

Implementation of Episodic Payment System for Certified Home Health Agencies

Webinar

**New York State Department of Health
November 10, 2011**

To facilitate today's discussion and assist the Department in efficiently addressing inquiries about today's Webinar, please direct all questions and comments to: HCWebinar@health.state.ny.us

Please include provider name and the topic of your inquiry (i.e., Methodology, Billing etc.) in the Subject Line of the email.

Episodic Payment System (EPS) Continues Medicaid Redesign Team (MRT) Efforts to Reduce and Control Utilization

- ▶ From 2003 to 2009:
 - Medicaid Costs for CHHAs increased 77.4%
 - Cost per patient increased 89.5%
 - The number of patients receiving CHHA services declined by 6.4%
- ▶ MRT Initiative #5
 - Phase 1: Effective April 1, 2011 implemented aggregate annual per patient spending limits
 - Phase 2: Effective April 1, 2012, Episodic Payment System Implemented
 - Phase 3: Effective April 1, 2012, begin roll-out of mandatory enrollment of certain individuals who require community-based long-term care - will include phase-in of dual eligible CHHA patients

Agenda

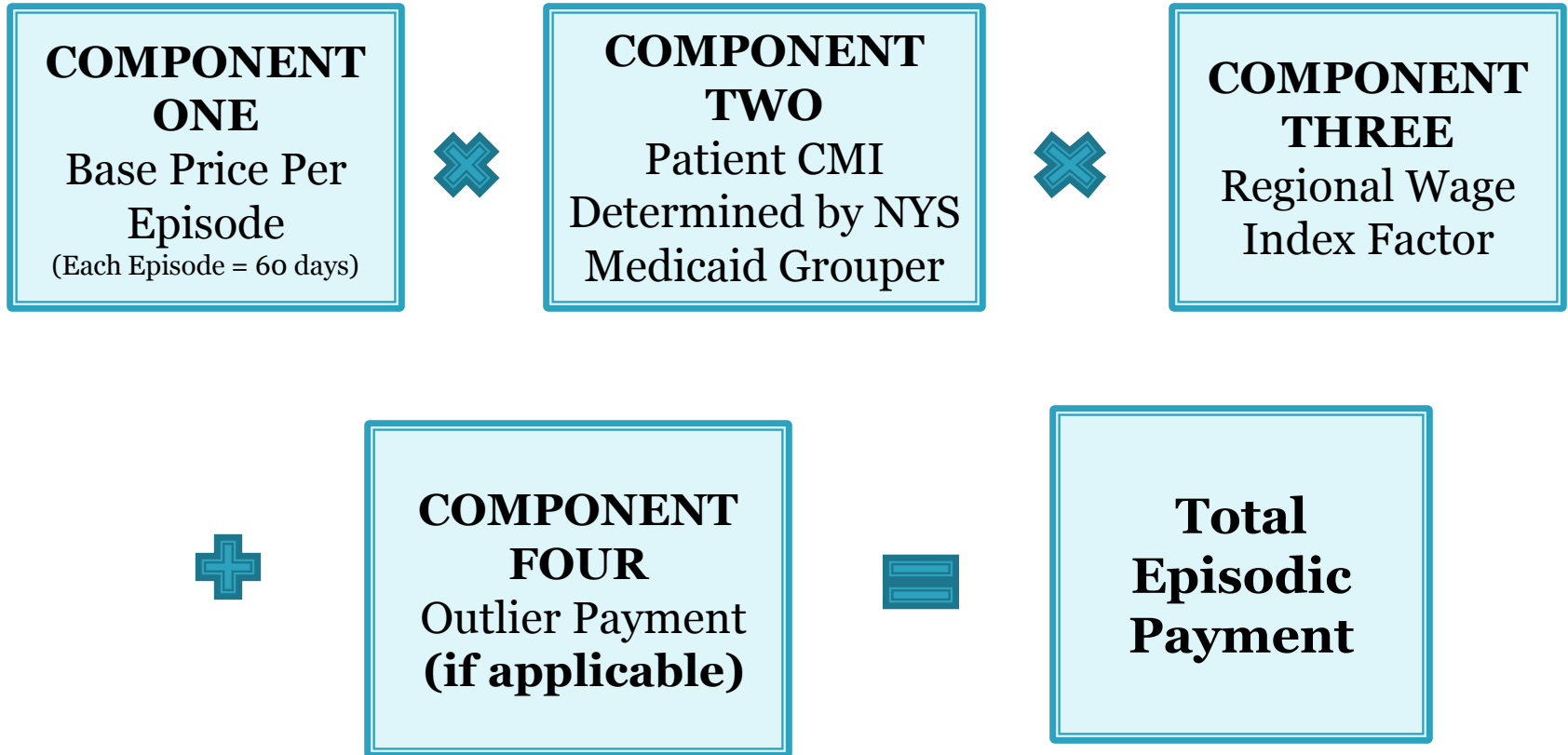
- ▶ Overview of Episodic Payment System
 - Base Price
 - Case Mix Adjustments – NYS Medicaid Grouper
 - Regional Wage Index
 - Outlier Payments
 - LUPAs
 - Length of Stay
 - Interim Payments
 - Examples: Calculating Episodic Payments
- ▶ Billing Procedures
- ▶ Next Steps
- ▶ Future Updates to EPS Methodology
- ▶ Appendix

**Overview of
Episodic Payment System (EPS)
Effective April 1, 2012**

NYS Episodic Payment System (EPS)

- ▶ EPS takes effect on April 1, 2012
- ▶ NYS EPS is similar to Medicare EPS, but there are significant differences
- ▶ Applies to all CHHA patients except:
 - Patients under 18 years of age (fee-for-service billing will continue for these patients)
- ▶ Effective April 1, 2012, dual eligible individuals who will need community-based services for more than 120 days will start to be referred for enrollment to a Managed Long Term Care Plan (MLTCP) or Care Coordination Model (CCM). Mandatory enrollment will begin in New York City where there is sufficient MLTC capacity. DOH will initiate mandatory enrollment in other counties as capacity is established.
 - Details regarding the process and time frame for including CHHA patients are now under development by the Department
- ▶ A Statewide Base Price for 60-day episodes of care is adjusted for patient acuity using a NYS Medicaid grouper, regional wage differences, and if applicable, outlier payments

NYS Episodic Payment System (EPS)



Component One of EPS System: Base Price

Component One of EPS: Base Price

- ▶ Payments are based on 60-day episodes of care
- ▶ Statewide Base Price for all episodes = \$5,633
 - Low Utilization Payment Amount (LUPA) may be applicable
- ▶ Statewide base price adjusted for:
 - Case mix (patient acuity) using OASIS-C data and NYS Medicaid Grouper
 - Regional wage differences ~ Wage Index Factor
 - Outlier Payments (if applicable)

Component Two of EPS System: Case Mix Adjustment Using NYS Medicaid Grouper

NYS Medicaid CHHA Grouper

- ▶ Per statute, Medicaid Grouper developed using 2009 claims data and OASIS-B assessment information
- ▶ The 2009 Medicaid Grouper is compatible with the OASIS-C assessment data
- ▶ OASIS-C assessment data now in effect will be run through the Medicaid CHHA Grouper to determine the case mix component of EPS system

Overview of NYS Medicaid Grouper (Used to Determine Case Mix Adjustment)

NYS Medicaid Grouper	
Clinical	Medicaid Clinical Measures – 3 Groups (A,B,C)
Functional	Medicaid Functional Measures – 3 Groups (E,F,G)
Assessment Reason	2 Groups – Start of Care or Recertification (0 , 1)
Age	6 Age Groups (1-6)
Total # Case Mix Groups/Weights	Total: 108 Case Mix Groups (3*3*2*6)

OASIS-C Clinical and Functional Factors Included in NYS Medicaid CHHA Groupers

7 Clinical Factors

- 1) Diabetes diagnoses
- 2) Orthopedic diagnoses
- 3) Dementia diagnoses
- 4) HIV diagnoses
- 5) Bowel Incontinence
- 6) Urinary Incontinence
- 7) Shortness of Breath

3 Clinical Groups:

- A=0-4 points
B=5-14 points
C=15+ points

4 Functional Factors

- 1) ADL Dressing upper body
- 2) ADL Dressing lower body
- 3) ADL Toileting
- 4) ADL Transferring

3 Functional Groups:

- E=0-18 points
F=19-51 points
G=52+ points

OASIS-C Age and Assessment Factors Included in NYS Medicaid CHHA Groupers

Assessment Reason (2 Groups)

- o) Start of Care (M0100=1 or 3)
- 1) Recertification of Care (M0100=4 or 5)

Age (6 Groups)

- 1) Less than 60
- 2) 60-69
- 3) 70-74
- 4) 75-79
- 5) 80-84
- 6) 85+

NYS Medicaid CHHA Grouper

(Point Scale to Determine Clinical and Functional Groups)

Response Level

Item	Item Number OASIS-C	0	1	2	3	4	5	
Dx of Diabetes	M1020/M1022	0	4					
Dx of Orthopedic	M1020/M1022	0	2					
Dx of Dementia	M1020/M1022	0	24					
Dx of HIV	M1020/M1022	0	10					
Bowel Incontinence	M1620	0	0	0	0	0	5	
Urinary Incontinence	M1610	0	6	0				
Shortness of Breath	M1400	0	4	4				
Dress Upper	M1810	0	8	18	18			
Dress Lower	M1820	0	0	12	21			
Toilet	M1840	0	13	20	20	20		
Transfer	M1850	0	0	9	9	15		15

Example Case Mix ~ Mrs. Smith

Mrs. Smith Assessment Reason: Recertification =1 Age Group 70-74 (Age = 3)	Points
Diabetes	4
Orthopedic Condition (Arthritis)	2
Dementia diagnosis	0
HIV diagnosis	0
Bowel Incontinence less than Once Weekly Response 1	0
Urinary Incontinence Response 1	6
No Shortness of Breath	0
Clinical Score (A= 0-4, B=5-14, C=15+)	12 = B

Example Case Mix ~ Mrs. Smith

Mrs. Smith Assessment Reason: Recertification =1 Age Group 70-74 (Age = 3)	Points
Dress Upper Body Response 1 (needs clothes laid out)	8
Dress Lower Body Response 1 (needs clothes laid out)	0
Toileting Response 1 (needs to be reminded, supervised, assisted)	13
Transferring Response 1	0
Functional Score (E=0-18, F= 19-51, G=52+)	21=F
Mrs. Smith : Case Mix Group = 1 B F 3	

108 Case Mix Groups Are Assigned Individual Rate Codes

- ▶ Each of the 108 Case Mix Groups will be tied to a **Rate Code**
- ▶ Following table provides 6 examples of the 108 Rate Codes (See Appendix for complete list)

Assessment Reason*	Clinical Group	Functional Group	Age Group	Case Mix	Rate Code
0	A	E	1	.243422	4810
0	B	F	2	.691567	4835
0	C	G	3	1.963598	4860
1	A	E	4	.515132	4867
1 (Mrs. Smith Ex.)	B	F	3	.934108	4890
1	C	G	6	2.480934	4917

* Assessment Reason 0: Start of Care 1: Recertification

Developing a Grouper Module

- ▶ Providers/vendors will need to create their own module which will generate one of the **108 Rate Codes** to be used in billing
- ▶ NYS will make available SAS code to providers if this is helpful to them

Latest Available OASIS will be Used to Transition Patients to EPS

- ▶ To transition patients eligible for Medicaid fee-for-service coverage, providers will begin an initial episode effective April 1, 2012 using the latest OASIS assessment available (within the last 60 days) for that patient
- ▶ The initial episode will end with the date prior to the date of the next assessment cycle
- ▶ The initial episode will result in a partial episodic payment based on the Dates of Service as claimed on UB-04, field 6 “Statement Covers Period From/Through”
- ▶ Synchronizes Medicaid eligible episodes with future assessments

OASIS Transition Example

- ▶ Medicare Episode: March 15 – May 13
- ▶ Medicaid Eligible Services Begin April 1
- ▶ Initial Medicaid Claim: April 1 – May 13
 - Uses OASIS data related to the beginning of the March 15 Medicare episode
 - Results in partial episodic payment for Medicaid
- ▶ Subsequent Medicaid Claim: May 14 – July 12
 - Is now synchronized with Medicare episode

NOTE: At the provider's discretion, the agency may choose to discharge the patient March 31 and re-admit April 1, rather than using the "partial episode" approach described above.

Component Three of EPS System: Regional Wage Index Factor

Calculation of Wage Index Factors

- ▶ The WIFs are calculated for 10 Labor Market Regions defined by the NYS Department of Labor
- ▶ Average wages are extracted from the Occupational Employment Statistics compiled by the Federal Bureau of Labor Statistics for five occupational categories:
 - Home Health Aides, Registered Nurses, Occupational Therapists, Physical Therapists, Speech Therapists
- ▶ Occupational categories are weighted according to each Region's Medicaid utilization as reported in the CHHA certified cost reports
- ▶ Wage Index Factors are adjusted proportionately to ensure that the application of the factors will be revenue neutral
- ▶ The Wage Index Factor is applied to 77% of the total reimbursement rate
 - Percentage is roughly equal to the percentage used in Medicare EPS to measure the average portion of agency costs which are labor-related

Wage Index Factors

(TBD – Will be Calculated Using Latest Available Data Prior to 4.1.12)

Region	Wage Index	Counties
Capital	TBD	Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren, Washington
Central New York	TBD	Cayuga, Cortland, Madison, Onondaga, Oswego
Finger Lakes	TBD	Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates
Hudson Valley	TBD	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Long Island	TBD	Nassau, Suffolk
Mohawk Valley	TBD	Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie
New York City	TBD	Bronx, Kings, Queens, New York, Richmond
North Country	TBD	Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence
Southern Tier	TBD	Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins
Western New York	TBD	Allegany, Cattaraugus, Chautauqua, Erie, Niagara

Example of Wage Index Factor Calculation: Capital Region

	Registered Nurses	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aides
Regional Average Wage	\$28.93	\$30.99	\$27.43	\$29.99	\$12.28
Statewide Average Wage	\$35.91	\$35.78	\$34.92	\$32.59	\$11.16
Ratio (Region/Statewide)	.8055	.8659	.7855	.9202	1.1008
Weighting *	.6511	.1293	.0175	.0402	.1619

WIF - Total weighted ratio .8654 (Example only - Actual Index TBD)**

WIF - Adjusted for revenue neutrality .8864 (Example only - Actual Index TBD)

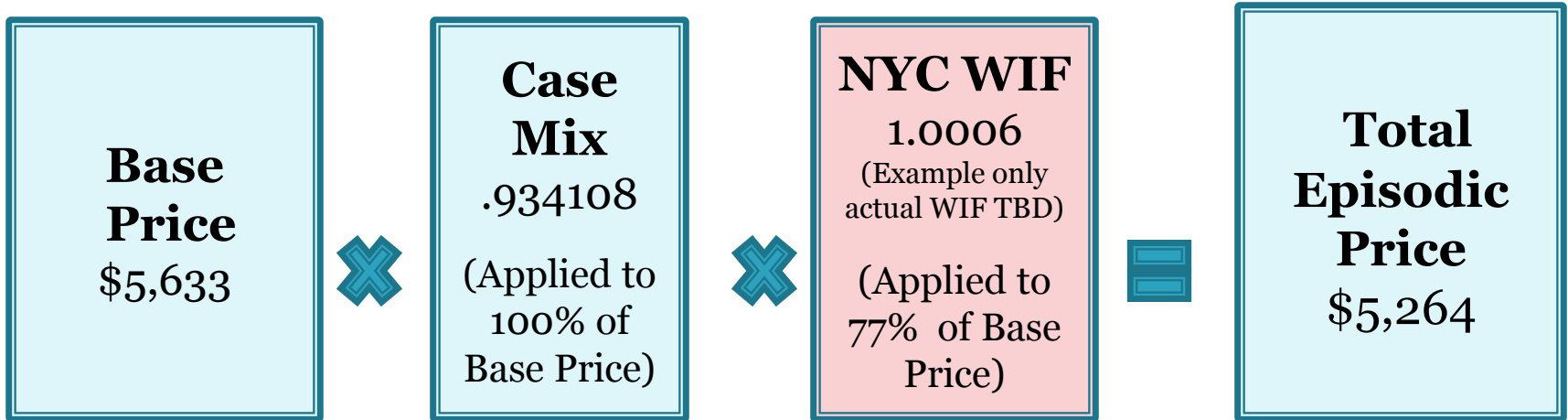
** $(.8055 \times .6511) + (.8659 \times .1293) + (.7855 \times .0175) + (.9202 \times .0402) + (1.1008 \times .1619) = .8654$

*** Weighting is based on Medicaid visits reported in certified cost reports by CHHAs in Capital Region:**

Nursing:	37,562	(.6511)
PT:	7,459	(.1293)
Speech:	1,010	(.0175)
OT:	2,318	(.0402)
HHA:	9,342	(.1619)

Example: Mrs. Smith (1BF3)

Recertification Assessment, New York City CHHA, Clinical B, Functional F,
Age Group 3: 70-74



**Component Four of EPS System:
Outlier Payments
(If Applicable)**

Outlier Payments and Thresholds

- ▶ Outlier Payments (made in addition to the case mix and WIF adjusted base price) are applicable to costs which exceed an outlier threshold
- ▶ A separate and unique percentile threshold is established for each of the 108 case mix groups (see Appendix)
- ▶ The outlier percentile threshold increases with patient need/severity of condition
 - Higher clinical – higher percentile threshold
 - Higher functional – higher percentile threshold
 - Older age – higher percentile threshold
- ▶ Outlier payments are equal to 50% of the costs that exceed the outlier threshold

Examples of Outlier Threshold Percentiles

(See Appendix for complete list)

Assessment Reason	Clinical Group	Functional Group	Age Group	Outlier Threshold
Start of Care = 0	A	E	70-74 = 3	\$3,660
Start of Care = 0	A	G	85+ = 6	\$17,619
Start of Care = 0	B	F	Under 60 = 1	\$6,991
Start of Care = 0	C	E	75-79 = 4	\$8,821
Start of Care = 0	C	G	80-84 = 5	\$26,679
Recertification = 1	A	F	60-69 = 2	\$8,670
Recertification = 1	B	E	80-84 = 5	\$6,318
Recertification = 1 (Mrs. Smith Ex)	B	F	70-74 = 3	\$9,720
Recertification = 1	C	E	75-79 = 4	\$10,269
Recertification = 1	C	G	85+ = 6	\$28,600

Determining Costs and Calculating Outlier Payments

- ▶ The EPS will use the latest fee-for-service rates in effect as of April 1, 2012 to calculate statewide weighted average rates for specific CHHA services to determine the “Cost” of each episode of care
- ▶ The latest rates in effect will be tied to **Revenue Codes**
- ▶ The provider will report units of service (hours, visits, etc) provided on each date during each episode
- ▶ The eMedNY system will multiply the units of service times the statewide rates associated with the appropriate **Revenue Codes** to compute the cost of the episode
- ▶ If the costs exceed the outlier threshold for the case mix group, the CHHA will receive the Base Price adjusted by Case Mix and WIF PLUS 50% of the costs that exceed the outlier threshold
 - The outlier payment will be adjusted by the WIF

Revenue Codes for EPS

Service	Unit	Statewide Weighted Average Rate	Revenue Code
Skilled Nursing	Visit	TBD	0551
Physical Therapy	Visit	TBD	0421
Speech Language Pathology Therapy	Visit	TBD	0441
Occupational Therapy	Visit	TBD	0431
Home Health Aide	Hour	TBD	0572
Shared Aide	Qtr. Hour	TBD	0579
AIDS Skilled Nursing	Visit	TBD	0559
Telehealth I, II, III	Day	TBD	0780
Telehealth Installation	One-Time	TBD	0590
MOMS Health Supportive Services	Visit	TBD	0581

Example: Outlier Payment for Mrs. Smith

Recertification Assessment, New York City CHHA, Clinical B, Functional F,
Age Group 70-74



Mrs. Smith			
Total cost of visits/hours (Statewide Rates Multiplied by Appropriate Revenue Codes)	Outlier Threshold	Costs in Excess of Outlier Threshold	Outlier Payment (50% of Excess, with 77% Adjusted by WIF)
\$12,000	\$9,720	\$2,280	\$1,140* 1.0006 (applied to 77%) = \$1,141

LUPAs, Length of Stay (Partial/Full), and Interim Payments

Low Utilization Payment Amounts (LUPAs)

- ▶ If cost of episode is \$500 or less, the CHHA receives a Low Utilization Payment Amount (LUPA)
- ▶ The cost of the episode is computed by multiplying the units of service times the statewide weighted average rates associated with the appropriate Revenue Codes
- ▶ The LUPA is equal to the computed cost
 - The payment is adjusted by the applicable Wage Index Factor (applied to 77% of cost)

NOTE: \$500.00 threshold is applied BEFORE wage adjustment – Wage-adjusted LUPA payment can be more than \$500.00 even if unadjusted charges (based on Revenue Codes) are \leq \$500.00

Partial and Full Episodic Payments ~

Payments for Patients Discharged in Less Than 60 Days

- ▶ To maintain billing integrity and to properly implement the new EPS while certain CHHA patients are enrolled in MLTCPs/CCMs, episodes of less than 60 days will result in partial payments if the CHHA patient is discharged to another Long Term Care setting, including MLTC/CCM, LTHHCP, Nursing Home
- ▶ Partial episodic payments also will apply to patients who are discharged to another CHHA
- ▶ Full episodic payments will be made for CHHA patients who are discharged in less than 60 days only if discharged to:
 - The Community/Home
 - Hospital
 - Hospice
 - Or in cases of death

(See examples in the “Billing Procedures” section of this presentation)

Interim Payments

- ▶ To assist providers with cash flow during an episode, providers may submit a claim early in the episode for an Interim Payment
- ▶ Interim Payments are equal to 50% of the episodic base price, based on the reported Rate Code, adjusted for CMI and Wage Index
 - Interim payments must include at least one date of service showing the applicable Revenue Code
- ▶ When the final claim for the same episode is submitted, the full final payment is calculated
 - The full final payment is processed as an adjustment or “takeback” of the Interim Claim and full payment of the final claim

Examples: Calculating Reimbursement Under the EPS

Episodic Payment System: Reimbursement Examples

The following pages provide 6 examples of how payments to providers will be calculated:

1. Interim Payment
2. Full episode - no LUPA, no outlier reimbursement
3. Full episode - with outlier reimbursement
4. Full episode – LUPA
5. Partial episode - no LUPA, no outlier reimbursement
6. Partial episode – with outlier reimbursement

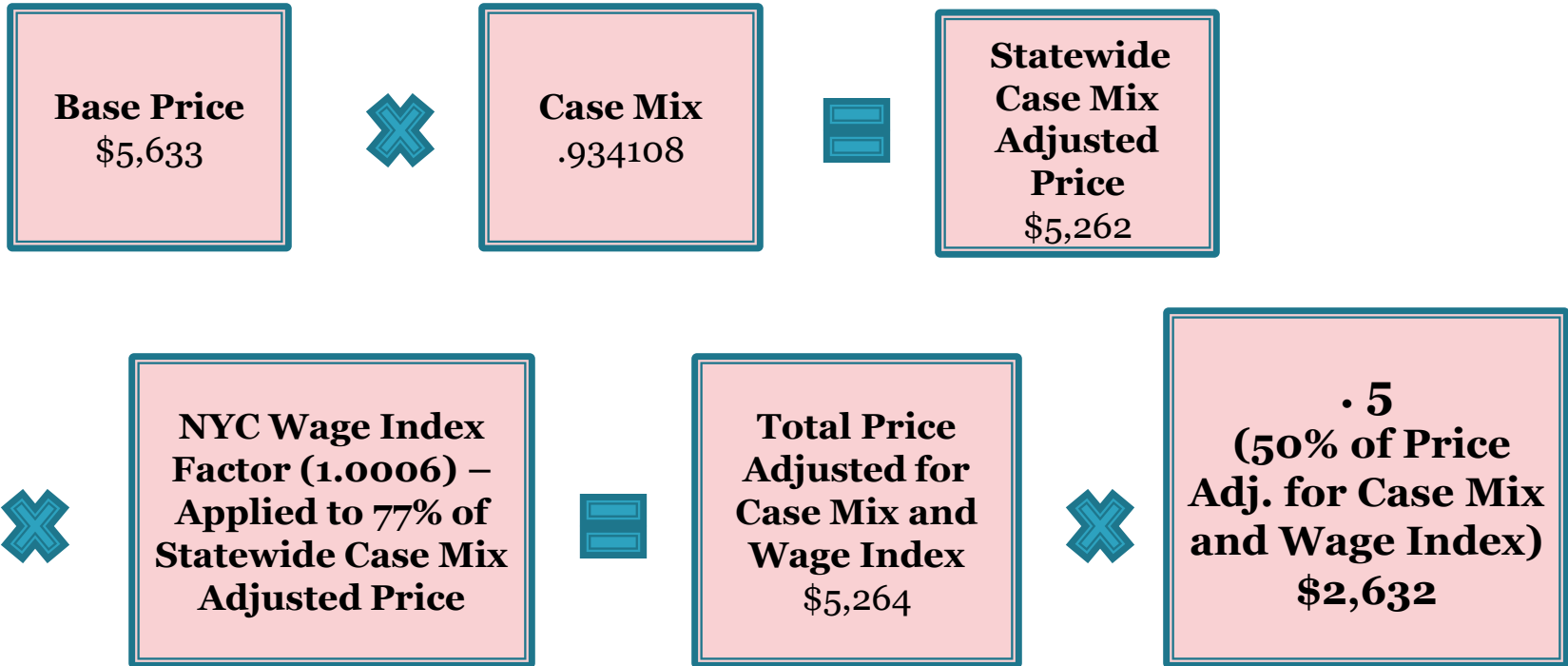
Episodic Payment System: Reimbursement Examples

The following information will apply to all 6 payment examples:

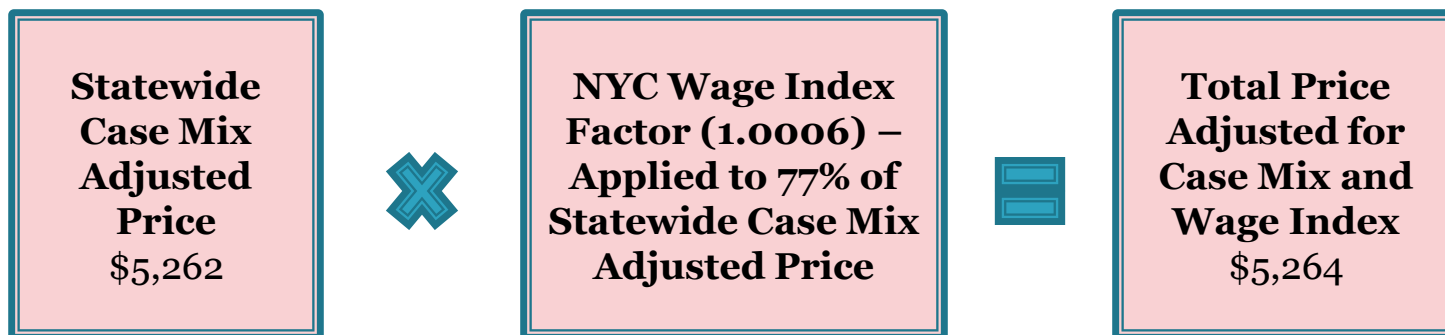
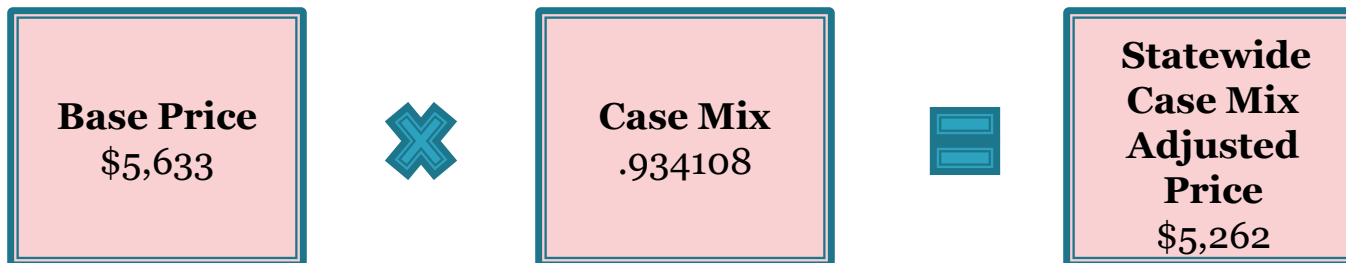
- Patient is served by a CHHA in New York City
- Reason for OASIS assessment is Recertification (1)
- Clinical group is B
- Functional Group is F
- Patient is 72 years old (Age Group 3)

- Statewide Base Price is \$5,633
- Case Mix Index for Resource Group 1-B-F-3 = 0.934108
- Outlier Threshold for 1-B-F-3 = \$9,720
- Wage Index applied to 77% of reimbursement

Example #1: Interim Payment (1BF3)



Example #2: Full Episode – No LUPA, No Outlier Adjustment (1BF3)



(If Interim Payment was received, provider will receive Final Payment of \$5,264 minus “takeback” of Interim Payment - e.g. \$2,632 in Example #1).

Example #3: Full Episode with Outlier Reimbursement

Total charges for visits, hours, etc. reported by CHHA based on Revenue Codes =
\$12,000

Outlier Threshold for this Resource Group = **\$9,720**

Charges in excess of outlier threshold = **\$2,280**

Provider will receive outlier payment of $\$2,280 \times 50\% = \$1,140$
77% of this amount will be adjusted by Wage Index Factor
Net outlier payment (NYC Provider) = **\$1,141**

Base Price adjusted for
WIF and Case Mix (from
Example #1): **\$5,264**



Outlier Payment,
adjusted for WIF:
\$1,141



Total Episodic
Payment:
\$6,405

(Interim Payment, if any, will be
deducted when Final Payment is made)

Example #4: Full Episode – Low Utilization (LUPA) (1BF3)

**Total charges for visits, hours, etc. reported by CHHA based on
Revenue Codes = \$450.00**

**As this is less than (or equal to) \$500.00, Low Utilization Payment
will apply – REGARDLESS of length of episode**

**Provider will receive actual charges produced by Revenue Codes:
77% of this amount will be adjusted by Wage Index Factor
Net payment (NYC Provider) = \$450.21**

(Interim Payment, if any, will be deducted when Final Payment is made)

Example #5: Partial Episode – No LUPA, No Outlier Adjustment (1BF3)

“From” Date on Claim Form: April 15, 2012
“Through” Date on Claim Form: May 24, 2012
Length of Episode: 40 Days

**Episodic Price
Adjusted for Wage
Index Factor and Case
Mix
(from Example #1):
\$5,264**



40 / 60



**Total
Reimbursement
for Partial
Episode: \$3,509**

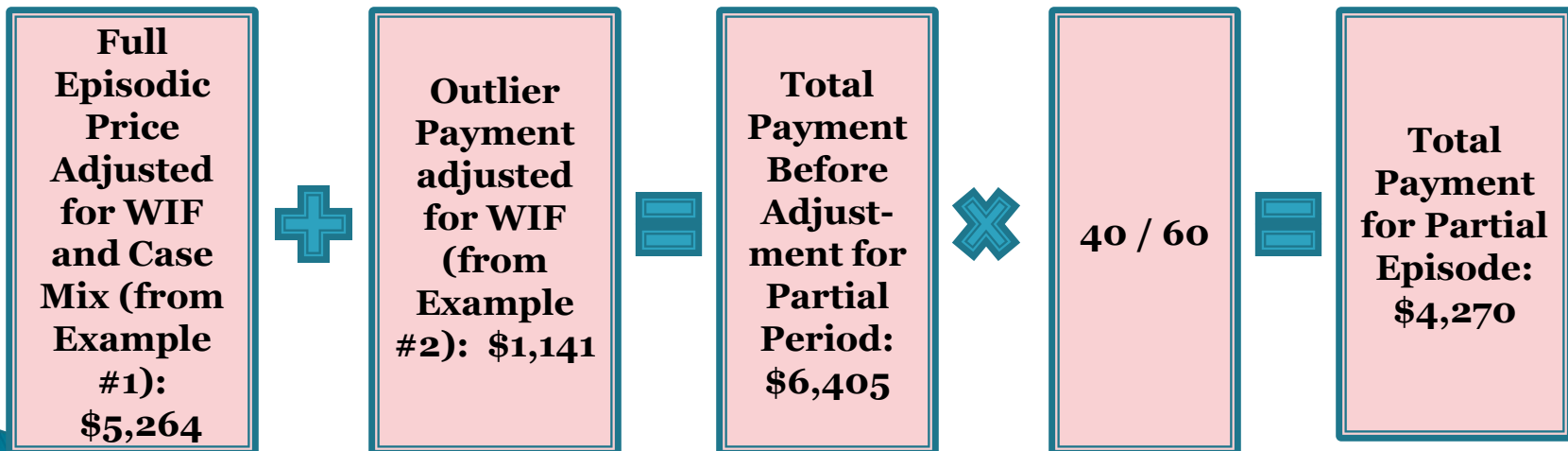
**(Interim Payment, if any, will be deducted when
Final Payment is made)**

Example #6: Partial Episode with Outlier Reimbursement (1BF3)

“From” Date on Claim Form: April 15, 2012
“Through” Date on Claim Form: May 24, 2012
Length of Episode: 40 Days

Total charges for visits, hours, etc. reported by CHHA based on Revenue Codes = \$12,000

Charges in excess of outlier threshold = \$2,280



(Interim Payment, if any, will be deducted when Final Payment is made)

Billing Procedures

General Information

- ▶ Fee-for-Service billing and payments will continue through March 31, 2012 (the authorization to bill fee-for-service generally ends on April 1, 2012)
- ▶ EPS takes effect on April 1, 2012 and applies to Medicaid CHHA services provided on and after that date
 - Exceptions apply to billings for patients under 18: fee-for-service payments will continue to be made
- ▶ OASIS assessments will continue to be completed in accordance with Federal requirements and will be used by the NYS Medicaid Grouper to determine case mix
- ▶ Service authorization requirements will be consistent with existing requirements (e.g., physician order, medical record, etc.)

General Information

- ▶ Only those services which are properly billable to Medicaid may be listed on the Medicaid claim forms
 - Services which are otherwise covered by Medicare or other payer should not be included
- ▶ Billing for non-CHHA programs (e.g., LTHHCP) must be billed on separate claims and may not be included in the UB-04 CHHA Claim
- ▶ **The UB-04 Claim will NOT change and will be used to calculate EPS payments**
 - ▶ **However, there are new procedures for completing UB-04 Claims**

New Procedures for Completing UB-04 Claims

- ▶ The third digit of “Type of Bill” (UB-04 field #4) must be shown as:
 - “2” for Interim Claim
 - “9” for Final Claim (full or partial) or Adjusted Claim
- ▶ The Occurrence Code 50 (fields 31-36) should be used to report Date of Assessment (OASIS)
- ▶ Rate Code (fields 39-41) must be one of the new 108 episodic Rate Codes
 - Rate Codes should be based on patient’s age at the END of the Episode
- ▶ Revenue Code (field 42) and Service Units (field 46) must be shown for each Service Date (field 45).
- ▶ Procedure Code (field 44) must continue to be completed

New Procedures for Completing UB-04 Claims

- ▶ The Length of episode will be determined by “Statement Covers Period From/Through” dates (UB-04 field #6)
- ▶ The “From and Through” dates on the claim represent the beginning and end of an episode
 - If the Episode is First Medicaid Episode:
 - From Date: Date of the first billable Medicaid service (a Medicaid Start of Care episode cannot begin until a billable service is provided)
 - Through Date: End of 60-day period or the last date services provided if partial episode
 - If the Episode is a Subsequent Episode (continuous care is provided to patient):
 - From Date: the date immediately following the through date for the previous episode
 - Through Date: End of the 60-day period or the last date of services provided if partial episode

Examples of How to Report From and Through Dates in “Statement Covers Period”

In all 5 cases below: Start of Care is May 1 and Discharge Date is June 1			
Discharge Location	Length of Stay (days)	Dates to be Reported on Claim Form (“Statement Covers Period”)	
		From	Through
Community	32	May 1, 2012	June 29, 2012
Hospital	32	May 1, 2012	June 29, 2012
Another CHHA	32	May 1, 2012	June 1, 2012
MLTC	32	May 1, 2012	June 1, 2012
Death	32	May 1, 2012	June 29, 2012

New Procedures for Completing UB-04 Claims

▶ Interim Claims:

- Must include at least one date of service showing the applicable Revenue Code
- When the final claim for the same episode is submitted, the full final payment is calculated
 - The full final payment is processed as an adjustment or “takeback” of the Interim Claim and payment of the final claim
 - This will be reflected on the remittance in the same way an adjusted claim is shown now under fee-for-service billing
- The TCN on the Final Claim must match the TCN on the Interim Claim
- Interim Claims will be voided after 120 days if no final claim is received

New Procedures for Completing UB-04 Claims

- ▶ All service units billable to Medicaid should be listed on the final claim
- ▶ Any surplus/spend-down amount should be offset on the final claim in fields 39-41 of the UB-04
 - It will be the provider's responsibility to report all surplus/spend-down amounts during the appropriate time period
- ▶ Claims must be submitted within 90 days after the end of the episode

Next Steps

- ▶ DOH to Revise and Publish Billing Instructions by Dec. 31, 2011
- ▶ DOH to finalize statewide rates to be associated with revenue codes (for LUPAs and Outliers) by Feb. 1, 2012
- ▶ DOH to finalize Wage Index Factors by Feb. 1, 2012
- ▶ Additional information regarding the process and timeframe for enrolling certain CHHA patients to MLTCPs/CCMs
- ▶ EPS System will be available for testing beginning Jan. 1, 2012 in eMedNY's "Provider Test Environment" – additional information available at:
https://www.emedny.org/hipaa/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf

Future Updates to EPS Methodology

- ▶ As required by statute, the elements of the EPS (Base price, Medicaid Grouper, outlier payments, etc.) were developed using 2009 claims data, and OASIS-B assessment information which do not reflect the transition of CHHA patients to MLTCPs/CCMs
- ▶ When sufficient data is available from the 2012-13 claims, the Department will re-evaluate the elements of the EPS, including:
 - The Base Year
 - The Base Price
 - The Medicaid Grouper
 - Partial Episodic Payments

Appendix

- ▶ ICD-9 Codes for Diagnoses
- ▶ SAS Code
- ▶ 108 Case Mix Groups, Indices, Rate Codes, Outlier Thresholds
- ▶ Questions and Answers

Questions

To assist the Department in efficiently addressing inquiries about today's Webinar, please direct all questions and comments to:

HCWebinar@health.state.ny.us

Please include provider name and the topic of your inquiry (i.e., Methodology, Billing etc.) in the Subject Line of the email.