Ambulatory Patient Group Webcast - Understanding and Preparing an Impact Analysis

February 6, 2009
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Scott D. Morgan, Director
Matthew Grob, CPHIMS, FHIMSS, Director
New York State’s Policy Change

• New York’s growing budget deficit will require significant gap closing measures.

• In 2008, the State’s almost $50 billion Medicaid program drives nearly 30% of General Fund spending.
  ➢ A need to control future growth in Medicaid expense

• Ambulatory investments are made possible only through the reallocation of funds drawn from inpatient reform and rebasing.

• Payment restructuring coupled with targeted primary care enhancements are central to Medicaid reform.
CHCANY S Board of Directors APG Statement

The CHCANY S Board adopted a resolution stating:

“CHCANY S recommends that community health centers not pursue the APG reimbursement methodology put forth in the Department of Health’s letter dated November 4, 2008. CHCANY S urges the Department of Health to deliver data for analysis and answers to questions about the APG system so that the impacts on community health centers can be assessed.”
APG Payment Methodology

- Ambulatory Patient Groups, or APGs, is a patient classification system designed to pay providers on the amount and type of resources used during a patient visit. Therefore, payment varies based on service intensity.

- Patients in a given APG have similar clinical characteristics as well as similar resource use and cost.
  - Relative payment “weights” do not vary by practice setting.
  - Base rates do vary to recognize differing cost structures between settings.

- The APG payment system emphasizes diagnoses (ICD-9 codes) and procedures (CPT codes) over service volume. All services associated with the visit, including lab and x-ray, must be properly coded and included in the claim.
### APG System Phase-In for D&TCs and FQHCs (who opt-in)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Portion of Facility's Average Medicaid Reimbursement per Visit for CY 2007 (only for services subsumed in APGs)</th>
<th>Portion of APG Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2009 - June 30, 2009</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>(Previously Mar 1, 2009 – Dec 31, 2009)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2009 – June 30, 2010</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(Previously CY 2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2010 – June 30, 2011</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>(Previously CY 2011)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2011</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>(Previously Jan 1, 2012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Above “revised” time periods are those included in the Governor’s proposed 09/10 budget.
### Overview of APG Payment Structure

<table>
<thead>
<tr>
<th>EAPG Category</th>
<th>EAPG Weight</th>
<th>Base Rate</th>
<th>EAPG Operating Payment Rate</th>
<th>Add-on: Capital and R&amp;R</th>
<th>EAPG Payment Rate</th>
<th>Number of Visits</th>
<th>APG Payments (@ 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>377 – Preventive Dental Procedures</td>
<td>0.2241</td>
<td>$127.29</td>
<td>$28.53</td>
<td>$15.00</td>
<td>$43.53</td>
<td>2,000</td>
<td>$87,060</td>
</tr>
<tr>
<td>362 – Level II Dental Restorations</td>
<td>0.5334</td>
<td>$127.29</td>
<td>$67.90</td>
<td>$15.00</td>
<td>$82.90</td>
<td>500</td>
<td>41,450</td>
</tr>
<tr>
<td>562 – Infections of Upper Respiratory Tract</td>
<td>0.6939</td>
<td>$127.29</td>
<td>$88.33</td>
<td>$15.00</td>
<td>$103.33</td>
<td>1,500</td>
<td>154,995</td>
</tr>
<tr>
<td>766 – Routine Prenatal Care</td>
<td>0.7570</td>
<td>$127.29</td>
<td>$96.36</td>
<td>$15.00</td>
<td>$111.36</td>
<td>2,000</td>
<td>222,720</td>
</tr>
<tr>
<td>871 – Signs, Symptoms &amp; Other Factors Influencing</td>
<td>0.6666</td>
<td>$127.29</td>
<td>$84.85</td>
<td>$15.00</td>
<td>$99.85</td>
<td>6,000</td>
<td>599,100</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AVERAGES</strong></td>
<td><strong>0.6058</strong></td>
<td><strong>$127.29</strong></td>
<td><strong>$77.11</strong></td>
<td><strong>$15.00</strong></td>
<td><strong>$92.11</strong></td>
<td><strong>12,000</strong></td>
<td><strong>1,105,325</strong></td>
</tr>
</tbody>
</table>

**NOTE:** Above does NOT take into account factors such as discounting and consolidating that are part of the APG billing and payment algorithm.
APG Base Rate

- DTC Base Rates will be established for distinct peer groups taking into consideration Service Setting, Provider Type, Patient Type, Region (Upstate, Downstate) and Procedure Type.

- DTC Peer Groups
  - General Clinic (includes all clinics except those designated by DOH as Dental or Renal Clinics)
  - General Clinic – MR/DD patient
  - Dental Clinic
  - Renal Clinic
  - Ambulatory Surgery Center

- Peer groups are further broken down between Downstate (New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Duchess, and Orange counties) and Upstate (the rest of the state)
Base Rate Variables

- Case Mix Index (CMI) – the average allowed APG weight per visit for a defined group of visits (by peer group and time period)
- Coding Improvement Factor (CIF) – a numeric value used to adjust for the assumption that the coding of claims subsequent to the implementation of APGs will become more complete and accurate (CMIs will increase)
- Visit Volume
- Targeted Expenditure Level
  - Base Year Expenditures
  - Investment Dollars
- Reported Provider Cost by Peer Group (for scaling of investments)
Base Rate Formula (for each peer group)

\[
\text{PROJECTED MEDICAID EXPENDITURES} \\
\quad \text{\quad (Base Year Expenditures + Investments)} \\
\hline
\quad \text{“WEIGHTED” BASE YEAR VISITS} \\
\quad \text{\quad (CMI x CIF x Base Year Visits)}
\]
# Base Rate Formula

## Projected DTC Medicaid Expenditures:

<table>
<thead>
<tr>
<th></th>
<th>Downstate</th>
<th>Upstate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Year Expenditures:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider-specific 2007 paid claims</td>
<td>$ 169,118,132</td>
<td>$ 53,601,450</td>
</tr>
<tr>
<td>Ancillary – add-on</td>
<td>13,976,694</td>
<td>3,617,433</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>183,094,826</td>
<td>57,218,883</td>
</tr>
<tr>
<td>Investment</td>
<td>22,957,763</td>
<td>6,955,958</td>
</tr>
<tr>
<td><strong>TOTAL PROJECTED MEDICAID EXPENDITURES</strong></td>
<td>$ 206,052,589</td>
<td>$ 64,174,841</td>
</tr>
</tbody>
</table>
## Base Rate Formula

### “Weighted” DTC Base Year Visits:

<table>
<thead>
<tr>
<th></th>
<th>Downstate</th>
<th>Upstate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average CMI (based on 2005 claims)</td>
<td>0.8824</td>
<td>0.8753</td>
</tr>
<tr>
<td>Coding Improvement Factor</td>
<td>1.1020</td>
<td>1.1020</td>
</tr>
<tr>
<td>“Projected” CMI</td>
<td>0.9724</td>
<td>0.9646</td>
</tr>
<tr>
<td>Base Year Visits (2007 paid visits)</td>
<td>1,346,894</td>
<td>522,652</td>
</tr>
<tr>
<td>TOTAL “WEIGHTED” BASE YEAR VISITS</td>
<td>1,309,726</td>
<td>504,140</td>
</tr>
</tbody>
</table>
Base Rate Formula

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<td>504,140</td>
</tr>
<tr>
<td>PHASE 1 BASE RATES</td>
<td>$157.33</td>
<td>$127.29</td>
</tr>
</tbody>
</table>
**Sample Blend Calculations** (all figures are FQHC statewide, preliminary, and subject to revision)

<table>
<thead>
<tr>
<th>Year 1 Blend</th>
<th>Year 2 Blend</th>
<th>Year 3 Blend</th>
</tr>
</thead>
<tbody>
<tr>
<td>(25%/75%)</td>
<td>(50%/50%)</td>
<td>(75%/25%)</td>
</tr>
<tr>
<td>$138.44</td>
<td>$140.32</td>
<td>$142.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Avg. APG Operating Payment</th>
<th>Avg. Existing Operating Payment</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$144.08</td>
<td>$136.56</td>
<td>$138.44</td>
</tr>
</tbody>
</table>

**Note:** These calculations are based on statewide averages and ignore peer groups. APG operating payments are actually visit specific.

**Note:** Existing payment for blend is provider specific, and thus will vary from provider to provider.

**Note:** The calculated blend payment is frozen throughout the period of the phase-in.
Sample Extract from Greg Allen Letter (Jan 27, 2009)

A. Peer Group: General Clinic
B. Base Rate Region: DOWNSTATE
C. Base Rate: $157.33
D. MR/DD/TBI Base Rate (if applicable)\(^1\): $188.80
E. 2007 Existing Operating Payment (for Blend)\(^2\): $181.98
F. 2005 Case Mix Index (CMI)\(^3\): 0.9408
G. Average Blended Operating Payment Per Visit Under APGs\(^4\): $173.59
H. APG Capital Add-on\(^5\): $24.51
I. Average Total Payment per Visit Under APGs (G+H): $198.10
J. 2007 Clinic Volume\(^6\): 21,485
K. Impact of APGs((G – E) x J)\(^7\): ($180,259)
2007 Existing Operating Payment (for Blend)
(Line E – Sample Extract from Greg Allen Letter)

- For visits that would be subject to APG reimbursement
- **Average operating amount** paid for calendar year 2007 visits ($181.98)
  - All payments for calendar year 2007 are added up (excluding capital and R&R) and divided by total paid FFS visits
  - Also includes DOH’s add-on for ancillary services
- Does not include capital or recruitment and retention add-ons
- After adjustment for the ancillary add-on, this is essentially the operating component of the PPS rate for 2007 (It won’t match exactly due to 10/1 MEI increases and copayment issues)
- During Phase One – 75% of this rate will be blended with 25% of APG visit specific rate to calculate payment
2005 Case Mix Index (CMI)
(Line F – Sample Extract from Greg Allen Letter)

• Case Mix Index is the average APG weight for all of your 2005 visits adjusted by a Coding Improvement Factor

• The State has assigned each center a Coding Improvement Factor (CIF) based on their estimate of the accuracy of coding in 2005

• The State anticipates improvement in coding (10.2%) once APGs are implemented!
2005 Case Mix Index (CMI) ....continued
(Line F – Sample Extract from Greg Allen Letter)

- Case Mix Index is calculated as follows:
  - Diagnoses and procedure codes for each paid visit are run through the 3M Grouper software
  - This results in a list assigning all visits to individual APGs for all included services
  - Visits which did not group (APG 999) were assigned the average weighting for your peer group
  - The sum of all APG-weighted visits was divided by your 2005 paid FFS Medicaid claims (visits) to result in the average APG-weight
  - The average APG-weight was multiplied by your CIF to derive your Case Mix Index
2005 Case Mix Index (CMI) …continued
(Line F – Sample Extract from Greg Allen Letter)

- Case Mix Index is calculated as follows:

\[
\text{CMI} = \frac{\sum \text{APGs for 2005 Visits}}{\text{Count of visits}} \times \text{CIF}
\]

CMI = 18,342 APG-weights \times 1.102
21,485 visits

CMI = 0.9408
Average Blended Operating Payment Per Visit Under APGs
(Line G – Sample Extract from Greg Allen Letter)

- Average blended operating payment per visit under APGs was calculated by taking 75% of the existing operational payment rate (Line E) and adding it to 25% of the APG payment rate:

\[
\text{Blended Rate} = 2007 \text{ Operating Rate} \times 75\% + \text{Base Rate} \times \text{CMI} \times 25\%
\]

- The average APG payment rate was calculated by taking the applicable Base Rate (line C or Line D) and multiplying it by the adjusted 2005 CMI (Line F):

\[
\$173.49 = (\$181.98 \times 75\%) + (\$157.33 \times 0.9408 \times 25\%)
\]

(Actual amount on Line G = $173.59 - $.10 difference due to MR/DD patients seen)
APG Capital Add-on
(Line H – Sample Extract from Greg Allen Letter)

- $24.51 includes current capital and recruitment and retention add-ons (as applicable)
- This capital rate is only paid once per visit and is added on to the payment for the primary service
- DOH has not proposed any change in capital rates methodology at this time
Average Total Payment per Visit Under APGs
(Line I – Sample Extract from Greg Allen Letter)

• Calculated by adding the Average Blended Operating Payment per visit under APGs to APG capital add-on (Line G + Line H)

$198.10 = $173.59 (line G) + $23.51 (line H)
Impact of APGs

(Line K – Sample Extract from Greg Allen Letter)

- Derived by calculating the difference between the Average Blended Operating Payment Per Visit Under APGs (Line G) and the 2007 Existing Operating Payment (Line E) and multiplying the result by the 2007 Clinic Volume

$$\text{Impact} = (\text{Blended APG Rate} - \text{2007 Operating Payment}) \times \text{Visits}$$

$$= ($180,259) = ($173.59, \text{line G} - $181.98, \text{line E}) \times 21,485$$

- This is based on the 75%/25% Blend. Total impact of APGs would be greater once APGs is fully implemented.

- This assumes 100% of claims that would be paid under the current system are paid (grouped) under APGs and that the Medicaid FFS claims volume in 2009 is similar to 2007.

- Assumes an improvement in coding quality and accuracy (10.2%).
Perform Your Own Financial Impact Analysis

• Utilize estimated 2009 Medicaid FFS visits

• If Phase 2 occurs on July 1, 2009, need to revise Blended Operating Payment Under APGs (line G)

• How does your 2009 projected operating revenue under APGs compare to your:
  – Operating component of the 2009 FQHC Medicaid PPS rate
  – Projected costs of assuming liability (expense) for laboratory and radiology services for your Medicaid FFS patients

• How will this impact your reimbursement for Medicare/Medicaid dual-eligibles?
Other APG Implementation Issues to Consider

• Cash flow issues
  – Claims/visits denied as “ungroupable”
  – If need to access hold-harmless, severe lag
• Hold-harmless calculation has not been developed
• Coding and improvement
• Upgrades to practice management systems –
  – Revenue recording and receivable management
• Ancillary service contracts and processes
• Primary care “enhancements” (diabetes and asthma educators, evenings and weekend hours, smoking cessation)
APG Implementation Issues – Hold-Harmless Reconciliation to PPS

- FQHCs are held harmless – they must be paid up to what they would have been paid under PPS
- DOH has not yet developed the methodology.
  - How will items such as increased cost of ancillary services, Medicare/Medicaid dual-eligibles and visits denied as “ungroupable” be included?
- DOH expects to calculate any payment due for the period March 1, 2009 through December 31, 2009, subsequent to March 31, 2010
- Therefore, the “annual” reconciliation payment for 2009 would not be paid until the second or third quarter of 2010
APG Implementation Issues – Coding and Charge Capture

- In order to ensure appropriate payment under APGs, coding must be accurate and complete
- Charge capture must be optimized to ensure appropriate payments
- All ancillary charges must be captured (i.e. lab, radiology)
- Time of service must be captured in order to be eligible for payments related to “after-hours” services
APG Implementation Issues – 3M Grouper/Pricer

• In order to determine anticipated payments under APGs, your Center would need to acquire and implement the 3M APG Grouper/Pricer application
• An interface (real-time or batch) is needed between the 3M application and your practice management system
• Your practice management system and/or other applications need to be capable of:
  – Filing the APG codes returned from the 3M application
  – Calculating APG payments based on the 3M-generated codes
  – Reconciling submitted claims with payments received
  – Reconciling tests/procedures ordered with those invoiced by the ancillary provider
APG Implementation Issues – Ancillary Services

• Today, in many cases your lab and radiology providers direct bill DOH for services provided
• Under APGs, your Center will receive payment for ancillary services as they are packaged into the APG payment rates
• This may require new or amended contracts with your lab and radiology providers
• Open issues include:
  – How to reconcile ancillary services that are ordered with those that are actually provided
  – What is the window of time between visit date and date of service of the ancillaries for those ancillary services to be bundled with a particular claim (e.g. labs or x-rays ordered at visit but not collected/processed until “n” days later)
What To Do?

- When making your decision, prepare careful analyses of:
  - The 2009 financial impact on revenues
  - The anticipated increase in ancillary costs
  - Your coding and level of denials you may incur
  - Whether you have reserves to absorb potential cash flow issues
  - Is your practice management system ready
  - Will you be ready, operationally, to implement by March 1, 2009
Wrap up

• CHCANYs will continue to work with and urge the Department of Health to answer our questions regarding APG implementation and to implement policies that are supportive of community health centers.
• Please let CHCANYs know if you have questions.
• Please let CHCANYs know if you plan to opt-in to APGs this year.
• Thanks!