EPISODIC PAYMENT SYSTEM FOR CHHAs: ADDITIONAL Q & A

APRIL 10, 2012

1. How will a CHHA bill a PRI assessment for a Medicaid patient? This is usually a one-time skilled nursing visit and no OASIS is completed.

A new Rate Code 4919 has been created to accommodate this situation. This Rate Code is to be used only for Assessments in which total service costs are below the LUPA threshold ($500). Occurrence Code 50 (date of OASIS) will not be required for this Rate Code.

The Case Mix Index for this Rate Code has been set to 0.001. Consequently, if the LUPA threshold is exceeded, the provider will receive an episodic payment of $5.63 (base price of $5633 X 0.001), prior to regional wage adjustment. An Interim Claim would result in a payment of $2.82, prior to wage adjustment. Consequently, providers may wish to submit only Final Claims utilizing this Rate Code.

2. What are the limitations on billing professional services to Medicare and home health aide services to Medicaid during the same period of time?

The Office of the Medicaid Inspector General has clarified an audit protocol for episodic payment that will require that if a patient is dually eligible and the CHHA is billing for both Medicare and Medicaid services, the provider must report 35 hours per week of combined skilled nurse and home health aide services to the Medicare PPS prior to billing the remainder of the home health aide hours during each episodic week to the Medicaid EPS. Only those home health aide services which are properly billable to Medicaid may be listed on the Medicaid claim form after exhausting the maximum reportable billing to the Medicare PPS benefit. Medicaid remains the payer of last resort.

Medicare will cover 35 hours per week of combined skilled nursing and home health aide services. If the services do not exceed the combined number of hours, the Medicaid EPS should not be billed unless for fee for service that is not coverable under the Medicare PPS.

3. How are CHHAs expected to account for workforce monies - specifically the Worker Recruitment & Retention (WRR) and Recruitment, Training & Retention (RTR) funding - under the episodic payment system?

The recruitment and retention funding, as well as the provider requirements for use of the

funding, remain in effect in accordance with current statute (PHIL 3614.8 and 9 -10) through March 31, 2014. The Medicaid episodic methodology payment prices have been determined to include the full amount of the statutorily authorized funding for CHHAs. Under Medicaid episodic payment, agencies will continue to be required to properly provide such funding to direct care workers and to continue to account for the funding in accordance with requirements detailed in the above-noted statutory provisions. The episodic payment prices are based on 2009 expenditure data, which in turn is based on the 2009 per unit fee-for-service rates which contain the historical add-ons for both the recruitment and retention (3%) and the recruitment, training and retention (4.70%) funding.

4. Will an agency be required to transfer all patients with more than two episodes to a Managed Long Term Care Program? Will this apply to patients who have already been under care for more than 120 days when the episodic payment system begins on May 1, 2012?

Information about the timetable and process for transitioning long-term CHHA patients into Managed Long Term Care can be obtained at the following website:

http://www.health.ny.gov/health_care/medicaid/redesign/managed_ltc_workgroup.htm

This site includes extensive information relating to the ongoing efforts of the Managed Long Term Care Implementation and Waiver Redesign Work Group, which is responsible for the development of this process.

For patients 18 and older who are receiving appropriate care from Certified Home Health Agencies and have not yet been enrolled in Managed Long Term Care programs, CHHA services will be billed under the episodic payment system effective May 1, 2012.

5. If a patient's 60-day episode of care extends from June 5 through August 3, but the patient does not meet the spend down requirement for August, the provider can only bill for an episode from June 5 through July 31 (partial episode - 57 days). If the patient was discharged to home on August 3, can the CHHA include this discharge reason in the episodic bill for June 5 through July 31?

No. If the patient has not been discharged on or before day 57 of the episode (the last day billable to Medicaid in this example), the provider cannot report a discharge code on the submitted claim.

6. How will we know if a patient has been or currently is open to another agency?

The New York State Medicaid billing system does not presently have the capability of allowing a CHHA to determine if a specific patient is being served by another agency.

7. How will we bill Medicaid products such as Options, Fidelis, Family Health Plus, etc.?

The Episodic Payment System will apply only to services billed directly to NYS Medicaid by Certified Home Health Agencies on a fee-for-service basis.

8. How will reimbursement be calculated if rates change in the middle of the episode?

Reimbursement will be based on the values in effect at the beginning of the episode for rates, case mix index, outlier thresholds, wage index factors, and the weighted average rates associated with revenue codes.

However, please note that the billed rate code must correspond to the patient's age at the end of the episode.

9. What are the rounding conventions used in the calculation of reimbursement amounts?

For all numbers expressed as dollars and cents, amounts calculated as a half cent or more will be rounded up to the nearest cent. Amounts less than a half cent will be rounded down.

For the base rate reimbursement amount (not including LUPAs or outliers), the statewide base price of $5,633.00 is multiplied by the Case Mix Index applicable to the Rate Code. The result is rounded to the nearest cent. Outlier thresholds are entered in the billing system as whole dollar amounts.

Partial episode reimbursement is calculated by first determining the total reimbursement amount for a full (60-day) episode, applying the Wage Index Factor (see question #10), then dividing by 60 for a daily rate (rounded to the nearest cent), which is then multiplied by the number of days being reimbursed.

10. How does the eMedNY system apply the regional Wage Index Factors?

As previously noted, the 10 regional Wage Index Factors are applied to 77% of the reimbursement amount, representing the estimated average percentage of total costs which are labor-related. The eMedNY system uses a "Single Adjustment Factor" (SAF) which is derived from the Wage Index Factor and is applied to 100% of the total reimbursement amount.

The table below shows the current Wage Index Factors and the corresponding SAFs which will be applied to all episodic reimbursement amounts:

Region	Wage Index Factor 5/1/2012	Single Adjustment Factor 5/1/2012
Capital	0.911944	0.93220
Central New York	1.002872	1.00221
Finger Lakes	1.093141	1.07172
Hudson Valley	1.125693	1.09678
Long Island	1.078872	1.06073
Mohawk Valley	0.955006	0.96535
New York City	0.991433	0.99340
North Country	0.955610	0.96582
Southern Tier	0.866871	0.89749
Western New York	0.903208	0.92547