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METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR HOSPITALS LICENSED BY THE
OFFICE OF MENTAL HEALTH

In accordance with the New York State Mental Hygiene Law, the State's Office of Mental Health establishes Medicaid rates of reimbursement for hospitals issued operating certificates by the Office of Mental Health. The class of facilities defined as hospitals includes the subclass of Residential Treatment Facilities for Children and Youth ("RTFs") which furnish inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by the Director of the Budget. The Methods and Standards set forth below do not apply to hospitals operated by the Office of Mental Health or to hospitals licensed by the Department of Mental Health.

A. HOSPITALS OTHER THAN RESIDENTIAL TREATMENT
FACILITIES FOR CHILDREN AND YOUTH

1. OPERATING COSTS

Medicaid rates are established prospectively and are all inclusive, taking into account all allowable patient days and all allowable costs and are effective for a twelve month period. Payment rates for a rate year are based on base year financial and statistical reports submitted by hospitals to the Office of Mental Health. The base year is the fiscal year two years prior to the rate year. The financial and statistical reports are subject to audit by the Office of Mental Health.

Allowable base year operating costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and must relate to patient care. Allowable costs may not include costs for services which have not been approved by the Commissioner.

Hospitals which have no previous costs or operating experience will submit a budget report as the basis for calculating a prospective Medicaid rate. The budget report will contain all proposed revenues and expenses for the period under consideration. The operating cost component of the rate will be the lower of the calculated per diem, utilizing the approved budgeted operating costs and the approved budgeted patient days, or 110% of the statewide weighted average of the operating cost component of all private psychiatric hospitals. The hospital is required to submit a cost report after it has operated for six months at a minimum occupancy level of at least 75%. This cost report will be used to set a cost based rate for the hospital effective the first day of the cost report period.

TN #92-15

Supersedes TN #91-15

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In determining allowable operating costs for any base year there is applied a limitation, which is derived from the fiscal year one year prior to the base year, increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. Both the base year and the limitation are subject to an administration cost screen. The administration cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e. the same cost year the limitation is derived from), and is the group average cost plus ten percent. Separate administration cost screens are calculated for hospitals greater than 100 beds (group one), and hospitals less than 100 beds (group two). The allowable costs are the lesser of the base year operating costs or the limitation. The allowable operating costs are then increased for inflation to the rate year by the Medicare inflation factor described above, except that the 1996 Medicaid rates will not include an inflation factor for 1996 effective July 1, 1996, and the 2010 Medicaid rates will not include an inflation factor for 2010 effective January 1, 2010, and the 2014 Medicaid rates will not include an inflation factor for 2014 effective January 1, 2014. Such inflation factor shall be as determined by the Federal Government each year prior to the effective date of the payment rates calculated herein.

Rates of payment in effect on December 31, 2011, will continue in effect for the periods January 1, 2012 through December 31, 2012, and January 1, 2013 through December 31, 2013.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

[1]2. CAPITAL COSTS

[To] [a] Allowable capital cost will be added to allowable operating costs [are added allowable capital costs]. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

The allowed capital cost component of the budget based rate will be based upon approved annual budgeted costs and approved budgeted patient days retroactively adjusted to actual certified costs divided by the higher of the actual patient days or the approved budgeted patient days.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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Supersedes TN #12-0027 Effective Date January 1, 2014

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3. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

If it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the hospital because a medically necessary long term care bed is not available in the community ("alternate care determination"), and it is determined by the Commissioner that there is a significant excess of operational beds at the hospital or in private psychiatric hospitals located in the OMH region in which the hospital is located, the hospital will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services were furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the hospital for the most recently reported twelve month period is less than 80%, of the hospitals bed capacity, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in the OMH region if the overall occupancy rate for private psychiatric hospitals in the region is less than 80%. Alternate care days are counted as occupied beds. Effective October 1, 1984, occupancy rates will be determined without including alternate care days.

Alternate care determinations must be reported to the Office of Mental Health ("OMH") on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data.

TN #92-15

Supersedes TN #91-15

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New York
2B

[4. Additional Disproportionate Share Payment

The State’s methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State’s Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household’s regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to the hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient’s eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person’s eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person’s current valid official benefits card or a copy of an eligibility verification confirmation received from the Department’s Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.]

Due to State’s reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for hospitals licensed by the Office of Mental health does not include a disproportionate share adjustment.

TN #11-0016- B

Approval Date 07/26/2018

Supersedes TN #96-40-B

Effective Date 01/01/2011

New York
2C

[A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process, and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.]

TN #11-0016-B

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Approval Date 07/26/2018

Effective Date 01/01/2011

New York
2D

5. **Compensation Increases for Eligible Rate Based Programs.**

- a. **January 1, 2020 Increase.** Rates will be revised to incorporate a two percent increase to total salaries for direct care and direct support professional employees. The compensation increase will be included in the provider's cost base used to develop rates beginning effective January 1, 2020. The compensation increase funding will include associated fringe benefits.

- b. **April 1, 2020 Increase.** In addition to the compensation funding increase effective January 1, 2020, providers will receive a two percent increase to total salaries for direct care, direct support and clinical professionals effective beginning April 1, 2020. The compensation increase funding will include associated fringe benefits. The compensation funding increase for the nine-month period of April through December will be included in the provider's cost base used to develop rates beginning effective January 1, 2020 for an annualized payment.

- c. The compensation funding increase as stated in paragraphs 5a and 5b will be included in the cost base used for rate development until such time the increased costs are included in the cost base.

TN #20-0019

Approval Date June 4, 2020

Supersedes TN NEW

Effective Date January 1, 2020

New York

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1905(a)(16) Inpatient Psychiatric Hospital – PRTF**B. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH**

Medicaid rates for Psychiatric Residential Treatment Facilities for Children and Youth (“PRTFs”) are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The PRTF fiscal year and rate year are for the twelve months July 1 through June 30. Alternate Cost Reports will be utilized to align with appealed rate periods until such time that the appealed information would be fully reflected in the facilities annual cost report. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 90 percent. The minimum utilization requirements will be waived by the Commissioner of the Office of Mental Health (OMH) if provider visit volume falls below 90% due to public health, natural, or environmental emergencies, or in the case of suspended admissions resulting from an inability to maintain required operational standards. Such reduction in minimum utilization requirements will not be less than 50%.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the OMH and effective on or after July 1, 2022, will exclude eligible medically necessary early and periodic screening, diagnostic and treatment (EPSDT) services that are not otherwise included in the PRTF rate when those services are reflected in the youth’s plan of care. EPSDT services not provided by the PRTF will be reimbursed directly to the provider of service using the Fee-for-Service Program for Institutional or Non-Institutional payment methods authorized under attachments 4-19-A and 4.19-B of the State Plan and administered by the New York Department of Health commencing on the date the child is determined to be Medicaid eligible. The cost of those EPSDT services provided to the child before the determination of Medicaid eligibility will be the responsibility of the PRTF and considered an allowable cost in the development of the provider’s reimbursement rate for Medicaid PRTF stays. The EPSDT services that are not included in the PRTF rate after Medicaid eligibility is determined, include but are not limited to:

- (i) Specialty physician and physician’s assistant nursing services,
- (ii) Specialty services of Nurse Practitioners,
- (iii) Dental services,
- (iv) Eye and low vision services,
- (v) Audiology services,
- (vi) Laboratory and radiology services,
- (vii) Physical therapy services,
- (viii) Durable medical equipment,
- (ix) Prosthetics and orthotics,
- (x) Prescription and physician ordered non-prescription drugs and medical supplies,
- (xi) Inpatient hospital care,
- (xii) Outpatient hospital care,
- (xiii) Emergency room visits,
- (xiv) Urgent Care Center visits,
- (xv) Family planning and reproductive health care services and supplies,
- (xvi) Neuropsychological testing/evaluation services, and
- (xvii) Ambulance transportation services (emergency and non-emergency).

TN #22-0078 _____

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Supersedes TN #20-0062 _____

Effective Date July 1, 2022

**New York
3(a)**

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

In determining the allowability of costs, the OMH reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the PRTF. The categories of costs include:

- (i) Clinical/Direct Care (C/DC). This category of costs includes salaries and fringe benefits for clinical and direct care staff.
- (ii) Administration, Maintenance and Supports (AMS). This category of costs includes the costs associated with administration, maintenance and child support.
- (iii) Purchased Health Services (PHS). This category of costs includes clinical services such as MD on call and response, purchased on a contractual basis and not subject to the clinical standard if the services are not uniformly provided by all PRTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

Allowable per diem operating costs in the category of C/DC are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount.

Allowable per diem operating costs in the category of AMS are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the C/DC and AMS categories are computed as follows. For PRTFs located in the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all PRTFs in this geographic area and 25 percent of the average per diem cost for all PRTFs in the state; increased by seven and one half percent. For PRTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all PRTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 25 percent of the average per diem cost for all PRTFs in the state; increased by seven and one half percent. For facilities with inadequate cost experience, provider costs will be based on alternative cost reports or satisfactory cost projections, trended to the statewide base period.

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**New York
3(b)**

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

On or after July 1, 2022, The State will increase the rates of payment to include necessary costs for additional staff to meet updated programmatic needs and standards, as approved by the OMH, which are not included in the historical cost reports utilized to develop the rates. The new costs to support additional staff, include the following:

- 5% increase to all provider-specific approved C/DC FTE levels for all PRTFs
- For PRTFs that have not had a staff plan increase or review since 7/1/2020, an additional 26% increase to all provider-specific approved FTE levels
- Addition of 1.0 FTE “Permanency/Family Connections Specialist” per PRTF
- Addition of 1.0 FTE “Intake Specialist” per PRTF
- Doubling of PRTF Transition Coordinator staff by decreasing the staff: client ratio from 1:12 to 1:6

Cost adjustments for prospective staff will be based on OMH approved staffing plans and applicable C/DC standard amounts calculated as described above on page 3(a). The C/DC standard amounts will be trended as described in this section to the appropriate period and added to the applicable cost basis until the Department of Health has determined costs associated with the additional staff are reflected in the cost reports used for rate setting.

On or after July 1, 2022, a length of stay (LOS) adjustment will be applied to the operating component of the rate. The LOS adjustment will be a percentage adjustment to the operating component of the rate determined by the duration of an individual recipient’s care episode in accordance with the below chart:

Duration of Individual Recipient’s Care Episode:	Percentage Adjustment to Operating Component:
Days 1 – 28	109%
Days 29 – 365	100%
Days 366+	90%

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**New York
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1905(a)(16) Inpatient Psychiatric Hospital – PRTF

Allowable operating costs as determined in the preceding paragraphs will be trended by the Medicare inflation factor.

Effective July 01, 2021 through March 31, 2022, operating rates of payment will be increased for a Cost-of-Living Adjustment (COLA), calculated to support a one percent (1.0%) annual aggregate payment to be paid out over the 9 month period between July 1, 2021 and March 31, 2022, and a one percent (1%) annual increase to be paid out over 12 months in subsequent years until such time as the COLA increase is reflected in the base period cost reports.

Effective on or after February 1, 2022, the C/DC rate component will be adjusted to include a twenty-five percent (25%) increase to include additional funds, not included in the base year, appropriate to maintain the required level of care. This increase will be included until such a time as the increase is reflected in the base period cost reports.

Effective April 01, 2022, through March 31, 2023, operating rates of payment will be increased for a Cost-of-Living Adjustment (COLA) to support a five-point four percent (5.4%) increase until such time as the COLA increase is reflected in the base period cost reports.

Effective on or after July 01, 2022, operating rates of payment for all providers will receive an eight percent (8.0%) increase. This increase will be included until such a time when the Department of Health has determined costs associated with the increase are reflected in the cost reports used for rate setting.

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New York
4(a)

4. NEW RESIDENTIAL TREATMENT FACILITIES WITH INADEQUATE COST EXPERIENCE

Rates of payment for a new residential treatment facility with inadequate cost experience [shall] will be determined on the basis of satisfactory cost projections as submitted to the Commissioner. The rate of payment [shall] will [take into consideration] be subject to total allowable costs, total allowable days, [and shall be subject to] staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner.

Financial reports, reflecting actual cost and statistical information, in a form prescribed by the Commissioner, [shall] will be required within one hundred twenty days following the first six month period during which the Residential Treatment Facility has operated at an average utilization of at least ninety percent or one year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened.

5. DISPROPORTIONATE SHARE ADJUSTMENT

Due to State's reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for residential treatment centers for children and youth does not include a disproportionate share adjustment.

TN #20-0062

Supersedes TN #09-0051

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Effective Date July 1, 2020

**New York
4(b)**

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

Adjustment for Minimum Wage Increases - Effective January 1, 2017, and every January 1, thereafter until the minimum wage reaches the state statutorily described per hour wage as shown below, a minimum wage add-on will be developed and applied to all residential treatment facility rates.

Minimum Wage (MW) Region	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021
New York City	\$11.00	\$13.00	\$15.00	\$15.00	\$15.00	\$15.00
Nassau, Suffolk, & Westchester counties	\$10.00	\$11.00	\$12.00	\$13.00	\$14.00	\$15.00
Remainder of the State	\$9.70	\$10.40	\$11.10	\$11.80	\$12.50	\$13.20*

*Effective January 1, 2022, the minimum wage value for the Remainder of the State will be \$13.20.

The minimum wage adjustment will be developed and implemented as follows:

1. Minimum wage costs will mean the additional costs incurred beginning January 1, 2017, and thereafter, as a result of New York State statutory increases to minimum wages until all regions of the State reach \$15.00 per hour.
2. The 2017 facility specific minimum wage add-on will be developed based on collected survey data received and attested to by residential treatment facility providers. If a facility does not submit a survey, the minimum wage add-on will be calculated based on the facility’s Consolidated Fiscal Report (CFR) wage data from two years prior to the period being calculated. If a facility fails to submit both the attested survey and the CFR cost report, the facility’s minimum wage add-on will not be calculated.
 - i. Minimum wage cost development based on survey data collected.
 - a. Survey data will be collected for facility specific wage data.
 - b. Facilities will report by wage bands, the total count of FTEs and total hours paid to all employees (contracted and non-contracted staff) earning less than the statutory minimum wage applicable for each region.
 - c. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
 - d. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the facility has reported total hours paid. To this result, the facility’s average fringe benefit percentage is applied and added to the costs.
 - ii. Minimum wage cost development based on the CFR cost report data.
 - a. The average hourly wages of employees where the reported average hourly wage is below the regional statutory minimum wage are identified.
 - b. The total payroll hours of the employees identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.
 - c. The facility’s fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
 - d. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.

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Supersedes TN #17-0010 _____

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New York
4(c)

- 3. The facility specific cost amount will be adjusted by a factor calculated by dividing the facility's average dollar per hour under minimum wage by the regional average. The resulting amount will be divided by patient days to arrive at a rate per diem add on, which will be applied to only Medicaid days for purposes of Medicaid reimbursement.
- 4. In subsequent years until the minimum wage is completely implemented statewide, the Department will survey facilities utilizing the methodology employed in year one. If a facility fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the personnel wage data reported on the Facility's latest available CFR cost report. If a facility fails to submit both the survey and the CFR cost report, its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the nursing home rate, the minimum wage add-on will be excluded from the rate.
- 5. **Minimum Wage Reconciliation** - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the reconciliation survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the reconciliation survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider's minimum wage add-on for the calendar year covered by the survey will be recouped.
 - a. Total annual minimum wage funding paid to the provider (as determined from the minimum wage add-on to claims paid for services rendered in the prior calendar year) for the Medicaid share of the minimum wage law increase requirement. (This information will be supplied by the Department of Health.) Medicaid's share is the percentage of minimum wage costs that are attributable to Medicaid services based on the proportion of Medicaid services to a provider's total services.
 - b. Medicaid's share of the total amount the provider was obligated to pay to bring salaries up to the minimum wage for the calendar year. (This information will be completed by the provider.)
 - c. Minimum wage funds to be recouped or additional funds to be received by the provider. (This information will be completed by the provider.) This will be the difference between the amount paid to the provider for the Medicaid share of the minimum wage law increase requirement and the corresponding amount the provider determined it was actually obligated to pay.
 - d. The State agency will review providers' submissions for accuracy and reasonableness, following which it will process associated payments and recoupments via retroactive per unit rate adjustments as quickly as practical thereafter.

The agency's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.

TN <u> #17-0010 </u>	Approval Date <u> January 12, 2018 </u>
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New York
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1905(a)(16) Inpatient Psychiatric Hospital – PRTF (Continued)

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health's Prior Approval Review (PAR) procedures must be reviewed and approved by the Office of Mental Health. On or after July 01, 2022, the capital component of the rates will be adjusted once annually to account for actual billing over the rate period to compensate for the variation between allowable capital for the period and capital reimbursement actually received.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership will be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

3. APPEALS

The Commissioner will consider requests for rate revisions which are based on errors in the calculation of the rate or based on significant changes in costs resulting from changes in:

- Capital projects approved by the Commissioner in connection with OMH's PAR procedures.
- OMH approved changes in staffing plans submitted to DOH in a form as determined by the DOH.
- OMH approved changes in capacity approved by the Commissioner in connect with OMH's PAR procedures;
- Other rate revisions will be based on requirements to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs.

Revised rates will utilize existing facility cost reports, adjusted as necessary. The rates of payment will be subject to total allowable costs, total allowable days, staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner. These rates must be certified by the Commissioners of OMH and DOH and approved by the Director of the Budget.

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New York

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[year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened, unless the Commissioner determines that the facility has not achieved the status of a stable, ongoing operation with reliable cost information, in which case the budget based rate will be continued, adjusted as necessary, for updated budget projections as appropriate.

5. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

Effective twelve months after the date the RTF submits financial reports reflecting actual operating costs or two years after the RTF begins operating, whichever is earlier, if it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the RTF because a medically necessary long term care bed is not available in the community, and it is determined by the Commissioner that there is a significant excess of operational beds at the RTF or in the RTFs located in the OMH region in which the RTF is located, the RTF will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services are furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the RTF for the most recently reported twelve month period is less than 80 percent in the case of RTFs with certified bed capacities greater than 20 beds or 60 percent in the case of RTFs with certified bed capacities of 20 beds or less, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational bed exists in an OMH region if the overall occupancy rate for RTFs in the region is less than the weighted average of 80 percent for RTFs in the region with certified bed capacities greater than 20 beds and 60 percent for RTFs in the region with certified bed capacities of 20 beds or less. The occupancy rate shall be determined without including alternate care days. The determination of average occupancy rate for RTFs in the region is applied to each of the five geographical OMH regions and is based on RTFs which are subject to the provisions of this section and which are located within the same OMH Region.

Alternate care determinations must be reported to the Office of Mental Health on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data prior to the effective date of the reduced payment provision.]

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New York
6

RESERVED

[Due to State’s reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for residential treatment centers for children and youth does not include a disproportionate share adjustment.]

New York
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RESERVED

[A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly composed of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.]

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**New York State Office of Alcoholism
and Substance Abuse Services (OASAS)**

**SUMMARY OF INPATIENT MEDICAID
PAYMENT METHODOLOGY FOR SERVICES IN
PRIVATE PSYCHIATRIC HOSPITALS**

OASAS establishes all inclusive program specific per diem rates on a prospective basis. Rates are established on the basis of certified cost reports which are submitted at least one year prior to the first day of the rate year which is the calendar year. For example, rates for the 1994 calendar year rate year were based upon 1992 calendar year data. A rolling base year is utilized, i.e. each year, rates are re-calculated using a new base year.

Allowable operating and capital costs from the base year are determined in accordance with Medicare Principles of Reimbursement (HIM-15) and Generally Accepted Accounting Principles (GAAP). Increases in operating costs from base year to base year are limited by application of a growth factor. The growth factor changes each year and is defined as the trend factor for the base year plus 2%.

A trend factor is then added to the lower of a program's base year operating costs or the operating costs as limited by the growth factor. The trend factor is developed for OASAS by the NYS Office of Health Systems Management (OHSM). The trend factor has two components, personal services and non-personal services. Calculation of the personal services component is multi-step process. First, personal services costs are broken down into various categories, i.e., managerial and administrative, professional and technical, clerical, service occupations and blue collar. Each category is then assigned a sub-weight representing its percentage relationship to total personal services costs. The assigned subweight is then multiplied by the price movement for each of these categories using United States Department of Labor, Bureau of Labor statistics. The sum percentage of these calculations is then multiplied by a percentage representing personal services costs to total costs. The non personal services component is determined by multiplying the GNP implicit price deflator by a percentage representing non personal costs to total costs. The trend factor for the 1994 rate year is 2.99%.

The program specific per diem rate is then calculated by dividing the sum of allowable trended adjusted operating costs and allowable capital costs by the higher of actual patient days (in the base year) or 90% of possible base year days for inpatient rehabilitation programs; for primary care (detoxification) programs, the higher of actual base year patient days or 85% or possible base year days is used. Possible days for each program is calculated by multiplying the certified bed capacity by the number of days in the base year, i.e. either 365 or 366. Rates which are based upon actual certified costs data are provisional pending audit. There is a process for a provider to appeal a provisional rate.

TN #94-31 Supersedes TN NEW Approval Date August 12, 1999 Effective Date April 1, 1994

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For new providers with inadequate cost experience, rates are calculated on the basis of a program specific 12 month budgeted cost report. As with actual cost based rates, allowable operating and capital costs are determined in accordance with HIM-15 and GAAP. Unlike actual cost based programs, operating costs will be limited to 115% of the statewide average for similar programs. The sum of allowable adjusted operating costs and allowable capital costs is then divided by the higher of budgeted days or 90%/85% of possible days to arrive at a budgeted per diem. Budgeted base rates are adjusted to actual rates upon receipt of actual certified cost reports. Program specific provisional rate are then established retroactively to the effective date of the budgeted rate.

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**New York State Office of Alcoholism
and Substance Abuse Services (OASAS)**

Inpatient Psychiatric Services for Individuals under 21

Inpatient Psychiatric Services for individuals under 21 who are admitted to Residential Rehabilitation Services for Youth (RRSY) programs that are certified by the New York Office of Alcoholism and Substance Abuse Services. Services are limited to those provided for those recipients who are medically certified as requiring this level of care in accordance with 42 CFR 441.152. Service are limited to individuals under the age of twenty-one (21), or receiving services immediately before attaining the age of twenty-one (21), not to extend beyond the earlier of:

- (1) the date the services are no longer required; or
- (2) the date the individual reaches the age of twenty-two (22).

Coverage of services will be limited to those services provided within a residential rehabilitation services program for youth that is certified by the New York Office of Alcoholism and Substance Abuse Services.

[Residential Rehabilitation Services for Youth

Medicaid fees for Residential Rehabilitation Services for Youth ("RRSY") services are established using a cost model based on service requirements established by the Commissioner of the Office of Alcoholism and Substance Abuse Services ("the office") pursuant to regulation at 14 New York Code of Rules and Regulations Part 817 ("Part 817").

Definitions.

- (1). "Eligible residential rehabilitation services for youth provider" will mean a residential rehabilitation services for youth provider that has been certified by the Office to provide services pursuant to Part 817.
- (2) "Allowable costs" will mean those costs incurred by an eligible residential rehabilitation services for youth provider which are eligible for Medicaid payments. To be allowable, costs must be reasonable and necessary for efficient provision of chemical dependence services, related to patient care, recurring, and approved by the commissioner.]

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Approval Date June 11, 2019

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Medicaid fees for RRSY services shall be based on both bed size and the county in which the facility is located. The fees shall be inclusive of both operating and capital reimbursement. There shall be no capital add-on to these fees or any separate Medicaid reimbursement for capital costs. These fees shall be effective on and after January 1, 2019.

For both existing and new facilities, the "bed size" shall be based on the OASAS-certified capacity of the program site. To calculate the fee, the "statewide fee" based on bed size shall be taken from the first table below and then adjusted by the applicable regional factor from the second table. If the certified bed size changes, the rate shall be revised accordingly and shall be effective on the date of the bed size change. Facilities with fewer than 14 certified beds shall use the 14 bed fee. Facilities with 60 or more certified beds shall use the 60 bed fee.

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1905(a)(16): IMD under age 21

Statewide RRSY Fees:

Bed Size	RRSY Fees										
14	\$418.43	22	\$374.90	30	\$347.69	38	\$328.28	46	\$313.39	54	\$301.41
15	\$411.47	23	\$370.88	31	\$344.93	39	\$326.21	47	\$311.75	55	\$300.07
16	\$405.07	24	\$367.06	32	\$342.28	40	\$324.21	48	\$310.16	56	\$298.76
17	\$399.14	25	\$363.44	33	\$339.73	41	\$322.27	49	\$308.61	57	\$297.48
18	\$393.64	26	\$359.99	34	\$337.27	42	\$320.39	50	\$307.10	58	\$296.22
19	\$388.50	27	\$356.70	35	\$334.90	43	\$318.56	51	\$305.63	59	\$294.99
20	\$383.69	28	\$353.57	36	\$332.62	44	\$316.79	52	\$304.19	60+	\$293.79
21	\$379.17	29	\$350.56	37	\$330.41	45	\$315.06	53	\$302.78		

The geographic regions and regional cost factors applicable to the statewide RRSY fees from the first table are as follows:

Region	Factor	Counties
1	1.2267	Bronx, Kings, New York, Richmond, Queens
2	1.2001	Westchester
3	1.1825	Nassau, Suffolk, Rockland, Orange
4	1.1009	Dutchess, Putnam
5	1.0317	Erie, Niagara
6	0.9710	Madison, Onondaga, Oswego, Tompkins, Jefferson, Herkimer, Oneida
7	0.9192	Rest of State

Effective April 1, 2022, the January 1, 2019 rates in the table above will receive a cost-of-living adjustment of 5.4% and will be published at the following link:

<https://oasas.ny.gov/reimbursement/non-ambulatory>

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(6) With the approval of CMS, the service operating fees may be updated to adjust for programmatic changes or service operating cost variations not addressable by the annual trend factor. The process of updating service operating fees may include one or more of the following:

- (i) the establishment of a new base year and fee cycle;
- (ii) a change in the number of fee levels;
- (iii) a change in the upper and/or lower service capacities of the fee levels; or
- (iv) other necessary changes not specifically addressed above.

Capital add-on.

To be considered as allowable, capital costs must be both reasonable and necessary to patient care under Part 817. Allowable capital costs shall be determined in accordance with the following:

- (1) The Office shall use, as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services' Centers for Medicare and Medicare Services.
- (2) Where HIM-15 is silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

Allowable capital costs may include:

- (1) the costs of owning or leasing real property;
- (2) the costs of owning or leasing moveable equipment and personal property; and
- (3) the cost of up to three months of pre-operational program start-up expenses, and associated interest, for new services, programs, or facilities for which initial reimbursement levels are being established. Pre-operational start-up costs may include, but are not limited to, rent, employee compensation, utilities, staff training and travel, and expensed equipment.

No capital or start-up expenditure for which approval by the office is required in accordance with the operating requirements of the office shall be included in allowable capital cost for purposes of computation of provider reimbursement unless such approval shall have been secured. For projects requiring approval by the office, reimbursement for capital costs shall be limited to the amount approved by the commissioner. To be considered allowable for

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reimbursement, capital and start-up costs must be both reasonable and necessary, incurred by the provider, and chargeable to necessary patient care.

The capital add-on to the service operating fee shall be calculated for each fee period on a provider-specific basis by dividing the provider's allowable capital costs for that fee period by the allowable patient days for that fee period. The capital add-on may be adjusted by the office on a retroactive or prospective basis to more accurately reflect the actual or anticipated approved capital cost.

New eligible RRSY providers.

(1) Once a new eligible RRSY provider has at least six months of cost and operating experience, they shall submit reports at least 180 days prior to the beginning of the fee period for which a fee is being requested unless otherwise waived by the commissioner.

(2) Each new eligible RRSY provider which has less than six months of cost and operating experience shall prepare and submit to the commissioner a budgeted cost report. Such report shall:

- (i) include a detailed projection of revenues and a line item expense budget with regard to staffing, non-personal service costs including capital;
- (ii) include a detailed staffing plan;
- (iii) include a projected month by month bed utilization program;
- (iv) cover a 12 month period; and
- (v) such budget report shall be completed and submitted at least 180 days prior to the beginning of the rate year for which a rate is being requested.

(3) The service operating fee and capital add-on for each new eligible RRSY provider shall be calculated and reimbursed pursuant to these requirements.

(4) Upon submission of the financial reports the commissioner may adjust retroactively the eligible RRSY provider's existing capital add-on to more accurately reflect the reported operating costs and program utilization, based on patient days of the eligible RRSY provider.

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