

APG Revenue Calculator Instructions

BACKGROUND

The APG Revenue Calculator is a tool developed to assist providers in projecting their Medicaid revenues for Part 822 Clinics and Part 828 Clinics during APG implementation. The Excel spreadsheet enables providers to enter volume projections for each APG service category and, thereby, project Medicaid reimbursement for APGs. The tool provides revenue projections for each phase-in period as well as at full APG implementation. In addition, the tool provides supplemental information on the intensity of services, revenue per unit of service, and staff utilization. Freestanding clinics should use the Freestanding Program APG Revenue Calculator. Hospital-Based clinics should use the Hospital-Based Program APG Revenue Calculator and refer to additional instructions in the addendum attached to these instructions.

OPENING THE EXCEL APG REVENUE CALCULATOR FILE

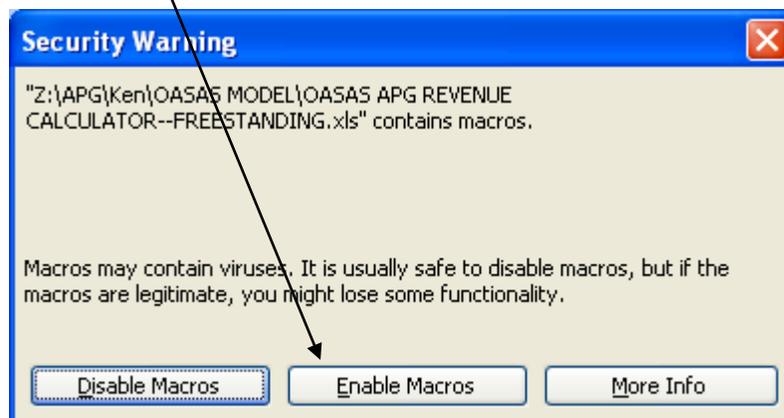
Since the Freestanding Program and the Hospital-Based Program APG Revenue Calculator files utilizes macros, it is important to verify that macros are enabled. Depending on the version of Excel that is being used, the method to check the macro security varies.

- For Excel 2007, **Open** the APG Revenue Calculator file. When the file opens, under the Tool bar but above the Formula bar, the following message may appear “**Security Warning** Some active content has been disabled Options.” On that line, click on the **Options** button. A Microsoft Office Security Options box will open. Under Macros & ActiveX, **Click** on the button for Enable this content and then click **OK**.
- For Excel 2003, **Open Excel**. From the Tool bar, select **Tools**. If a short list of options appears with a round button with down arrows at the bottom of the list, **click on the round button** and then click on the line that reads **Macro**. If a long list appears when **Tools** is selected from the Tool bar, then click on the line that reads **Macro**. From here, select **Security**. Next, a dialog box entitled Security will open. On the Security Level tab, select **Medium** and then click **OK**.

Now proceed to **Open** the APG Revenue Calculator file.

Even though the macro security has been set to Medium, when opening this file, a Security Warning dialog box may still appear.

Please click on the **Enable Macros** button, if this box appears.



DEFINITIONS

<ul style="list-style-type: none"> ▪ Annual Medicaid Revenue: The Medicaid revenue for clinic services covering a 12 month period. 	<ul style="list-style-type: none"> ▪ Hospital Based Programs: Clinic programs operated under the corporate control of a hospital.
<ul style="list-style-type: none"> ▪ APG Blended Payment: An APG reimbursement made during phase-in consisting of a portion of the legacy payment and a portion of the APG payment. 	<ul style="list-style-type: none"> ▪ Legacy Payment: The Medicaid reimbursement rate preceding APG implementation.
<ul style="list-style-type: none"> ▪ APG Full Payment: The reimbursement that will be made based on the full amount that the APG methodology calculates for the delivered service. 	<ul style="list-style-type: none"> ▪ Medicaid Rate Per Service: The amount reimbursed for each APG service. This is calculated by multiplying the assigned APG Peer Group Base Rate by the assigned weight for the APG service.
<ul style="list-style-type: none"> ▪ APG Peer Group Base Rate: The reimbursement rate assigned to a peer group. ▪ APG Weight: The numeric value that reflects the relative expected average resource utilization for each service. 	<ul style="list-style-type: none"> ▪ OASAS Ambulatory Patient Groups Policy and Medicaid Billing Guidance Manual: The document which provides clinical and billing advice/direction for APG categories. ▪ Service: A Part 822/828 APG service category.
<ul style="list-style-type: none"> ▪ Average Weekly Number of Medicaid Persons Served: For Part 828, Opiate Treatment programs, the number of unique Medicaid patients served in a week regardless of the number of times the recipient visits the clinic in a week. 	<ul style="list-style-type: none"> ▪ Second Service: An additional service provided to a patient on a single visit day. ▪ Service Volume: Number of services.
<ul style="list-style-type: none"> ▪ Downstate Peer Group: The five counties comprising New York City (Bronx, Kings, New York, Queens, and Richmond counties), and the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, and Westchester. 	<ul style="list-style-type: none"> ▪ Second Service Discount: A price reduction assigned to the lower weighted service delivered on the same visit day, to the same patient. ▪ Upstate Peer Group: All counties not listed in the Downstate Peer Group.
<ul style="list-style-type: none"> ▪ Freestanding Programs: Non-Hospital based programs. 	<ul style="list-style-type: none"> ▪ Visit: One or more services provided to a patient on a single given day.

EXPLANATION OF DATA ENTRY FIELDS

TAB A--Part 822 APG Revenue and TAB D--Part 828 APG Revenue Tabs

These tabs (TAB A and TAB D) project Medicaid Revenue based upon volume estimates entered for each APG service category. **THESE ARE THE ONLY TABS THAT REQUIRE DATA ENTRY.**

The type of program you operate determines which tab is selected: Part 822 programs should select Tab A and Part 828 programs should select Tab D. Throughout the instructions, you only enter data in the Tab you selected based upon your program type. Hospital-Based clinics should, also, refer to the Addendum for Hospital-Based Clinics.

THE FIELDS THAT CAN/NEED TO HAVE DATA ENTERED ARE HIGHLIGHTED IN YELLOW ON TAB A AND TAB D.

➤ At the Top of TAB A for Part 822 Providers and TAB D for Part 828 Providers:

1. **Click** on the YELLOW box to the right of “Enter Your APG Peer Group Designation of Downstate or Upstate From the Drop Down List”, **Click** on the down arrow for the Drop-Down menu and **Select** Downstate or Upstate depending on your clinic’s APG Peer Group Designation.

APG Peer Group counties are as follows:

- Downstate: The five counties comprising New York City (Bronx, Kings, New York, Queens, and Richmond counties), and the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, and Westchester.
 - Upstate: All other counties.
2. **Enter** your program’s Legacy Rate using the table named OASAS Legacy Rates. If your program receives an Article 28 Diagnostic and Treatment Center rate, enter this rate as the legacy rate.
 3. **Enter** the most recent annual Medicaid revenues for your Part 822 or Part 828 program. This revenue will be used to provide a comparison of current revenues to projected revenues during implementation of APGs.
 4. Part 828 providers only, **Enter** the Average Weekly Number of Medicaid Patients Served in Your Part 828 Clinic. When determining the number of persons served, count each person served only once regardless of the number of times they visit the clinic in a week.
 5. Data needs to be **Entered** in Column I and Column L. See explanation of Column I and Column L below for data entry details.

EXPLANATION OF TABS

- Explanation of each column in Tab A—Part 822 APG Revenue and Tab D—Part 828 APG Revenue
- **Column B--APG Number** and **Column C--OASAS Service Category** is a list of all OASAS APG service categories and some physical health service categories. The model does not include other APG service categories which might be billed during a patient visit, e.g. a Mental Health service.
 - **Column D--Previous Medicaid Billing Codes** cross-references existing OASAS Medicaid billing codes to APG service categories to assist providers who choose to assign volume using existing billing code information. Please note: there are several instances in which “Previous Medicaid Billing Codes” appear under multiple APG service categories. In most instances, when a previous Medicaid billing code appears in multiple APG service categories, it is because the service is offered for various time intervals compared to just one choice under Threshold pricing. Providers will need to think about the service being provided and determine which APG service category CPT/HCPCS code is appropriate to bill.
 - **Column E--CPT/HCPCS Codes** and **Column F--CPT/HCPCS Code Service Description** is a list of OASAS Part 822/Part 828, Smoking Cessation, and Physical Health/Exam APG CPT/HCPCS codes with existing service code definitions. (Note: The service definitions and associated CPT or HCPCS codes listed in the calculator are for the purpose of billing the New York State Medicaid program. It is recognized that in some instances the OASAS service definition and applicable CPT or HCPCS codes may vary from the service definition listed in the CPT or HCPCS manuals; and/or, be different from codes that are used with commercial or Medicare billing. However, when billing the New York State Medicaid system, programs must use the code in Column E--CPT/HCPCS Codes for the OASAS Service Category provided in Column C. For additional clarification or information, providers should refer to definitions in the Ambulatory Patient Groups Policy and Medicaid Billing Guidance Manual available on OASAS’ website: <http://www.oasas.ny.gov/admin/hcf/APG>
 - **Column G--APG Weight** identifies the weight assigned to each APG service category.
 - **Column H--Medicaid Rate Per Service** shows the Medicaid amount reimbursed per service for each APG service category. The Medicaid rate is determined by multiplying the designated OASAS APG Peer Group Base Rate by the assigned APG weight for each APG service category.
 - **Column I--ENTER Yearly Projected Service Volumes** is used to enter the clinic’s estimated yearly projected Medicaid service units for each APG service category.

THIS IS A YELLOW HIGHLIGHTED COLUMN AND REQUIRES DATA ENTRY.

- **Enter** the total estimated number of Medicaid units for each APG service category on the appropriate lines in this column.

For each OASAS Service Category, determine the number of Medicaid units your program expects to provide annually. This number should be the total estimated service units for each APG service category including projected second services that may be provided on the same day.

- APGs do not change/impact the current policy for the ordering of or payment of lab services. As such, lab services should not be reflected in the APG Revenue Calculator.
 - Smoking Cessation has been included in the APG Revenue Calculator to assist providers in estimating their Medicaid Revenue. This category of service will pay using the APG Peer Group selected above. This service does not receive a 2nd service discount.
 - Physical Health and Physical Exam services are provided on the APG Revenue Calculator to assist providers in estimating their Medicaid Revenue. These services do not receive a 2nd service discount.
- **Column J--WEIGHTED Yearly Projected Service Volumes** calculates the number of weighed units provided for each APG service category. The calculation multiplies the weight for the APG service by the Yearly Projected Service Volume units for each APG service category.
 - **Column K--Projected Medicaid Revenue Before 2nd Service Discount** calculates the total annual Medicaid revenue, before any discounting, for each APG service category based upon the number of units entered. The calculation multiplies the Yearly Projected Service Volume units by the Medicaid Rate Per Service for each APG service category.
 - **Column L--ENTER Yearly Projected Number of 2nd Services** is used to enter the estimated number of Medicaid second services expected to be provided.

THIS IS A YELLOW HIGHLIGHTED COLUMN AND REQUIRES DATA ENTRY.

A second service is an APG service category provided with another APG service category to the same recipient, in one visit, and both services may be reimbursed. Two of the same APG service categories may not be reimbursed on the same visit.

- **Enter** the number of projected Medicaid second services expected to be provided.

From the estimated yearly projected Medicaid service units reported in **Column I-ENTER Yearly Projected Service Volumes** for each APG service category, estimate how many of these service units will be provided on the same day, to the same recipient.

Certain APG services are not considered a second service for purposes of discounting. The cells for these services are gray-shaded and no data should be entered in the cell.

Listed below are the APG services excluded from the second service discount:

▪ Complex Care Coordination	90882
▪ Intensive Outpatient Service	S9480
▪ Medication Admin & Observ	H0033
▪ Medication Admin & Observ	H0020
▪ Med Mgt & Monit-Routine	H0014
▪ Med Mgt & Monit-Routine	M0064
▪ Med Mgt & Monit-Complex	90862
▪ Outpatient Rehab-Half Day	H2001
▪ Outpatient Rehab-Full Day	H2036
▪ Peer Counseling	H0038
▪ Physical Health-New Pt	99201-99205
▪ Physical Health-Exist'g Pt	99212-99215
▪ Physical Exam-New Pt	99382-99387
▪ Physical Exam-Exist'g Pt	99392-99397
▪ Smoking Cessation	G8402
▪ Smoking Cessation	G8403
▪ Smoking Cessation	S9075

- **Column M—2nd Service Discount** calculates the amount of discount for second services in each APG service category. Except for the services listed above as excluded, second services are discounted 10%. The lower weighted service is discounted. The calculation multiplies the Yearly Projected Number of 2nd Services units by the Medicaid Rate Per Service for each APG service category and then multiplies the results for each APG service category by 10%.
- **Column N--Projected Medicaid Revenue after Discount** calculates the total annual Medicaid revenue for each APG service category after the 2nd service discount.
- **Column O--Blend or Full** illustrates the type of payment the APG service category receives during phase-in. Blend means that that APG service category receives a portion of the legacy payment and a portion of the APG payment. Full means that the APG service category receives the full portion of the APG payment and no portion of the legacy payment.
 - The APG services listed below will be reimbursed at the Full APG payment amount at implementation. The phase-in of legacy payment and APG payment does not apply to these services.

▪ Complex Care Coordination	90882
▪ Med Mgt & Monit-Routine	H0014
▪ Med Mgt & Monit-Routine	M0064
▪ Med Mgt & Monit-Complex	90862
▪ Peer Counseling	H0038
▪ Physical Health-New Pt	99201-99205
▪ Physical Health-Exist'g Pt	99212-99215

(continued on next page)

- Physical Exam-New Pt 99382-99387
- Physical Exam-Exist'g Pt 99392-99397
- Smoking Cessation G8402
- Smoking Cessation G8403
- Smoking Cessation S9075

- **Row 44--Summary of Units and Revenues** on the lower part of this spreadsheet shows a summary of the number of service units and revenues, including 2nd service units and total revenue with 2nd services discounting. These totals represent Medicaid revenues at **full** APG implementation.

The **Statistical Data** chart on this tab is discussed under Tab C-Part 822 Scenario Saver and Tab F-Part 828 Scenario Saver.

➤ Explanation of each column in **TAB B—PART 822 Phase In** and **TAB E—PART 828 Phase In**

These tabs (TAB B and TAB E) illustrate the impact of APG projected service volumes and anticipated revenue information from **TAB A—Part 822 APG Revenue** or **TAB D—Part 828 APG Revenue** for each phase-in period.

Data entered by the provider on Tab A or Tab D is used in Tab B or Tab E to calculate the projected Medicaid revenues for each Phase-In period

For Freestanding Programs, APG reimbursement implementation is being phased-in over a 30 month period. Phase 1 is a 12 month period, Phase 2 is a 12 month period, Phase 3 is a 6 month period, with full APG implementation beginning January 1, 2014.

Each phase-in period consists of a “blended” payment which includes a percentage of the “legacy” payment and a percentage of the APG payment.

- Phase-In Percentages for Freestanding Programs*:
 - Phase 1: 75% of Legacy payment plus 25% of APG payment
 - July 1, 2011 – June 30, 2012
 - Phase 2: 50% of Legacy payment plus 50% of APG payment
 - July 2, 2012 – June 30, 2013
 - Phase 3: 25% of Legacy payment plus 75% of APG payment
 - July 1, 2013 – December 31, 2013
 - Full Implementation: 100% APG payment
 - Begins January 1, 2014

*The following APG categories pay at full APG reimbursement regardless of the phase-in period:

- 426--Med Mgt & Monit
 - 451--Smoking Cessation Treatment
 - 490--Complex Care Coordination/Peer Services
 - 840--Physical Health/Physical Exam-Opioid Dependence
 - 841--Physical Health/Physical Exam-Cocaine Dependence
 - 842--Physical Health/Physical Exam-Alcohol Dependence
 - 843--Physical Health/Physical Exam-Other CD
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- **Line 5--Phase-in/Phase-out** through Line 8 provides the Legacy phase-out and APG phase-in blend percentages.
 - **Line 10--Legacy Revenue & Rate Projection** through Line 14 calculates the legacy portion of the blended revenue for each phase-in period.
 - **Line 16--APG Revenue & Rate Projection** through Line 24 calculates the APG portion of the blended revenue for each phase-in period.
 - **Line 26--Legacy and APG Revenue Summary** through Line 29 illustrates the total blended revenue for each phase-in period.
 - **Line 31--Revenue Comparison** through Line 34 shows a comparison of each phase-in period’s Medicaid revenue with the provider’s self-reported Annual Medicaid revenue. The anticipated Change In Revenue is, also, illustrated.

➤ Explanation of **Tab C—Part 822 Scenario Saver** and **Tab F—Part 828 Scenario Saver**

Tab C for Part 822 programs and Tab F for Part 828 programs allows users to save up to six different revenue calculator scenarios, shown side by side, so a comparison can be made of several scenarios. These tabs are linked to the data and calculations contained in Tab A and B or Tab D and E. The blue highlighted column is the current scenario. To save the results of the current scenario, choose a scenario column and click on the button labeled “CLICK HERE TO COPY CURR SCENARIO.”

The following is an explanation of each data set contained in the scenario saver:

▪ **Projected APG Revenue Data Set**

○ **APG Projected Revenue for Part 822/828 Services**

This is the projected APG Medicaid revenue associated with services provided in Part 822/Part 828 programs.

○ **APG Projected Revenue for Smoking Cessation Services**

This is the projected APG Medicaid revenue associated with APG Smoking Cessation services.

○ **APG Projected Revenue for Physical Health/Physical Exam Services**

This is the projected APG Medicaid revenue associated with APG Physical Health/Physical Exam services.

○ **APG Projected Revenue Total**

This is the sum of projected APG Medicaid revenue for Part 822/828 services, Smoking Cessation services and Physical Health/Physical Exam services at Phase 4—Full Implementation.

○ **Medicaid Revenue Prior to APG Implementation**

This is the annual Part 822 or Part 828 Medicaid revenue reported by the provider on Tab A or Tab D. The Medicaid revenue reported is prior to APG implementation.

○ **Change in Revenue After Full APG Implementation**

This amount is the difference between the APG Projected Revenue Total at Phase 4 and Medicaid Revenue Prior to APG implementation.

▪ **Phase-In Data Set**

This represents the projected Change In Revenue for each phase-in period. The amount shown for each Phase of implementation is the difference between the APG Projected Phase-in Revenue Total for that Phase and Medicaid Revenue Prior to APG Implementation.

Note: Phase 1 and Phase 2 each represent a 12 month period at the particular phase-in rates. For Phase 3, the calculation represents 6 months at 25% Legacy payments and 75% APG payments plus 6 months at 100% APG payments. Phase 4 represents 100% APG payments.

- **Projected Service Volume Data Set**

This data set captures and analyzes projected service volumes entered on Tab A or Tab D.

- **Projected Total Service Volume Unweighted**

This is the sum of the service volume entered on Tab A or Tab D for each APG category with no differentiation for service weight (intensity).

- **Projected Total Service Volume Weighted**

This is the total service volume after applying the APG weight to the service volume for each APG service category. This provides an indicator of the intensity of resources utilized for the projected service volume.

- **Average Total APG Weight (Case Mix Index)**

This is the average weight of all services provided. It is calculated by dividing the Projected Total Service Volume-Weighted by the Projected Total Service Volume-Unweighted.

At the top of Tab C and Tab F is the statewide average APG weight (case mix index) which can be used as a baseline to compare your service intensity.

- **Average Reimbursement Data Set**

- **Average Reimbursement Per Unweighted Service**

This is the average Medicaid reimbursement for each unweighted service. The average reimbursement does not reflect service intensity. The calculation is APG Projected Revenue Total divided by Projected Total Service Volume-Unweighted.

- **Average Reimbursement Per Weighted Service**

This is the average Medicaid reimbursement for each weighted service. A higher average reimbursement reflects higher weighted service volumes. The calculation is APG Projected Revenue Total divided by Projected Number of Weighted Services.

- **Projected APG Revenue Per Part 828 Medicaid Client**

(Part 828 Providers only)

This is the average Medicaid revenue projected to be received per Part 828 Medicaid client based upon clients served and projected service volumes. This is calculated by dividing the APG Projected Revenue Total by the Average Weekly Number of Medicaid Persons Served in your Part 828 Clinic.

- **Projected Service Volume Distribution Data Set**

- **Unweighted Service Volume**

The numbers in this column represent the Yearly Projected Service Volumes entered on Tab A or Tab D for each APG service category.

- **Distribution By Percentage**

This column illustrates the percentage of services attributable to each APG service category. The calculation is the Yearly Projected Service Volume for the individual APG service category divided by Projected Total Service Volume Unweighted.

ADDENDUM FOR HOSPITAL-BASED CLINICS:

Hospital-Based Clinics should use the Hospital-Based Program APG Revenue Calculator.

▪ **Data Entry Fields**

- For TAB A for Part 822 Providers and TAB D for Part 828 Providers:

- **Enter** your program's Legacy Rate. This is the rate your program is currently receiving. Please remember to only enter the rate assigned from Dept. of Health. Do **NOT** include the Capital Add-On portion of the rate.

▪ **Phase-In Periods**

APG reimbursement for Hospital Based clinics begins at Phase 2 and consists of a "blended" rate which includes a percentage of the "legacy" payment and a percentage of the APG payment. Each phase-in period has a distinct Base Rate for calculating APG payments for that particular period.

▪ **Phase-In Percentages**

- Phase 2: 50% of Legacy payment plus 50% of APG payment
(Commencement of APGs through December 31, 2010)
- Phase 3: 25% of Legacy payment plus 75% of APG payment
(January 1, 2011 through December 31, 2011)
- Full Implementation: 100% APG payment
(January 1, 2012)

▪ **Phase-In Base Rates**

The current Hospital base rates can be found on Tab A and Tab D of the OASAS Hospital-Based Program APG Revenue Calculator.

▪ **TAB B—Part 822 Phase In and TAB E—Part 828 Phase In**

For the Phase In tabs, each phase-in period has the respective Base Rate applied to the Yearly Projected Service Volumes that were entered on Tab A or Tab D.

▪ **TAB C—Part 822 Scenario Saver and TAB F—Part 828 Scenario Saver**

The Current Scenario illustrated on the respective Scenario Saver tabs uses the Base Rates assigned at Full Implementation.

For an electronic copy of the APG Revenue Calculator, visit OASAS's website:

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

If you have any questions about the APG Revenue Calculator, please contact your respective OASAS Field Office Representative or send an e-mail to:

APG@oasas.ny.gov