recognized by both
General Billing – Questions

- Q: Medicaid allows one main NPI# only and additional sites to which locator codes are assigned. The NPI# is in this instance the main site NPI# no matter the site providing service. Is this OK with Medicaid?
  - A: To be compliant with Medicaid billing rules, the provider submits the NPI# and the zip plus 4 of the service location.

- Q: FQHC’s want assurance that submitting the billing provider NPI of the location other than where services are provided will not be deemed non-compliant per CMS regulations?
  - A: Submitting a claim to Medicaid using a location (aka, zip plus 4) other than where services were rendered is not appropriate.
Contact for Billing Questions:

- Managed Care Finance:
  - Contact Name: Nick Cioffi
    - Phone Number: (518) 474 – 5050

- Fee For Service:
  - Provider enrollment and rate code assignments:
    - Division of Provider Relations and Utilization Management
    - Phone Number: (518) 474-8161
  - Billing and Claims submissions:
    - eMedNY Call Center
    - Phone Number: 1-800-343-9000
  - eMedNY and Computer Sciences Corporation (CSC)
    - Contact Guide: [https://www.emedny.org/contacts/telephone%20quick%20reference.pdf](https://www.emedny.org/contacts/telephone%20quick%20reference.pdf)
2010 AHCF

- **Why is this report required:**
  - Capital
  - Indigent Care
  - Fiscal Analysis
  - Upper Payment Limit (UPL)

- **Data Integrity Project:**
  - CMS has real concerns with data as reported in past years as used for UPL
  - Letter sent to all clinics outlining
  - 2010 Report will have greater instructions and clarifying information for clinics
2010 AHCF (con’t.)

- A facility will have 60 days from the date the 2010 AHCF software is released
  - Due to reporting data requirements from the Centers for Medicare and Medicaid Services (CMS) to NYS, there will be no extensions
- When will the software be released
  - Facilities can prepare using 2009 as a template.
- Details of the report changes
  - Session will be scheduled to review software changes and provide a demonstration of the software.
- Health Commerce System (HCS)* Account
  - For a staff member of the facility to download the software and upload the report, they need to have an account on the HCS and access granted to the “D&TC Cost Report” application. Contact Phyllis Casale at 518-474-3020 for questions regarding an HCS account or access to the application.

*HCS website: https://commerce.health.state.ny.us/hcspportal/appmanager/hcs/home
Developing a Facility Data Analysis Table that will provide facilities with information regarding their cost report.

- **Goal:** To supply this report annually which facilities can use to review their cost report data they submitted to assist in determining if the data in the report accurately reflects their facility.

**Data included in Analysis sheet:**
- % of Visits/Procedures by Payor Source
- Variance of Medicaid Fee-for-Service AHCF reported visits from paid claims data reported on eMedNY
- Summary of Revenue and Costs & FTE data reported
- Balance Sheet information and Financial Ratios

**Date to be provided to facilities to be determined**
- 2010 AHCF-1 taking precedence over the completion of this project.
Questions?