

# **FY2009–10 Budget**

## **Healthcare Reimbursement Reform**

Department of Health

MMC Plan and Commercial Payor Presentation

July 2009

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

- Required that Medicaid FFS 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

# 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

# *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*

# Medicaid FFS 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)

# Medicaid FFS Inpatient Reform

## Full Annual Impact

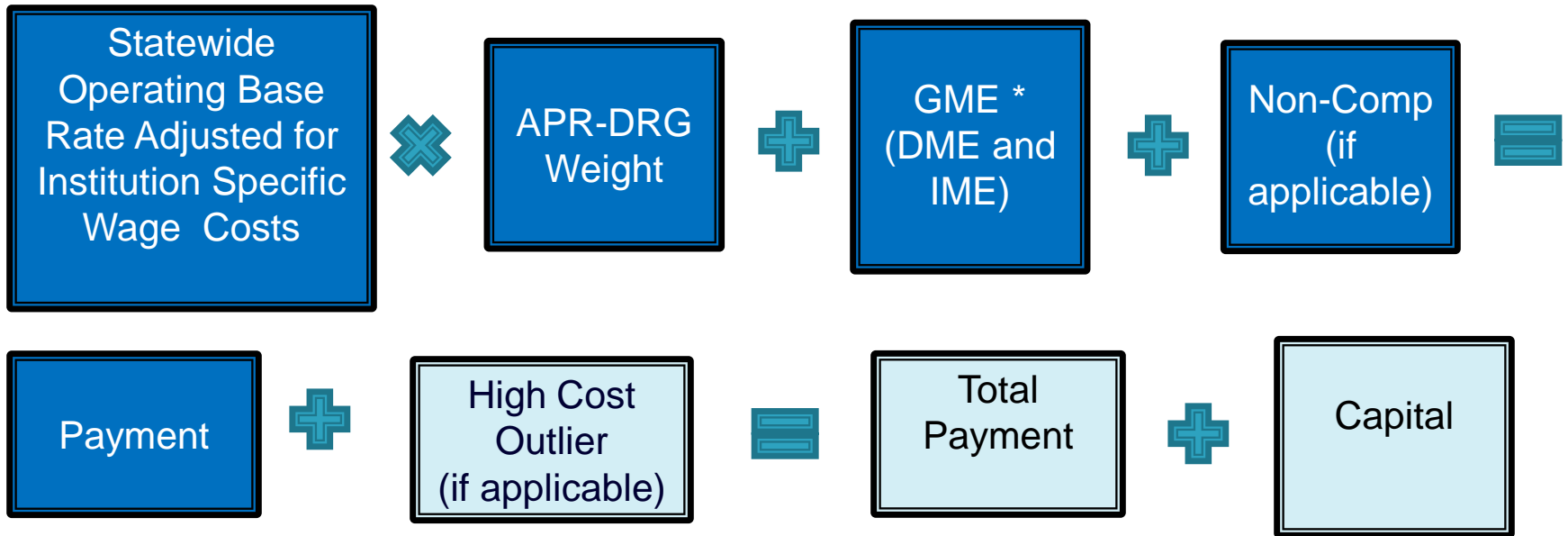
- ❑ \$207.4M in Inpatient Reform Savings
  - ❑ Acute Reimbursement Reform (\$225M)
  - ❑ Exempt Unit Rebasing (+\$10.2M)
  - ❑ Elimination of Public R&R Grants (\$36.3M)
  - ❑ Full Implementation of Detox Reform (\$31.3M)
  - ❑ Transitional Funding (+\$75M)

# New FFS 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 FFS Inpatient Rate Methodology *effective 12/1/09*



\* GME will be carved out of MMC rates

# Components of New Medicaid FFS 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
- ❑ 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. These “All Payor” weights can be used by all non-Medicare payors.
- ❑ APR weights are scaled to 1.0
- ❑ Permits analysis of potentially preventable readmissions and complications
- ❑ AP DRGs will not be maintained

# Component: Graduate Medical Education (FFS)

## 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 – Medicaid FFS

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

Alternate Payment Rate would exclude GME

# Component: Cost Outlier Payment

- ❑ Cost based outlier thresholds are developed for each base APR-DRG 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– Medicaid FFS

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



# Transfer Payment Example– Medicaid FFS

Assumptions: DRG 190; Severity 2 (Acute Myocardial Infarction); Weight: 1.138

1	2	3	$4=(1/2)*3$	$5=4*120\%$	$6=1 \text{ or } 5$
<b>Inlier Payment</b>	<b>Average Length of Stay (LOS)</b>	<b>Actual Length of Stay (LOS)</b>	<b>(Inlier Payment/ Average LOS) x Actual LOS</b>	<b>Transfer Payment Factor (20%)</b>	<b>Lower of Inlier Payment or Transfer Payment</b>
\$11,419	4	1	\$2,855	\$3,426	\$3,426



Statewide Base Price	WEF	Adjusted Price	APR Weight (190-2)	Weighted Price	DME per Discharge	IME Add-on	Non-Comp Ambulance Add-on	Capital Add-on	Inlier Payment
\$6,662	1.016	\$6,769	1.138	\$7,703	\$1,591	\$1,770	\$163	\$192	\$11,419

Alternate Payment Rate would exclude GME

# Funds Available for Hospital Transition

## Medicaid FFS

- ❑ Assist hospitals to adjust operations consistent with state health care priorities and revenue streams
- ❑ Total Medicaid (MMC and FFS) discharges must be at least 17.5% of total discharges to qualify
- ❑ 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 – Medicaid FFS

- ▶ 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 – Medicaid FFS

- ▶ **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 – \$414 m \***
  - \$300 m HHC for 2 years and there are discussions to pursue additional available statewide DSH cap
  - \$114 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
- ▶ Summer 2009: DoH to meet with Hospitals eligible for Transition Funds
- ▶ May –July 2009: DoH to brief Health Plans and conduct regional hospital briefings on changes
- ▶ May– July 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
- ▶ On going 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

# Timeline for Practitioner Investments

## January 1, 2009

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- ✓ 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

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- ✓ 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.

# 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