

Medicaid-Designated NYC Hospitals for Bariatric Surgery for Obesity

QUESTIONS AND ANSWERS

RFA Number 0810300900

All questions are stated as received by the deadline announced in the RFA. The NYSDOH is not responsible for any errors or misinterpretation of any questions received.

The responses to questions included herein are the official responses by the State to questions posted by potential bidders and are hereby incorporated into the RFA 0810300900. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

Who May Apply Related Questions

Q1:

Our hospital commenced performing Bariatric Surgery procedures in 2008. Are we eligible to apply?

A1:

The RFA has been amended and the eligibility criteria have changed to include hospitals performing these procedures in 2008. Your hospital is eligible to apply. (Amendment Section II “Who May Apply” and Attachment 1).

Q2:

Are there restrictions on a Health system applying on behalf of several of its hospitals identified as eligible to apply?

A2:

Yes, there are restrictions. Each application must be on behalf of a single hospital. Only the volume of bariatric surgery procedures performed at that hospital will be considered to meet the eligibility criteria.

Q3.

Do the surgeons apply, or does the hospital apply?

A3.

The hospital applies for the RFA.

Q4.

What is the minimum volume for the number of procedures a hospital must perform to be considered for the RFA?

A4.

The hospital had to perform at least one bariatric procedure in 2008.

Q5.

In regards to surgeon experience, do surgeons need to have performed a specific number of procedures?

A5.

For the purposes of the RFA, we will evaluate surgeon experience in terms of volume relative to their peers.

Bid Related Questions

Q6:

What are the Department's expectations with regard to submitting a realistic and competitive reimbursement rate (i.e. can the Department share any parameters concerning the expected magnitude of the rate discount that would be acceptable)?

A6:

We expect the proposed reimbursement rate to be less than the current rate paid for AP-DRG 288. (Section III B of RFA, page 7) We do not have any parameters.

Q7:

How is a postoperative complication defined? Is it a complication that occurs during the surgical admission or one that occurs within 30 days and requires readmission?

A7:

For this RFA, postoperative complications are conditions occurring during the surgical admission or require readmission within 30 days of discharge.

Q8:

Are there any requirements for the proposed rate to cover the professional component of billing for inpatient bariatric surgery procedures?

A8:

If a professional component is included in the current Medicaid AP-DRG 288 payment to the hospital then it must be included in the proposed payment rate for the RFA response (i.e. at minimum all charges currently included in Medicaid DRG payment). (Section III B of RFA, page 7).

Q9:

Are there any requirements for the proposed rate to cover outpatient pre- and post-operative care?

A9:

The proposed rate will include 72 hour pre-op charges, post-op charges (including any readmissions occurring within 30 days related to post surgical follow up care and/or complications) and all inpatient care associated with the inpatient stay in which the surgery took place (i.e. at minimum, all charges currently included in Medicaid DRG 288 payment.) (Section III B of RFA, page 7)

Q10:

Will the selected hospitals be the sole Medicaid Fee-For-Service New York City contracted hospitals for all patients with a primary discharge of AP-DRG 288, or only for those discharges with the diagnostic and procedure codes on page 5 of the RFA (Under "Who May Apply"), that have been used to determine the eligible applicant hospitals?

A10:

Only New York City hospitals contracted through this RFA will be able to bill the state's Medicaid Program for AP-DRG 288. All other NYC hospitals will be denied payment for AP-DRG 288 for Medicaid Fee for Service (FFS) recipients. AP-DRG 288 claims for procedure code 44.32 (Percutaneous Gastrojejunostomy) will be scrutinized by the Medicaid review agent and be subject to payment recoupment if determination is that inpatient admission was not medically necessary. There was only one Medicaid case of AP-DRG 288 for Percutaneous Gastrojejunostomy in New York City in 2007.

Q11:

Are there any outlier payments that will be considered reimbursable for Bariatric Surgery outside of the proposed discounted rate?

A11:

The proposed rate will be a percentage of the hospitals' Medicaid AP-DRG 288 (O.R. Procedures for Obesity) payment that is less than 100 percent. **This percentage will also apply to outlier payments (i.e. short stay, long stay and high cost).** (Section III-B, page 7)

Q12:

Is it the Department's expectation that the proposed rate will cover all readmission costs for typical Bariatric Surgery complications (below or above the 30 day post-discharge period), including the complications listed on Attachment 2 of the RFA?

A12:

The proposed rate will cover all readmission costs, including complications listed on Attachment 2 of RFA, within 30 days of inpatient discharge. (Section III-B, page 7)

Q13:

How will Medicaid pay for open bypass, laparoscopic bypass and laparoscopic lap band surgeries that are NOT coded into DRG 288 (i.e., DRG 565)?

A13:

AP-DRG 565 is not subject to this RFA and will continue to be paid to all hospitals. AP-DRG 565 is a Major CC DRG with cases from many of the core AP-DRGs in Major Diagnostic Category 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders). The Bariatric Surgery cases assigned to AP-DRG 565 will be monitored by the Department and subject to scrutiny by the Medicaid review agent for medical appropriateness and quality.

Q14:

How will Medicaid pay for bariatric surgeries that do NOT fall into the three main types of bariatric procedures listed in the RFA (open bypass, laparoscopic bypass and laparoscopic lap band), such as sleeve gastrectomies? Sleeve gastrectomies are currently recognized by both the American College of Surgeons (ACS) and American Society of Metabolic and Bariatric Surgery (ASMBS).

A14:

Sleeve gastrectomy procedures are not assigned to AP-DRG 288 by the grouper logic and are not included in the bariatric procedures defined in this RFA. Also, sleeve gastrectomies are not recognized by CMS at their Centers of Excellence. For the selected hospitals, sleeve gastrectomy procedures for obesity will be reviewed by the Medicaid review agent and will be subject to recoupment.

Q15:

Does the reimbursement have to be a percentage of DRG, meaning could it be a straight case rate?

A15:

The proposed rate must be a percentage of the hospitals' Medicaid AP-DRG 288 (O.R. Procedures for Obesity) payment that is less than 100 percent of the current rate. **This percentage will also apply to outlier payments (i.e. short stay, long stay and high cost).** (Section III-B of RFA, page 7)

Q16:

On the spreadsheet there is an average DRG rate. Is this rate across all payers?

A16:

It is Medicaid only.

Q17:

In Table 4, what is the definition of a 'related' condition occurring within 30 days?

A17:

The 3M Potentially Preventable Readmission software will be used to assess readmissions after bariatric surgery. The conditions used to define whether or not a readmission is potentially preventable are defined by that software.

Q18:

Are you including sleep studies and other post-operative procedures in the proposed rate?

A18:

If the service is included in the current Medicaid AP-DRG 288 payment to the hospital then it must be included in the proposed payment as well as readmissions within 30 days as determined by the 3M Potentially Preventable Readmissions (PPR) software.

Q19:

Are physician fees included in the rate?

A19:

The RFA requests a percentage discount of DRG 288. For some hospitals, this will include the physician fees. The recently passed NYS budget legislation will allow hospitals to bill Medicaid separately for hospital-based physicians effective February 1, 2010. **Please note that the percentage of the Medicaid AP-DRG 288 bid in response to this RFA will be the percentage for the duration of the contract. Adjustments to the percentage will not be accepted once the contract is implemented.**

Q20:

If we add the physician fee to the bid, do we indicate what percentage will cover the hospitalization and what percentage will cover the surgeon?

A20:

If physician fees are not reimbursed to the hospital in the current AP-DRG 288 Medicaid payment, they should not be included in the bid. The authorizing legislation is specific to inpatient demonstrations, episode of care payment proposals to include outpatient services cannot be considered for this RFA.

Q21:

How do you estimate the need for the surgery and estimated number of cases for the future?

A21:

We have only determined the number of cases previously performed and have not projected the need for bariatric surgery in New York City and cannot predict the number of cases a hospital may treat. The following are counts, by borough of hospital location, of bariatric surgery for Medicaid in 2007: Bronx 98, Brooklyn 214, Manhattan 315, Queens 29 and Staten Island 14.

Q22:

If we give a rate today, how would this adjust for future rate changes?

A22:

The proposed rate will be a percentage discount off the DRG price. If the DRG price were to increase, the same percentage would be discounted.

Q23:

Wouldn't a flat rate be better than a percentage off the DRG?

A23:

The RFA is requiring a percentage discount of the DRG rate.

Surgeon Experience Related Questions

Q24:

If a surgeon practices at many hospitals, and one hospital is not awarded, can they still perform Medicaid FFS surgery?

A24:

Only surgery performed at a hospital contracted through the RFA will be reimbursable for Medicaid FFS.

Q25:

If a surgeon practices in many hospitals, how do you account for their experience?

A25:

Surgeon experience would be recorded in Table 2 of the spreadsheets. The spreadsheet requests the number of cases the surgeon performs in a year without regard to the hospital in which the surgery was performed. **Please note the data year requested in the spreadsheets is now amended to 2008.**

Q26:

Objective 4 (Page 6 of the RFA) states that the applicants must provide "assurance of access to appropriate surgery by skilled surgeons". Can the Department clarify what are acceptable parameters of "access" to care, and define the qualifications of "skilled surgeons" acceptable to this RFA?

A26:

Skilled surgeons would be high volume, low complication rate surgeons as identified by analyses of SPARCS data. Applicants should refer to the CMS Bariatric Surgery Centers of Excellence standards and requirements for further guidance.

Q27:

For the provider experience in the spreadsheets, is this all payer, or just Medicaid?

A27:

The volume for surgeons (Table 2) is all payer and the Volume for the hospital (Table 3) requires volume separately for Medicaid FFS, Medicaid Manage Care and Non-Medicaid. **Please note the data year requested in the spreadsheets is now amended to 2008.**

Contract Reporting Related Questions

Q28:

What timeframe is required for the patient information to be submitted to the Department?

A28:

Post-surgical data must be submitted annually for each patient for a period of not less than 5 years. The Department defines the 5 year period to be from date of surgery. (Section III D, page 8). The due date of the initial report will be determined based on the actual start date of the contract.

Q29:

Page 17, paragraph #4, how does the state want the report? Utilizing our database or does the state have their own format?

A29:

The NYSDOH will work with selected hospitals to develop a format by which hospitals will be required to submit data describing patient characteristics and outcomes. Every reasonable effort will be made to use the same data items and same data format as required by the American College of Surgeons so that requirements for additional data collection will be minimized. Every reasonable effort will also be made to standardize the data items collected in order to ensure that the data collected are the same across participating hospitals. (Section III-D of RFA, page 8)

Transportation Related Questions

Q30:

Objective 6 (Page 6 of the RFA) states written assurance must be provided by the applicants “that clients will have appropriate access to transportation for surgery and required post-operative visits”. Can the Department define what “appropriate access to transportation” is for the purposes of this RFA? Because only up to five hospitals will be selected, clients may have higher costs for transportation, because they will have to travel farther for care, possibly outside their borough of residence. Will the selected bidders be expected to reimburse or provide the cost of transportation from the discounted DRG rates, including costs for ambulettes and/or specialized medical transportation services? What are the Department’s expectations of the responsibilities of the successful contracted hospitals to facilitate client transportation under RFA Objective 6?

A30:

Transportation is a Medicaid covered service paid separate from the Medicaid DRG payment, for most hospitals. However, all successful bidders will be required to coordinate appropriate transportation for their patients (e.g. ambulettes appropriately equipped for transportation of the morbidly obese). Applications must demonstrate the hospital’s ability and willingness to coordinate appropriate transportation in conjunction with the New York City Human Resource Administration office.

Q31:

I also had a question about transportation. Will the hospital be responsible in having a service to pick up and drop off these patients or can we use existing systems within the hospital (which usually requires a request to be filled out and approval by the insurance to be obtained)?

A31:

This RFA only applies to Medicaid Fee for Service patients and coordination is required with the New York City Human Resource Administration office.

Geographic Related Questions

Q32:

Will proximity to other potential applicants be considered during the selection process?

A32:

Geographical dispersion of the awards is desirable but not a requirement of the award process.

Q33:

Will the selected five hospitals be able to handle all the Medicaid FFS surgeries for NYC?

A33:

Yes.

Q34:

Will the RFA be awarded to 1 hospital per borough or could there be many hospitals in one borough?

A34:

Awards will be made from the highest scoring application to the next highest scoring application until up to five contracts have been awarded (Section V., page 19).

Other Questions

Q35:

Can the Department provide guidance as to what are the required components of a “comprehensive approach to the treatment of obesity and related conditions” (RFA page # 3), that the successful bidders will need to provide?

A35:

Bariatric surgery programs must address all aspects of patient care and long term management requiring an interdisciplinary focus to achieve positive patient outcomes. Applicants should also refer to the CMS Bariatric Surgery Centers of Excellence standards and minimum requirements for guidance. (Section I, page 5)

Q36:

What is the difference between this CMS designation and the Surgical Review Corporation or the American College of Surgeons?

A36:

CMS Center of Excellence designation requires certification by the American College of Surgeons (ACS) or the American Society of Metabolic and Bariatric Surgery (ASMBS),

Q37:

What is the reason that CMS is now designating centers of excellence for Bariatric Surgery?

A37:

We cannot answer for CMS. The reasons may be stipulated in the Federal Register notice issued for the CMS initiative.

Q38:

Is there a fee for applying?

A38:

No.

Q39:

We wanted to confirm that there are only five hospitals in NYC being selected for Medicaid-grant applications.

A39:

Up to 5 hospitals may be selected for participation as a result of this RFA.

Q40:

In the event our center does not receive this designation, will our hospital be able to continue performing bariatric surgery for Medicaid patients and those with Medicaid HMO plans?

A40:

You will not be paid for performing bariatric surgeries for FFS Medicaid recipients; only selected hospitals will be reimbursed for FFS Medicaid recipients. For managed care recipients please contact the recipient's managed care plan regarding coverage.

Q41:

What is the time frame for surgical complication rates? 1 year, 2 years?

A41:

We currently assess in-hospital complication rates during the hospital stay in which the surgery took place. We don't have a time frame for assessing post-discharge complications at this point.

Q42:

How is liver disease a complication of Bariatric Surgery?

A42:

The condition did not exist prior to the surgery (was not a co-morbidity) but did exist after the surgery.

Q43:

If a hospital is awarded the RFA, and it turns out to not be financially suitable, can the hospital op-out of the RFA?

A43:

If the Department and selected hospital are not able to execute a contract, the Department may contract with the next qualified applicant (Section IV-E, page 11). The contract may be terminated by written mutual agreement, however, this may negatively impact the hospital for future contracts with the State (Agreement Section III, page 26).

Q44:

I have a question about bariatric sensitivity training. What are the requirements of the training?

A44:

It is assumed that ACS and ASMBS certified bariatric programs comply with the certification requirements to provide sensitivity training. Applicant hospitals not having such certification are required to explain how they meet such standards.

Q45:

How is a postoperative complication defined? Is it a complication that occurs during the surgical admission or one that occurs within 30 days and requires readmission?

A45:

For this RFA, postoperative complications are conditions occurring during the surgical admission or require readmission within 30 days of discharge.

Q46:

Is the hospital required to take all Medicaid FFS patients, or can patients be denied surgery?

A46:

Surgery may only be denied for clinically valid reasons based on evaluation that is documented.

Q47:

When counting the number of bariatric procedures, do you count those in AP-DRG 288, or any procedure?

A47:

Bariatric procedures for the RFA are defined by AP-DRG 288.

Q48:

Does this RFA apply to Medicaid FFS only?

A48:

Yes.

Q49:

In the future, will Medicaid Managed Care plans be pushed to follow the same guidelines as Medicaid FFS, in that they would only send patients to those five hospitals?

A49:

The Department will be encouraging the Medicaid Managed Care plans to contract with CMS designated Centers of Excellence.

Q50:

Is the goal of this RFA to increase the volume of bariatric surgery or to provide better quality of care?

A50: The Department goal is to enhance the quality of care provided for bariatric surgery. Published research has shown an association of increased volume to higher quality of care.

Q51:

In Table 1, does a Center of Excellence only refer to CMS designations, or can it include other designations for Centers of Excellence, such as Blue Cross Designated Center?

A51:

A Center of Excellence is designated by CMS, ACS or ASMBS as stated in the RFA.

Q52:

After all the RFAs are submitted, what is the timeframe until we hear a decision?

A52:

It is the Department's desire to expedite this process. However, the timeframe depends on the number of applications we receive and have to review.