CHCANYS
Statewide Conference 2012
Medicaid Updates

John W. Gahan Jr.

Janet Baggetta

Agenda

- Indigent Care (IC) Process and Payments
- Electronic Health Record System (EHRS)
- FQHC
  - Scope of Services
  - CON reform Legislation
  - Hold Harmless
- APG Update
- AHCF 2011 Cost Report
- Health Commerce System (HCS)
- Safety Net/VAP Program
- Questions and Answers

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

- FY 2012, the State decreased $55.5M by 2% and a total State share of Indigent Care Pool (ICP) became $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

NEW YORK state department of HEALTH

- Waiver brings Federal Match – Total amount of IC pool for the period 1/1/12-12/31/12 has increased to $108,780,000.

2012 Indigent Care Pool Amounts	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 of 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 of 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 2012 Indigent Care calculation, data from 2010 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 of 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 (BPACR posts a letter with supplemental application form to the Health Commerce System (HCS) website.

Indigent Care (IC) Process and Payments

- **Supplemental IC (Cont.)**
  - **Eligibility of 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

NEW YORK state department of HEALTH

- **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 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 BHOFA 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 BHOFA.

- **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.

Electronic Health Record System (EHRS)

- Authorization: Section 364-j-2 of the Social Services Law, and State Plan Amendment (SPA) #08-40 and #09-31.

- Supplemental payment of $7,388,000 for the period 10/1/08-12/31/08 and 10/1/09-12/31/09 respectively, shall be 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)

NEW YORK state department of HEALTH

- **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

FQHC
Scope of Services

- **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.
  - A change in the scope of FQHC/RHC services shall occur when:
    - The center/clinic has added or has dropped 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.

FQHC
Scope of Services

- **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.
    - 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)
    - 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 shall be the date the project is completed and in use".

FQHC
Scope of Services

- **Information Required by DOH to file a Medicaid Appeal**
  - The facility must submit documentation with their appeal in regards to the provisions of BIPA 2000, Section 702, PPS for FQHCs, and Section 2807, subdivision 8, of the New York State Public Health Law.
  - 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, must submit the CON Project # of the applicable project as approved by the CON.

FQHC Capital Projects

- 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
- New draft regulations are being prepared to reflect this statute change
- Anticipated to be effective on and after November 1, 2012

FQHC

- **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

- **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

- **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

- **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
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.
  - APG "opt-in" request does not need to be completed each year.
  - Authorization form can be found at the following APG's web site.
    http://www.health.ny.gov/health_care/medicaid/rates/apg/
- Hold Harmless for FQHC's which opt into APGs
  - 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 currently on hold pending additional investment approval by CMS.

APG
Rate Update

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➢ Investments / State Plan Amendment

- Investments
  - o $9.375M effective 9/1/2009 – 11/30/2009 ($12.5M Annualized)
  - o SPA 09-66 requesting additional $37.5M investment annually
  - o $50M annually beginning 12/1/2009 and forward
- Reviewing CMS questions from October 3rd
- Currently paying January 1, 2010 rates

➢ Capital Rates for clinics

- Capital in the rate paid in 2007
- Capital will be updated based on 86-8.4 of our regulations
- Timing for implementation – dependent on investment approval

APG Update
Public Website

- Reorganization
  - 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 2011 Cost Report Changes and Updates

NEW YORK state department of HEALTH

➢ Changes for 2011

- October 11, 2012 email blast with 2011 Instructions and Screen changes
- Exhibit I, Part C – made an additional 3 lines available under Other Procedures
- Exhibit III, Part A– Removed Ryan White and Section 330 grants
- Exhibit III, Part A – Added Restricted Grants and Section 330 grants
- Eliminated Exhibit I, Part C, Section 5 (General & Statistical Information – Statistics)
- Critical edits for contact information
  - Communication by email
- Summation screens – What are they used for?
- 2% penalty for non-filers

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

Safety Net/VAP

- Phase I: HEAL 21/RFA Process
- 2012-13 State Budget allotted $86.4M
- Awarded 13 providers for $24.8M
  - Temporary Medicaid Rate Adjustment Agreement (TMRAA)
  - Transparency and Accountability
- Phase II: Balance of $61.6M
  - General Criteria:
    - Facility Financial Viability
    - Community Service Needs
    - Quality Care Improvements
    - Health Equity

Safety Net/VAP

- MRT Waiver: $1.5B
- Two Programs:
  - Safety Net Provider Program
    - Short Term Funding to achieve defined operational goals such as facility closure, integration or reconfiguration of services
  - Vital Access provider Program (VAP)
    - Longer term support to ensure financial stability and advance ongoing operational changes to improve community care

MRT Waiver

- **Funding request over Next 5 years to CMS:**
  - Primary Care Expansion ($1.25B)
  - Health Home Development ($525M)
  - New Care Models ($375M)
  - Expand Vital Access/Safety Net Program ($1.5B)
  - Public Hospital Innovation ($1.5B)
  - Medicaid Supportive Housing ($750M)
  - Long Term Transformation – Integration to Managed Care ($839.1M)
  - Capital Stabilization for Safety Net Hospitals ($1.7B)
  - Hospital Transition ($520M)
  - Workforce Needs meet New Era of Health Care Reform ($500M)
  - Public Health Innovation ($395.3M)
  - Regional Health Planning ($25M)
  - MRT and Waiver Evaluation ($500M)

Questions and Answers