NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Ambulatory Health Care Facility (AHCF) Cost Report

New York State Department of Health
Office of Health Insurance Programs
Division of Finance & Rate Setting
Bureau of Mental Hygiene Services, Hospital & Clinic Rate Setting (BMHRHC)
November 28, 2017

Agenda

- Centers for Medicare and Medicaid Services (CMS) data requirements & concerns
- Who is required to file an AHCF and why is it required?
- Calendar Year vs Fiscal Year reporting
- Selection of Services – Configuration Screen
- Total Cost Requirement
- DOH Rate Codes used in the UPL
- 2016 AHCF Cost Report Changes
- Visits & Procedures Clarification and Edits
- Timing for Cost Report Software & Completion
- Accessing the software on the Health Commerce System (HCS)
- Cost Report Document Filing Requirements
- APG website
- Contacts

Centers for Medicare and Medicaid Services (CMS) Data Requirements & Concerns

- Upper Payment Limit (UPL) Demonstration: A demonstration to CMS that what Medicaid pays is at or below what Medicare would pay.
  - Method for clinic is cost compared to payment
  - *A review is completed by facility HOWEVER the final result is a statewide comparison of total costs vs total payments within the following groups: Voluntary, State Public & Non-State Public*
  - *"UPL Room" = Costs – Payments (Costs must be greater than payments)*
- New York State attempted to complete the 2012 UPL for freestanding clinics based on calendar year 2010 data.
  - During the process of analyzing data, concerns arose about the accuracy of cost report and claims data submitted by providers
  - CMS concluded that there was no UPL room after the inclusion of all APG State Plan Amendments (SPAs) for 2012 through 2017 and 12 SPAs were required to be withdrawn.
- CMS and the Department agreed that the Department would develop a Corrective Action Plan for improving the accuracy of the data going forward. (SPA 16-0002)

Centers for Medicare and Medicaid Services (CMS) Data Requirements & Concerns (Continued)

- The next full UPL calculation is required to use 2017 data for 2018 calendar year.
  - *If the Department can prove integrity of the data, a UPL may be able to be submitted earlier allowing the submission of SPAs.*
- Data Issues
  - Non-submission of cost reports
    - ✓ CMS will no longer allow proxy costs be developed for a provider that did not submit their cost report. A provider's payments will be included in the UPL calculation with $0 costs reducing "room".
    - ✓ 100% compliance with cost report submission is needed
  - Medicaid FFS claim counts in eMedNY not in agreement with Medicaid FFS Visits in the AHCF
  - Medicaid FFS claim counts in eMedNY greater than Total Visits in the AHCF
  - The Medicaid charge per visit should not equal the Medicaid rate. Facilities should have a uniform charge structure applied to all payors.

Who is required to file an AHCF?

- Part 86-4.3(a): "… 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)…"

- Part 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…. Each facility shall also file a copy of the audited financial statements…."

  - ✓ Part 86-4.4 Certification of Reports
    - Section (a): Certified by Independent CPA
    - Section (b): *CPA certification shall not apply* to facilities operated by units of the NYS government whose total operating costs are less than $100,000
    - Section (c): Certified by the operator of a proprietary facility, an officer of a voluntary facility or public official responsible for the operation of a public facility

- Failure to file: Part 86-4.3(h) states that the Commissioner shall reduce the facility's current rate paid by state governmental agencies by 2%.

Why is the AHCF Cost Report required?

- Upper Payment Limit (UPL) calculation for CMS
- Capital component for APG rates or any rate component where cost data may be used
- FQHC Rate (appeals)
- Distribution calculations
  - Safety Net Clinic distribution (Article 28 clinics providing comprehensive services as their principal mission)
  - United Cerebral Palsy distribution (Article 28 clinics providing services to the developmentally disabled as their principal mission)
- Fiscal analysis
  - State Budget proposals
  - Cost vs Payment comparisons
  - Certificate of Need application
- In any data analysis review you want your provider counted

AHCF Calendar Year vs Fiscal Year Reporting

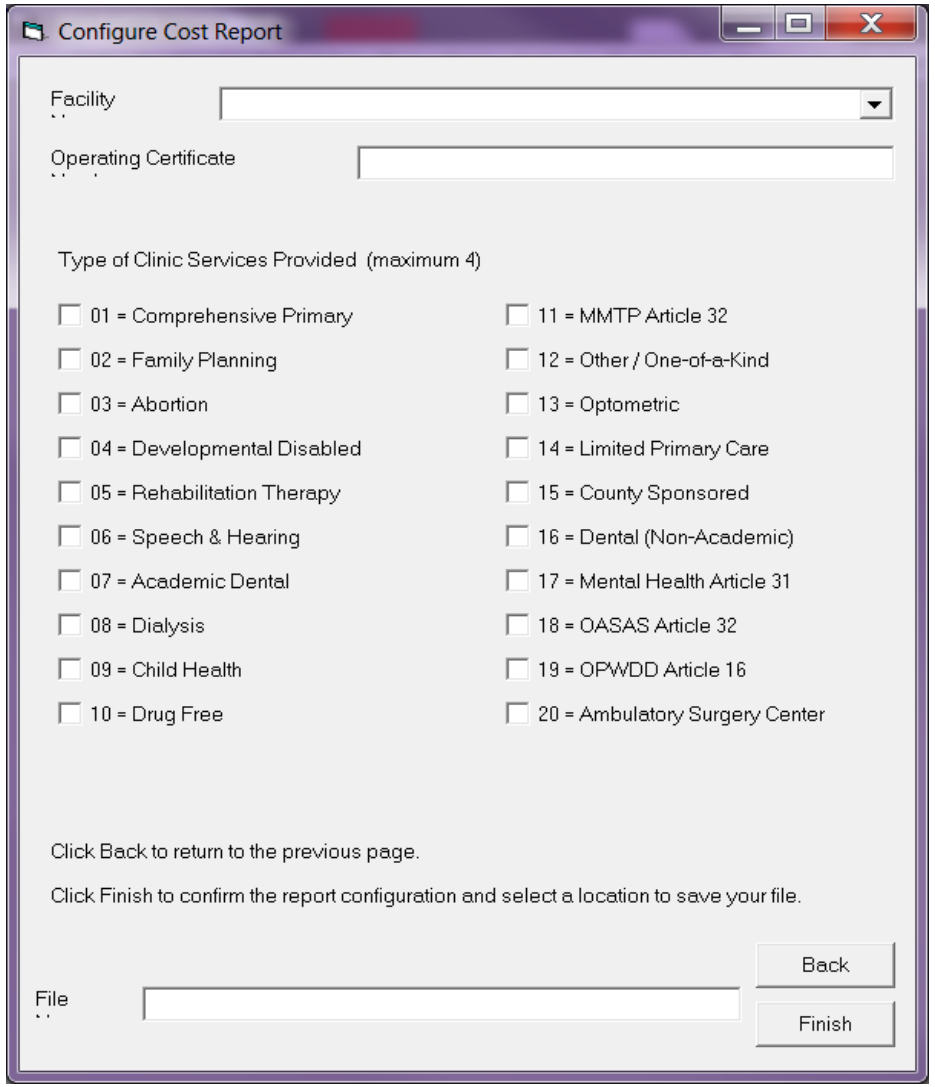
➢Calendar Year submission or Fiscal Year?

- Providers can elect to use a 12/31 or 6/30 year end for cost reporting
- Election is made at the time of the initial cost report submission

➢Historical Information

- In 1997, Section 2807 was amended for reporting requirements.
- Providers were contacted to make an election by 9/2/1997 for their cost reporting period.
- Once election was made, providers could not change it.
- Providers that opened after 1997 elect Calendar or Fiscal Year at the time of their first full year cost report submission.

Selection of Services - Configuration Screen



- Select appropriate services (the software will then provide the appropriate screens for each service).
- Services represents the different clinic environments.
- What is the clinic's principal mission? (Part 86-4.13)
- The AHCF reports "Total Provider" costs.
- Dually/Jointly licensed providers:
  - ✓ Report Article 28 (DOH Primary Care), Article 16 (OPWDD), Article 31 (OMH) & Article 32, Including OTP/MMTP (OASAS) separately.
  - ✓ By selecting these services on the configuration screen, the software will provide the ability to separate the Article 28 costs from the Article 16, 31 & 32 costs.
- If selection is not labeled "Article 16, Article 31 & Article 32" the selections are to report the Article 28 primary care costs and statistics for your provider.
- Article 28 FQHC locations are Comprehensive.

Total Cost Requirement on the AHCF Cost Report

➢Total facility clinic costs are to be reported

- Requirement to report entire agency clinic costs
  - ✓ Overall look at a provider
  - ✓ Percentage of business is primary care
- Capital rates historically developed on total provider clinic capital costs
  - ✓ SPA 15-0059 submitted to use Article 28 costs only
  - ✓ APG SPA and was not required to be withdrawn by CMS
    - ❖ Delay of APG capital rate updates beginning 1/1/2016
- Federally Qualified Health Centers (FQHC)
  - ✓ OMH and OASAS use the DOH calculated FQHC rate
  - ✓ CMS Inquiry: Ability to separate FQHC and non-FQHC locations (non-FQHC should be included in the UPL calculation)
    - ❖ 2017 AHCF: Further guidance to be provided at a later time for “FQHC Comprehensive” & “Non-FQHC Comprehensive”
    - ❖ Separation of FQHC Comprehensive & Other Principal Mission Costs

DOH Rate Codes used in the UPL

- Only DOH Displayed – Many Mental Hygiene Rate Codes Used Also

Rate Code	Rate Code Description	Rate Code	Rate Code Description
1228	COMPREHENSIVE WHEELCHAIR EVALUATION AND MANAGEMENT	1498	APG GEN CLINIC MR/DD/TBI (EDIT EXEMPT)
1381	SBHC FLU SEASONAL VACCINES - ADMINISTRATION ONLY	1604	MOMS HEALTH SUPPORTIVE SERVICE
1382	SBHC FLU H1N1 VACCINE - ADMINISTRATION ONLY	1610	INDIAN HEALTH SERVICES
1383	SBHC PNEUMO, VACCINES - ADMINISTRATION ONLY	1850	DAY HEALTH CARE SERVICE (HIV)
1407	D & T CLINIC APG	3257	INDIVID BRIEF PSYCHOTHERAPY 20-30 MIN WITH PATIENT
1408	D & T AMBULATORY SURGERY APG	3258	INDIVID COMPR PSYCHOTHERAPY 45-50 MIN WITH PATIENT
1422	DTC GENERAL CLINIC- APG EPISODE BASE RATE	3259	FAMILY PSYCHOTHERAPY WITH OR W/O PATIENT PRESENT
1425	DTC CLINIC MR/DD/TBI - APG EPISODE BASE RATE	4257	INDIVID BRIEF PSYCHOTHERAPY 20-30 MIN WITH PATIENT
1428	D&T CLINIC APG - DENTAL CLINIC	4258	INDIVID COMPR PSYCHOTHERAPY 45-50 MIN WITH PATIENT
1435	D&T CLINIC APG - GEN CLINIC (MR/DD/TBI PATIENT)	4259	FAMILY PSYCHOTHERAPY WITH OR W/O PATIENT PRESENT
1438	D&T CLINIC APG - RENAL CLINIC	5246	COLLABORATIVE CARE MONTHLY CASE PAYMENT - YEAR 1
1447	D & T CLINIC APG - SCHOOL BASED HEALTH CENTER	5248	COLLABORATIVE CARE RETAINAGE - YEAR 1
1453	D&T CLINIC APG - SCHOOL BASED HEALTH (EPISODE)	5313	TB/DIRECTLY OBSERVED THERAPY-DNST LEVEL 2
1456	D&T CLINIC APG - RENAL (EPISODE)	5318	TB/DIRECTLY OBSERVED THERAPY-UPST LEVEL 2
1459	D&T CLINIC APG - DENTAL CLINIC (EPISODE)	5388	PRESCHOOL SUPPORTIVE HEALTH PROGRAM - IEP

2016 AHCF Cost Report Changes

- Requirements:
  - Develop a visit screen that will accommodate all services
  - Calculate an appropriate capital rate
  - Provide appropriate data for the UPL

- 2016 Exhibit Changes:
  - Exhibit IC – Statistics by Patient Care
    - ✓ Expanded detailing patient care services between capital and non-capital related
  - Exhibit ID – Statistics & Revenue by Payer
    - ✓ Changes on Exhibit IC did not require changes on Exhibit ID
    - ✓ Revised to collect data for distribution payments
  - Exhibit IIIA – Costs by Service
    - ✓ Eliminated ability to remove School Based Health Care Center's costs from Total Costs
    - ✓ Adjusted formula for APG capital to use appropriate visits from Exhibit IC
  - Exhibit IIIF – Statement of Revenue
    - ✓ Revised to collect data for distribution payments

2016 AHCF Cost Report Changes – Exhibit IC

➢Visits, Exhibit IC – Statistics by Patient Care

- Revised headers
- Moved School Based Health Centers from Section 2 to Section 3
  - ✓ Receives a full APG payment + Capital
- Enhanced Section 3
  - ✓ Row 025 used for APG Capital Rate development
    - ❖ Does not include services that do not receive a capital payment
  - ✓ Added “Other Visits By Patient Care”
    - ❖ Payments do not receive a capital payment but are included in the UPL
  - ✓ Moved OTP (formerly MMTP to a section within Section 3) [Configuration screen MMTP Article 32]
  - ✓ Provided a line for OASAS Medical Visits [Configuration screen OASAS Article 32]
- New row 052 for Total Visits including OASAS
  - ✓ Row 052 should = row 960 on Exhibit ID (Visits by Payer) [Fatal Edit]
- Section 4, Procedures - Added a row for Ambulatory Surgery

2016 AHCF Cost Report Changes – Exh IC (Cont'd)

- Visits, Exhibit IC – Statistics by Patient Care (Sections 1 & 2)

	Exhibit I - General & Statistical Information C. Statistics *Name of Service*		
Revised Text	Facilities should report ambulatory surgery, abortions, sterilization		
	and dialysis as procedures in number 4 below. The threshold		
	visits should not contain any visits related to these procedures.		
	1. Total No. of Users	**001**	
	2. Visit Statistics		
No change to Edit: line 002 = line 025	a. Total number of threshold visits	**002**	EDIT w Ln 025
	b. Off site visits		
	Home	**003**	
	Hospital	**004**	
	Nursing Home	**005**	
Move row to threshold vistis	~~School Based Health Centers (SBHC's)~~	**~~006~~**	Move (1)
	Other:		
		007	
		008	
		009	
Revised Header & Formula	TOTAL OFFSITE (Sum of 003 thru 005 + 007 thru 009)	**010**	Formula

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2016 AHCF Cost Report Changes – Exh IC (Cont'd)

➢Visits, Exhibit IC – Statistics by Patient Care (Section 3)

	3. Threshold visits by patient care cost center		
	Primary Medical Care	011	
Revised Header	Dental (Including Mobile Dental Unit)	012	
	Family Planning	013	
	Mental Health		
	Psych Social Work Group Visit (Number of Clients seen in group setting)	037	
	Psych Social Work Individual Visit (FQHC only)	038	
	Mental Health other visit	039	
	Total Mental Health (Sum of lines 038 + 039)	014	Formula
	Speech & Hearing	015	
	Physical Therapy	016	
	Occupational Therapy	017	
	Other Rehabilitation Therapies	018	
	Other Health	019	
Added row from above	School Based Health Centers (SBHC's)	006	From Above (1)
Move to new section and Revise Header	~~Methadone Dispensing (Weekly Visits)~~	~~020~~	Move (2)
Revised Header	Other Threshold Visits:		
		021	
		022	
		023	
		024	
		036	
Revised header & formula	TOTAL THRESHOLD (Sum of 006 + 011 thru 019 + 021 thru 024 + 036)	025	Formula

Line 025 used to develop APG Capital Rate

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2016 AHCF Cost Report Changes – Exh IC (Cont'd)

➢Visits, Exhibit IC – Statistics by Patient Care (Section 3 - New)

New Section	OTHER VISITS BY PATIENT CARE		
New Row	Collaborative Care (Monthly & Retainage)	043	New
New Row	FQHC Group Therapy (# of clients in group setting)	044	New
New Row	LCSW/LMSW (Clinic & SBHC)	045	New
New Row	MOMS Health Supportive Service	046	New
New Row	SBHC Vaccines (Administration Payment Only)	047	New
New Row (Header Only)	Other:		
New Row		048	New
New Row		049	New
New Row and Formula	TOTAL VISITS (Sum of 025 + 043 thru 049)	050	Formula
Row from above w new header	Opioid Treatment Program (formerly MMTP: Article 32)	020	From Above (2)
New Row	OASAS Medical Visit (Article 32 MMTP & OP Rehab)	051	New
New Row and Formula	**TOTAL VISITS INCL OASAS (Sum of 050 + 020 + 051)**	052	**EDIT w Exh ID**

For Visits, Row 052 should equal Line 960 on Exhibit ID

2016 AHCF Cost Report Changes – Exh IC (Cont'd)

- Visits, Exhibit IC – Statistics by Patient Care (Section 4)

	4. Procedures		
	Abortions	031	
	Sterilization	032	
	Dialysis	033	
New row	Ambulatory Surgery	053	New
	Other:		
		026	
		027	
		028	
		029	
		030	
		034	
		040	
		041	
		042	
Revised Header & Formula	TOTAL PROCEDURES (Sum of 026 thru 034 + 040 thru 042 + 053)	035	EDIT w Exh ID

For Procedures, Row 035 should equal Line 960 on Exhibit ID

2016 AHCF Cost Report Changes – Other Exhibits

- Exhibit ID – Visits/Revenue & Exhibit IIIF - Revenue
  - Added Lines for distributions collected
    - ✓ Line 78: Clinic Safety Net distribution (For eligible providers began 4/1/2016)
    - ✓ Line 79: Vital Access Provider (VAP) distribution
    - ✓ Line 80: Delivery System Reform Incentive Payment (DSRIP)
- Exhibit IIIA – Costs
  - Removed ability to adjust out School Based Health Center's costs
    - ✓ Costs should be included
    - ✓ 2017 AHCF will eliminate column

Visits & Procedures Clarification

➢Threshold Visits

- According to part 86-4.9(b), a threshold visit, including all part-time clinic visits, shall occur each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit.
- According to the Policy Guidelines Manual for Article 28 Clinics, “a qualifying threshold visit is one where the registered clinic patient has an encounter with a physician, physician assistant, nurse practitioner or licensed midwife for services that include comprehensive primary care.”
- Is a visit with an RN a threshold visit?
  - ✓ Even though a registered nurse (RN) is not a qualified licensed practitioner, if an RN administers chemotherapy or other infusion drugs under a physician’s order in a clinic setting (and an APG claim is to be filed to Medicaid with an infusion procedure code for the administration of the infusion drug), this encounter with an RN does qualify as a threshold visit for cost reporting purposes
- The following shall not constitute a threshold visit if the visit was solely for (86-4.9(c)):
  - ✓ Ordered Ambulatory Services, Pharmacy, Respiratory Therapy, Nutrition, Recreation Therapy, Medical Social Services

Visits & Procedures Clarification (Cont'd)

➢Procedures

- If included in Procedures, do NOT include in Visits.
- Per Part 86-4.9(a): The unit of service used to establish rates of payment shall be the threshold visit, except for dialysis, abortion, sterilization services and freestanding ambulatory surgery, for which rates of payment shall be established for each procedure.
- For reimbursement purposes, all the visits related to the procedure, regardless of the number of visits are to be considered and counted as part of one procedure. They are not billable as separate visits. [Procedure = Pre-Visit, Actual Procedure, Post-Visit]

➢Reporting of OTP (formerly MMTP)

- Example: 5 daily visits in 1 week: Report the 5 daily visits

Visits & Procedures Clarification

➢Ordered Ambulatory Services

❖ Ordered ambulatory services are defined as specific services provided to non-registered clinic patients at the facility upon order and referral.

- If the service is billed and reimbursed as an Ordered Ambulatory Services, it should be reported as an Ordered Ambulatory Service.
- These services cannot be billed using the clinic rate.
- When a provider submits an APG claim, all ancillaries ordered by the Diagnostic and Treatment Center must be coded on the claim and must code the modifier U6 at the line level for each ancillary for which they are requesting payment.
  - ✓ Modifier U6 will provide payment to the clinic for the ancillary service. If the service is contracted and not provided at the clinic, the U6 modifier is not included and APG payment is reduced.
- Statistics for ordered ambulatory services must be maintained by each facility as a matter of record:
  - ✓ Visits are not included as threshold visits.
  - ✓ Costs associated with these services must be identified and removed from operating costs.
  - ✓ Visits and Revenue are reported on Exhibit 1D

Visit & Procedure Data Edits

- Exhibit IC: Line 002 = Line 025

2. Visit Statistics	
a. Total number of threshold visits	**002**
3. Threshold visits by patient care cost center	
TOTAL THRESHOLD (Sum of 006 + 011 thru 019 + 021 thru 024 + 036)	**025**

- Exhibit IC and Exhibit ID:
  - Visit Edit: Exhibit IC Line 052 = Exhibit ID Line 960
    - ✓ Exhibit IC | TOTAL VISITS INCL OASAS (Sum of 050 + 020 + 051) | **052** |
    - ✓ Exhibit ID – Visits Column | TOTAL SOURCE OF PAYMENT | **960** |

    Note: AHCF FFS Medicaid reported visits should = eMedNY claims used in the UPL

  - Procedures Edit: Exhibit IC Line 035 = Exhibit ID Line 960
    - ✓ Exhibit IC | TOTAL PROCEDURES (Sum of 026 thru 034 + 040 thru 042 + 053) | **035** |
    - ✓ Exhibit ID – Procedures Column | TOTAL SOURCE OF PAYMENT | **960** |

    Note: AHCF FFS Medicaid reported procedures should = eMedNY claims used in the UPL

Timing for Cost Report Software & Completion

- Starting with 2015 Survey
  - If the Department can provide good data to CMS, there is a possibility of completing a UPL earlier than 2018.
  - Survey distributed using same design as Minimum Wage
    - ✓ Will be for Exhibit IC and Exhibit ID
    - ✓ Not recasting any distributions or rates developed using the 2015 survey data.

      ONLY USED FOR THIS PURPOSE.
    - ✓ Exhibit IIIA for Costs should not need to be resubmitted
      - ❖ All costs should already have been reported.
      - ❖ School Based Health Centers costs were to be included in total and adjusted out providing the added costs needed.
- 2016 Software release and completion
  - Software in development
  - Providers receive 60 days from release of the software to complete
    - ✓ The Department will take into consideration the upcoming holidays
  - Can begin developing data based on layout of the screens provided

Accessing the AHCF Software on the HCS

- In order to retrieve the software, providers must have an HCS account
- The Health Commerce System (HCS) is a communication tool

https://commerce.health.state.ny.us/public/hcs_login.html

- Email blasts
  - ✓Keep email address current
  - ✓Provider responsibility
  - ✓Email blast separate from public website Electronic Mailing List
  - ✓Removal of employee when leave provider's employment
- Secure network for posting provider specific information
  - ✓AHCF Cost Report software download and upload
  - ✓Rate Sheets (APG capital & FQHC)
  - ✓Distribution calculations

Accessing the AHCF Software on the HCS (Continued)

- An HCS account is required to access the software
  - BMHRHC cannot establish an HCS account
  - Accounts are person specific not provider specific
  - Providers that have an HCS coordinator:
    - ✓ The coordinator can set up an HCS account for an individual at their facility
  - For new providers as well as existing providers:
    - ✓ If no coordinator at the facility, contact the NYS Department of Health Commerce Accounts Management Unit Support (CAMU) at 1-866-529-1890
  - HCS accounts gets you access to the HCS but not access to the AHCF Cost Report Application on the HCS
    - ✓ Must complete an Access Application Form

Accessing the AHCF Software on the HCS (Continued)

- Access Application Form
  - HCS homepage
    - ✓ Click “Applications” from the Title Bar at the top of the screen
    - ✓ Find “D&TC Cost Report” application by clicking “D” at the top “Browse by”
    - ✓ Click “i” in the Profile column of “D&TC Cost Report” application
    - ✓ Scroll down to find “*DFRS D&TC Access Application Form*” in “Access Information”
    - ✓ Print out and complete the Form
- The individual user must complete Section I of the form and an HCS coordinator must complete Section II.
- Signatures for the user and the HCS coordinator must be notarized.
- Email the completed Form to dtcffsunit@health.ny.gov

Cost Report Document Filing Requirements

➢What should be submitted?

- Electronic AHCF using the HCS
- CEO Certification
- CPA Certification
- Audited Financial Statements (AFS)

❖CEO and CPA certifications are the first pages of AHCF Cost Report. Providers must print out these certification pages and complete. Alternative certification forms will not be accepted by NYS DOH.

❖***A <u>complete submission</u> includes not only the electronic AHCF submission but also the CEO & CPA certification and AFS. Without these required documents, the reporting requirement has <u>not</u> been met.***

Cost Report Document Filing Requirements (Cont'd)

➢When should they be submitted?

- The Certifications and AFS should be filed within 5 business days following the electronic submission of AHCF Cost Report.

➢How should they be submitted?

- Certifications and AFS should be submitted by email to dtcffsunit@health.ny.gov
- Subject Line: 2016 AHCF Documentation_Name of Your Facility
- No longer requiring hardcopy submissions
- Naming Convention:
  - ✓Opcert#_CEO_2016.pdf
  - ✓Opcert#_CPA_2016.pdf
  - ✓Opcert#_AFS_2016.pdf

APG Website

- APGs (Ambulatory Patient Groups):
  - Contact information (including O Agencies)
  - Rates – both APG & FQHC
  - Method of communication to providers
  - APG Electronic Mailing List for website updates

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

Contacts

➢Questions regarding completing the AHCF Cost Report:

- Email dtcffsunit@health.ny.gov

✓Please identify yourself in the email:

- o Your name
- o Name of facility
- o Facility Operating Certificate Number
- o Telephone number

➢Should you experience any problems with the electronic submission, a toll-free HCS helpline is available at 1-866-529-1890.

Questions:

D&TC Fee-for-Service Unit:
dtcffsunit@health.ny.gov

A Q&A will be provided based on questions received from the webinar