

FY2009–10 Budget

Healthcare Reimbursement Reform

Department of Health

Regional Hospital Presentations

June 2009

FY 2009/10 Builds on Health Care Reform Adopted in 2008/09

- Required that Medicaid inpatient rates move from 1981 cost base to 2005 cost base over four years
- Reduced inpatient rates by \$154 million annually effective December 1, 2008 and reduced inpatient detox rates by approximately \$70 million annually, phased in over 4 years
- Reinvested Medicaid dollars from inpatient rates to ambulatory care rates in hospital clinics, community clinics and physician offices
- Authorized new ambulatory care reimbursement methodology
- Anticipated additional inpatient rate reductions and ambulatory care rate enhancements anticipated in future budget

FY 2008/09 Budget Established a Technical Advisory Committee (TAC) to Continue Medicaid Inpatient Rate Reform

TAC Charge was to:

- ▶ Evaluate inpatient reimbursement methodology
- ▶ Review data showing amount by which hospital Medicaid inpatient revenue exceeds Medicaid inpatient costs
- ▶ Examine impact of proposed methodological changes on hospitals
- ▶ Review data showing differences between Medicaid outpatient costs and Medicaid payments
- ▶ Examine role of hospitals in delivering ambulatory care services to Medicaid beneficiaries

Commissioner of Health issued findings and recommendations

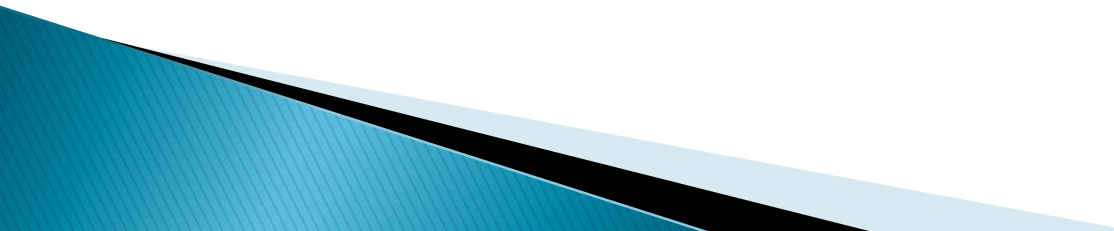
2009–10 Budget Continued a Broad Medicaid Reform Agenda

- ▶ Inpatient FFS Reform guided by work of the TAC
- ▶ Increasing investment in Ambulatory Services
- ▶ Advancing medical homes and improving care coordination
- ▶ Supporting public hospitals with more disproportionate share funding
- ▶ Supporting services for uninsured patients
- ▶ Expanding and improving access to coverage
- ▶ Addressing reimbursement reform for both nursing homes and homecare
- ▶ Providing incentives for long term care in the appropriate setting
- ▶ Significant investment of HEAL funds to assist reform

HEAL and CON Reforms

- **HEAL** : Continued appropriation at \$300 m
 - New discretionary capital pool of \$25m (matched with F-SHRP \$50m) to assist eligible hospitals with inpatient reimbursement reform transition
 - Provides for another category of HEAL spending to assist increased capital access (Will require Federal approval)
- **Restructuring Pool Loan Program**: Continued at \$19.6 m appropriation
- **Electronic Health Records**
 - Creates a new State revolving loan program, administered through DASNY , to participate in the opportunity created by the Federal ARRA
 - Working with industry to position hospitals to maximize Medicaid and Medicare EHR incentive payments
 - Includes working with DASNY to explore financing potential of this dedicated revenue stream.

HEAL Phase 1 1

- ▶ \$175 million
 - ▶ For mergers, shared governance and other collaborative activities between hospitals
 - ▶ To reduce excess inpatient capacity in favor of ambulatory and outpatient care
 - ▶ Applications due July 1, 2009.
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CON Regulatory Reforms

▶ Non-clinical projects

- Shift projects \leq \$10M to limited review: *Adopted.*
- Shift projects \leq \$15M to limited review: *Under review.*
- Shift projects \geq \$15M to admin. review: *Under review.*

▶ Acquisition of medical equipment

- Shift MRIs to administrative review: *Adopted.*
- Shift MRIs and CT scanners to limited review for hospitals; deregulate lithotripters: *Under Review.*

▶ Relocation of extension clinic in same service area (< \$3M)

- Shift from admin. to limited review: *Adopted.*

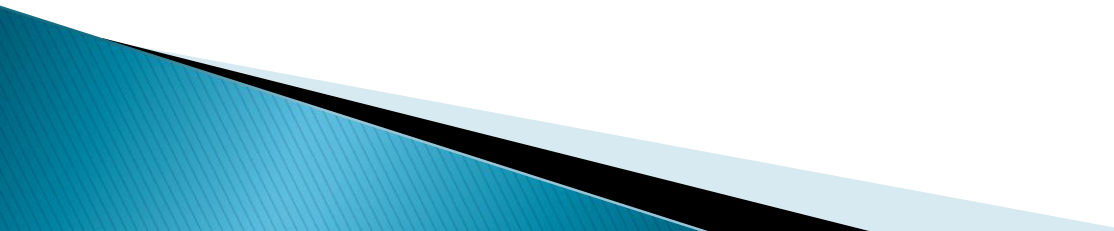
▶ Monetary thresholds

- Raise administrative review threshold from \$3M to \$6M: *Under Review.*
- Raise full review threshold from \$10M to \$15M: *Under Review.*

▶ Project Amendments

- Shift some to administrative review.

Other Reform Efforts

- ▶ Electronic CON application – NYSE–CON
 - ▶ Public communication
 - Website re–design and ListServ
 - Public comment period for written comments on CON applications (admin. and full review)
 - PQI
 - ▶ Strengthen local planning
 - ▶ Improve character and competence standards
 - ▶ Improve pre–opening process
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New CON Fees to Fund NYSE-CON

▶ Establishment:

- Hospitals, Nursing Homes: \$3,000
- D&TCs, Home Care, Hospice: \$2,000
- Safety Net D&TCs: \$1,000

▶ Construction (if both, only construction applies):

- Hospitals, Nursing Homes, D&TCs (exc. Safety Net D&TCs)
 - Full Review: \$2,000 (+ 0.55% of costs if approved)
 - Admin. Review: \$2,000 (+ 0.30% of costs if approved)
 - Limited Review: \$1,000 (A/E) or \$500 (other limited)

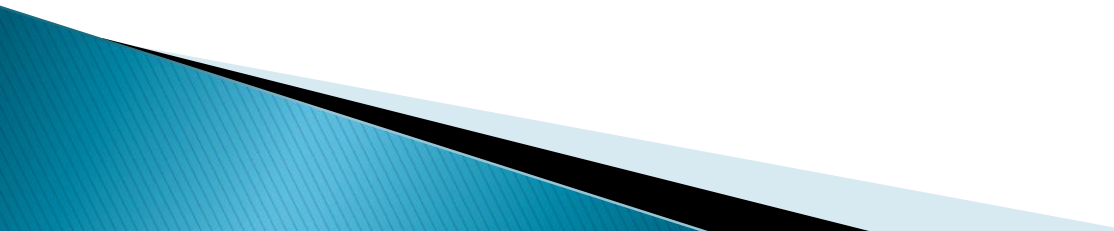
Safety Net D&TCs

- ▶ Operated by not-for-profit or local health dept.
 - FQHCs, Look-Alikes, Healthcare for the Homeless programs
 - Family Planning Clinics
 - D&TC Indigent Care Pool Grantees
 - Other D&TCs that serve significant numbers of Medicaid beneficiaries and uninsured
- ▶ Fees
 - Full Review: \$1,250 (+0.45% of costs if approved)
 - Admin. Review: \$1,250 (+0.25% of costs if approved)
 - Limited Review: \$500 (A/E) or \$250 (other limited)

Health IT and CON

- ▶ Project Cost \leq \$10M:
 - Treated as “non-clinical” – subject to abbreviated review process.
 - Certification of compliance with statewide policy guidance and connection with SHIN-NY.
- ▶ Project Cost $>$ \$10M
 - Full review with presumption of need.
 - Certification of compliance with statewide policy guidance and connection with SHIN-NY.

Local Planning

- ▶ **HEAL 9:** \$7M for local collaborative efforts to identify community health needs, prioritize those needs, and develop strategies to align health care resources with needs.
 - ▶ **Prevention Agenda:** Collaborations focused on specified public health priorities.
 - ▶ **PQI Tool:** Web-based planning tool displaying ambulatory care sensitive admission data.
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Inpatient Reimbursement DRP and Reform

Deficit Reduction Plan (DRP)

- ❑ \$44.1M in 2008–09 DRP Savings (enacted Feb 2009)
 - ❑ Elimination of the 2008 trend reconciliation (\$32.1M)
 - ❑ Reduction of public R&R grants (\$12M)

- ❑ \$261.5M in 2009–10 DRP Savings (enacted Apr 2009)*
 - ❑ Elimination of Remaining 2008 & 2009 Trend Factors (\$156.8M)
 - ❑ Gross Receipts Tax (\$135.6M)

** Reflects full annual impacts*

Inpatient Reform - 2009-10 Impact

- ❑ \$40.3M in Inpatient Reform Savings
 - ❑ Acute Reimbursement Reform (\$46.9M; effective 12/09)
 - ❑ Exempt Unit Rebasing (+\$2.1M; effective 12/09)
 - ❑ Elimination of Public R&R Grants (\$12M; effective 12/09)
 - ❑ Accelerate Detox Reform (\$17M; effective 4/09)
 - ❑ Transition Funding (+\$33.5M; effective 12/09)

Inpatient Reform – Full Annual Impact

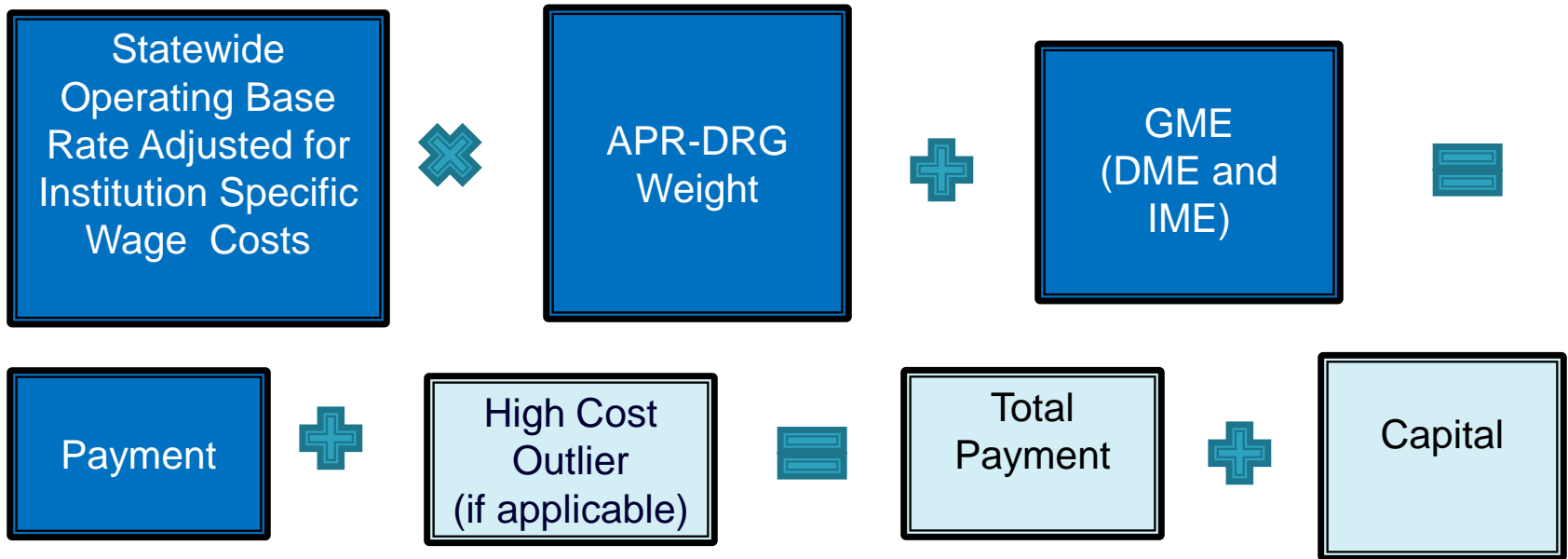
- ❑ \$207.4M in Inpatient Reform Savings
 - ❑ Acute Reimbursement Reform (\$225M)
 - ❑ Exempt Unit Rebasing (+\$10.2M)
 - ❑ Elimination of Public R&R Grants (\$36.3M)
 - ❑ Full Implementation of Detox Reform (\$31.3M)
 - ❑ Transitional Funding (+\$75M)

New Inpatient Methodology Followed Medicaid Reform Principles Adopted by TAC

- Be transparent
- Promote high value, quality driven health care services
- Pay for Medicaid patients
- Not cross-subsidize non-Medicaid payers
- Encourage care in the right setting
- Reinforce health system planning and advance state health care priorities
- Be updated periodically
- Comply with Federal Medicaid rules
- Be consistent with Budget constraints

New Medicaid Inpatient Rate Methodology

effective 12/1/09



Components of New Medicaid Inpatient Rate

- ❑ Cost base updated from 1981 to 2005 (trended)
 - ❑ Statewide base rate using Medicaid FFS costs
 - ❑ Adjusted for each hospital's labor costs (WEF)
 - ❑ Adjusted for each hospital's GME costs using updated costs basis and formula
- ❑ Adjusted for patient severity of illness using All Patient Refined DRGs (APR-DRGs)
 - ❑ Built off of AP-DRGs
 - ❑ Restructured Newborn DRGs and additional pediatric DRGs
 - ❑ Major Diagnostic Category (MDC) definitions and surgical hierarchies have been revised
- ❑ Provides non-comp rate add-ons for physician costs of Teaching Election Amendment (TEA) hospitals and ambulance costs as reported on the ICR
- ❑ Capital reimbursement remains unchanged

Component: Wage Equalization Factor (WEF)

Wage Equalization Factor (WEF)

- ❑ Updated to use 2005 data from the ICR (i.e., fringe costs and labor share)
- ❑ Uses 2005 wage compensation and provider hours data as reported to Medicare and found on the CMS website each year
- ❑ Applies the WEF on a hospital specific basis

* The Power Equalization Factor (PEF) has been eliminated

Component: APR-DRG Weight

- ❑ Weights are adjusted for patient severity of illness and risk of mortality
- ❑ 314 DRGs are further divided into 4 sub-classes of severity: minor (1) to extreme (4)
- ❑ Short stay and long stay outliers are no longer necessary given the severity levels; all are now considered inliers
- ❑ Weights are developed using 3 years (2005–2007) of non-Medicare SPARCS data
- ❑ New weights resulted in an upweighting of safety net services including OB and Trauma
- ❑ Permits analysis of potentially preventable readmissions and complications

Component: Graduate Medical Education (GME)

Direct Medical Education

- ❑ Updated to reflect 2005 costs (trended)
- ❑ Per discharge add-on is **not** severity adjusted; add-on applied to the case payment rate *after* application of the APR-DRG weight

Indirect Medical Education

- ❑ Updated regression analysis results in a teaching adjustment factor of 4.2% (compared to 7.7% in the current methodology)
 - ❑ Uses Medicaid only costs; APR-DRG case mix; and, updated WEFs
- ❑ Similar to Medicare, uses staffed beds rather than certified beds
- ❑ Uses 2005 acute resident counts
- ❑ IME Payment Formula: $[(1 + \text{"IRB"})^{0.405} - 1] * 1.03$

Inlier Payment Example

Assumptions: DRG 791; Severity 4 (OR Procedure for Other Complications of Treatment); Weight: 7.275

1	2	3=1x2	4	5=3x4	6	7	8	9	10=5+6+7+8+9
Statewide Price	WEF	Adjusted Price	APR Weight (791-4)	Weighted Price	DME per Discharge	IME Add-on	Non-Comp Ambulance Add-on	Capital Add-on	Total Inlier Payment (including capital)
\$6,662	1.016	\$6,769	7.275	\$49,244	\$1,591	\$11,316	\$163	\$192	\$62,506



Weighted Base Price	IME %	IME Add-on
\$49,244	22.98%	\$11,316

Component: Cost Outlier Payment

- ❑ Cost based outlier thresholds are developed for each APR–DRG level so that all severity levels for a given APR–DRG would have the same threshold
 - ❑ This approach, as opposed to creating severity level thresholds, limits lower severity cases from becoming outliers and enables more of the higher severity cases to qualify
 - ❑ APR severity level thresholds are also problematic due to low case volumes
- ❑ Cost thresholds are calculated using 2007 Medicaid claims data and will be inflated to reflect 2009 values
- ❑ Thresholds are adjusted by each facility's WEF
- ❑ In the payment system, claim charges would be converted to cost using hospital specific ratios of costs to charges (RCCs) and compared to the applicable threshold
- ❑ 100 percent of costs that exceed the threshold will be paid as a cost outlier payment (in addition to the inlier payment)

Cost Outlier Payment Example

Assumptions: DRG 791; Severity 4 (OR Procedure for Other Complications of Treatment); Weight: 7.275

1	2	3=1x2	4	5=3-4	6	7=5+6	8=3-7
DRG 791-4 Charges	Hospital RCC	DRG 791-4 Cost	DRG 791-4 Adj. Cost Threshold	Cost Outlier Payment	Inlier Payment (including capital)	Total Payment	Un-reimbursed Cost
\$260,761	0.6098	\$159,012	\$68,031	\$90,981	\$62,506	\$153,487	\$5,525



DRG 791-4 Cost Threshold	WEF	DRG 791-4 Cost Threshold (adjusted)
\$66,960	1.016	\$68,031

Funds Available for Hospital Transition

- ❑ Assist hospitals to adjust operations consistent with state health care priorities and revenue streams
- ❑ Transition funds available for 4 years
 - ❑ \$33.5 m in 2009-10 (beginning 12/1/09)
 - ❑ \$75 m in 2010-11
 - ❑ \$50 m in 2011-12
 - ❑ \$25 m in 2012-13
- ❑ Eligible hospitals must submit board-approved business plan
- ❑ After 2 years, a progress report must be submitted to receive additional funding
- ❑ Additional \$25 m to Medicaid safety net hospitals (voluntary hospitals whose Medicaid discharges are 40% or greater) to assist projected Medicaid losses from enacted budget
- ❑ Excludes public hospitals

Components of New Inpatient Exempt Rate

- ▶ Exempt Units/Hospitals – effective 12/1/2009
 - **Medical Rehab and Chemical Dependency Rehab**
 - 2005 costs trended to 2009, held to 110% of regional operating costs excluding DME
 - **Critical Access Hospitals**
 - 2005 costs trended to 2009 held to 110% of statewide average of all CAH
 - **Specialty Hospitals (Cancer/Long Term Acute)**
 - 2005 costs trended to 2009, no ceilings
 - **Children's Hospital (Blythedale)**
 - 2007 costs trended to 2009

Components of New Inpatient Exempt Rate

- ▶ **Psychiatric Exempt: Effective 12/1/2009**
 - 2005 operating cost trended to 2009
 - Case mix adjusted per diem
 - Working with OMH and industry to develop new case mix factors
 - Looking at Medicare
- ▶ **Detox:**
 - OASAS certified detox programs only
 - Two year phase-in:
 - 4/1/2009 – 3/31/2010: 67.5% new/ 32.5% 2007
 - 4/1/2010: 100% 2006 costs with regional ceilings.
 - Currently @ 25/75% for 12/1/2008 – 3/31/2009
- ▶ AIDS, Epilepsy and Burn rates now set using APR-DRGs
- ▶ Budgeted capital adjusted to actual as currently implemented

Increases in Support for Services Provided to Uninsured Patients

Calendar Year 2009

- **PEP/DSH Transition Pool – \$331 m (\$307 m in PEP/GME and \$24 m GME-based Indigent Care)**
 - Funding to be allocated to teaching hospitals as indigent care payments at same amounts as GME payments from 2008
 - The distribution of the \$307 m is dependent upon approval from CMS, otherwise the 2010 allocation method will be used (See next slide)

- **Non-Teaching Hospital Uninsured Pool– \$16 m ***
 - Distribution based on relative share of uninsured need (Units x Medicaid rate)

- **Public Hospital DSH Enhancement – \$430 m ***
 - \$300 m HHC for 2 years and there are discussions to pursue additional available statewide DSH cap
 - \$130 m other public hospitals to accelerate 2007 and 2008 payments

* Continues into 2010

Increases in Support for Services Provided to Uninsured Patients (con't)

Calendar Year 2010 and Thereafter

- ❑ **Teaching Hospital Uninsured Pool– \$269.5 m ***
 - ❑ Distribution based on each eligible hospitals relative proportion of 2007 uncovered uninsured need
 - ❑ Each region allocated same proportionate amount of \$269.5 m as received from GME/PEP Pool
- ❑ **Safety Net Hospital Uninsured Pool –\$25 m ***
 - ❑ Medicaid safety net hospitals (voluntary hospitals whose Medicaid discharges are 40% or greater) based on relative share of uninsured costs
- ❑ **Major Academic Reform and Quality Innovation Pool –\$24.5 m ***
 - ❑ State only funding for assisting negative impacts to voluntary academic medical centers
 - ❑ Develop quality standards linked to APR–DRGS, best practices for high risk specialties like OB, inpatient psychiatric case payment, medical home standards and reforms to residency training

*Public hospitals not eligible due to DSH enhancement

□ **Federal Waiver** Will be working with industry on a recently submitted Federal waiver to develop alternative expansions of health insurance for New Yorkers

- Waiver approved by CMS in 1997 and provides authority for NY's mandatory Medicaid managed care program
- Savings allows NY to receive federal financial participation for expansion populations (safety net enrollees, FHPlus adults without children, family planning benefit program)
- Three -year extension request submitted to CMS on March 31st
- In addition to extending the programs for three additional years, the extension requests:
 - Federal approval and support to expand FHPlus to 200% of the federal poverty level
 - Federal match on payments made to community clinics that provide services to uninsured patients
 - Enhanced financial participation to support state reform activities embodied in the HCIA of 2009 in order to promote patient-centered care and improve access to and the quality of primary and ambulatory care.

Next Steps

Key Dates

- ▶ April 2009: DoH Briefs CMS on Budget Reforms
- ▶ May–June 2009: DoH to meet with Hospitals eligible for Transition Funds
- ▶ May and June 2009: DoH to brief Health Plans and conduct regional hospital briefings on changes
- ▶ May 2009: DoH to set up meeting with industry, health plans and 3–M to discuss APR–DRG implementation
 - Revisit select issues like low birth weight babies and minor technical areas
- ▶ June 1, 2009 State Plans submitted to CMS
- ▶ July 2009: Industry to resubmit 2005 recertified ICR
- ▶ September 2009: Beta Testing of New Rates
- ▶ October 1, 2009: Notice Rates Available
- ▶ December 1, 2009: New Rates Effective

Ambulatory Care Reform

Moving Dollars, Moving Care

Building a Sound Primary Care Infrastructure

❑ The 2008–09 Budget Began Ambulatory Care Reform

- ❑ New outpatient payment method (APG) replaces per-visit payment system
- ❑ \$178 million invested in hospital clinics, ambulatory surgery and ER
- ❑ Additional investments in D&TCs and physicians
- ❑ Enhancements for weekend/evening hours, and diabetes/asthma educators

❑ The 2009–10 Budget Builds on these Reforms

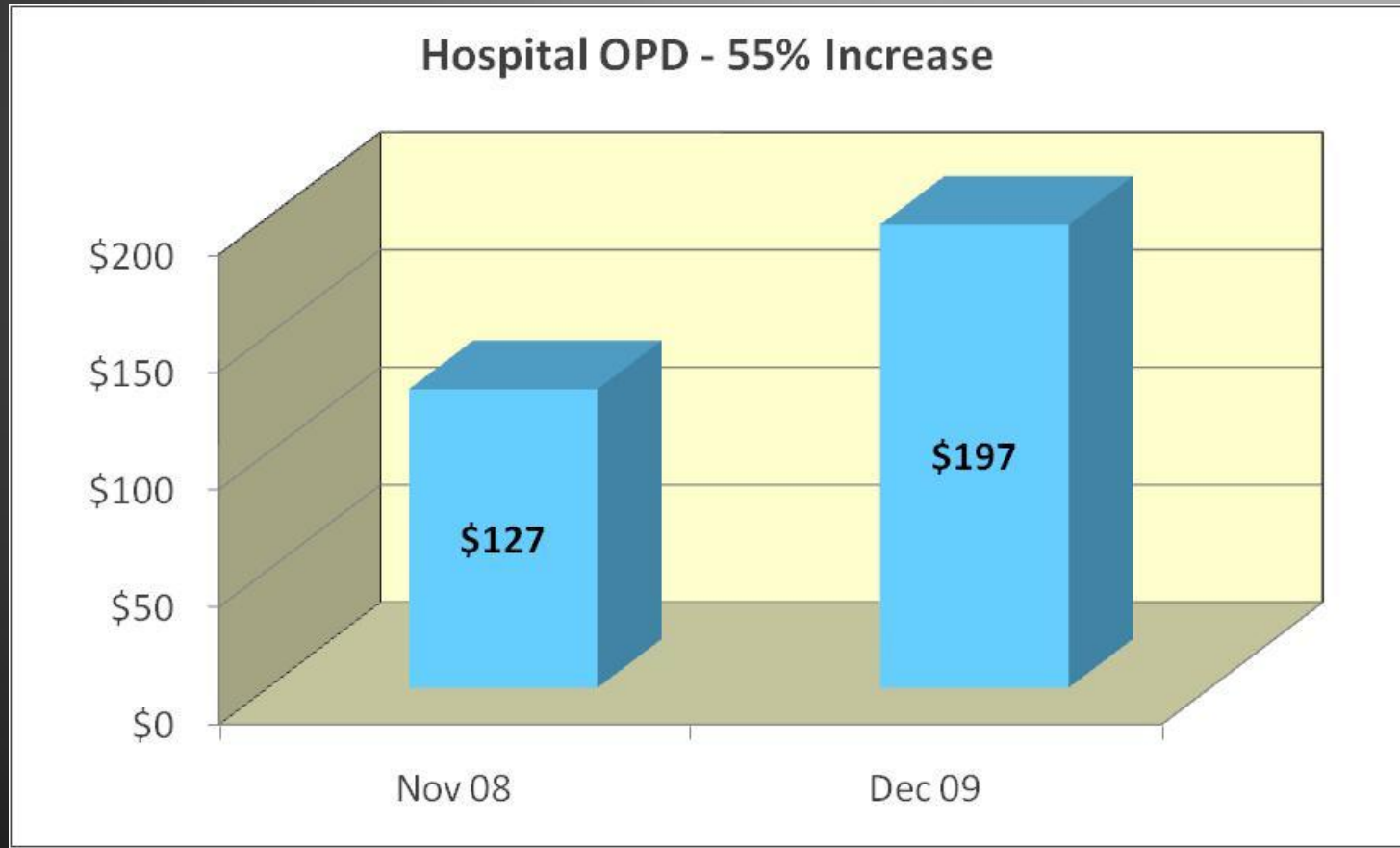
- ❑ Increases investment in hospital and community clinic rates
 - ✓ Medicaid will cover approximately 90% of average hospital clinic costs
 - ✓ Medicaid will cover approximately 90% of average D&TC costs
- ❑ Increases investment in physician fees
 - ✓ Payments to physicians will increase by 80% over 2007 levels
- ❑ Enhances payments for providers that meet medical home standards
- ❑ Coverage for smoking cessation, cardiac rehabilitation, and screening and counseling for substance abuse patients in ER

Total Ambulatory Care Reform Package

(Gross \$ in Millions)	<u>Approved in SFY 08/09</u> Budget (Full Annual)	Additional Funding Approved in SFY 09/10 Budget (Full Annual)	<u>Total Investment SFY</u> <u>10/11</u> (Full Annual)
Hospital Programs	\$178.0	\$92.0	\$270.0
Outpatient Clinic	\$88.0	\$92.0	\$180.0
Ambulatory Surgery	\$40.0	\$0.0	\$40.0
Emergency Room	\$50.0	\$0.0	\$50.0
Freestanding Programs	\$12.5	\$37.5	\$50.0
Primary Care Investments	\$38.0	\$90.1	\$128.1
Asthma and Diabetes Education (08/09 Enacted)			
Expanded "After Hours" Access (08/09 Enacted)			
Social Worker Counseling (08/09 Enacted)			
Smoking Cessation (08/09 Enacted)			
Nurse Family Partnership (08/09 Enacted)			
Cardiac Rehabilitation (09/10 Enacted)	N/A		
SBIRT (09/10 Enacted)	N/A		
Smoking Cessation (09/10 Enacted)	N/A		
Primary Care Standards/Medical Home (09/10 Enacted)	N/A		
Adirondack Medical Home (09/10 Enacted)	N/A		
Physicians	\$120.0	\$68.0	\$188.0
Mental Hygiene Enhancements	N/A	\$2.7	\$2.7
Detoxification Services Reform			
TOTAL	\$348.5	\$290.3	\$638.8

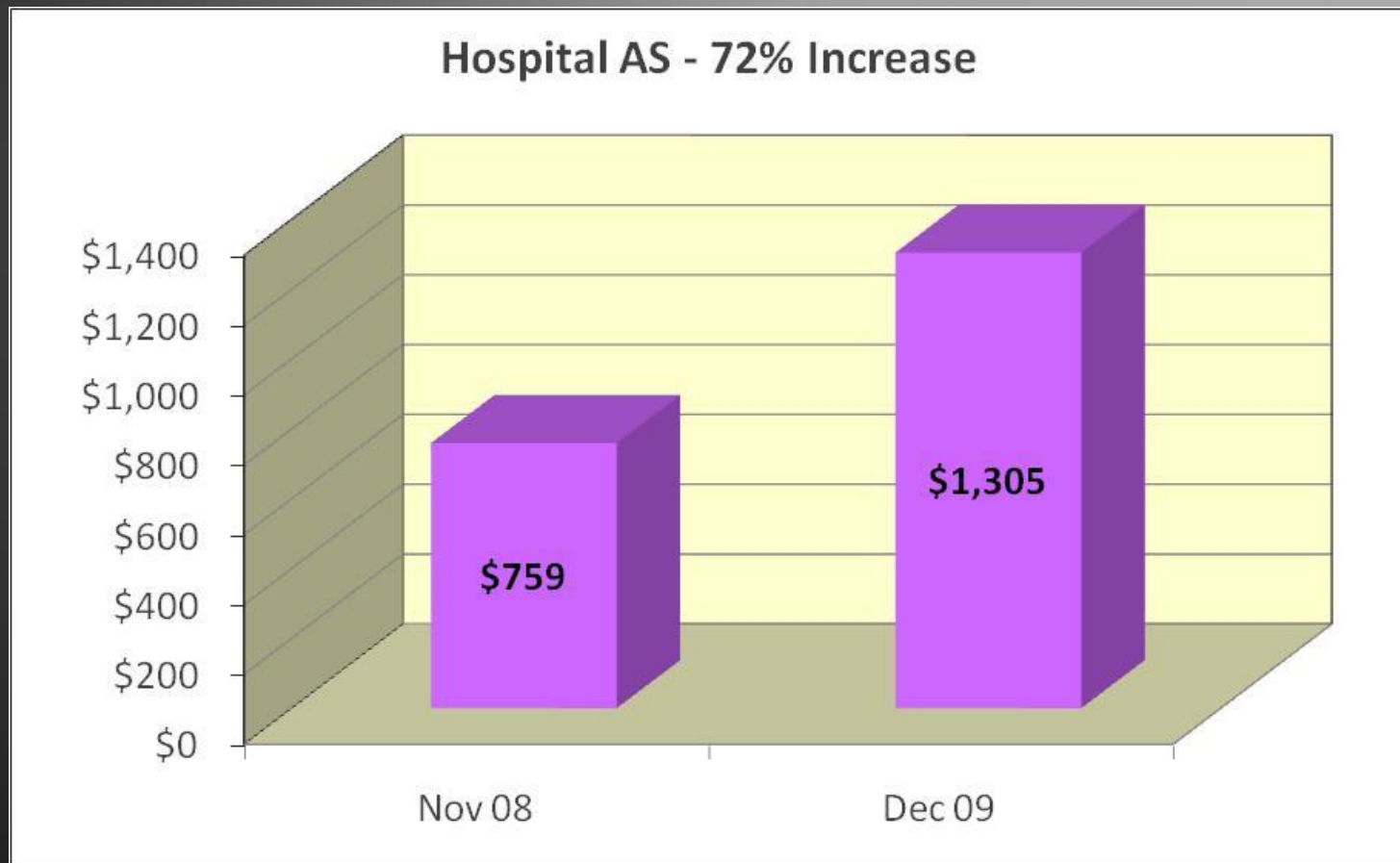
Hospital APG Impacts – OPD

(Phase 2 – Beginning December 1, 2009)



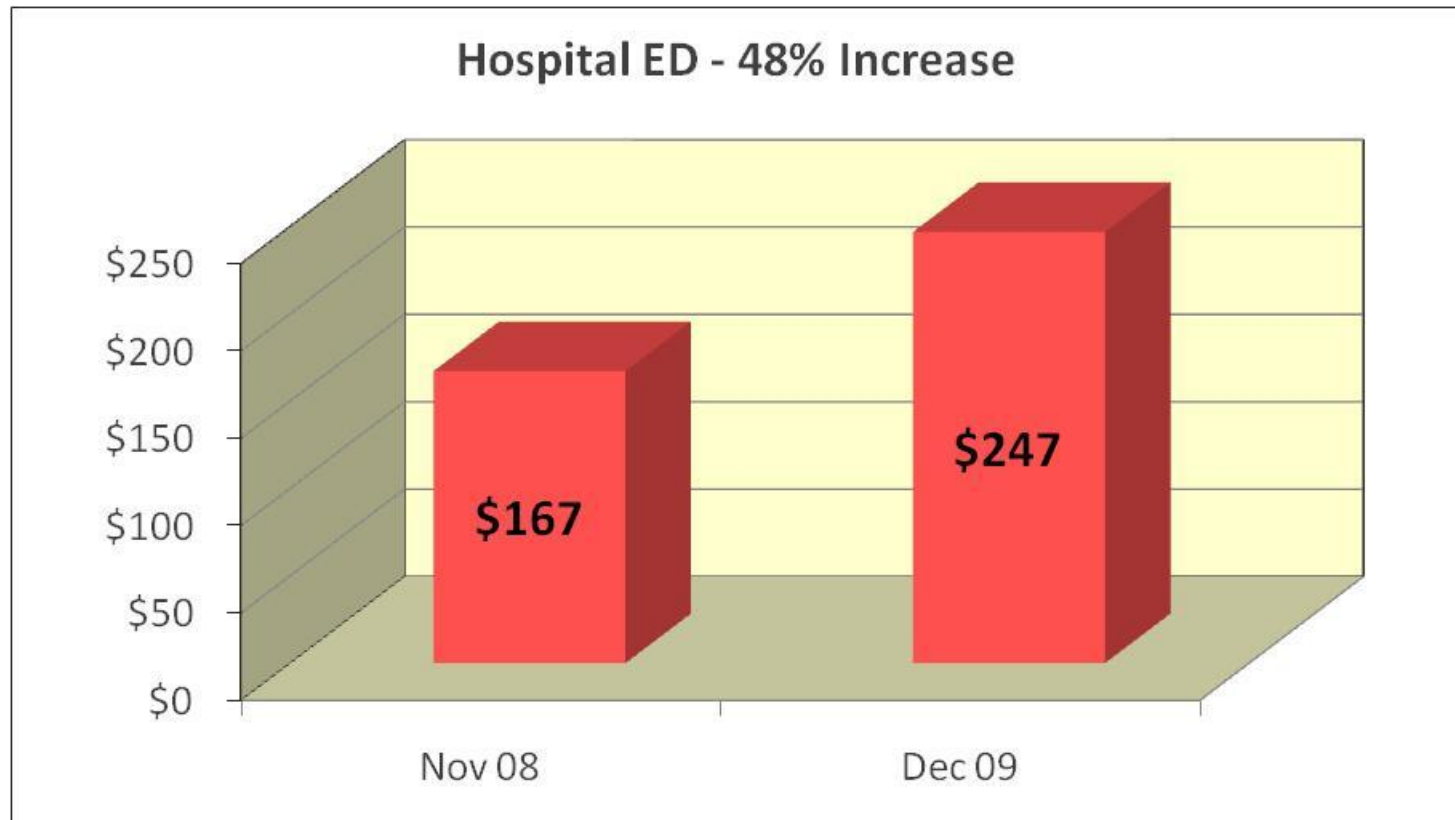
Hospital APG Impacts – Ambulatory Surgery

(Phase 2 – Beginning December 1, 2009)



Hospital APG Impacts – Emergency Room

(Phase 2 – Beginning December 1, 2009)



Timeline for Practitioner Investments

January 1, 2009

- ✓ Medicaid fees for physicians and other practitioners were indexed to the 2008 Medicare physician fee schedule.
- ✓ Medicaid pays physicians an additional 10% for serving Medicaid patients in federally-designated Health Professional Shortage Areas (HPSAs).

February 1, 2010

- ✓ Medicaid will permit physicians to bill the physician fee schedule for all billable services provided in any hospital outpatient department or inpatient setting.
- ✓ Medicaid will make additional investments in critical primary and preventive care services.

Physician Fees

Effective January 1, 2009, physician fees were increased on average almost 40% above their current levels. The following chart shows updated facility based physician fees for commonly billed services :

Procedure Codes	Procedure Description	Physician Fee: Facility Based	
		Current	New
99213	Outpatient visit	\$5.00	\$21.54
99214	Outpatient visit	\$5.00	\$33.69
99232	Subsequent hospital care	\$5.00	\$26.01
99283	Emergency department visit	\$6.50	\$24.17
71010	Chest x-ray (single view)	\$10.00	\$20.24
71020	Chest x-ray (two views)	\$15.00	\$26.29
90935	Hemodialysis, one evaluation	\$7.50	\$33.72
43239	Upper GI endoscopy	\$100.00	\$100.00
45378	Diagnostic colonoscopy	\$80.00	\$102.22

Nurse Practitioner Fees

Effective January 1, 2009, Nurse Practitioner fees were increased on average more than 43% above their current levels. The following chart shows updated facility based, nurse practitioner fees for commonly billed services:

Procedure Codes	Procedure Description	Nurse Practitioner Fee: Facility Based	
		Current	New
99212	Outpatient visit	\$5.00	\$9.66
99213	Outpatient visit	\$5.00	\$18.31
99214	Office / outpatient visit	\$5.00	\$28.64
99308	Nursing facility care	\$7.00	\$20.32
99283	Emergency department visit	\$6.50	\$20.54
43760	Change gastrostomy tube	\$20.00	\$21.20
12001	Repair superficial wound(s)	\$8.00	\$40.25

Midwife Fees

Effective January 1, 2009, Midwife fees were increased on average almost 20% above their current levels. The following chart shows updated facility based midwife fees for commonly billed services:

Procedure Codes	Procedure Description	Midwife Fee: Facility Based	
		Current	New
99212	Outpatient visit	\$5.00	\$9.66
99213	Outpatient visit	\$5.00	\$18.31
59400	Routine obstetrical care	\$1,037.00	\$1,462.64
59409	Vaginal delivery only	\$630.00	\$649.38
54150	Circumcision	\$20.00	\$42.69

▶ Update on APGS

APG Rebasing – July 1, 2009

- Hospital OPD, Amb Surg, and ED will be rebased.
 - Volume and case mix will be adjusted as needed.
 - Fee schedule reimbursement for ancillary lab and radiology services, previously billed directly to Medicaid by ancillary vendors, will be factored into the July base rate calculation.
 - The case mix indices will also be adjusted to reflect the service intensity of the ancillaries.
- The existing payment for blend for OPDs will be updated to reflect the fee schedule reimbursement for ancillaries that is added to the APG base rate for OPD.

General APG Payment Policy for Ancillary Lab and Radiology Services

- ▶ Lab and Radiology services ordered by practitioners for clinic patients are included in the APG payment to the clinic.
- ▶ Clinics must make arrangements to pay outside lab and radiology service providers for services provided for clinic patients.
- ▶ CPT codes for lab and radiology services should be billed on an APG claim.
- ▶ Ancillary providers may not bill eMedNY for services related to an APG reimbursed visit.

APG Ongoing Billing Rules for Ancillaries

For Date Of Service on and after July 1, 2009:

- ▶ All lab and radiology services (exceptions noted later), even those referred to outside vendors, are the fiscal responsibility of the hospital and must be included on an APG claim.
- ▶ For all lab and radiology services, the date of service reported on the claim should be the date of the medical visit/significant procedure, even if the lab or radiology procedure is performed subsequent to the clinic visit.
- ▶ Use of the date of the medical visit/significant procedure to report claims for ancillaries performed prior to the clinic visit is currently under consideration.

Ancillary Services

Compliance and Enforcement

- ▶ OHIP will monitor lab/radiology services billed to hospital OPD and ED patients for dates of service on and after July 1, 2009.
- ▶ Shortly after the July 1 implementation date, OHIP will begin identifying lab/radiology procedures that were billed to Medicaid that may be the fiscal responsibility of the ordering hospital OPD/ED.
- ▶ If ancillary lab/radiology procedures were ordered by hospital OPD/ED practitioners for their patients, the laboratory/radiology providers will need to void their Medicaid claims and bill the clinic.

Exceptions to the Rule

- ▶ Lab and radiology tests performed on behalf of FQHCs that do not participate in APGs
- ▶ Procedure codes carved out of APGs (e.g. lead screen, HIV viral load, virtual phenotype, blood factors, etc.)
- ▶ Lab and radiology services associated with specialty clinic rate codes carved of APGs (e.g. HIV counseling and testing visit, AIDs clinic therapeutic visit, etc.)
- ▶ Procedure codes which optionally may be carved out of APGs (e.g. urine pregnancy test in family planning clinic when not part of an E&M visit) .

Billing for Radiology Services

- ▶ The professional component of radiology services is carved out of all APG payments.
 - The radiologist should bill Medicaid using the radiology fee schedule for the physician component of the radiological procedures provided.
- ▶ The facility providing the radiology service should bill the technical component back to the referring hospital or DTC.
- ▶ The referring hospital or DTC should include the radiology procedure in the APG claim. The date of service on the claim should be the date of the medical visit/significant procedure in which the radiology procedure was prescribed.

APG Payment for Radiology Service (MRI Brain w/o Dye) Referred to Outside Provider

**Free-Standing APG Provider Payment for CPT Code 70551 (MRI Brain w/o Dye)
- when sent out as a ordered ambulatory service -**

	<u>Apparent Payment (from Rate)</u>	<u>Actual Payment (Calculated)</u>	
DTC APG Base Rate(Phase 1 - Downstate) >	\$ 157.33	\$ 157.33	
APG Weight (APG 294) >	2.2816	2.2816	
Full APG Payment (@ 100%) >	\$ 358.96	\$ 358.96	
APG Blend Percentage >	25%	25%	
APG Portion of Blend >	\$ 89.74	\$ 89.74	
Provider-Specific Existing Payment for Blend >	\$ 133.00	\$ 276.11	< Payment from Ordered Ambulatory Fee Schedule - Included in Existing Payment for Blend
Existing Payment Blend Percentage >	75%	75%	
Existing Payment Portion of Blend >	\$ 99.75	\$ 207.08	
Total APG Payment >	<u>\$ 189.49</u>	<u>\$ 296.82</u>	
Payment in Comparison to Fee Schedule >	<u>\$ (86.62)</u>	<u>\$ 20.71</u>	

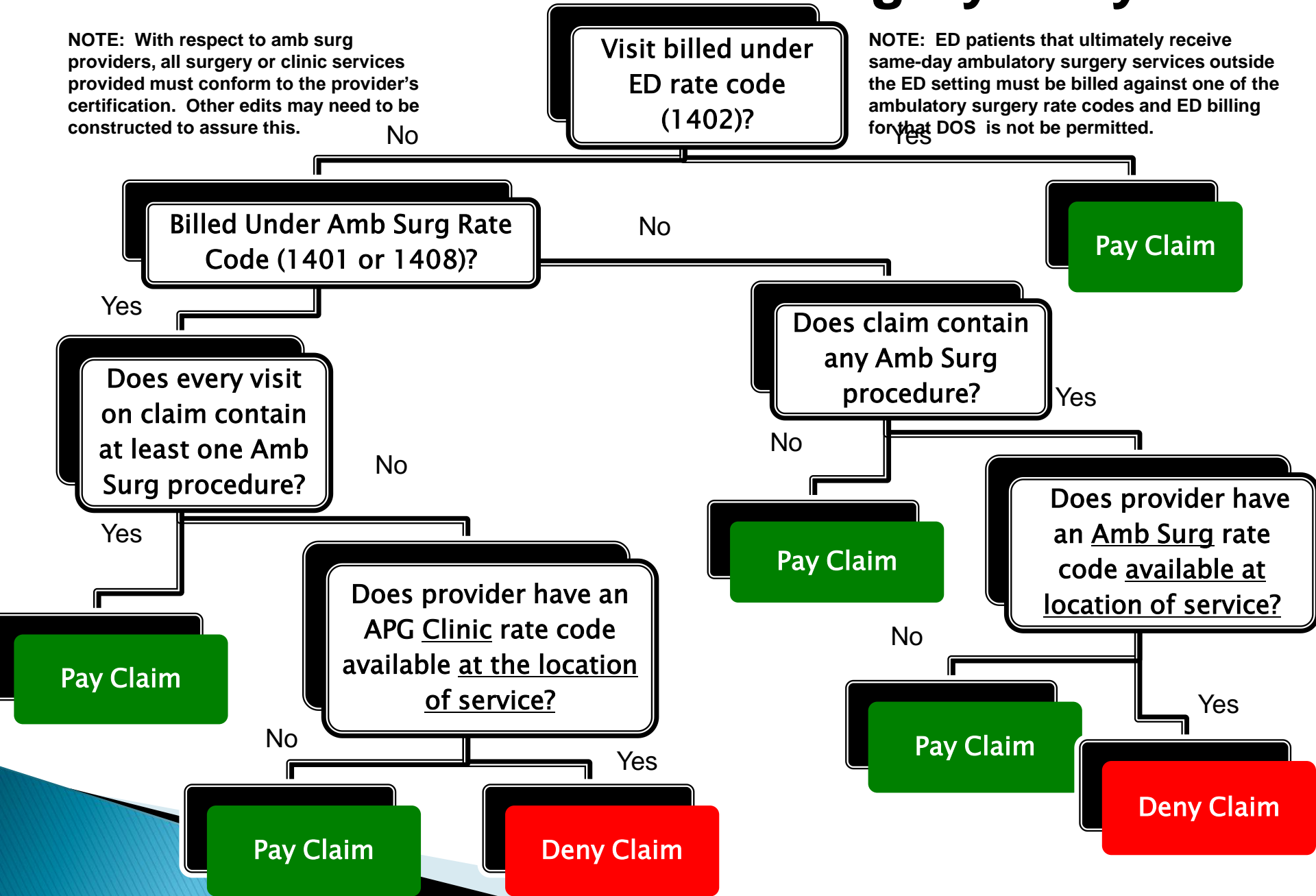
Ambulatory Surgery Billing Policy

- Facilities with both OPD and ambulatory surgery (AS) rate codes assigned to them should bill designated AS procedures (as identified by DOH on the ambulatory surgery procedures list) under the AS APG rate code (1401).
- Facilities with only the OPD rate code (1400) may bill the OPD rate code when they perform a procedure on the ambulatory surgery procedures list (if consistent with their Operating Certificate).
- If a patient is admitted to the ED and ultimately receives an AS procedure the provider may only bill using the ED rate code (1402) if the procedure is performed in the ED setting.
- On the other hand, if the procedure is performed in an AS setting, the claim must be billed to the AS rate code (1401).

eMedNY APG Ambulatory Surgery-Only Edit

NOTE: With respect to amb surg providers, all surgery or clinic services provided must conform to the provider's certification. Other edits may need to be constructed to assure this.

NOTE: ED patients that ultimately receive same-day ambulatory surgery services outside the ED setting must be billed against one of the ambulatory surgery rate codes and ED billing for that DOS is not be permitted.



Ambulatory Surgery

Pre and Post Surgical Lab Tests

- ▶ Pre-surgical lab testing
 - If the patient is a “clinic patient” and the pre-surgical lab testing has been ordered by the clinic practitioner, the pre-surgical lab tests should be included on the clinic APG claim.
 - If the pre-surgical lab tests are ordered by the surgeon in the AS unit or a physician not associated with the clinic, e.g., community physician, the lab tests should be billed using the ordered ambulatory laboratory fee schedule.
- ▶ Post surgical testing (e.g., pathology)
 - All post-surgical lab tests are not included in the amb surg APG payment and should be billed using the laboratory fee schedule.

Other Changes in 3M APG Software

- Ancillary billing:
 - Beginning July 1, 2009 all hospitals will be allowed to code “outside” ancillaries that result from an APG visit, using the date of the medical visit or significant procedure , even if the laboratory or radiology procedure is performed after the clinic visit.
- ▶ Dental Anesthesia Payment:
 - Due to an error in the payment logic for dental claims, coding dental anesthesia (APG 375) incorrectly caused the highest weighted significant procedure to be discounted rather than paid in full. This will be changed on July 1, 2009.
- ▶ Immunizations:
 - Beginning April 1, 2009 visits in which an RN provides immunization(s) may be billed under APGs. An E&M code should not be claimed unless the patient is seen by a physician, NP or PA.
 - Immunizations have been removed from the “If Stand Alone, Do Not Pay” list so they will be paid even if they are the only procedures on a claim.
 - Immunizations will not have an “existing payment” component (i.e., there will be no blend).

Other Changes...continued

- New APG Carve Outs
 - White Blood Cell Count Test (Clozaril/Clozapin/Fazaclo)
 - Partial Thromboplastin Time Test, plasma or whole blood for (Coumadin only)
- ▶ New Optional Carve Outs (family planning clinics only)
 - when the following services are delivered by an RN (not part of an E&M visit) they may be billed outside of APGs.
 - Urine Pregnancy Test
 - Patient sees only an R.N. for family planning counseling and the pregnancy test.
 - An APG claim should not be billed to Medicaid.
 - Pregnancy test should be billed using the laboratory fee schedule.
 - RN Administration of Depo-Provera – may be billed using the ordered ambulatory fee schedule if not billable with an E&M under APGs.

APG Drug Re-Groupings

- ▶ OHIP has identified the following drugs that are not being reimbursed adequately under APGs:
 - J2355 Oprelvekin injection
 - J0475 Baclofen pump (Lioresal)
 - J2503 Pegaptanib sodium
 - J3488 Reclast injection (Reclast)
 - J2323 Natalizumab injection (Tysabri)
 - J9303 Panitumumab injection
 - J1300 Eculizumab injection (Solaris)
- ▶ These drugs are being re-classified into higher weighted APGs to ensure appropriate Medicaid reimbursement (effective July 1, 2009).

Patient Encounters with an RN

- ▶ Patient encounters with **only** an RN are not reimbursed under APGs except in the following instances:
 - An RN administers chemotherapy or other drug infusion.
 - an APG claim should be billed.
 - An RN administers an immunization.
 - an APG claim should be billed for vaccine administration and vaccine material with no E&M.
 - An RN in a family planning clinic performs a urine pregnancy test.
 - urine pregnancy test , 81025, should be billed using the lab ordered amb fee schedule; an APG claim should not be billed.
 - An RN in a family planning clinic administers Depo-Provera.
 - Depo-Provera, J1055, should be billed using the ordered ambulatory fee schedule; an APG claim should not be billed.
- ▶ In no case should and E&M code be claimed for services provided by an RN.

Physician Professional Component

- ▶ Effective February 1, 2010, reimbursement for physician professional services provided by hospital OPDs will be carved out of the APG payment, except where precluded by law (six federally designated HHC hospitals).



- ▶ **Primary Care Enhancements**

Cardiac Rehabilitation

- Medicaid will cover Cardiac Rehabilitation effective January 1, 2010.
 - must be provided as part of a prescribed, supervised exercise program that is part of post-hospital recuperation.
 - limited to patients with certain specific diagnosis, e.g., acute myocardial infarction, angina pectoris, heart transplant, heart valve replacement, heart bypass/angioplasty.
 - should be provided two or three times per week over a 12–18 week period.
 - supportive counseling (e.g., dietary counseling, psychosocial intervention, lipid management, stress management) are components of the program and are not separately reimbursed.
 - Cardiac rehab will be covered in the Art 28 hosp OPD/free-standing clinic setting as well as in a physician's office.
 - CPT codes 93797/93798 group to APG 094, Cardiac Rehabilitation

Smoking Cessation Counseling

- ▶ Medicaid currently covers SCC for pregnant women.
- ▶ The Executive Budget for 2009–10 provides for an expansion of SCC to postpartum women (180 days following delivery) and to children & adolescents ages 10–19 years.
- ▶ Counseling must be provided by a physician, registered physician's assistant, registered nurse practitioner, or licensed mid-wife during a medical visit (no group sessions).
- ▶ Pregnant women are allowed 6 SCC sessions during pregnancy and 6 SCC sessions during the postpartum period (180 days following delivery).
- ▶ Children and adolescents ages 10–19 years of age are allowed a total of 6 SCC sessions (no group) during a continuous 12 month period.
- ▶ CPT codes 99406 (3–10 min) and 99407 (>10 min) group to APG 451.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

- The Department of Health 2009–10 Executive Budget provides for Medicaid payment for SBIRT for Medicaid recipients in hospital emergency departments.
- SBIRT is a model designed to identify individuals with or at risk of substance use related problems, assess the severity of substance abuse and the appropriate level of intervention required, and provide brief intervention or brief treatment within a community setting.
- The goal of SBIRT is to make screening or substance abuse a routine part of medical care, and to identify and treat problems early in order to avoid more serious medical problems.
- Two procedure codes have been established for Medicaid billing purposes by hospital emergency departments, which are:
 - H0049 - Alcohol and/ or drug screening
 - H0050 - Alcohol and/ or drug service, brief intervention, per 15 minutes
- Both CPT codes currently map to APG 315

Statewide Patient Centered Medical Home (PCMH)

- ▶ 2009–2010 Executive Budget provides for a PCMH to improve health outcomes and efficiency through patient care continuity and coordination of health services
 - ▶ Clinics and office–based practices that meet NCQA standards for recognition as a “primary care medical home” will receive incentive payments tied to E&M visits.
 - ▶ There will be three levels of payment commensurate with levels of NCQA “medical home designation.”
 - ▶ The program will be implemented December 1, 2009
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