

# **Overview of Episodic Payment System (EPS) for Certified Home Health Agencies**

**Effective May 1, 2012**

(Revised April 17, 2013)

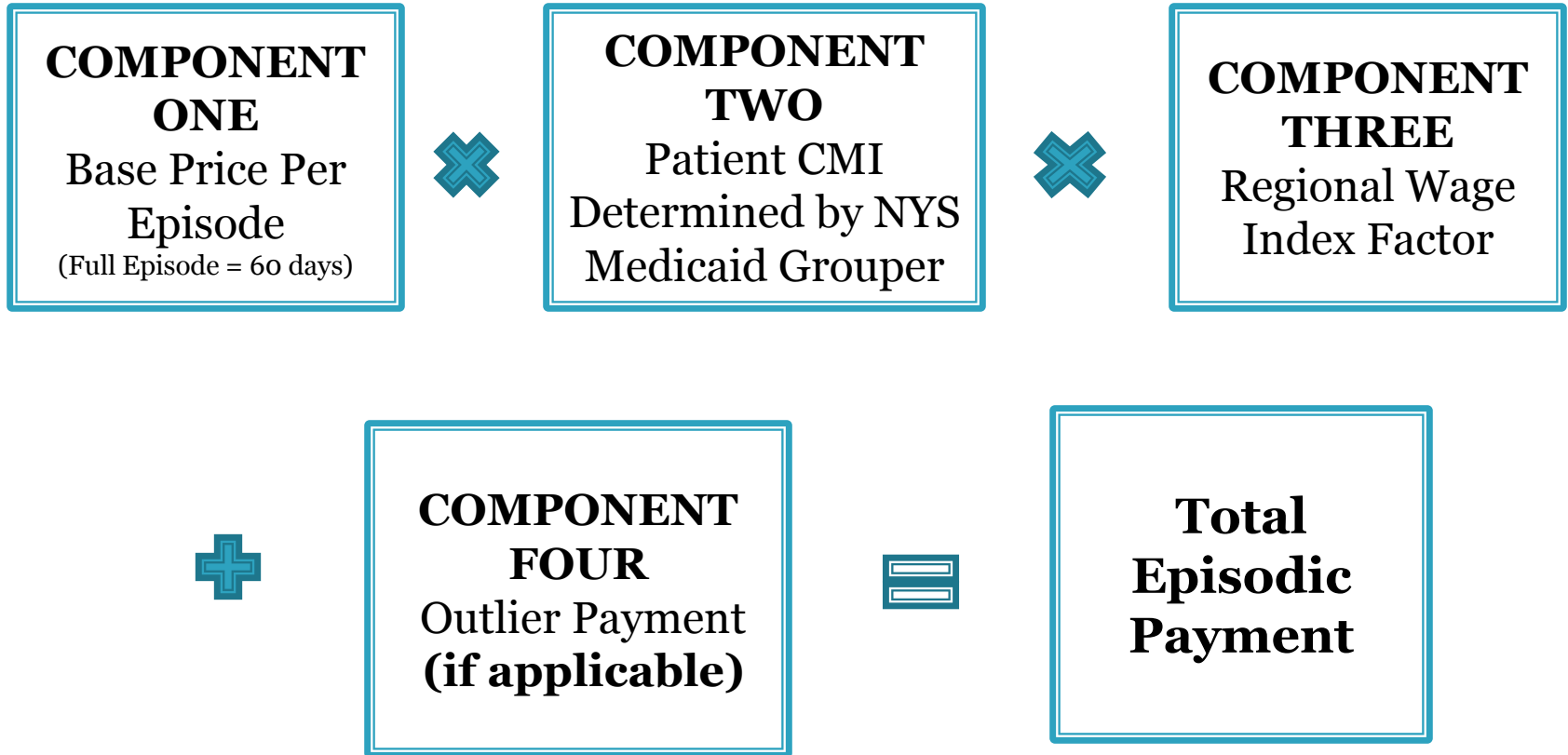
# Episodic Payment System (EPS) Continues Medicaid Redesign Team (MRT) Efforts to Reduce and Control Utilization

- ▶ From 2003 to 2009:
  - Medicaid Costs for CHHAs increased 77.4%
  - Cost per patient increased 89.5%
  - The number of patients receiving CHHA services declined by 6.4%
- ▶ MRT Initiative #5
  - Phase 1: Effective April 1, 2011 implemented aggregate annual per patient spending limits
  - Phase 2: Effective May 1, 2012, Episodic Payment System Implemented
  - Phase 3: Effective 2012/2013, begin roll-out of mandatory enrollment of certain individuals who require community-based long-term care - will include phase-in of dual eligible CHHA patients

# NYS Episodic Payment System (EPS)

- ▶ EPS took effect on May 1, 2012
- ▶ NYS EPS is similar to Medicare EPS, but there are significant differences
- ▶ Applies to all CHHA patients except:
  - Patients under 18 years of age
  - Participants in a pilot program approved by the Department of Health to provide services to medically complex and fragile children, adolescents and young disabled adults
  - Traditional fee-for-service billing will continue for both of these patient groups
- ▶ A Statewide Base Price for 60-day episodes of care is adjusted for patient acuity using a NYS Medicaid grouper, regional wage differences, and if applicable, outlier payments.

# NYS Episodic Payment System (EPS)



# **Component One of EPS System: Base Price**

# Component One of EPS: Base Price

- ▶ Payments are based on 60-day episodes of care
- ▶ Statewide Base Price for all episodes = \$5,633 effective May 1, 2012
  - Low Utilization Payment Amount (LUPA) may be applicable
- ▶ Statewide base price adjusted for:
  - Case mix (patient acuity) using OASIS data and NYS Medicaid Grouper
  - Regional wage differences ~ Wage Index Factor
  - Outlier Payments (if applicable)

# **Component Two of EPS System: Case Mix Adjustment Using NYS Medicaid Grouper**

# NYS Medicaid CHHA Grouper

- ▶ Per statute, Medicaid Grouper developed using 2009 claims data and OASIS-B assessment information
- ▶ The 2009 Medicaid Grouper is compatible with the OASIS-C assessment data
- ▶ OASIS-C assessment data now in effect will be run through the Medicaid CHHA Grouper to determine the case mix component of EPS system



# Overview of NYS Medicaid Grouper (Used to Determine Case Mix Adjustment)

NYS Medicaid Grouper	
Clinical	Medicaid Clinical Measures – 3 Groups (A,B,C)
Functional	Medicaid Functional Measures – 3 Groups (E,F,G)
Assessment Reason	2 Groups – Start of Care or Recertification (0 , 1)
Age	6 Age Groups (1-6)
Total # Case Mix Groups/Weights	Total: 108 Case Mix Groups (3*3*2*6)

# OASIS-C Clinical and Functional Factors Included in NYS Medicaid CHHA Grouping

## **7 Clinical Factors**

- 1) Diabetes diagnoses
- 2) Orthopedic diagnoses
- 3) Dementia diagnoses
- 4) HIV diagnoses
- 5) Bowel Incontinence
- 6) Urinary Incontinence
- 7) Shortness of Breath

## **3 Clinical Groups:**

- A=0-4 points
- B=5-14 points
- C=15+ points

## **4 Functional Factors**

- 1) ADL Dressing upper body
- 2) ADL Dressing lower body
- 3) ADL Toileting
- 4) ADL Transferring

## **3 Functional Groups:**

- E=0-18 points
- F=19-51 points
- G=52+ points

# OASIS-C Age and Assessment Factors Included in NYS Medicaid CHHA Grouping

## **Assessment Reason (2 Groups)**

- o) Start of Care (M0100 = 1 or 3)
- 1) Recertification of Care (M0100 = 4 or 5)

## **Age (6 Groups)**

- 1) Less than 60
- 2) 60-69
- 3) 70-74
- 4) 75-79
- 5) 80-84
- 6) 85+

# NYS Medicaid CHHA Grouper

## (Point Scale to Determine Clinical and Functional Groups)

Response Level

Item	Item Number OASIS-C	0	1	2	3	4	5		
Dx of Diabetes	M1020/M1022	0	4						
Dx of Orthopedic	M1020/M1022	0	2						
Dx of Dementia	M1020/M1022	0	24						
Dx of HIV	M1020/M1022	0	10						
Bowel Incontinence	M1620	0	0	0	5	5	5		
Urinary Incontinence	M1610	0	6	0					
Shortness of Breath	M1400	0	4	4					
Dress Upper	M1810	0	8	18	18				
Dress Lower	M1820	0	0	12	21				
Toilet	M1840	0	13	20	20	20			
Transfer	M1850	0	0	9	9	15			15

# Example Case Mix ~ Mrs. Smith

<b>Mrs. Smith</b> <b>Assessment Reason: Recertification =1</b> <b>Age Group 70-74 (Age = 3)</b>	<b>Points</b>
Diabetes	4
Orthopedic Condition (Arthritis)	2
Dementia diagnosis	0
HIV diagnosis	0
Bowel Incontinence less than Once Weekly Response 1	0
Urinary Incontinence Response 1	6
No Shortness of Breath	0
<b>Clinical Score (A= 0-4, B=5-14, C=15+)</b>	<b>12 = B</b>

# Example Case Mix ~ Mrs. Smith

<b>Mrs. Smith</b>	<b>Points</b>
<b>Assessment Reason: Recertification =1</b>	
<b>Age Group 70-74 (Age = 3)</b>	
Dress Upper Body Response 1 (needs clothes laid out)	8
Dress Lower Body Response 1 (needs clothes laid out)	0
Toileting Response 1 (needs to be reminded, supervised, assisted)	13
Transferring Response 1	0
<b>Functional Score (E=0-18, F= 19-51, G=52+)</b>	<b>21=F</b>
<b>Mrs. Smith: Case Mix Group = 1 B F 3</b>	

# 108 Case Mix Groups Are Assigned Individual Rate Codes

- ▶ Each of the 108 Case Mix Groups is tied to a **Rate Code**
- ▶ The following table provides 6 examples of the 108 Rate Codes.

Assessment Reason*	Clinical Group	Functional Group	Age Group	Case Mix	Rate Code
0	A	E	1	.243422	4810
0	B	F	2	.691567	4835
0	C	G	3	1.963598	4860
1	A	E	4	.515132	4867
<b>1</b> (Mrs. Smith Ex.)	<b>B</b>	<b>F</b>	<b>3</b>	<b>.934108</b>	<b>4890</b>
1	C	G	6	2.480934	4917

\* Assessment Reason 0: Start of Care 1: Recertification

# Developing a Grouper Module

- ▶ Providers/vendors need to create their own module which will generate one of the **108 grouper-based rate codes** to be used in billing.
  - Two additional rate codes will be used for special situations (see “Billing Procedures” section).
- ▶ NYSDOH also has made SAS code available to providers.



## Latest Available OASIS will be Used to Transition Patients to EPS

- ▶ To transition patients eligible for Medicaid fee-for-service coverage, providers will begin an initial episode effective May 1, 2012 or later using the latest OASIS assessment available (within the last 65 days) for that patient.
- ▶ Providers will have the option of using a partial Medicaid episode (less than 60 days) to synchronize episodes with Medicare and with the existing assessment cycle.
- ▶ If claim reflects a partial episode, a pro-rated payment will be based on the Dates of Service as claimed on UB-04, field 6: “Statement Covers Period From/Through” (see “Billing Procedures” section for exceptions).

# OASIS Transition Example

- ▶ Medicare Episode: April 15 – June 13
- ▶ Medicaid Episodic System Begins May 1
- ▶ If provider chooses to synchronize Medicaid and Medicare episodes:
  - Initial Medicaid Claim: May 1 – June 13
  - Use OASIS data collected no more than 65 days prior to May 1
  - Results in partial episodic payment for Medicaid
  - Subsequent Medicaid Claim: June 14 – August 12
  - Is now synchronized with Medicare episode
- ▶ OR: CHHA may claim a full Medicaid episode, May 1 – June 29

# **Component Three of EPS System: Regional Wage Index Factor**

# Calculation of Wage Index Factors

- ▶ The WIFs are calculated for 10 Labor Market Regions defined by the NYS Department of Labor
- ▶ Average wages are extracted from the Occupational Employment Statistics compiled by the Federal Bureau of Labor Statistics for five occupational categories:
  - Home Health Aides, Registered Nurses, Occupational Therapists, Physical Therapists, Speech Therapists
- ▶ Occupational categories are weighted according to each Region's Medicaid utilization as reported in the CHHA certified cost reports
- ▶ Wage Index Factors are adjusted proportionately to ensure that the application of the factors will be revenue neutral
- ▶ The Wage Index Factor is applied to 77% of the total reimbursement amount
  - Percentage is approximately equal to the percentage used in Medicare PPS to measure the average portion of agency costs which are labor-related

# Wage Index Factors

Effective May 1, 2012

Region	Wage Index	Counties
Capital	.911944	Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren, Washington
Central New York	1.002872	Cayuga, Cortland, Madison, Onondaga, Oswego
Finger Lakes	1.093141	Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates
Hudson Valley	1.125693	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Long Island	1.078872	Nassau, Suffolk
Mohawk Valley	.955006	Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie
New York City	.991433	Bronx, Kings, Queens, New York, Richmond
North Country	.955610	Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence
Southern Tier	.866871	Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins
Western New York	.903208	Allegany, Cattaraugus, Chautauqua, Erie, Niagara

# Example of Wage Index Factor Calculation: Capital Region

	Registered Nurses	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aides
Regional Average Wage	\$29.75	\$32.46	\$30.57	\$31.17	\$12.48
Statewide Average Wage	\$36.08	\$37.62	\$37.42	\$33.99	\$11.37
Ratio (Region/Statewide)	.8244	.8627	.8169	.9171	1.0973
Weighting *	.6298	.1386	.0287	.0488	.1541

**WIF - Total weighted ratio\*\* .876061**

**WIF - Adjusted for revenue neutrality .911944**

**\* Weighting is based on Medicaid visits reported in certified cost reports by CHHAs in Capital Region:**

Nursing:	30,417	(.6298)
PT:	6,695	(.1386)
Speech:	1,387	(.0287)
OT:	2,356	(.0488)
HHA:	7,443	(.1541)

\*\*  $(.8244 \times .6298) + (.8627 \times .1386) + (.8169 \times .0287) + (.9171 \times .0488) + (1.0973 \times .1541) = .876061$

# Application of Wage Index Factors

To calculate reimbursement amounts, the Wage Index Factor (applicable to 77% of total) is converted to a “Single Adjustment Factor” (SAF) which is applied to 100% of the claim.

SAFs used by the payment system are as follows:

Region	“Wage Index Factor” effective 5/1/12	“Single Adjustment Factor” effective 5/1/12
Capital	.911944	.93220
Central New York	1.002872	1.00221
Finger Lakes	1.093141	1.07172
Hudson Valley	1.125693	1.09678
Long Island	1.078872	1.06073
Mohawk Valley	.955006	.96535
New York City	.991433	.99340
North Country	.955610	.96582
Southern Tier	.866871	.89749
Western New York	.903208	.92547

**Example: Mrs. Smith (1BF3)**

Recertification Assessment, New York City CHHA, Clinical B, Functional F,  
Age Group 3: 70-74





**Component Four of EPS System:  
Outlier Payments  
(If Applicable)**

# Outlier Payments and Thresholds

- ▶ Outlier Payments (made in addition to the case mix and WIF adjusted base price) are applicable to costs which exceed an outlier threshold
- ▶ A separate and unique threshold is established for each of the 108 case mix groups
- ▶ The outlier threshold increases with patient need/severity of condition
  - Higher clinical – higher threshold
  - Higher functional – higher threshold
  - Older age – higher threshold
- ▶ Outlier payments are equal to 50% of the costs that exceed the outlier threshold

# Examples of Outlier Threshold Percentiles

Assessment Reason	Clinical Group	Functional Group	Age Group	Outlier Threshold
Start of Care = 0	A	E	70-74 = 3	\$3,660
Start of Care = 0	A	G	85+ = 6	\$17,619
Start of Care = 0	B	F	Under 60 = 1	\$6,991
Start of Care = 0	C	E	75-79 = 4	\$8,821
Start of Care = 0	C	G	80-84 = 5	\$26,679
Recertification = 1	A	F	60-69 = 2	\$8,670
Recertification = 1	B	E	80-84 = 5	\$6,318
<b>Recertification = 1 (Mrs. Smith Ex)</b>	<b>B</b>	<b>F</b>	<b>70-74 = 3</b>	<b>\$9,720</b>
Recertification = 1	C	E	75-79 = 4	\$10,269
Recertification = 1	C	G	85+ = 6	\$28,600

# Determining Costs and Calculating Outlier Payments

- ▶ The EPS will use the latest fee-for-service rates in effect as of May 1, 2012 to calculate statewide weighted average rates for specific CHHA services to determine the “Service Cost” of each episode of care
- ▶ The average rates will be tied to **Revenue Codes**
- ▶ The provider will report units of service (hours, visits, etc) provided on each date during each episode
- ▶ The eMedNY system will multiply the units of service times the statewide rates associated with the appropriate **Revenue Codes** to compute the service cost of the episode
- ▶ If the costs exceed the outlier threshold for the case mix group, the CHHA will receive the Base Price adjusted by Case Mix and WIF plus 50% of the costs that exceed the outlier threshold
  - The outlier payment also will be adjusted by the WIF

# Revenue Codes for EPS

Service	Unit	Statewide Weighted Average Rate	Revenue Code
Skilled Nursing	Visit	\$102.15	0551
Physical Therapy	Visit	\$113.89	0421
Speech/Language Pathology/Therapy	Visit	\$112.83	0441
Occupational Therapy	Visit	\$108.67	0431
Home Health Aide	Hour	\$17.92	0572
Shared Aide	Qtr. Hour	\$4.48	0579
AIDS Skilled Nursing	Visit	\$102.15	0559
Telehealth I, II, III	Day	\$9.52	0780
Telehealth Installation	One-Time	\$50.00	0590
MOMS Health Supportive Services	Visit	\$77.88	0581

## Example: Outlier Payment for Mrs. Smith

Recertification Assessment, New York City CHHA, Clinical B, Functional F,  
Age Group 70-74



Mrs. Smith			
Total cost of visits/hours (Statewide rates for each revenue code, multiplied by units of service)	Outlier Threshold	Costs in Excess of Outlier Threshold	Outlier Payment (50% of Excess, with 77% Adjusted by WIF)
\$12,000	\$9,720	\$2,280	\$1,140* .99340 (SAF) = \$1,132.48

# **LUPAs, Length of Stay (Partial/Full), and Interim Payments**

# Low Utilization Payment Amounts (LUPAs)

- ▶ If “service cost” of episode is \$500 or less, the CHHA receives a Low Utilization Payment Amount (LUPA)
- ▶ The service cost of the episode is computed by multiplying the units of service times the statewide weighted average rates associated with the appropriate Revenue Codes
- ▶ The LUPA is equal to the computed cost
  - The payment is adjusted by the applicable Single Adjustment Factor (based on the Wage Index Factor)

**NOTE: \$500.00 threshold is applied BEFORE wage adjustment – Wage-adjusted LUPA payment can be more than \$500.00 even if unadjusted charges (based on Revenue Codes) are  $\leq$  \$500.00**



# Partial and Full Episodic Payments ~

## Payments for Patients Discharged in Less Than 60 Days

- ▶ To maintain billing integrity and to properly implement the EPS while certain CHHA patients are enrolled in MLTCPs/CCMs, episodes of less than 60 days will result in partial payments if the CHHA patient is discharged to another Long Term Care setting, including MLTC/CCM, LTHHCP, Nursing Home
- ▶ Partial episodic payments also will apply to patients who are discharged to another CHHA
- ▶ Full episodic payments will be made for CHHA patients who are discharged in less than 60 days only if discharged to:
  - The Community/Home
  - Hospital
  - Hospice
  - Or in cases of death

(See examples in the “Billing Procedures” section of this presentation)

# Interim Payments

- ▶ To assist providers with cash flow during an episode, providers may submit a claim early in the episode for an Interim Payment
- ▶ Interim Payments are equal to 50% of the episodic base price, based on the reported Rate Code, adjusted for CMI and Wage Index
  - Interim claims must include at least one date of service showing the applicable Revenue Code
- ▶ When the final claim for the same episode is submitted, the full final payment is calculated
  - The full final payment is processed as an adjustment or “takeback” of the Interim Claim and full payment of the final claim

# **Examples: Calculating Reimbursement Under the EPS**

# Episodic Payment System: Reimbursement Examples

The following pages provide 6 examples of how payments to providers will be calculated:

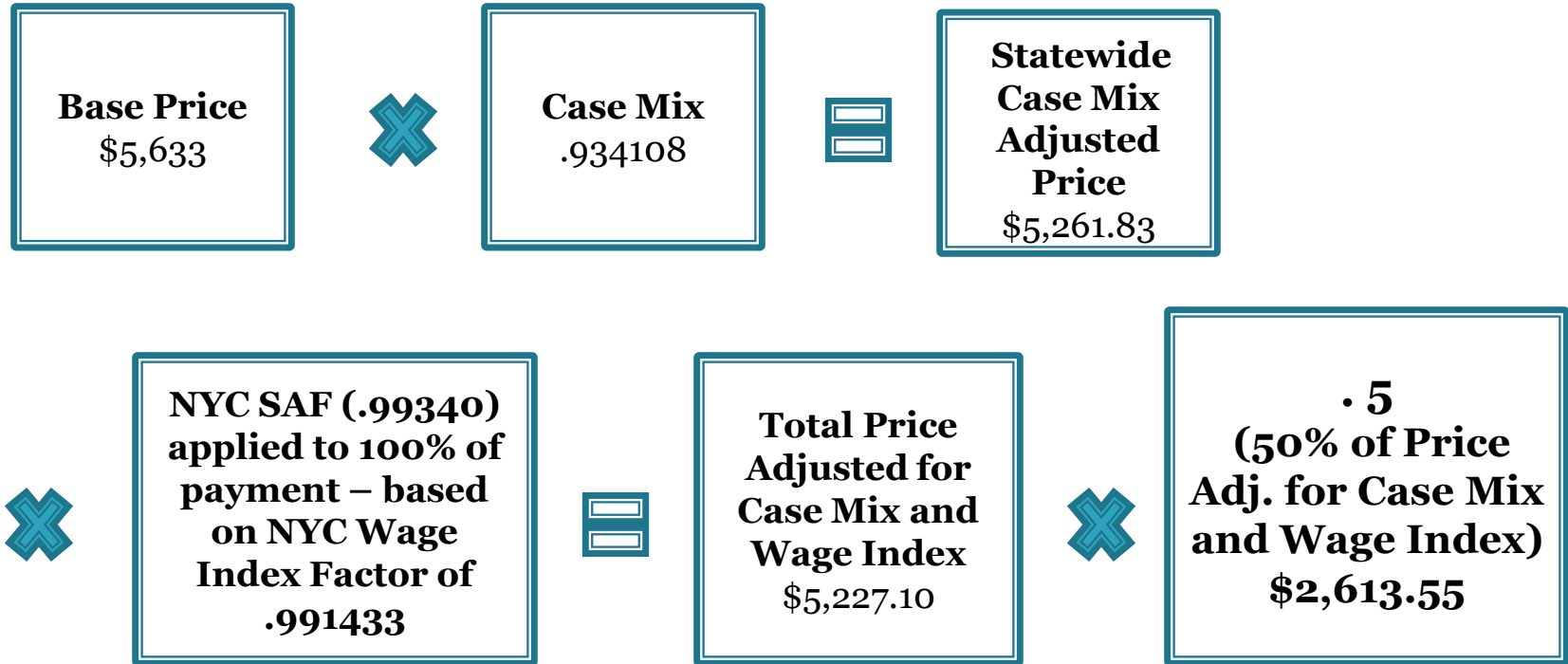
1. Interim Payment
2. Full episode - no LUPA, no outlier reimbursement
3. Full episode - with outlier reimbursement
4. Full episode – LUPA
5. Partial episode - no LUPA, no outlier reimbursement
6. Partial episode – with outlier reimbursement

# Episodic Payment System: Reimbursement Examples



**The following information will apply to all 6 payment examples:**



- Patient is served by a CHHA in New York City
- Reason for OASIS assessment is Recertification (1)
- Clinical group is B
- Functional Group is F
- Patient is 72 years old (Age Group 3)
  
- Statewide Base Price is \$5,633
- Case Mix Index for Resource Group 1-B-F-3 = 0.934108
- Outlier Threshold for 1-B-F-3 = \$9,720
- Wage Index Factor applied to 77% of reimbursement; Single Adjustment Factor (SAF) applied to 100% of reimbursement

# Example #1: Interim Payment (1BF3)



## Example #2: Full Episode – No LUPA, No Outlier Adjustment (1BF3)

<b>Base Price</b> \$5,633		<b>Case Mix</b> .934108		<b>Statewide Case Mix Adjusted Price</b> \$5,261.83
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<b>Statewide Case Mix Adjusted Price</b> \$5,261.83		<b>NYC SAF (.99340) applied to 100% of payment – based on NYC Wage Index Factor of .991433</b>		<b>Total Price Adjusted for Case Mix and Wage Index</b> \$5,227.10
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(If Interim Payment was received, provider will receive Final Payment of \$5,227.10 minus “takeback” of Interim Payment - e.g. \$2,613.55 in Example #1).

## Example #3: Full Episode with Outlier Reimbursement

Total charges for visits, hours, etc. reported by CHHA based on Revenue Codes =  
**\$12,000**

Outlier Threshold for this Resource Group = **\$9,720**

Charges in excess of outlier threshold = **\$2,280**

Provider will receive outlier payment of  $\$2,280 \times 50\% = \$1,140$   
This amount will be adjusted by SAF (based on Wage Index Factor)  
Net outlier payment (NYC Provider) = **\$1,132.48**

Base Price adjusted for  
WIF and Case Mix (from  
Example #1): **\$5,227.10**



Outlier Payment,  
adjusted for WIF:  
**\$1,132.48**



Total Episodic  
Payment:  
**\$6,359.58**

(Interim Payment, if any, will be  
reversed when Final Payment is made)



**Example #4: Full Episode – Low Utilization (LUPA)  
(1BF3)**

**Total charges for visits, hours, etc. reported by CHHA based on  
Revenue Codes = \$450.00**

**As this is less than (or equal to) \$500.00, Low Utilization Payment  
will apply – REGARDLESS of length of episode**

**Provider will receive actual charges produced by Revenue Codes:  
This amount will be adjusted by the SAF (based on Wage Index Factor)  
Net payment (NYC Provider) = \$447.03**

**(Interim Payment, if any, will be reversed when Final Payment is made)**

## Example #5: Partial Episode – No LUPA, No Outlier Adjustment (1BF3)

**“From” Date on Claim Form:** May 15, 2012  
**“Through” Date on Claim Form:** June 23, 2012  
**Length of Episode:** 40 Days

**Episodic Price  
Adjusted for Wage  
Index Factor and Case  
Mix  
(from Example #1):  
\$5,227.10**



40 / 60



**Total  
Reimbursement  
for Partial  
Episode:  
\$3,484.73**

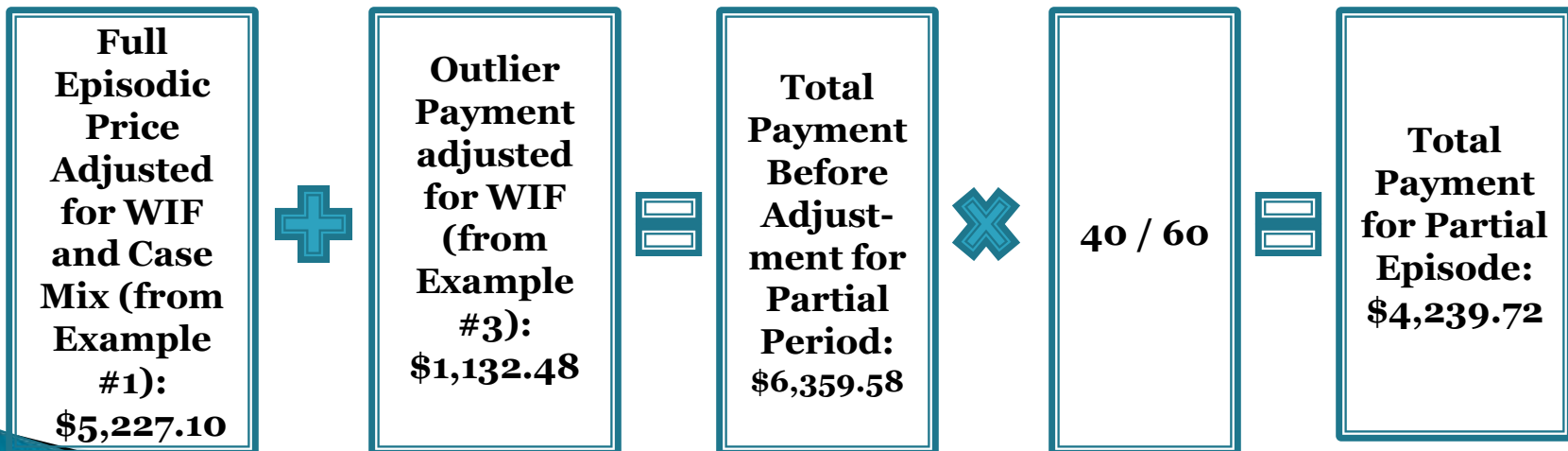
**(Interim Payment, if any, will be reversed when  
Final Payment is made)**

## Example #6: Partial Episode with Outlier Reimbursement (1BF3)

**“From” Date on Claim Form:** May 15, 2012  
**“Through” Date on Claim Form:** June 23, 2012  
**Length of Episode:** 40 Days

**Total charges for visits, hours, etc. reported by CHHA based on Revenue Codes =  
\$12,000**

**Charges in excess of outlier threshold = \$2,280**



**(Interim Payment, if any, will be reversed when  
Final Payment is made)**

# Billing Procedures

# General Information

- ▶ The Episodic Payment System took effect on May 1, 2012 and applies to CHHA Medicaid services provided on and after that date
  - Exceptions apply to services provided to patients under age 18 and specified pilot programs
- ▶ OASIS assessments will continue to be completed in accordance with Federal requirements and will be used by the NYS Medicaid Grouper to determine case mix
- ▶ Medicaid continues to be the “payer of last resort” - services which are covered by Medicare or other payers should not be included on Medicaid claim forms

# New Procedures for Completing Medicaid Claims

- ▶ The third digit of “Type of Bill” (UB-04 field #4) must be shown as:
  - “2” for Interim Claim
  - “9” for Final Claim (full or partial) or Adjusted Claim
- ▶ The Occurrence Code 50 (fields 31-36) should be used to report Date of Assessment (OASIS) – required field for Rate Codes 4810 through 4917
- ▶ Rate Code (fields 39-41) must be one of the new 110 episodic Rate Codes
  - Rate Codes should be based on patient’s age as of the “Through” date on the claim
- ▶ Revenue Code (field 42) and Service Units (field 46) must be shown for each Service Date (field 45).
- ▶ Procedure Code (field 44) must continue to be completed

# New Procedures for Completing Medicaid Claims

- ▶ The Length of episode will be determined by “Statement Covers Period From/Through” dates (UB-04 field #6)
- ▶ The “From and Through” dates on the claim represent the beginning and end of an episode
  - If the Episode is First Medicaid Episode:
    - From Date: Date of the first billable Medicaid service (a Medicaid Start of Care episode cannot begin until a billable service is provided)
    - Through Date: End of 60-day period or the last date services provided if partial episode
  - If the Episode is a Subsequent Episode (continuous care is provided to patient):
    - From Date: the date immediately following the through date for the previous episode
    - Through Date: End of the 60-day period or the last date of services provided if partial episode

# New Procedures for Completing Medicaid Claims

## ▶ Interim Claims:

- Must include at least one date of service showing the applicable Revenue Code
- When the final claim for the same episode is submitted, the full final payment is calculated
  - The full final payment is processed as an adjustment or “takeback” of the Interim Claim and payment of the final claim
  - This will be reflected on the remittance in the same way an adjusted claim is shown now under fee-for-service billing
- The TCN on the Final Claim must match the TCN on the Interim Claim
- Interim Claims will be voided after 150 days if no corresponding final claim is received



# New Procedures for Completing Medicaid Claims

- ▶ All service units billable to Medicaid should be listed on the final claim
- ▶ Any applicable surplus/spend-down amount should be offset on the claim in fields 39-41 of the UB-04
  - It will be the provider's responsibility to report all surplus/spend-down amounts during the appropriate time period
- ▶ Claims must be submitted within 90 days after the end of the episode

# Partial Episodes that Qualify for Full 60-Day Payment

- Reimbursement will be pro-rated for partial episodes (difference between From and Through dates is less than 60 days).
- **EXCEPTIONS:**
- CHHAs will receive full 60-day reimbursement amount if a partial episodic claim indicates one of the following Discharge Status Codes (field 17 on UB-04):
  - 01 – Discharged to Home or Self-Care
  - 02 – Discharged/Transferred to Hospital
  - 20 – Patient Expired
  - 50 – Discharged to Hospice (Home)
  - 51 – Discharged to Hospice (Medical Facility)
- If the CHHA later resumes care for the patient within 60 days of the original “From” date, the agency must file a corrected claim to prevent double billing.

# Episodic Rate Codes

- ▶ 108 rate codes are based on NYS Medicaid Grouper methodology (rate codes 4810 through 4917).
- ▶ Rate code 4919: Assessments only – no other services in 60-day period – should be used only for LUPA claims.
- ▶ Rate code 4920: Maternity only – maternity patients 18 and older, no OASIS available – Case Mix Index and Outlier Threshold are the same as rate code 4810 (lowest acuity group).
- ▶ Occurrence Code 50 (used to report OASIS assessment date) is not required for rate codes 4919 and 4920.

# Future Updates to EPS Methodology

- ▶ As required by statute, the elements of the EPS (Base price, Medicaid Grouper, outlier payments, etc.) were developed using 2009 claims data and OASIS-B assessment information which do not reflect the transition of CHHA patients to MLTCPs/CCMs
- ▶ When sufficient data is available from the 2012-13 claims, the Department will re-evaluate the elements of the EPS, including:
  - The Base Year
  - The Base Price
  - The Medicaid Grouper
  - Partial Episodic Payments

# Resources

Detailed information about the Episodic Payment System is available at the following DOH website:

[http://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/](http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/)

This information includes:

- ▶ Base price, resource groups, case mix indices, rate codes
- ▶ Outlier thresholds
- ▶ Weighted average rates for LUPAs and outliers
- ▶ Regional wage index factors
- ▶ Billing guidelines
- ▶ Medicaid grouper details
- ▶ Episodic Payment System Q&A

# Resources

Billing updates have been posted to the DOH website regarding the following subjects:

- ▶ Acceptable assessment dates
- ▶ Requirements for written medical orders
- ▶ Maximum number of service units per day
- ▶ Proper reporting of spend down and surplus

Future updates will be posted on the same site.

Questions regarding the Episodic Payment System should be submitted to the following email address:

[bltcr-ch@health.state.ny.us](mailto:bltcr-ch@health.state.ny.us)