

FY2009–10 Budget

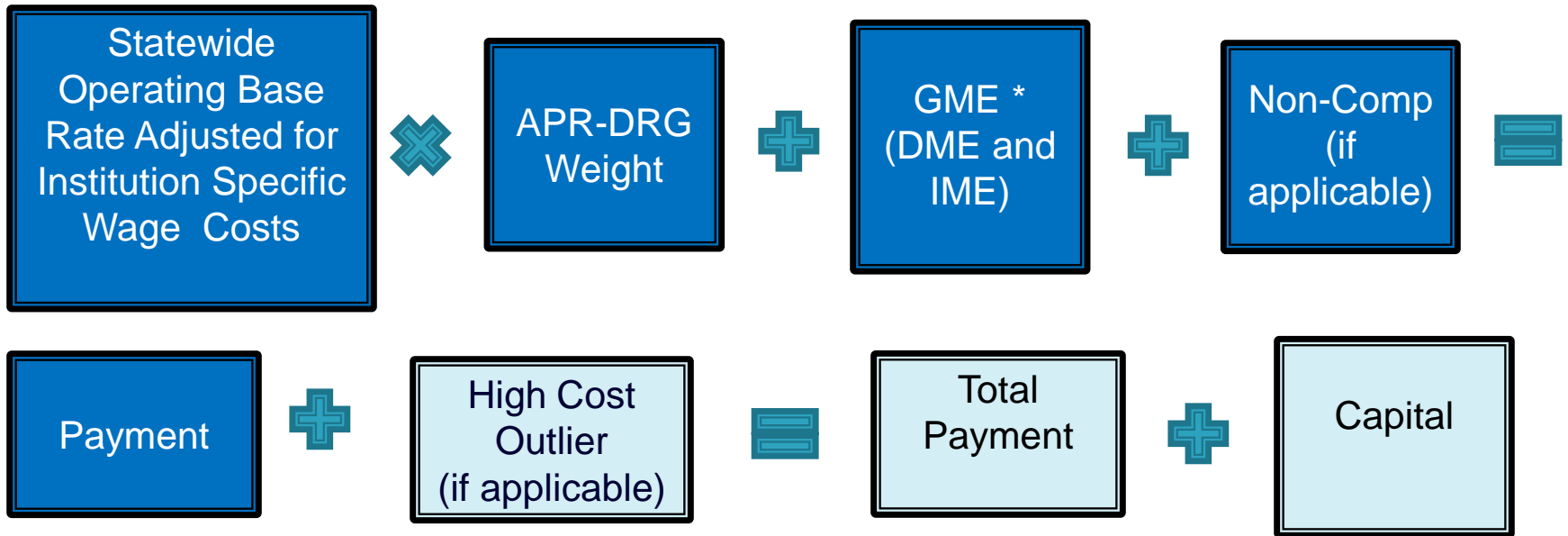
Healthcare Reimbursement Reform

Department of Health

Vendor Presentation

July 2009

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 | $4=(1/2)*3$ | $5=4*120\%$ | $6=1 \text{ or } 5$ |
|-----------------------|-------------------------------------|------------------------------------|---|--|--|
| Inlier Payment | Average Length of Stay (LOS) | Actual Length of Stay (LOS) | (Inlier Payment/ Average LOS) x Actual LOS | Transfer Payment Factor (20%) | Lower of Inlier Payment or Transfer Payment |
| \$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 and 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

- ✓ 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, on a provider-specific basis, 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).

Episode Payment Option (July 2009)

- ▶ New episode payment rate codes will signal the APG grouper–pricer to treat all lines coded on a clinic claim as if they occurred on the same date of service (i.e., the APG grouper–pricer views all lines on the claim as a single visit).
 - ED already uses episode payment (rate code 1402)
- ▶ The episode payment logic allows ancillaries occurring subsequent to a medical visit to be matched to the visit within the APG logic without “reassigning” the date of the medical visit to the ancillaries.
- ▶ Episode payment will not apply to ambulatory surgery claims, which will continue to be billed under rate code 1401.

Episode Payment (slide 2)

- ▶ Under visit-based payment, all procedures on a claim with a common date of service are treated as a “visit” by the APG grouper-pricer. Therefore, multiple visits (based on multiple dates of service) can be coded on a single claim.
- ▶ Under episode payment, because DOS is not factored into the APG logic, only a single “episode”, defined as all medical visits and/or procedures that occurred on a single date of service and their associated ancillaries (regardless of their dates of service), may be coded on a single claim.
 - NOTE: Coding multiple medical visits or procedures that occurred on different dates of service on the same episode-based claim could result in unwarranted discounting or consolidation.

Episode Payment (slide 3)

- ▶ New Hospital Episode Payment Rate Codes (and effective dates):
 - 1432 – General Clinic (July 1, 2009)
 - 1450 – School Based Health Clinic (October 1, 2009)
- ▶ Use of the episode payment rate code will be optional from July 1 – Dec 31, 2009
- ▶ Beginning on January 1, 2010 the use of the episode payment rate codes will be mandatory and the visit based rate codes (1400, 1444) will no longer be used.
- ▶ Edit issues related to “duplicate claims” being rejected based on the claim header’s “from” and “to” dates will be resolved on August 27, 2009.
 - NOTE: Some rebilling may be required at that time.

Out of State (OOS) Providers

- ▶ Out of State hospitals move to APG reimbursement for outpatient services effective July 1, 2009.
- ▶ Out of State Hospital Rate codes:
 - 1413 – Clinic
 - 1416 – Ambulatory Surgery
 - 1419 – Emergency Department
 - 1441 – Clinic (Episode Based – October 1, 2009)

Hospital Clinic MR/DD/TBI Base Rate

- ▶ Effective January 1, 2010, a new hospital clinic base rate will be established to reflect the higher cost of serving the MR/DD and TBI population.
 - MR/DD/TBI rate code - 1489 (episode-based)
- ▶ Eligibility to bill a patient under this code will be based on the patient being flagged with recipient MC exempt restriction code 95 (MR/DD) or recipient exception code 81 (TBI) in the eMedNY billing system.