



**OASAS**

Improving Lives.

NEW YORK STATE

OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES

*Addiction Services for Prevention, Treatment, Recovery*

# Ambulatory Patient Groups

## Introduction to Clinical Services, Billing, and Budgeting Webinar

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# APGs: Introduction and Overview

## APG Webpage

<http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm>

# Why APGs?

## Federal and State Perspective / Benefit

### **Federal Needs:**

- Federal directive to ensure that individual State's Medicaid claiming process are compliant with overall HIPPA claim formats.
- Increased Federal interest in State's development of Medicaid pricing schema that provides greater clarity and transparency of Medicaid payment structure and methodology.

### **State Needs:**

- State's ability to respond to Federal needs listed above.
- Support key component of New York State's overall effort to reform Medicaid reimbursement and rationalize service delivery. This includes encouraging migration of services from inpatient to ambulatory/primary care settings.

# Why APGs?

## OASAS Perspective Clinical and Payment Benefits

- Supports movement by the addictions field towards one outpatient system of care.
- Allows for a range of medically necessary clinic services for patients based on the evidence of what works to promote recovery from chemical dependency.
- Replaces the current threshold visit reimbursement system for OASAS certified programs. The threshold system paid outpatient clinics one service per day and opiate treatment programs one weekly payment, regardless of the resources needed to deliver unique services or the number of services provided.
- Pays for multiple services on same visit date.
- Provides Medicaid reimbursement for some chemical dependence services that were not previously billable, e.g. complex care coordination.
- Allows for some services that are integral to the treatment of patients in chemical dependency treatment such as mental and physical health services.

# APG Development Process

## Discussions Among All Behavioral Health Agencies

- DOH led a multi-agency effort that included OASAS, OMRDD, and OMH.
- APGs are part of an overall State goal to transition Medicaid payment for most physical and behavioral health outpatient services from the current threshold prices to a cost-based pricing structure.
- APGs support disaggregation of the current Medicaid threshold rates and service categories into discrete service categories and payment levels that more accurately define services and reflect Medicaid reimbursable costs associated with delivering a particular service.
- In the OASAS system, APGs will apply to OASAS Certified Part 822, Part 823, and Part 828 Programs.

# APG Development Process

## OASAS Initial Field Input

- OASAS held provider forums to gather provider input on service groupings. In general, the public concerns expressed included:
  - Developed fees should accurately reflect average costs for outpatient services;
  - System-wide Medicaid revenue should not be reduced;
  - The APG pricing and service delivery model should reflect differences between the medical and behavioral health care systems;
  - Changes to the billing system to support APGs should be fully understood and providers should have the appropriate technical assistance to execute timely and accurate Medicaid claims;
  - Overall, pricing and regulatory framework should support patient centered services and movement towards one outpatient system of care.

# APG Services

# How Were the OASAS APG Service Categories Developed?

- Regional forums with Providers to gather input on service categories
- Identified services that occur in outpatient substance abuse settings
- Compared with OMH and OMRDD partners – where shared services APGs will have shared weight
- Compared to National Coding Systems (HCPCS/CPT)

# APG Map

## Service

Screening/Brief Intervention  
or Treatment

Assessment Brief

Assessment Norm

Assessment Extended

Individual Brief

Individual Normative

Intensive Outpatient

Outpatient Rehab

## Service

Group

Family Collateral

Complex Care

Peer Counseling

Outreach

Medication Administration

Medication Management Routine

Medication Management Complex

# Clinical and Medical Staff Definitions

- **Clinical Staff**: Staff who provide services directly to patients, including licensed staff, credentialed staff, non-credentialed staff, and student interns. Clinical staff includes medical staff.
- **Medical Staff**: Physicians, nurse practitioners, registered physician assistants, registered nurses, and licensed practical nurses licensed and/or certified by the State Education Department practicing within the scope of, and in accordance with, the terms and conditions of such licenses and certifications, and working with, or under the supervision of, a physician, if required by law.
- **Prescribing Professional**: Is any medical professional appropriately licensed under New York State law and registered under federal law to prescribe approved medications.

# Physical Health Services\*

Programs may bill from a limited list of Evaluation and Management (E/M) code list when medical staff provide substance abuse related physical health services for example:

- HIV Infection
- Diabetes
- Skin Ulcers
- Smoking Cessation Treatment

\* A full list of codes is pending approval

# APG Service Payment Development

# Elements of an APG Service Payment

## Each Element Defined

- **APG Service Categories:**
  - The map with APG Service Billing Categories.
- **Weight:**
  - Each APG has an associated payment weight based on service intensity, e.g. the resources needed to provide the service.
- **Case Mix Index (CMI):**
  - CMI means the average service weight of the total services delivered. The total volume of each service multiplied by the weight of that service – each service category is added to create the total CMI.
- **Base Rate:**
  - Base Rates are established for peer groups. Within each peer group, the downstate and upstate counties have differing rates.

# How Were the Service Weights Developed?

- Weights were developed through benchmark pricing for each service category – What do we want the service to pay?
- The benchmark prices were vetted through the APG committees
- This allowed the agencies to establish a relative weight or service intensity – for example:
  - Group is weighted at .3207
  - Individual Normative is weighted at .8275  
(Individual Normative is a higher service intensity and will pay higher than Group)

# Case Mix Index

- OASAS used actual billed visit data from eMedNY and provider reported visit data from Client Data System (CDS) to determine the current service pattern intensity or Case Mix Index (CMI)
- CMI means the average service weight of the total services delivered or the total volume of each service multiplied by the weight of that service – each service category is added for a total CMI
- The Average CMI for Part 822 is .4217 and for Part 828 .1900
- OASAS projected conservative service delivery for new APG's to determine the CMI

# Base Rate

The Base Rate was calculated by dividing the total weighted services into the total 2008 Medicaid Revenue for Each Peer Group.

# Peer Groups

Groups of Providers that are similar in cost and case mix

- Hospital (DOH Base Rate) Upstate/Downstate
- Part 822 (Part 822.4) Upstate/Downstate
- Part 828 (Part 822.5) Upstate/Downstate

# Phase One Base Rates

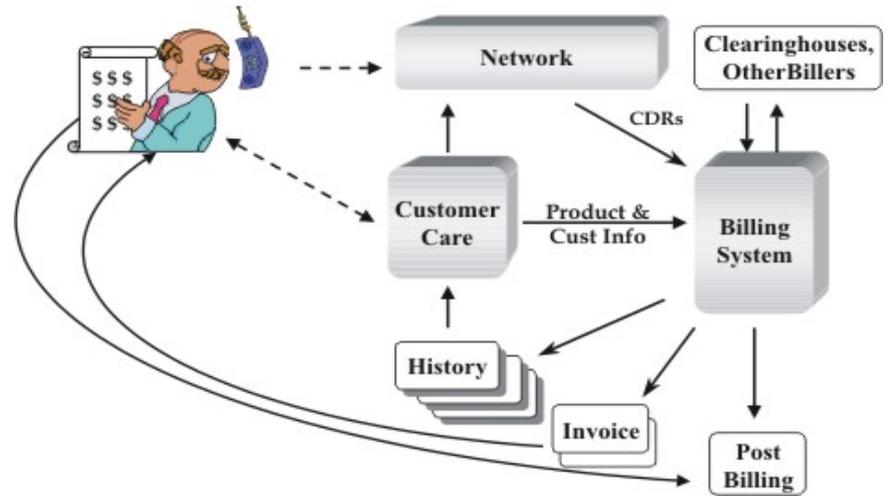
<b>Base Rate (See Note One)</b>	<b>Downstate (DS)</b>	<b>Upstate (US)</b>
<b>Methadone</b>	\$159.17	\$136.04
<b>Outpatient Clinic</b>	\$172.69	\$147.59

# How Will The Base Rate Be Adjusted?

- Base Rates will be adjusted, at least, annually but can be adjusted more frequently.
- Base Rate adjustments will be based on actual Medicaid billing patterns.
- The current Base Rate was adjusted to cost and pays the average cost per service.

# How Can I Prepare for Base Rate Adjustments?

- Use the current Base Rate when budgeting revenue calculations for next year.
- Recognize that the Base Rate may decrease/increase within that budgeted year and plan accordingly.
- The phase-in period should be protective as providers learn to adjust for APG fluctuation and the Base Rate settles as actual billing patterns are determined.



# Billing Process and Rules





**Upon conversion to the APG payment structure, the former rate codes will be eliminated and providers must bill Medicaid using CPT / HCPCS codes.**

# Outpatient Clinic Billing Components

- Under APGs, programs will now be able to submit one claim per patient per day AND that claim will reflect multiple services lines.
- The claim will correspond with the actual visit date and the multiple lines will represent all the services delivered on one day.

# Methadone Program Billing Components

- Opioid Treatment Program (OTP) claims will be submitted using a weekly episode of care construct. As with the prior weekly threshold claims process, APGs will also have one weekly episode claim per opiate patient submitted.
- However, under APGS the single episode claim will potentially include multiple CPT or HCPCS codes to reflect the services that are delivered on the individual days encased within the episode.

# How to Calculate the Phase-In Payment Outpatient Clinic

75% of the provider's pre-APG Medicaid payment	+	25% of the full APG payment for that service	=	APG payment for a single service
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# How to Calculate the Phase-In Payment

## Methadone Program Phase One

75% of Weekly Rate

+

25% of each APG

=

Total Weekly Billing

# Discounting

- In those instances where more than one procedure/service applies to a visit, the highest value procedure shall be paid at its full-fee value.
- Payments for additional procedures related to the visit will be discounted by 10 percent; with the discount applied to the APG payment portion of the claim.

# APG Phase-In For Freestanding Programs

	<b>Current Threshold Legacy Payment</b>	<b>APG Payment</b>
Phase 1	75%	25% of the full APG Payment
Phase 2	50%	50% of the full APG Payment
Phase 3	25%	75% of the Full APG payment
Phase 4	0	100% of the full APG Payment

# Outpatient Clinical and Billing: Example

	Monday		Tuesday		Wednesday		Thursday	
W e e k O n e	<u>Service</u>	<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>	<u>Code</u>	<u>Service</u>	<u>Code</u>
	Assessment Extended	<b>H0002</b>	Assess Brief	<b>T1023</b>	Individual Normative 45 mins	<b>G0397</b>	Multi-Family Group - Collateral Visit	<b>90849</b>
	Collateral Contact	<b>T1006</b>			Group	<b>90849</b> 10% discount applies		
					Collateral Contact	Not billed		

# Clinical and Billing Example: Methadone

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		Assessment Extended <b>CODE H0002</b>  Medication Management Complex <b>CODE 90862</b>  Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>  Individual Brief 25 mins <b>CODE G0396</b>	Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>	

# Revenue Calculator

# OASAS APG Revenue Calculator

- Overview –
  - Excel Based models available on OASAS website
  - Calculators enable revenue projections to support transition planning
  - Strengthen familiarity with “APG logic”
  - Up-to-date definition of CPT services, weights, peer group rates, and calculation rules
  - Easily updated on website, as elements change
  - Excel flexibility:
    - Modify to provider environment
    - Add supplemental financial, statistical, staffing resource schedules
    - Excel 97-03, upward compatible with Windows Vista & 2007

# OASAS APG Revenue Calculator

- Models Available –
  - Freestanding: Part 822 Clinic and Part 828 Clinic
  - Hospital-Based: Part 822 Clinic and Part 828 Clinic
- Key Questions for Projections –
  - How will current volumes relate to CPT services?
  - What currently non-reimbursable services become billable?
  - What new services may become financially viable to better meet client's needs?

Questions/Comments

# Need More Information?

- OASAS APG WEBPAGE:

<http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm>

- APG Questions: [APG@oasas.ny.gov](mailto:APG@oasas.ny.gov)