



**Department
of Health**

**Office of
Health Insurance
Programs**

CHCANYS Conference

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Ms. Donna Cater

Deputy Director

Division of Finance and Rate Setting

Ms. Janet Baggetta

Director

Bureau of Mental Hygiene Services, Hospital and Clinic Rate Setting

Division of Finance and Rate Setting

Ms. Kristina Thouin

Associate Health Care Fiscal Analyst

Bureau of Mental Hygiene Services, Hospital and Clinic Rate Setting

Division of Finance and Rate Setting

Agenda

- Safety Net Payment (Uncompensated Care Distribution Replacement)
- Vital Access Provider (VAP) Program
- Long Acting Reversible Contraceptive (LARC)
- Telehealth
- Billing for a Dental Hygienist's Services
- October 1, 2016 FQHC Rate Update
- FQHC Hold Harmless Calculation
- Trending of Group Psychotherapy & Offsite Rates
- FQHC Rate Appeals
- Electronic Health Records (EHR)
- Ambulatory Health Care Facility (AHCF) Cost Report
- Health Commerce System (HCS)
- Department of Health Public Website
- Contacts
- Questions?

Safety Net Payment (Uncompensated Care Distribution Replacement)

- **The Centers for Medicare and Medicaid Services (CMS) denied the continuation of the waiver for the Clinic Uncompensated Care distribution.**
- **State Plan Amendments (SPAs) submitted to CMS**
 - Federal Public Notice effective July 28, 2016
 - SPA 16-0046: FQHC
 - SPA 16-0047: Non-FQHC
- **SPAs propose:**
 - First year distribution commences July 28, 2016 – March 31, 2017
 - Distribution will be SFY thereafter
 - Distribution paid in aggregate quarterly payments
 - 2014 AHCF cost report used as the base year for first year distribution and advanced one year for each subsequent period
- **Requirement to use Medicaid utilization in the distribution method**

Safety Net Payment (Continued)

➤ Eligible Clinic Types:

- Federally Qualified Health Centers (FQHCs)
 - ✓ Voluntary non-profit and publicly sponsored D&TCs licensed under Article 28 or Article 31.
 - ✓ Received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).
- Diagnostic and Treatment Centers (D&TCs)
 - ✓ Voluntary non-profit and publicly sponsored D&TCs licensed under Article 28 or Article 31.

➤ **Webinar will be held with details and proposed by facility distributions once CMS provides confirmation of their support of the method.**

➤ **Ongoing discussions**

Vital Access Provider (VAP)

➤ VAP Funding Approvals

- The release of VAP funding to DOH approved providers was contingent upon obtaining approval from the federal Centers for Medicare and Medicaid Services (CMS) for the applicable NYS Medicaid State Plan Amendment and subsequently federal financial participation (FFP). *At this time, DOH has received CMS approval for all of the VAP FQHC SPAs.*

➤ DOH and CMS agreed to pay the FQHC VAP awards using the following methodology:

- The supplemental payment was distributed between fee-for-service (FFS) and the wrap payment based on the percentage relationship between the FQHC rate and the wrap rate.
- The FQHC portion was included in the VAP SPA and subject to the threshold test of 10% of annual FFS Medicaid payments. This is sometimes referred to as the Economy and Efficiency Test.

➤ Using this methodology

- 8 FQHCs met the 10% threshold test and DOH paid the full VAP award.
- 2 FQHCs do not meet the 10% FFS threshold. These awards were reduced as required.

Long Acting Reversible Contraception (LARC)

- **State Plan Amendment (SPA) 16-0028 was approved by the Centers for Medicare and Medicaid Services (CMS)**
- **Effective April 1, 2016**
 - IUD
 - Implantable contraceptive
- **Cost of LARC is carved out of the FQHC PPS rate**
 - Bill LARC as ordered ambulatory service on a 837-P claim form
 - Bill PPS for threshold visit on 837-I claim form
 - Delay reason code 3 is permitted on retroactive LARC claims until 12/31/16
- **September 2016 Medicaid Update article**
 - https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-09.htm#larc_carveout

Long Acting Reversible Contraception (LARC) (Continued)

➤ Categories of Service

- To bill separately for the cost of the LARC, clinics must be enrolled in one of the following categories of service:
 - ✓ 0163 (diagnostic and treatment center ordered ambulatory)
 - ✓ 0282 (hospital based ordered ambulatory)

➤ Procedure Codes

- Allowable LARC procedure codes billed as an ordered ambulatory service. These services should NOT be billed as a clinic visit or as part of a clinic visit.
 - ✓ J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration (Liletta)
 - ✓ J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (Mirena)
 - ✓ J7300 Intrauterine copper contraceptive (ParaGard)
 - ✓ J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg, 3 year duration (Skyla)
 - ✓ J7307 Etonogestrel (contraceptive) implant system, including implant and supplies (Implanon or Nexplanon)

Long Acting Reversible Contraception (LARC) (Continued)

- **Provider's must limit the charges on the Medicaid ordered ambulatory claim for the LARC device to the actual invoice cost of the LARC device.**
 - Devices obtained at 340B prices must be reported with the "UD" modifier.
 - Medicaid reimbursement for practitioner-administered drugs, including intrauterine devices (IUDs) and implantable contraception, is based on the provider's acquisition cost by invoice.
 - It is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the LARC device.

Telehealth

➤ Telehealth Parity

- New York became the 22nd state to pass telehealth reimbursement parity legislation.
- Telehealth parity law, effective January 1, 2016
- Requires commercial insurers and the Medicaid program to provide reimbursement for services delivered via telehealth if those services would have been covered if delivered in person

➤ Definition

- Telehealth is limited to:
 - ✓ Telemedicine
 - ✓ Store-and-forward
 - ✓ Remote patient monitoring
- Telehealth excludes audio-only, fax-only and email-only transmissions

Telehealth (Continued)

➤ Telehealth Applications

- **Telemedicine** - “the use of synchronous two-way electronic audio visual communications to deliver clinical health care services which include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.”
 - ✓ Distant site – location of the telehealth provider
 - ✓ Originating site – location of the patient
- **Store and Forward** - “the asynchronous, electronic transmission of a patient’s health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.”
 - ✓ Limited to ophthalmology, dermatology and other disciplines as determined by the Commissioner.
- **Remote patient monitoring** - “the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a person at an originating site that is transmitted to a telehealth provider at a distant site for use in treatment and management of medical conditions that require frequent monitoring.”

Telehealth (Continued)

➤ Telehealth Provider Definition

- Providers eligible for reimbursement include:

- ✓ Physician
- ✓ Physician Assistant
- ✓ Dentist
- ✓ Nurse Practitioner
- ✓ Podiatrist
- ✓ Optometrist
- ✓ Psychologist
- ✓ Social Worker
- ✓ Speech Pathologist
- ✓ Audiologist
- ✓ Midwife
- ✓ Occupational Therapist
- ✓ Physical Therapist
- ✓ Certified Diabetes Educator
- ✓ Certified Asthma Educator
- ✓ Genetic Counselor
- ✓ Hospital
- ✓ Home Care
- ✓ Hospice
- ✓ Registered Nurses, only when receiving data by means of remote patient monitoring
- ✓ Any other provider as determined by the Commissioner pursuant to regulation

Telehealth (Continued)

➤ Reimbursement

- Qualified telehealth providers must be licensed in NY State and enrolled in NY State Medicaid.
- When the FQHC is the “originating site” for a telemedicine encounter, the FQHC will be responsible for paying the consulting practitioner who is located at the “distant site.”
- The FQHC must append the telemedicine claim with the “GT” modifier.
- If all or part of the telehealth service is undeliverable due to a failure of transmission or other technical difficulty, reimbursement will not be provided.

➤ Status of Telehealth Regulations

- Currently going through the rule making process.
- To be published in the State Register for a 45 day public comment period.
- State Plan Amendments (SPAs) for store and forward technology and remote patient monitoring were submitted and have been approved by CMS.
- A Medicaid Update outlining the final regulations and reimbursement methodology for each telehealth application will be published when the regulations are adopted.

Medicaid Reimbursement to Article 28 Clinics for Oral Assessments by Dental Hygienists with Collaborative Practice Agreements

➤ **State Education Law Change**

- Changes to State Education Law now permit registered dental hygienists who provide dental services in facilities organized under Article 28 of the Public Health Law to enter into a collaborative practice agreement with a licensed and registered dentist who has a formal relationship with the same facility.

➤ **Formal Relationship**

- In order to constitute a “formal” relationship, the collaborating dentist must either be employed by the Article 28 facility or have a contract to provide services within the Article 28.

➤ **Effective September 1, 2016**

- Medicaid will reimburse Article 28 clinics for oral assessments provided by a registered dental hygienist in accordance with a collaborative practice agreement.
- In addition, Medicaid will reimburse the clinic for a follow up visit with a dentist for an oral exam or treatment.

Medicaid Reimbursement to Article 28 Clinics for Oral Assessments by Dental Hygienists with Collaborative Practice Agreements (Continued)

- **A registered dental hygienist providing services pursuant to a collaborative arrangement shall:**
- Only provide those services that may be provided under general supervision, provided that the physical presence of the collaborating dentist is not required for the provision of such services;
 - Instruct individuals to visit a licensed dentist for comprehensive examination or treatment;
 - Possess and maintain certification in cardiopulmonary resuscitation; and
 - Provide collaborative services only pursuant to a written agreement that is maintained in the practice setting of the dental hygienist and collaborating dentist.

Billing for a Dental Hygienist's Services

➤ For institutional claims submitted for a dental hygienist's services (offsite):

- A dental hygienist screening of a patient should be billed using D0190.
- The clinic should bill for any other procedures provided by the hygienist within their scope of practice (e.g., prophylaxis). These claims will be identified by the D0190 code to indicate that a dental hygienist performed the services provided.
- D0190 should only be billed for screening performed by a dental hygienist. Claims billed with a screening for a patient using D0190 will not include a capital add-on.

➤ For institutional claims submitted for a dentist's services (patient previously seen by dental hygienist):

- The clinic is permitted to bill for any services rendered by the dentist with the exception of D0190.
- Do not report D0190 for services provided by a dentist. Current policy remains in place for frequency limitations for procedures.

Billing for a Dental Hygienist's Services (continued)

➤ **Patient seen in an Article 28 facility by a dentist & dental hygienist on the same date of service:**

- Only one claim should be submitted when a patient is seen by a dentist and a dental hygienist on the same date of service.
- All services provided should be reported on the claim.
- D0190 should not be billed since the patient will be seen by a dentist providing an oral exam.

Billing for a Dental Hygienist's Services (continued)

➤ Federally Qualified Health Center (FQHC) Billing:

- Please see the following chart for billing guidance based on the location where services are provided:

Satellite Site (SBHC, etc.)	Host site	How to Bill
Dental Hygienist at a non-FQHC (Billing APGs)	Dentist at an FQHC	Satellite may bill through APGs per guidance above. Host site may bill PPS rate.
Dental Hygienist at an FQHC	Dentist at a non-FQHC (Billing APGs)	Satellite site may only bill PPS rate. Host site may not bill.
Dental Hygienist at an FQHC	Dentist at an FQHC	Satellite or Host site may only bill one PPS rate.

- Please see the August 2016 Medicaid update located on the NYS DOH website for additional information regarding reimbursement for dental hygienists.

October 1, 2016 FQHC Rate Update

- **Fee-for-Service (FFS) Rates effective October 1, 2016 completed in advance of October 1st**
- **Dear Administrator letter and FFS rate sheets were posted to the Health Commerce System (HCS) on September 16, 2016.**
 - Operating Cost Increase
 - ✓ Medicare Economic Index (MEI) for 10/1/2016 is 1.1%
 - ✓ FFS Rates updated in Cycle # 2039
 - ✓ MMC Wrap & Litigation Rates are complete and in the Department's review stage.
 - ✓ The ceilings have been posted on the Department's public website.

https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_trended_ceilings.htm

FQHC Hold Harmless Calculation (Providers opting into APGs)

➤ January 1, 2015 through December 31, 2015

- Dear Administrator letter and schedules posted to HCS August 1, 2016
 - ✓ Lump sum payment was made in Cycle 2031.
- Identify Bill Type on FQHC claims
 - ✓ Use bill type 0771
 - ❖ “0” for not used yet
 - ❖ “7” for clinic
 - ❖ “7” for FQHC services
 - ❖ “1” for admit to discharge claim
- January 1, 2016 through December 31, 2016 completed during summer of 2017

Trending of Group Psychotherapy and Offsite Rates

➤ **Original State Plan Page 2(c)(iv)**

- Federally Qualified Health Centers & Rural Health Clinics
 - ✓ Specifically provides for increasing the PPS rate by the MEI
 - ✓ Did not provide for any change to the group psychotherapy and offsite rates
 - ✓ Inquired with CMS

➤ **State Plan Amendment (SPA) 15-0039**

- Federal Public Notice (FPN) in NYS Register April 29, 2015
 - ✓ Increased both rates effective May 1, 2015 by the MEI

Trending of Group Psychotherapy and Offsite Rates (Continued)

➤ SPA approved May 20, 2016

- Trend rates from 2006 base year
- MEI Roll factor from 10/1/2007 through 10/1/2016
- May 1, 2015 Rates:

	Group Psychotherapy	Offsite
Upstate	\$34.59	\$61.21
Downstate	\$38.56	\$68.52

➤ Division of the Budget Approval in Process

- Rate package developed and in Department review
- Notification will be sent to providers when rates are approved
- Increased rates will be loaded to eMedNY
- No action will be required by providers

FQHC Rate Appeals

➤ Appeal Submission

- Providers submit an appeal request to:
 - ❖ *Ms. Janet Baggetta*
Director
Bureau of Mental Hygiene Services, Hospital and Clinic Rate Setting
One Commerce Plaza – Room 1432
99 Washington Avenue
Albany, New York 12210

➤ Appeal processing steps

- Appeal request is reviewed for appropriateness by rate analyst
- Appeal number assigned and acknowledgement letter sent to provider
- Fee-for-Service rate developed
- Medicaid Managed Care Wrap Rate developed
- Appeal rates and write-up submitted for Department review and approval
- Appeal rates and write-up submitted for Division of the Budget approval

FQHC Rate Appeals (Continued)

➤ Appeal Rate Payment Steps:

- When Division of the Budget approval received
 - ✓ Rate prepared for loading to eMedNY system
 - Transmittal document with electronic transmission of rate
 - In order to transmit rate, *the provider needs to be enrolled in New York Medicaid, have a Medicaid Provider Number and Location Code established*
 - ✓ Division office approval for loading of rate due to Global Cap affect
 - ✓ Rate transmitted and documentation forwarded
 - Overnight load process
 - Electronic file run thru edits
 - Edit review
 - Thursday cycle processing
- Bureau recommendation mailed to Provider
 - ✓ Recommendation letter, appeal packet and attachments, if applicable
 - ✓ Hardcopy mailed - certified

FQHC Rate Appeals (Continued)

➤ Part 86-4.16 Revisions in certified rates

“(a) The commissioner shall consider only those applications for prospective revisions of certified or approved rates which are in writing and which address one or more of the issues set forth in this section.”

“(c) Documented increases in the overall operating costs of a facility resulting from the implementation of additional or expanded programs, staff or services specifically mandated for the facility by the commissioner may be the basis for an application for prospective revision of a certified or approved rate.....”

“(d) Documented increases in overall operating costs of a facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved by the commissioner through the certificate of need (CON) process may be the basis for an application for revision of a certified rate.....”

“(e) Upon receipt of actual cost data for appeals pursuant to subdivisions (c) and (d) of this section, the modified rate based on projections will be retroactively revised to reflect actually incurred costs held to operating cost ceiling limitations and utilization standards set forth in this Subpart.”

FQHC Rate Appeals (Continued)

➤ Budget to Actual Cost Process

- Implements actual costs based on first full year of cost experience
- “C” appeal number assigned for tracking process

➤ Budget to Actual appeal write up will provide

- “C” appeal number assigned
- Cost base year that will be used and effective date of the rate update

➤ Appeal Processing Order

- Prioritize
 - ✓ Appeals:
 - Provider does not have a Medicaid Rate
 - Provider is converting to FQHC
 - ✓ Payment Issues
 - ✓ Statewide Rate Packages
 - ✓ Appeals:
 - Added Capital or Scope of Services

FQHC Rate Appeals (Continued)

➤ Status of Appeals

Appeal Type	Count of Appeals	Status of Appeal				
		Waiting Processing / Initial Review	Budget to Actual	In Department Review	At the Division of the Budget	Final Processing Stage
New Facility (FQHC)	0	0	0	0	0	0
New Facility (APG)	5	3	0	0	2	0
Capital Rate Update	1	0	0	1	0	0
Scope of Services	3	1	0	2	0	0
Budget to Actual Facility Request	0	0	0	0	0	0
Budget to Actual C Appeals	14	1	13	0	0	0
Total Appeals	23	5	13	3	2	0

- To date in 2016, 21 appeals have been completed for freestanding providers and hospital FQHCs

Electronic Health Records

➤ 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 Records (Continued)

➤ Data Requirements

- Must have submitted a EHR 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

➤ Distribution Completed

- Approved by the Division of the Budget
- Paid as an add-on to FQHC rate
 - ✓ APM Attestation, CEO/CFO signed
 - ✓ No hold harmless

AHCF Cost Report

➤ Summary screens for APG Capital Calculation

- Began with 2014 AHCF Cost Report
- Article 28 APG capital rate calculation noticed to providers on October 14, 2015
- Displays the summation of a facility's ARTICLE 28 SERVICES ONLY
- Summary screens require no action by providers
- Screens that were included in the update:
 - ✓ Exhibit I, Part C
 - ✓ Exhibit I, Part D
 - ✓ Exhibit III, Part A
 - ✓ Exhibit III, Part F
- Exhibit III, Part A *provides the APG base year capital rate* for providers to review and submit with the cost report.

AHCF Cost Report (Continued)

- **For the facility to develop the capital rate accurately, the following is required:**
 - Providers must appropriately select the proper category/categories for their cost and statistical reporting on the configuration screen AND
 - Providers must discretely report the dually certified mental hygiene services

- **In order to properly categorize the APG capital rates, the following changes were made to the configuration screen:**
 - “07 = Dental” has been revised to “07 = Academic Dental”
 - ✓ Non-academic dental providers should use category “16 = Dental (Non-Academic)” for reporting purposes
 - “16 = Statewide No Group” has been revised to “16 = Dental (Non-Academic)”
 - ✓ The “Statewide No Group” category has been removed from the cost report selection
 - If a provider previously used this category, the proper category to select is “12 = Other / One-of-a-Kind.”

AHCF Cost Report (Continued)

➤ Facility Update Sheet

- Required question for all providers to be answered in order for dental costs and visits to be included in the proper category for the APG rate development:
 - ✓ “Are you an Academic Dental School Provider?”
The cost report will not be able to be submitted without responding to this question.

➤ Exhibit I, Part D (Statistical Data by Payer)

- Visits OR procedures should be reported based on the appropriate statistic for the service
- The AHCF cost report instructions provides details as to which statistic should be reported
 - ✓ Page 6 of instructions
- MMTP Reporting
 - ✓ Example: 1 week = 5 visits; Report 5

➤ Why keep all the categories when no longer setting by service rates?

- Analysis purposes
- Distribution calculations

➤ Cost Report Contact

- dtcffsunit@health.ny.gov
- Please do NOT use bvapr@health.ny.gov

Health Commerce System (HCS)

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

➤ Communication Tool

- Secure network for posting provider information
 - ✓ FQHC & APG Capital Rate Sheets, AHCF Cost Report, Safety Net
- Keep email address current
 - ✓ Facility's responsibility
 - ✓ Email blast separate from public website Electronic Mailing List
- Removal of employee when they leave your employment

➤ HCS Contacts

- Commerce Accounts Management Unit (CAMU) Help Desk:
1-866-529-1890 or hinhpn@health.ny.gov
 - ✓ HCS accounts
 - ✓ Password resets
 - ✓ removal of employee
 - ✓ New DTC to get established on the HCS
 - ✓ DTC does not have a Director or Coordinator
- Email dtcffsunit@health.ny.gov
 - ✓ Receiving access to the D&TC applications

Department of Health Public Website

➤ Information posted for APGs

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

➤ Information posted for FQHCs

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

- APG Option Declaration Form
- CHCANYS Conference Presentations
- Policy Updates
- Schedule of Rates
- FQHC Rate Ceilings (through 10/1/2016)
- Managed Care Visit and Revenue (MCVR) Report

➤ Electronic Mailing List

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

Contacts

➤ Bureau of Mental Hygiene Services, Hospital and Clinic Rate Setting

- Article 28 Fee-for-Service Rates, Freestanding Providers: dtcffsunit@health.ny.gov
- Article 28 Fee-for-Service Rates, Hospital Providers: hospffsunit@health.ny.gov

➤ Bureau of Acute & Managed Care Rate Setting

- Managed Care Rates: bmcr@health.ny.gov (wrap rates)

➤ Other Contacts

- **Contact Computer Sciences Corporation (CSC) at 1-800-343-9000**
 - ✓ Has my Provider Enrollment application been received?
 - ✓ What is the status of my Provider Enrollment application?
 - ✓ How do I submit a claim or why did my claim deny?
- **Medicaid Financial Management at mfm@health.ny.gov**
 - ✓ Liability balance
 - ✓ Make a payment on a liability
- **Contact Provider Enrollment at providerenrollment@health.ny.gov**
 - ✓ Is my location established on eMedNY?

Questions?