CHCANYS Conference 2013
Medicaid Updates
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Agenda

- DFRS Reorganization
- Indigent Care (IC) Process and Payments
- Electronic Health Record System (EHRS)
- FQHC CON Reform Legislation
- FQHC Rate Appeal Process
- APG Rate Update
- AHCF Cost Report
- Health Commerce System (HCS)
- Safety Net/VAP Program
- Questions and Answers

DFRS Reorganization

Bureau	Director	Responsibilities
Mainstream Acute Care/FFS Rate Setting	Stephanie Fargnoli	•Managed care Rates •FFS Rates (Inpatient) •FFS Rates (Outpatient and Clinics) •Stop Loss Program •Wrap/Hold Harmless
Managed Long Term Care/FFS Rate Setting	Robert Loftus	•MLTC Rates •FFS Rates – NH Operating/prices •FFS Rates –Other LTC •FFS Rates Foster Care, ALP, Hospice
Vital Access/Safety Net	John Gahan	•VAP/SN Program •Cost reports – All providers •Capital reimbursement – All providers •NH Litigation •Disaster Response/Special Analysis

DFRS Reorganization

Bureau	Director	Responsibilities
Federal Relations/Financial Analysis/provider Assessment	Roland Guilz	•Financial Analysis/Special Projects •UPL calculations •Indigent Care/DSH •Federal Relations – MRT Waiver, State Plans, •Provider Assessment Admin •Systems support
Global Cap/Administration	Vacant	•Global Cap •OHIP Budget •OHIP Admin
Mental Hygiene Rate Setting	Mike Ogborn	•All Mental Health Rate Setting •OMH, OASAS, OPWDD

Indigent Care (IC) Process and Payments

- Section 2807-l and 2807-p of the Public Health Law provide for up to $55.5M:
  - $52.5M for Regular
  - $3M for Supplemental
- SFY 2013/2014, the State decreased the $55.5M by 2% and the total State share of the Indigent Care Pool (ICP) totals $54.39M.
- CMS approved the extension of the New York Medicaid section 1115 demonstration, the Partnership Plan effective 8/1/2011, which allows the State to claim a federal match on the State funds provided through ICP by including mental health clinics in the ICP.

Indigent Care (IC) Process and Payments

- Waiver brings Federal Match – Total amount of IC pool for the period 1/1/13-12/31/13 has increased to $108,780,000.
- 1/1/2012 through 12/31/2012 Indigent Care Pool:

	Regular Indigent Care	Supplemental Indigent Care	Total	Coverage Ratio of Losses
State Share	$51,450,000	$2,940,000	$54,390,000	
Federal Financial Participation (FFP)	$51,450,000	$2,940,000	$54,390,000	
Total	**$102,900,000**	**$5,880,000**	**$108,780,000**	
Distribution to Article 31 OMH Clinics	$9,685,656	$0	$9,685,656	**46%**
Distribution to Article 28 D&TCs	$93,214,344	$5,880,000	$99,094,344	**53%**

Indigent Care (IC) Process and Payments

➢ Regular IC

- **Eligibility : Consideration for Distribution**
  - Article 28 D&TC clinics
  - Voluntary not-for-profit or Public (including HHCs)
  - Comprehensive Primary Care Providers (Previously referred Group 11,12,and 13 only, prior to the APG)
  - Must submit base year AHCF-1 cost report with ***All*** required documents (i.e. CEO & CPA certification, Audited F/S)
- **Eligibility : Threshold Requirements**
  - Must provide services to uninsured individuals to account for at least 5% of the total threshold visits. (At least 5% Self-pay/Free visits out of total threshold visits.)
  - Operating Costs (Medicaid rate × Self-pay/Free visits) must be larger than Net Patient Revenue from Self-pay/Free visits.

Indigent Care (IC) Process and Payments

➢ Calculation

- Period: Calendar Year (Jan. 1 – Dec. 31)
- Data: 2-year prior AHCF annual cost report.

  (i.e. For the 2013 Indigent Care calculation, data from 2011 AHCF cost reports are used.)

Example - Exhibit I-D data from AHCF cost report

Description	Visits	Net Patient Revenue
Uninsured/Self-Pay	**1,665**	**$30,875**
Free	**7,252**	**$10,000**
Total Threshold Visits	**13,113**	**-**

Medicaid Rate*	**$65.65**

*Medicaid Rate: APG Average Payment or FQHC PPS rate

Indigent Care (IC) Process and Payments

➢ Calculation (Cont.)

- % Eligible Visits = (Self-Pay visits + Free visits) ÷ Total Threshold visits = (1,665 + 7,252) ÷ 13,113 = 68.00%
- Net Operating Loss = (Self-Pay visits + Free visits) × Medicaid Rate – Net Patient Revenue from Self-Pay and Free visits = (1,665 + 7,252) × $65.65 - $30,875 -$10,000 = $544,526
- Nominal Loss = Net Operating Loss × (Eligible % ÷ % Eligible Visits) × Nominal Loss Coverage.

	Net Operating Loss	Eligible % based on Nominal Loss Coverage	% Eligible Visits	Nominal Loss Coverage	Nominal Loss
1st 15%	**$544,526**	**15%**	**68%**	**50%**	**$60,058**
2nd 15%		**15%**		**75%**	**$90,087**
Balance over 30%		**38%**		**100%**	**$304,294**
Total		**68%**			**$454,439**

- Indigent Care Award = Total Nominal Loss ÷ Total Statewide Nominal Loss × Indigent Care Pool Amounts

Indigent Care (IC) Process and Payments

➢ Supplemental IC

- **Eligibility : Consideration for Distribution**
  - New facilities: must be eligible to receive a budgeted Medicaid Rate before April 1.
  - Expanded facilities: must receive Certificate-of-Need (CON) approval, or submit either Limited Review Application (LRA) or Construction Notices, before April 1.
  - Must complete and submit a supplemental application form by established due date (a letter is posted, with supplemental application form, to the Health Commerce System (HCS) website.)

Indigent Care (IC) Process and Payments

➢ Supplemental IC (Cont.)

- **Eligibility : Threshold Requirements**
  - Must provide services to uninsured individuals to account for at least 5% of the total threshold visits.
  - Projected Net Operating Loss (Medicaid rate × Projected Self-pay/Free visits – Projected Net Patient Revenue from Self-pay/Free visits) must be larger than Net Operating Loss from base year AHCF cost report.
- **Payment**
  - Award amounts are determined on an annual basis, but paid prorated for the number of months operational as an expanded or new D&TC.

Indigent Care (IC) Process and Payments

➢ Indigent Care Process

- Post the Initial calculation to the HCS web site to allow providers 30 days to report any error. HCS account holders will receive an email notification.
- Post a Supplemental Application form in the HCS and provide at least 30 days to apply for it.
  - ✓ Supplemental application form & letter is posted at the same time when Initial calculation is posted.
- Finalize the Regular Indigent Care calculation with any error correction submitted during 30 days hotline period.
- Finalize the Supplemental Indigent Care calculation with submitted Applications.
- Post the Final Regular and Supplemental IC awards to the HCS.
- Start Pool Distribution process.

Indigent Care (IC) Distribution Process

- **Check the facilities' status in Public Goods Pool (PGP)**
  - Any PGP questions should be directed to the Bureau of Federal Relations at (518) 474-1673.
  - If the Indigent Care payment is withheld due to delinquency in PGP, the payment will be added to a next schedule. However, the payment may not be released if the facility is still delinquent in PGP.
  - If facilities are not paid due to delinquency in PGP but become current later, they have to wait until the next distribution. Also, in order to receive the Indigent Care payment, they must be current in PGP at the time when the next schedule is checked with the Federal Relations bureau.
- **Distribution schedule is forwarded to Medicaid Financial Management (MFM) to release the payments.**
  - This schedule includes only the facilities that are current in PGP.
  - The Indigent Care distribution amount will be included in a weekly Medicaid check.
  - Distribution will be made in only one cycle per month
  - Prior to August 1, 2011, the payment was made in a separate check. Any withheld amount awarded prior to August 1, 2011 will be paid in a separate check.

❖ The Indigent Care pool process is being transitioned to the Bureau of Federal Relations under Roland Guilz

Electronic Health Record System (EHRS)

- Authorization
  - Section 364-j-2 of the Social Services Law, and
  - State Plan Amendments (SPAs) #08-40 and #09-31

- Supplemental payment of $7,388,000
  - For each of the periods 10/1/08-12/31/08 and 10/1/09-12/31/09
  - Made to eligible covered providers as medical assistance payments for services provided to Medicaid beneficiaries to reflect additional costs associated with the development, training, maintenance, and support of electronic health record systems (EHRS).

Electronic Health Record System (EHRS)

➢ Facility Requirements

- Voluntary not-for-profit Article 28 D&TC clinics

➢ Eligibility

- Qualify for Indigent Care Program
- Or they received funding under section 330 of the Federal Public Health Services Act for health care for the homeless
- Or operate approved programs under the state Prenatal Care Assistance Program (PCAP)
- Or licensed free standing Family Planning clinics

Electronic Health Record System (EHRS)

➢EHRS Requirements

- Must be capable of and used for exchanging health information with other computer systems according to national standards.
- Must be certified by the Certification Commission for Health Information Technology.
- Must be capable of and used for supporting electronic prescribing.
- Must be capable of and used for providing relevant clinical information to the clinician to assist with decision making

Electronic Health Record System (EHRS)

NEW YORK state department of HEALTH

➢ Data Requirements

- Must have submitted a EHRS Survey with proper documentation by designated deadline.
- Must submit base year AHCF-1 cost report with all required documents (CEO & CPA certification and Audited F/S).
- Medicaid visits must be at least 25% of total threshold visits, or Medicaid visits and Uninsured visits* must be at least 30% of total threshold visits.

*Uninsured visits = Self-Pay visits + Free visits

Electronic Health Record System (EHRS)

- Calculation
  - Each qualified provider shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated, based upon the ratio of its visits from Medicaid recipients during the base year to the total number of Medicaid visits to all such qualified providers during the base year. The base year will be two years prior to the rate year.

- For example,
  - Medicaid visits = 50,000
  - Total Statewide Medicaid visits of all EHRS qualified providers = 1,800,000
  - EHRS Supplemental Pool Amount =$7,388,000
  - EHRS Award Amount = $7,388,000 × 50,000 ÷ 1,800,000 = $205,222

- The Department will be attempting to finalize this state fiscal year

FQHC
CON Reform Legislation

- Section 2807-z of the Public Health Law, as recently amended by Section 36 of Part D of Chapter 56 of the Laws of 2012

- Regulation was filed with the Department of State for publishing in the State Register.
  - Effective May 30, 2013
  - 90 day public comment period while the emergency regulation is in effect
  - Regular adoption process is in progress

FQHC
CON Reform Legislation

NEW YORK state department of HEALTH

- **Construction Projects of <u>under $3 Million</u> for Existing FQHCs**
  - The new law says that HRSA-funded projects *"with a budget of less than $3 million will not be subject to CON review." This is being interpreted to specifically mean Certificate-of-Need applications,* ***not Limited Review Applications (LRA) or Construction Notices.***
  - In order to operate and receive reimbursement as health care facilities, new and renovated facilities must obtain a valid operating certificate and comply with construction standards under 10 NYCRR.

FQHC
CON Reform Legislation

NEW YORK state department of HEALTH

- **Construction Projects of <u>under $3 Million</u> for Existing FQHCs (Cont.)**
  - FQHCs will still need to minimally submit an LRA or Construction Notice for projects under $3 million, in order to assure the space meets code and to allow for the capital costs to be recognized in the facility's rates.
  - FQHCs proposing to conduct renovations at an existing site that would otherwise require Administrative Review will, in most instances, submit an LRA.

FQHC
CON Reform Legislation

NEW YORK state department of HEALTH

- **Construction Projects of <u>over $3 Million</u> for Existing FQHCs**
  - The key to the new law is that DOH must expedite processing of such applications, in order for the FQHC to be operational and meet the requirements prescribed for the HRSA funding.
  - Within 30 days of receipt, DOH will deem such application complete or incomplete.
  - If DOH determines the application is incomplete or that more information is required, it will notify the applicant in writing and provide the applicant 20 business days to provide the necessary additional information or otherwise correct the deficiency in the application.

FQHC
CON Reform Legislation

NEW YORK state department of HEALTH

➢ Construction Projects of <u>over $3 Million</u> for Existing FQHCs (Cont.)

- Within 90 days of deeming the application complete, DOH will make a decision to approve or disapprove the application for such project. If DOH fails to take such action within the 90 days, the application will be deemed approved.

- For an eligible capital project requiring Full Review by the PHHPC, the CON application will be placed on the next PHHPC agenda following DOH deeming the application complete.

- Likewise, there are expedited requirements for processing contingency response material and for the Regional Office to "close-out" the project.

FQHC
Rate Appeal Process

➢ Appeal Submission

- Department must receive a letter from the provider detailing their "Item of Appeal".
  - New Provider Packet to be posted on public website under APGs
- A new FQHC facility requesting a PPS Medicaid rate must submit documentation from HRSA verifying their FQHC status.
- The provider's submission of documents can be either a proposed budget (anticipated utilization and operating costs) or the latest AHCF cost report submitted to this Bureau.
- Projects approved in accordance with the Certificate of Need (CON) requirements:
  - CON Project # of the applicable project
  - Costs as approved in the CON.
- An acknowledgement letter will be sent to the provider indicating their appeal number and the analyst contact.

FQHC
Rate Appeal Process

NEW YORK state department of HEALTH

➢ Types of Appeals

- A change in the 'scope of services' is defined as a change in the type, intensity, duration and/or amount of services.
- A change in the cost of a service is not considered in and of itself a change in the scope of services.
- Federal Law (Benefits Improvement and Protection Act (BIPA) of 2000, Section 702, also requires that any rates for fiscal year 2001 forward be adjusted to take into account any increase or decrease in the scope of services furnished by the facility.

FQHC
Rate Appeal Process

➢ Types of Appeals (Cont.)

- A change in the scope of FQHC/RHC services shall occur when:
  - The center/clinic has added or ceases to provide any service that meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C);
  - And the service is included as a covered Medicaid service under the Medicaid State plan approved by the Secretary.
  - If multiple projects/change in scope occur, the most recent year cost report reflecting the combined results of the various expansion efforts will be used to calculate a revised rate. The effective date of the rate change will be January 1st of the year of the cost report used.
  - Operating costs will be held to current ceilings

FQHC
Rate Appeal Process

NEW YORK state department of HEALTH

➢ Types of Appeals (Cont.)

- The Medicaid rate can be revised in accordance with Part 86-4.16(d) of the Commissioner of Health's Administrative Rules and Regulations.
  - Revised Part 86.4.16(d) pursuant to Section 2807-z of the Public Health Law states that FQHCs do not need CON approval for projects under $3 million.
  - Documented increases in overall operating costs of a facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff and services approved by the Commissioner through the Certificate of Need (CON)
  - Effective date of the rate revision:
    - Any modified rate certified or approved shall be the effective date the new service or program is implemented.
    - In the case of capital renovation, expansion or replacement, the effective date shall be the date the project is completed and in use.

APG Rate Update

➢ Investments / Base Rate Implementation

- Investments:
  - $9.375M effective 9/1/2009 – 11/30/2009 ($12.5M Annualized)
  - SPA 09-66 requested an additional $37.5M investment annually
  - $50M investment annually beginning 12/1/2009 and forward
- Base rates were updated in February and released in cycle 1853

➢ Capital Rates for clinics

- Capital was updated based on 86-8.4 of our regulations
- Original calculation used a 2-year base (released in cycle 1853)
- Recalculated using a phase-in approach as required in statute
- Revised rates were recently activated in cycle 1868

APG Rate Update

APG Election / Hold Harmless

- FQHC's may elect to participate in the APG reimbursement methodology
  - FQHCs must request to participate in the APG methodology by completing, signing and returning the authorization form by November 1st.
  - APG rate will be effective on the January 1st after the form submission.
  - Authorization form can be found at the following APG's web site.

    http://www.health.ny.gov/health_care/medicaid/rates/fqhc/
- Hold Harmless for FQHC's which opt into APG
  - Eligible to receive the difference between total APG reimbursement and the aggregate amount that would have been paid under the PPS rate, if PPS rate is higher.
  - Calculation was on hold pending additional investment approval by CMS and the recalculation of capital rates (phase-in method)

APG Rate Update
Public Website

- Reorganization of Public Website
  - More user friendly
  - Up to date information
  - Navigation Bar: “FQHC Reimbursement”
  - “Opt-in” letter
  - Other communication for FQHC providers
  - Contact information
  - APG Electronic Mailing List for website updates

http://www.health.ny.gov/health_care/medicaid/rates/apg/

AHCF Cost Report Filing Requirements

➢ Filing Requirements

- All Article 28 Diagnostic & Treatment Centers and Ambulatory Surgery Centers that have a full year of actual costs and statistical experience.
  - "… treatment centers and/or diagnostic centers shall submit to the New York State Department of Health a certified Ambulatory Health Care Facility-1 form (AHCF-1)…" (86-4.3 (a))
  - 86-4.3(b) states, "Each facility shall complete and file with the department and/or its agent annual financial and statistical report forms supplied by the department…."
  - In the event a facility fails to file the required financial and statistical reports on or before the due date or extended due date, or fails to comply with the provisions of section 86-4.4 of this Subpart, the commissioner shall reduce the facility's current rate paid by state governmental agencies by two percent …(86-4.3 (h))

AHCF Cost Report Filing Requirements

- **What should be submitted?**
  - Electronic Report
  - CEO Certification
  - CPA Certification
    - DCN agreement of Electronic Report and Certifications
  - Audited F/S
    - CEO and CPA certifications are the first pages of AHCF Cost Report. Providers must print out these certification pages and fill in the blanks. Alternative certification forms will not be accepted.

- **When should Certifications and Audited F/S be submitted?**
  - The Certifications and Audited F/S should be filed within 5 business days following the electronic submission of AHCF Cost Report.

- **How should they be submitted?**
  - Certifications and F/S should be submitted hardcopy by mail. Department reviewing electronic format (possible pdf).
    - Currently, electronic submission (i.e. email or fax) will not be accepted because original signed certifications are required.

AHCF Cost Report Changes for 2012

NEW YORK state department of HEALTH

➢ Changes to the 2012 AHCF

- Review of AHCF cost report instructions for enhancements.
- Critical error : The software error showing "-3 critical errors" when finalizing the AHCF was resolved.
- Epogen : effective January 1, 2012, epogen costs are no longer paid outside of the APG rates. The adjustment column will be removed.
- Release date:
  - TBD
  - 6 weeks programming time once submitted to programmers. Currently in the process of preparing changes.

Health Commerce System (HCS)

https://commerce.health.state.ny.us/hcsportal/hcs_home.portal

- **Communication Tool**
  - Secure network for posting provider information
    - AHCF Cost Report, Indigent Care, FQHC rate sheets
  - Keep email address current
    - Facility's responsibility
    - Email blast separate from public website Electronic Mailing List
  - Removal of employee when they leave your employment
- **Account required to access information**
  - A new D&TC will need to set up a HCS account for a HCS Director and HCS Coordinator. Contact Peter Farr.
  - An existing D&TC that currently does have a director or coordinator established but would like to add an additional coordinator (one director, multiple coordinators):
    - Form to complete can be downloaded from HCS or contact HCS Helpline
    - A HCS coordinator can also establish an HCS Director
  - An existing facility that no longer has any HCS Directors or HCS Coordinators, contact Peter Farr to set up a new account.
  - An HCS Director or Coordinator submits a request for a User account.
  - To access DTC Applications, complete BPACR Application Access Form

Health Commerce System (HCS) Questions

- **Contacts**
  - HCS Helpline 1-866-529-1890
    - HCS accounts
    - Password resets
    - removal of employee
  - Peter Farr (518) 402-1004
    - New DTC
    - DTC does not have a Director or Coordinator
  - BPACR contact Phyllis Casale at (518) 474-3020
    - General questions
    - Receiving access to the DTC applications

VAP /Safety Net Program

- Purpose
  - To reconfigure the operations of financially fragile vital access providers
- Outcomes
  - Financially stabilize facilities
  - Improve access to services
  - Improve quality of care
  - Reduce Medicaid program costs

VAP /Safety Net Program

- Vital Access Provider Program
  - Longer term support (up to 5 years) to ensure financial stability and advance ongoing operational changes to improve vital access and/or quality of care; or
- Safety Net Program
  - Short term funding (up to 3 years) to achieve defined operational goals such as facility closure, integration or reconfiguration of services

Safety Net/VAP

- Phase I: HEAL 21/RFA Process
- 2012-13 State Budget allotted $86.4M
- Awarded 12 providers for $23.8M
  - Temporary Medicaid Rate Adjustment Agreement (TMRAA)
  - Transparency and Accountability
- Phase II: Balance of $62.6M
  - General Criteria:
    - Facility Financial Viability
    - Community Service Needs
    - Quality Care Improvements
    - Health Equity

Safety Net/VAP

- Mini application sent out to all hospitals, nursing homes, clinics and CHHA's as part of the HEAL21 process
  - 156 applications received
    - 87 Hospitals
    - 24 Nursing Homes
    - 39 D & TC
    - 6 CHHA's
- Rate adjustments can only be for operating costs.
- Applications divided into three categories:
  - Negative Margin
  - Positive Margin < national average
  - Positive Margin > national average

Safety Net/VAP

- Funding in the future
  - 13/14 State budget has $182M gross
  - 14/15 proposed to go to $154M
  - MRT Waiver: $1.5B over 5 years

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Questions and Answers