

New York  
Cover Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

Description of the Policy and the Methods  
to be Used in Establishing Payment Rates

The Division of Health Economics of the New York State Department of Health has been charged with the responsibility of studying and determining fees for providers of medical and paramedical care.

In pursuit of these fee studies, the Division of Health Economics meets with the representative professional groups, studies published and unpublished fee surveys, makes comparisons with schedules of insurance carriers and Workmen's Compensation, and conducts informal surveys as the occasion demands.

When the Division of Health Economics develops a fee schedule which approximates average prevailing fees in the State, a fee schedule and supporting position paper are sent to all members of the Interdepartmental Committee on Health Economics. This Committee is composed of representatives from the Departments of Education (Division of Vocational Rehabilitation, Social Services, Health, Mental Hygiene, Correction, Civil Service, Insurance, Workmen's Compensation and the Division of the Budget. The Committee may approve the schedule as presented or make modifications. The schedule is then recommended to the Commissioner of Health who, if in agreement, recommends approval to the Director of the Division of the Budget. The Budget Director may then approve and promulgate the schedule.

Promulgated schedules apply to all State programs except Workmen's Compensation, and supersede all existing schedules including those previously promulgated by the Department of Education, Health and Social Welfare.

Fees contained in the schedules are to be considered full payment of the services rendered. Under the Medicaid Assistance Program, which is administered by local welfare districts, these fees represent maximum allowances for purposes of State reimbursement. Each local welfare district may determine the fees paid to practitioners for services to eligible recipients.

Fees for services or procedures which are not included in the fee schedule may be determined on an individual basis by the appropriate public agency. However, such determinations must be reported promptly to the Division of Health Economics which reviews the fee for the given procedure and subsequently recommends a fee for approval by the Interdepartmental Committee on Health Economics and for possible incorporation in the fee schedule.

TN   #74-2    
Supersedes TN   ---  

Approval Date   December 31, 1974    
Effective Date   January 1, 1974

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**Across the Board Reductions to Payments**

(1) For dates of service on and after September 16, 2010, through and including March 31, 2011, payments for services as specified in paragraph (2) of this Attachment shall be reduced by 1.1%, provided payment is made no later than March 31, 2011.

(2) Payments in this Attachment subject to the reduction in paragraph (1) include the following:

- a) Physician Services. Page 1
- b) Statewide Patient Centered Medical Home and the Adirondack Medical Home Multipayor Program for physicians, hospital based clinics and diagnostic and treatment centers. Pages 1(A)-1(A)(iii);  
1(c)(i)(A)-1(c)(i)(H)
- c) E-prescription financial incentive payments to dentists, podiatrists, optometrists, nurse midwives, and nurse practitioners. Page 1(A)(iv)-  
1(A)(viii)
- d) Reimbursement for dental services, podiatrists, optometrists, chiropractic services, nurse midwives, nurse practitioners, and clinical psychologists. Page 1(a)
- e) Methadone Maintenance Treatment Program (MMTP) services. Page 1(b)
- f) Outpatient reimbursement for Acute Care Children's Hospitals. Page 1(b)(ii)
- g) Ordered Ambulatory Services. Pages 1(c)-1(c)(i)
- h) Methadone Maintenance Treatment Program (MMTP) services and day health care services rendered to patients with HIV/AIDS which are provided in Freestanding Clinics certified under Article 28 of the State Public Health Law. Page 1(c)-1(d)
- i) Additional funding for Freestanding Clinics licensed under Article 28 of the State Public Health Law providing services to persons with developmental disabilities. Page 1(d)-1(d)(i)
- j) Services for medically supervised chemical dependence treatment and medically supervised withdrawal services provided in Freestanding Clinics licensed by Article 28 of the State Public Health law, excluding Federally Qualified Health Centers. Page 1(d)(i)

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| k) <u>Ambulatory Patient Group (APG) reimbursement for hospital outpatient and ambulatory surgery services; and for freestanding clinics and ambulatory surgery centers services, except for those services provided on federally recognized Indian nations to Native Americans.</u>                                                                                                                       | Pages 1(f)-1(p);<br>Pages 2(h)-2(t) |
| l) <u>Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.</u>                                                                                                                                                                                                                                                                                                           | Page 2                              |
| m) <u>AIDS/HIV Adult Day Health Care Services provided by a freestanding clinic.</u>                                                                                                                                                                                                                                                                                                                       | Pages 2-2(a)                        |
| n) <u>Services to AIDS/HIV positive patients; medically supervised chemical dependence treatment; and medically supervised withdrawal services provided in Hospital Based Outpatient Departments and Freestanding Clinics certified under Article 28 of the State Public Health law.</u>                                                                                                                   | Pages 2(b)-2(b)(ii)                 |
| o) <u>Workforce Recruitment and Retention payment for freestanding clinics.</u>                                                                                                                                                                                                                                                                                                                            | Pages 2(c)(vii)-<br>2(c)(viii)      |
| p) <u>Products of Ambulatory Care reimbursement for Hospital Based Clinics and Freestanding Clinics.</u>                                                                                                                                                                                                                                                                                                   | Pages 2(d)-2(e)                     |
| q) <u>Office of Mental Retardation and Developmental Disabilities (OMRDD) Clinic Treatment Programs and OMRDD Clinic Day Treatment Programs provided in facilities certified under Article 16 of the State Mental Hygiene Law.</u>                                                                                                                                                                         | Page 3-3(h)(12)                     |
| r) <u>Chemical Dependence Medically Supervised Treatment and Chemical Dependence Medically Supervised Withdrawal Services provided in facilities certified solely under Article 32 of the State Mental Hygiene Law.</u>                                                                                                                                                                                    | Page 3(i)                           |
| s) <u>Office of Mental Health Outpatient Programs licensed under 14 NYCRR Parts 579 and 585; including Clinic, Day and Continuing Treatment Programs.</u>                                                                                                                                                                                                                                                  | Pages 3(i)-3(k)                     |
| t) <u>Office of Mental Health Intensive Psychiatric Rehabilitation Treatment programs including, rehabilitative services for residents of community based residential programs; Personalized Recovery Oriented Services (PROS) Community Rehabilitation and Support program; Intensive Rehabilitation; Ongoing Rehabilitation and Support programs; and Assertive Community Treatment (ACT) programs .</u> | Pages 3(L)-3(M)                     |

TN #10-38Approval Date March 9, 2011Supersedes TN NEWEffective Date September 16, 2010

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<u>u) Laboratory services.</u>	<u>Page 4</u>
<u>v) Home health services provided by Certified Home health Agencies (CHHA), including services to patients diagnosed with AIDS.</u>	<u>Pages 4-4(a)(i)(2): 4(a)(ii)-4(b)</u>
<u>w) Personal Emergency Response Services (PERS).</u>	<u>Page 4(a)(i)(3)</u>
<u>x) Services provided to Medically Fragile Children.</u>	<u>Page 4(a)(i)(3)</u>
<u>y) Home Telehealth Services provided by CHAAs including those that provide AIDS home care services.</u>	<u>Pages 4(a)(i)(4) – 4(a)(i)(5)</u>
<u>z) Assisted Living Programs.</u>	<u>Page 4(c)(1)</u>
<u>aa) Prescribed Drugs; E-Prescription Financial Incentive program to retail pharmacies; Pharmacy Medication Therapy; immunization reimbursement for pharmacists; and Non-prescription drugs.</u>	<u>Pages 4(d)-5</u>
<u>bb) Private Duty Nursing; including nursing services provided to medically fragile children and services provided to eligible residents of an adult home or enriched housing program that is issued a limited license by the Department of Health.</u>	<u>Pages 5-5(a)(i)</u>
<u>cc) Physical Therapy.</u>	<u>Page 5(a)(i)</u>
<u>dd) Occupational Therapy.</u>	<u>Page 5(a)(i)</u>
<u>ee) Eyeglasses and Other Visual Services.</u>	<u>Page 5(b)</u>
<u>ff) Hearing Aid Supplies and Services.</u>	<u>Page 5(b)</u>
<u>gg) Prosthetic and Orthotic Appliances.</u>	<u>Page 5(b)</u>
<u>hh) Comprehensive Psychiatric Emergency programs.</u>	<u>Page 5(b)</u>
<u>ii) Durable Medical Equipment.</u>	<u>Page 6</u>
<u>jj) Medical/Surgical Supplies.</u>	<u>Page 6</u>

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<u>kk) Enterel Formula.</u>	<u>Page 6</u>
<u>ll) Transportation.</u>	<u>Page 6</u>
<u>mm) Out of State Services for fee based providers.</u>	<u>Page 6(a)</u>
<u>nn) HMO's and Prepaid Health Plans.</u>	<u>Page 6(a)</u>
<u>oo) Personal Care Services.</u>	<u>Pages 6(a)-6(a)(iv)</u>
<u>pp) Adult Day Health Care services including services provided to patients with HIV/AIDS.</u>	<u>Pages 7-7(b)(iii)</u>
<u>qq) Intensive Day Treatment Program certified by the Office of Mental Health pursuant to 14 NYCRR Part 581.</u>	<u>Pages 8-8(a)</u>
<u>rr) Office of Mental Health Clinic, Day and Continuing Treatment program services in facilities certified under Article 31 of the State Mental Hygiene Law.</u>	<u>Page 9</u>
<u>ss) Rehabilitative Services, including services provided to persons in freestanding chemical dependence residential facilities; Directly Observed Therapy (DOT); services provided by the Office of Mental Retardation and Developmental Disability (OMRDD) freestanding outpatient providers; Early Intervention providers; School Supportive Health Services; and Preschool Supportive Health Services.</u>	<u>Pages 10(a)- 10(1)(G)</u>
<u>tt) Case Management Services to Target Group B; Target Group D; Target Group D1; Target Group D2; Target Group F; Target Group G; Target Group A and E; Target Group C; Target Group H; Target Group I; and Target Group M.</u>	<u>Pages 10(2)-11(g)</u>
<u>uu) Preferred Physician and Children's Program.</u>	<u>Page 12(2)-12(3)</u>
<u>vv) Medicaid Obstetrical and Maternal Services (MOMS).</u>	<u>Page 12(4)</u>
<u>ww) Child Teen Health Program.</u>	<u>Page 12(5)</u>

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- xx) Health Maintenance Organization Obstetrical and Pediatric Services. Page 12(6)-12(7)
- yy) Emergency services for illegal aliens. Page 13
- zz) Primary Care Case Management. Page 16
- aaa) Program of All-Inclusive Care for the Elderly (PACE). Page 17
- bbb) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). Pages 17(d)-17(i)

**2% Across the Board Payment Reduction- Effective 4/1/2011-3/31/2013**

(1) For dates of service on and after April 1, 2011 and ending on March 31, 2013, payments for services as specified in paragraph (2) of this Attachment will be reduced by 2%.

(2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

- a) Physician Services, except for those physician services provided in an office based setting. Page 1
- b) Statewide Patient Centered Medical Home and the Adirondack Medical Home Multipayor Program for physicians, hospital based clinics and freestanding clinics. Pages 1(A)-1(A)(iii);  
1(c)(i)(A) -1(c)(i)(B)  
1(c)(i)(G)-1(c)(H)
- c) E-prescription financial incentive payments to dentists, podiatrists, optometrists, nurse midwives, and nurse practitioners. Page 1(A)(iv)-  
1(A)(viii)
- d) Reimbursement for dental services, podiatrists, optometrists, chiropractic services, nurse midwives, nurse practitioners, and clinical psychologists; except for those services provided in an office based setting. Page 1(a)
- e) Methadone Maintenance Treatment Program (MMTP) services. Page 1(b)
- f) Outpatient reimbursement for Acute Care Children's Hospitals. Page 1(b)(ii)
- g) Ordered Ambulatory Services. Pages 1(c)-1(c)(i)
- h) Methadone maintenance Treatment Program (MMTP) services and day health care services rendered to patients with HIV/AIDS which are provided in Freestanding Clinics certified under Article 28 of the State Public health Law. Page 1(c)-1(d)

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Supersedes TN #10-38

Effective Date April 1, 2011

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| i) <u>Ambulatory Patient Group (APG) reimbursement for hospital outpatient departments, emergency departments, and ambulatory surgery services.</u>                                                                                                      | Page 1(f)-1(p)                       |
| j) <u>Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.</u>                                                                                                                                                         | Page 2                               |
| k) <u>Services to AIDS/HIV positive patients provided in Hospital Outpatient Departments and Freestanding clinics.</u>                                                                                                                                   | Pages 2(b)                           |
| l) <u>Laboratory services.</u>                                                                                                                                                                                                                           | Page 4                               |
| m) <u>Home health services provided by Certified Home Health Agencies (CHHA), including services to patients diagnosed with AIDS.</u>                                                                                                                    | Pages 4-4(a)(i)(2);<br>4(a)(ii)-4(b) |
| n) <u>Personal Emergency Response Services (PERS).</u>                                                                                                                                                                                                   | Page 4(a)(i)(3)                      |
| o) <u>Services provided to Medically Fragile Children.</u>                                                                                                                                                                                               | Page 4(a)(i)(3)                      |
| p) <u>Home Telehealth Services provided by CHAAs including those that provide AIDS home care services.</u>                                                                                                                                               | Pages 4(a)(i)(4) –<br>4(a)(i)(5)     |
| q) <u>Private Duty Nursing: including nursing services provided to medically fragile children and services provided to eligible residents of an adult home or enriched housing program that is issued a limited license by the Department of Health.</u> | Pages 5-5(a)(i)                      |
| r) <u>Physical Therapy, except for those services provided in an office based setting.</u>                                                                                                                                                               | Page 5(a)(i)                         |
| s) <u>Occupational Therapy, except for those services provided in an office based setting.</u>                                                                                                                                                           | Page 5(a)(i)                         |
| t) <u>Eyeglasses and Other Visual Services.</u>                                                                                                                                                                                                          | Page 5(b)                            |
| u) <u>Hearing Aid Supplies and Services.</u>                                                                                                                                                                                                             | Page 5(b)                            |
| v) <u>Prosthetic and Orthotic Appliances.</u>                                                                                                                                                                                                            | Page 5(b)                            |
| w) <u>Comprehensive Psychiatric Emergency programs.</u>                                                                                                                                                                                                  | Page 5(b)                            |
| x) <u>Durable Medical Equipment.</u>                                                                                                                                                                                                                     | Page 6                               |

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y) <u>Medical/Surgical Supplies.</u>	<u>Page 6</u>
z) <u>Enteral Formula.</u>	<u>Page 6</u>
aa) <u>Transportation.</u>	<u>Page 6</u>
bb) <u>Out of State Services for fee based providers.</u>	<u>Page 6(a)</u>
cc) <u>Personal Care Services.</u>	<u>Pages 6(a)-6(a)(iv)</u>
dd) <u>Case Management Services to Target Group F; Target Group G; Target Group A and E; Target Group C; Target Group I; and Target Group M.</u>	<u>Pages 10(2)-11(g)</u>
ee) <u>Preferred Physician and Children's Program.</u>	<u>Page 12(2)-12(3)</u>
ff) <u>Medicaid Obstetrical and Maternal Services (MOMS).</u>	<u>Page 12(4)</u>
gg) <u>Child Teen Health Program.</u>	<u>Page 12(5)</u>
hh) <u>Health Maintenance Organization Obstetrical and Pediatric Services.</u>	<u>Page 12(6)-12(7)</u>
ii) <u>Emergency services for illegal aliens.</u>	<u>Page 13</u>
jj) <u>Primary Care Case Management.</u>	<u>Page 16</u>
kk) <u>Program of All-Inclusive Care for the Elderly (PACE).</u>	<u>Page 17</u>
ll) <u>Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).</u>	<u>Pages 17(d)-17(i)</u>

TN #11-72  
Supersedes TN NEW

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**2% Across The Board Rate Reduction – Early Intervention Services**

The reduction for payments for Early Intervention services will be effected through a [the] 2% Across the Board payment reduction in the base rates, which will be effective April 1, 2011 through January 31, 2013.

Page 10(1)(A)

Effective on and after February 1, 2013, payments for Early Intervention services will be exempt from the 2% Across the Board payment reduction.

TN #13-17

Approval Date November 27, 2013

Supersedes TN #10-06

Effective Date February 1, 2013

New York  
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**2% Base Rate Reduction**

The reduction for Ambulatory Patient Group (APG) reimbursement of freestanding clinic and ambulatory surgery center services will be effected through a 2% reduction in the base rates, which will be effective April 1, [2011] 2013 through March 31, [2013] 2015.

[Page 2(h)]  
Page 2(g)(1)-2(t)

TN #13-22

Approval Date November 6, 2013

Supersedes TN #11-72

Effective Date April 1, 2013

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**2% Across the Board Payment Reduction- Effective 4/1/2013-3/31/[2015]2014**

(1) For dates of service on and after April 1, 2013 and ending on March 31, [2015]2014, payments for services as specified in paragraph (2) of this Attachment will be reduced by 2%.

(2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

- a) Physician Services, except for those physician services provided in an office based setting. Page 1
- b) Statewide Patient Centered Medical Home and the Adirondack Medical Home Multipayor Program for physicians, hospital based clinics and freestanding clinics. Pages 1(A)-1(A)(iii);  
1(c)(i)(A) -1(c)(i)(H)
- c) E-prescription financial incentive payments to physicians, dentists, podiatrists, optometrists, nurse midwives, and nurse practitioners. Pages [1(A)(iii)-  
1(A)(viii)]  
1(a)(iv)-1(a)(viii)
- d) Reimbursement for dental services, podiatrists, optometrists, chiropractic services, nurse midwives, nurse practitioners, and clinical psychologists; except for those services provided in an office based setting. Page 1(a)
- [e] Methadone Maintenance Treatment Program (MMTP) services. Page 1(b)]
- [[f] e] Outpatient reimbursement for Acute Care Children's Hospitals. Pages 1(b)(i)-  
1(b)(iii)
- [g] f] Ordered Ambulatory Services. Pages 1(c)-1(c)(i)
- [h] Methadone maintenance Treatment Program (MMTP) services and day health care services rendered to patients with HIV/AIDS which are provided in Freestanding Clinics certified under Article 28 of the State Public Health Law. Page 1(c)-1(c)(i);  
1(c)(ii)-1(d)]

Note: For the services described on this page, the early termination of the 2% reduction effective March 31, 2014 does not apply to freestanding clinic providers. The termination of the 2% reduction for freestanding clinic providers will be effective March 31, 2015.

TN           #14-0030          

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Supersedes TN           #13-0022          

Effective Date April 1, 2014

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| g) <u>Methadone Maintenance Treatment Program (MMTP) services.</u>                                                                                                                                                                                | Page 1(b)                                                                                                         |
| h) <u>Methadone Maintenance Treatment Program (MMTP) services and day health care services rendered to patients with HIV/AIDS which are provided in Freestanding Clinics certified under Article 28 of the State Public Health Law.</u>           | Pages 1(c)(ii)-1(d)                                                                                               |
| i) Ambulatory Patient Group (APG) reimbursement for hospital outpatient departments, emergency departments, and ambulatory surgery services.                                                                                                      | Pages 1(e)(1)-1(p)                                                                                                |
| j) Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.                                                                                                                                                         | Pages 2-2(a)(ii)                                                                                                  |
| k) Services to AIDS/HIV positive patients provided in Hospital Outpatient Departments and Freestanding clinics.                                                                                                                                   | Pages 2(b)-2(b.1)                                                                                                 |
| l) Laboratory services.                                                                                                                                                                                                                           | Page 4                                                                                                            |
| m) Home health services provided by Certified Home Health Agencies (CHHAs), including services to patients diagnosed with AIDS.                                                                                                                   | Pages [4-4(a)(i)(2);<br>4(a)(ii)-4(b)] <u>4(1)-<br/>4(9); 4(a), 4(a)(i),<br/>4(a)(i)(A); 4(a)(1)-<br/>4(a)(2)</u> |
| n) Personal Emergency Response Services (PERS).                                                                                                                                                                                                   | Page 4(a)(i)(3)                                                                                                   |
| o) Services provided to Medically Fragile Children.                                                                                                                                                                                               | Page 4(a)(i)(3)                                                                                                   |
| p) Home Telehealth Services provided by CH[A]HAs including those that provide AIDS home care services.                                                                                                                                            | Pages 4(a)(i)(4) –<br>4(a)(i)(5)                                                                                  |
| q) Private Duty Nursing; including nursing services provided to medically fragile children and services provided to eligible residents of an adult home or enriched housing program that is issued a limited license by the Department of Health. | Pages 5-5(a)(i)                                                                                                   |
| r) Physical Therapy, except for those services provided in an office based setting.                                                                                                                                                               | Page 5(a)(i)                                                                                                      |
| s) Occupational Therapy, except for those services provided in an office based setting.                                                                                                                                                           | Page 5(a)(i)                                                                                                      |
| t) Eyeglasses and Other Visual Services.                                                                                                                                                                                                          | Page 5(b)                                                                                                         |
| u) Hearing Aid Supplies and Services.                                                                                                                                                                                                             | Page 5(b)                                                                                                         |
| v) Prosthetic and Orthotic Appliances.                                                                                                                                                                                                            | Page 5(b)                                                                                                         |
| w) Durable Medical Equipment.                                                                                                                                                                                                                     | Page 6                                                                                                            |

Note: For the services described on this page, the early termination of the 2% reduction effective March 31, 2014 does not apply to freestanding clinic providers. The termination of the 2% reduction for freestanding clinic providers will be effective March 31, 2015.

TN <u>          #14-0030          </u>	Approval Date <u>          April 12, 2017          </u>	
Supersedes TN <u>          #13-0022          </u>	Effective Date <u>          April 1, 2014          </u>	

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x) Medical/Surgical Supplies.	Pages 5(b)(1)- 6
y) Enteral Formula.	Page 6
z) Transportation.	Page 6
aa) Out of State Services for fee-based providers.	Page 6(a)
bb) Personal Care Services.	Page[s] 6(a)(1)[- 6(a)(iv)]
cc) Case Management Services to Target Group F; Target Group A and E; Target Group C; and Target Group M.	Pages 10(4)- 10(5)(a); 11-11(C); 11(g)
dd) Preferred Physician and Children’s Program.	Pages 12(2)- 12(3)
ee) Medicaid Obstetrical and Maternal Services (MOMS).	Page 12(4)
ff) Child Teen Health Program.	Page 12(5)
gg) Emergency services for illegal aliens.	Page 13
hh) Primary Care Case Management.	Page 16
ii) Program of All-Inclusive Care for the Elderly (PACE).	Page 17
jj) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).	Pages 17(e)-17(i)

Note: For the services described on this page, the early termination of the 2% reduction effective March 31, 2014 does not apply to freestanding clinic providers. The termination of the 2% reduction for freestanding clinic providers will be effective March 31, 2015.

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**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

     Additional Other Provider-Preventable Conditions identified below:

Effective July 1, 2011, Medicaid will not pay the incremental cost associated with the above situations occurring within an ambulatory health care setting. Implementation of this provision will include a ramp-up period and will be fully implemented on July 1, 2012. During the ramp-up implementation period, in the event cases are identified, Medicaid payment will not be made for such cases.

TN   #11-46-B   Approval Date   September 6, 2012    
Supersedes TN   NEW   Effective Date   July 1, 2011



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**Collaborative Care Services: Reimbursement for Physicians' Services**

Effective January 1, 2015, reimbursement will be provided to physicians for Collaborative Care Services provided to patients diagnosed with depression pursuant to the methodology for Collaborate Care Services for Freestanding Clinics outlined in Attachment 4.19-B, except reimbursement for Physicians' Services does not include a retainage withholding or payment. Reimbursement shall be a monthly case rate of \$112.50 per month for each patient enrolled in Collaborative Care Services. Reimbursement will be provided for a maximum of 12 months. With the approval of the New York State Office of Mental Health, reimbursement will be provided for an additional 12 months at a rate of \$75.00 per month. Physicians must provide the minimum amount of services to enrollees as set forth in item 9 of the Supplement to Attachment 3.1-A of the Plan. Effective January 1, 2018, reimbursement will be provided to physicians for Collaborative Care Services provided to patients with other mental illness diagnoses pursuant to the methodology described in this paragraph.

**New York**  
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**Supplemental Medicaid Payments for Eligible Professional Services**

**1. State University of New York (SUNY)**

- (a) Effective April 1, 2011, supplemental payments will be made to State University Eligible Medical Professional Providers for services eligible under this provision ("Eligible Services"). Supplemental payments for Eligible Services will be equal to the difference between the Average Commercial Rate, as defined below, and Medicaid payments otherwise made under this state plan. The supplemental payment will only be applicable to the professional component of the services provided.
- (b) State University Eligible Medical Professional Providers are:
- (1) Physicians, nurse practitioners and physician assistants;
  - (2) Licensed in the State of New York; and
  - (3) Participating in a plan for the management of clinical practice at the State University of New York.

Excluded providers are federally qualified health centers (FQHCs) and rural health centers (RHCs).

- (c) Eligible Services include only those services provided by a State University Eligible Medical Professional Provider while acting in their capacity as a participant in a plan for the management of clinical practice at the State University of New York. The following clinical practices will participate:
- (1) SUNY Syracuse
  - (2) SUNY Buffalo, and
  - (3) SUNY Stony Brook
- (d) Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee for service payment has been made to an eligible provider. Non commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.
- (e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.

TN #11-07-A

Approval Date February 25, 2013

Supersedes TN NEW

Effective Date April 1, 2011

**New York**  
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**(f) Calculating the Average Commercial Rate (ACR) For Matched Procedures**

- (1) The ACR will be calculated separately for each plan for the management of clinical practice at the State University of New York. The ACR will be based on the applicable rates for the appropriate region, and all commercial payers are utilized except for the New York State Health Insurance Program (NYSHIP) Empire Plan.
- (2) The ACR will be calculated annually using commercial payer data from the most recently completed twelve month period by Date of Service between July and June. The initial calculation, effective beginning April 1, 2011, will be based on commercial payer data from the period of July 1, 2009, through June 30, 2010 Date of Service.
- (3) For Eligible Service procedures (additionally distinguished by modifier and point of service) that are billed to Medicaid using codes that correspond to those recognized by commercial payers ("Matched Procedures"), a Procedure-Specific ACR will be calculated for each Matched Procedure by dividing the sum of total commercial payments for the Matched Procedure by the total number of the Matched Procedures paid by commercial payers. For services where physician extenders may be used the applicable percentage of the ACR will be applied.

**(g) Calculating ACR For Non-Matched Procedures**

- (1) For Eligible Service procedures that are billed to Medicaid using codes that do not correspond to those recognized by commercial payers ("Non-Matched Procedures"), a Procedure-Specific ACR will be calculated for each Non-Matched Procedure by calculating the overall average percentage of the matched procedures commercial payments to Medicaid payments.
- (2) This percentage is applied to the average Medicaid payments per unit for the non matched services to establish an ACR proxy payment per unit. The units for each non matched Medicaid service is multiplied by the ACR proxy, and then totaled to determine the payment ceiling.
- (3) The difference between the total Medicaid payments for the unmatched services and the ACR proxy total is the supplemental payment for unmatched services.

## New York

## 1.3

**(h) Determining the Supplemental Payment Amount**

- (1) For each Eligible Service procedure, the Procedure-Specific Ceiling Amount is the product of the Procedure-Specific ACR and the number of times the procedure was paid by Medicaid to State University Eligible Medical Professional Providers. The sum of all Procedure-Specific Ceiling Amounts for all Eligible Service procedures is the Supplemental Payment Ceiling.
- (2) The Supplemental Payment Amount is calculated by subtracting total Medicaid payments made for Eligible Services from the Supplemental Payment Ceiling.

**ACR Calculation Example****Example 1.****Calculation of Average Percentage of Commercial Payments to Medicaid Payments**

<u>CPT</u>	<u>Fee Code</u>	<u>Medicaid Volume</u>	<u>Medicaid Payments</u>	<u>ACR</u>	<u>ACR Medicaid Volume</u>
99201	Facility	9	\$ 98.33	\$ 37.56	\$ 338.02
99201	Non-Facility	29	\$659.46	\$ 48.16	\$1,396.50
99202	Facility	67	\$1,451.31	\$ 72.65	\$4,867.86
99202	Non-Facility	68	\$2,533.87	\$ 83.34	\$5,667.20
99203	Facility	255	\$8,491.44	\$110.72	\$28,234.48
99203	Non-Facility	154	\$8,590.88	\$123.25	\$18,980.55
99204	Facility	157	\$8,822.54	\$179.74	\$28,218.70
99204	Non-Facility	115	\$9,570.55	\$184.33	\$21,197.88
99205	Facility	63	\$4,485.55	\$234.13	\$14,750.23
99205	Non-Facility	38	\$3,805.95	\$237.02	\$9,006.72
<b><u>Total Fees</u></b>			<b><u>\$ 48,509.88</u></b>		<b><u>\$ 132,658.13</u></b>
<b><u>Average percentage of Commercial Payments to Medicaid Payments</u></b>					<b><u>273%</u></b>

**Example 2:****Calculation of Payment Ceiling for Non Matched Codes and Total Supplemental Payment**

<u>CPT</u>	<u>Fee Code</u>	<u>Medicaid Volume</u>	<u>Medicaid Payments</u>	<u>Average Medicaid Payment</u>	<u>Comm. % of Medicaid</u>	<u>Calculated ACR Proxy</u>	<u>Calculated Payment Ceiling</u>
59514	Facility	2	\$1,791.02	\$895.51	273%	\$2,448.92	\$4,897.83
59840	Facility	8	\$1,840.00	\$230.00	273%	\$628.97	\$5,031.78
27600	Facility	2	\$202.40	\$101.20	273%	\$276.75	\$553.50
92014	Non-Facility	118	\$6,537.35	\$55.40	273%	\$151.50	\$17,877.44
51728	Non-Facility	10	\$1,509.94	\$150.99	273%	\$412.92	\$4,129.18
<b><u>Totals</u></b>			<b><u>\$11,880.71</u></b>		<b><u>Payment Ceiling</u></b>	<b><u>\$32,489.73</u></b>	
						<b><u>Supplemental Payment</u></b>	<b><u>\$20,609.02</u></b>

TN #11-07-AApproval Date February 25, 2013Supersedes TN NEWEffective Date April 1, 2011

New York

1.4

**(i) Agreed Upon Procedures Requirement for ACR and supplemental payment calculation**

- (1) An independent accountant must conduct an Agreed Upon Procedures engagement to evaluate the ACR and supplemental payment calculations. Each plan may choose its own independent accountant, but the actual core Agreed Upon Procedures to be conducted must be presented to the State for approval. In order to evaluate the ACR and supplemental calculation, the following minimum core procedures are to be conducted by the independent accountants:
- (a) Validate if the Average Commercial Rate fee schedule utilized in the calculation is appropriate for the time period of the calculation.
  - (b) Select a random sample of at least 40 procedure codes with the highest amount of total payments to verify the mathematical accuracy of the calculation.
  - (c) Validate that only eligible providers are present in the calculation as described under this provision.

The independent accountants will design techniques that will enable them to render an "Independent Accountant's Report on Applying Agreed-Upon Procedures" to the practice plan for the State.

TN #11-07-A

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Approval Date February 25, 2013

Effective Date April 1, 2011

## New York

## 1.5

**Supplemental Medicaid Payments for Eligible Professional Services****2. Roswell Park Cancer Institute: Payment up to the Average Commercial Rate**

- (a) Effective April 1, 2011, supplemental payments will be made to Roswell Park Cancer Institute Clinical Practice Plan providers for services eligible under this provision ("Eligible Services"). Supplemental payments for Eligible Services will be equal to the difference between the Average Commercial Rate, as defined below, and Medicaid payments otherwise made under this state plan. The supplemental payment will only be applicable to the professional component of the services provided. However, supplemental fee payments will not be available for services provided at facilities participating in the Medicare Teaching Election Amendment.
- (b) Roswell Park Eligible Medical Professional Providers are:
- (1) Physicians, Nurse Practitioners and Physician Assistants; who are
  - (2) Employed by a public benefit corporation, or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a public benefit corporation facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid; and are
  - (3) Licensed by the State of New York.

Excluded providers are federally qualified health centers (FOHCs) and rural health centers (RHCs).

- (c) Eligible Services include only those services provided by a Roswell Park Eligible Medical Professional Provider while acting in their capacity as a participant in a plan for the management of the clinical practice at Roswell Park.
- (d) Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee for service payment has been made to an eligible provider. Non commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

TN #11-07-BApproval Date February 25, 2013Supersedes TN NEWEffective Date April 1, 2011

## New York

## 1.6

(e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.

**(f) Calculating the Average Commercial Rate (ACR) For Matched Procedures.**

- (1) The ACR will be calculated for Roswell based on applicable rates for the appropriate region, utilizing the top 5 commercial payers based on volume.
- (2) The ACR will be calculated annually before each state fiscal year using commercial payer data from the most recently completed twelve month period by Date of Service between July and June. The initial calculation, effective beginning April 1, 2011, will be based on commercial payer data from the period of July 1, 2010, through June 30, 2011 Date of Service.
- (3) For Eligible Service procedures (additionally distinguished by modifier and point of service) that are billed to Medicaid using codes that correspond to those recognized by commercial payers ("Matched Procedures"), a Procedure-Specific ACR will be calculated for each Matched Procedure by dividing the sum of total commercial payments for the Matched Procedure by the total number of the Matched Procedures paid by commercial payers. For services where physician extenders may be used the applicable percentage of the ACR will be applied.

**(g) Calculating ACR for Non-Matched Procedures**

- (1) For Eligible Service procedures that are billed to Medicaid using codes that do not correspond to those recognized by commercial payers ("Non-Matched Procedures"), a Procedure-Specific ACR will be calculated for each Non-Matched Procedure by calculating the overall average percentage of the matched procedures commercial payments to Medicaid payments.
- (2) This percentage is applied to the average Medicaid payments per unit for the non matched services to establish an ACR proxy payment per unit. The units for each non matched Medicaid service is multiplied by the ACR proxy, and then totaled to determine the payment ceiling.
- (3) The difference between the total Medicaid payments for the unmatched services and the ACR proxy total is the supplemental payment for unmatched services.

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Effective Date April 1, 2011

## New York

## 1.7

**(h) Determining the Supplemental Payment Amount**

- (1) For each Eligible Service procedure, the Procedure-Specific Ceiling Amount is the product of the Procedure-Specific ACR and the number of times the procedure was paid by Medicaid to Eligible Medical Professional Providers. The sum of all Procedure-Specific Ceiling Amounts for all Eligible Service procedures is the Supplemental Payment Ceiling.
- (2) The Supplemental Payment Amount is calculated by subtracting total Medicaid payments made for Eligible Services from the Supplemental Payment Ceiling.

**ACR Calculation Example****Example 1.****Calculation of Average Percentage of Commercial Payments to Medicaid Payments**

<u>CPT</u>	<u>Fee Code</u>	<u>Medicaid Volume</u>	<u>Medicaid Payments</u>	<u>ACR</u>	<u>ACR Medicaid Volume</u>
99201	Facility	9	\$ 98.33	\$ 37.56	\$ 338.02
99201	Non-Facility	29	\$659.46	\$ 48.16	\$1,396.50
99202	Facility	67	\$1,451.31	\$ 72.65	\$4,867.86
99202	Non-Facility	68	\$2,533.87	\$ 83.34	\$5,667.20
99203	Facility	255	\$8,491.44	\$110.72	\$28,234.48
99203	Non-Facility	154	\$8,590.88	\$123.25	\$18,980.55
99204	Facility	157	\$8,822.54	\$179.74	\$28,218.70
99204	Non-Facility	115	\$9,570.55	\$184.33	\$21,197.88
99205	Facility	63	\$4,485.55	\$234.13	\$14,750.23
99205	Non-Facility	38	\$3,805.95	\$237.02	\$9,006.72
<b><u>Total Fees</u></b>			<b><u>\$ 48,509.88</u></b>		<b><u>\$ 132,658.13</u></b>
<b><u>Average percentage of Commercial Payments to Medicaid Payments</u></b>					<b><u>273%</u></b>

**Example 2:****Calculation of Payment Ceiling for Non Matched Codes and Total Supplemental Payment**

<u>CPT</u>	<u>Fee Code</u>	<u>Medicaid Volume</u>	<u>Medicaid Payments</u>	<u>Average Medicaid Payment</u>	<u>Comm. % of Medicaid</u>	<u>Calculated ACR Proxy</u>	<u>Calculated Payment Ceiling</u>
59514	Facility	2	\$1,791.02	\$895.51	273%	\$2,448.92	\$4,897.83
59840	Facility	8	\$1,840.00	\$230.00	273%	\$628.97	\$5,031.78
27600	Facility	2	\$202.40	\$101.20	273%	\$276.75	\$553.50
92014	Non-Facility	118	\$6,537.35	\$55.40	273%	\$151.50	\$17,877.44
51728	Non-Facility	10	\$1,509.94	\$150.99	273%	\$412.92	\$4,129.18
<b><u>Totals</u></b>			<b><u>\$11,880.71</u></b>		<b><u>Payment Ceiling</u></b>	<b><u>\$32,489.73</u></b>	
						<b><u>Supplemental Payment</u></b>	<b><u>\$20,609.02</u></b>

TN #11-07-BApproval Date February 25, 2013Supersedes TN NEWEffective Date April 1, 2011

New York

1.8

- (i) Agreed Upon Procedures Requirement for ACR and supplemental payment calculation
  - (1) An independent accountant must conduct an Agreed Upon Procedures engagement to evaluate the ACR and supplemental payment calculations. Each plan may choose its own independent accountant, but the actual core Agreed Upon Procedures to be conducted must be presented to the State for approval. In order to evaluate the ACR and supplemental calculation, the following minimum core procedures are to be conducted by the independent accountants:
    - (a) Validate if the Average Commercial Rate fee schedule utilized in the calculation is appropriate for the time period of the calculation.
    - (b) Select a random sample of at least 40 procedure codes with the highest amount of total payments to verify the mathematical accuracy of the calculation.
    - (c) Validate that only eligible providers are present in the calculation as described under this provision.

The independent accountants will design techniques that will enable them to render an "Independent Accountant's Report on Applying Agreed-Upon Procedures" to the practice plan for the State.

**New York**  
**1.9**

**Supplemental Medicaid Payments for Professional Services**

**3. Medicare Fee Equivalent Calculation**

- a. Effective April 1, 2011, supplemental payments will be made to physicians, nurse practitioners and physician assistants who are employed by a Public Benefit Corporation (PBC), or a non-state operated public general hospital operated by a PBC or who are providing professional services at a PBC facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid. The supplemental payments will be applicable only to the professional component of the eligible services provided.
- b. Eligible providers are affiliated with:
  - i. New York City Health and Hospital Corporation (HHC), excluding facilities participating in the Medicare Teaching Election Amendment.
  - ii. Nassau University Medical Center, [and]
  - iii. Westchester Medical Center, and
  - iv. Erie County Medical Center, effective July 1, 2015.

Excluded facilities are Federal Qualified Health Centers and Rural Health Centers.

- c. Supplemental payments for eligible services will equal the difference between the Medicare Part B fee schedule rate and the average Medicaid payment per unit otherwise made under this Attachment.
- d. Supplemental payments will be made as an annual aggregate lump sum, and be based on the Medicaid data applicable to the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year. A final payment will be made one year following the initial payment to capture those claims for the payment year dates of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.
- e. Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee-for-service payment has been made to an eligible provider. Non-commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

TN 15-0005

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Supersedes TN #11-0007-C

Effective Date July 1, 2015

## New York

## 1.10

**Calculating the Supplemental Payment**

- (1) Each group will calculate their own supplemental payments for professional services using the following methodology:
  - (a) The identification of claims will be based on individual Current Procedural Terminology (CPT) codes contained in the New York State Medicaid program claims processing system- eMedNY.
  - (b) Supplemental payments for eligible professional services are available only for benefits covered by Medicare.
- (2) For Medicaid matched services, a Medicare Part B fee equivalent payment will be calculated by multiplying the Medicaid equivalent services/procedures by the applicable Medicare Part B fee schedule amount.
- (3) For eligible service procedures that are billed to Medicaid using codes that do not correspond to the applicable Medicare fee schedule ("non-matched" procedure), the percentage computed using a calculation of the overall average percent of the Medicaid payment to Medicare payment for the matched procedures will be applied to the non-matched Medicaid procedures.
- (4) The supplemental payment will equal the difference between the Medicare payment per procedure calculated in accordance with the methodology multiplied by the number of Medicaid claims for each procedure, and the applicable Medicaid payments for such procedures. For services where physician extenders may be used the computation will be based on the applicable percentage of the Medicare equivalent not the full physician payment.
- (5) The date of service will dictate the fee schedule to be used. The supplemental payment will be calculated annually using the most recent Medicare Part B fee schedule in effect applicable to the dates of service of the eligible services. The calculation will be based on the Medicare Part B fee schedule for each provider's geographic region and the Medicaid data applicable to the calendar year.
- (6) The Department will review the submitted computation and attest that the data and computation used to compute the supplemental payment are accurate and comply with the methodology included in the State Plan.

TN #11-07-CApproval Date February 25, 2013Supersedes TN NEWEffective Date April 1, 2011

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**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments. (refer to Addendum)
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: \_\_\_\_\_

**Method of Payment**

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code. (refer to Addendum)
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made:  monthly  quarterly

**Primary Care Services Affected by this Payment Methodology**

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). (refer to Addendum)

99288, 99318, 99339, 99340, 99358, 99359, 99360, 99363, 99364, 99366, 66367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99461, 99464, 99499, 90461

TN <u>#13-04</u>	Approval Date <u>May 30, 2013</u>
Supersedes TN <u>NEW</u>	Effective Date <u>January 1, 2013</u>

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**(Primary Care Services Affected by this Payment Methodology – continued)**

The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224 (4/1/11), 99225 (4/1/11), 99226 (4/1/11), 90460 (1/1/13), 90471 (1/1/13), 90472 (1/1/13), 90473 (1/1/13) & 90474 (1/1/13)

**Physician Services – Vaccine Administration**

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- Medicare Physician Fee Schedule rate
- State regional maximum administration fee set by the Vaccines for Children program
- Rate using the CY 2009 conversion factor

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:\_\_\_\_\_.
- A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \$17.85.
- Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: For VFC vaccines the vaccine product was billed with the "SL" modifier. The VFC administration fee was reimbursed.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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New York  
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**Effective Date of Payment**

**E & M Services**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>

**Vaccine Administration**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>

(refer to Addendum)

TN #13-04

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Effective Date January 1, 2013

New York  
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Addendum

**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**1. Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

New York's rates will reflect all Medicare site of service and locality adjustments. The Deloitte rates provided by CMS in the file *CMS New York – Primary Care Payment Rates for EM vaccine administration ser.xlsx* provided on March 28, 2013 and the 2014 file will be used. New York will not update the rates throughout the year.

**2. Method of Payment**

New York's MMIS is being modified to make payment at the higher rate to each E&M and vaccine administration code.

**3. Primary Care Services Affected by this Payment Methodology**

This section contains a description of New York's methodology and specifies the affected billing codes. New York will not make payment under this SPA for certain listed codes, as described in this section, for which it did not make payment for as of 7/1/09. New York will make payment under this SPA for the following codes (as described in this section) which have been added to the fee schedule since 7/1/09:

- **Subsequent observation care services** were covered and reimbursed by New York State Medicaid as of 7/1/09. Provider Manual Reference for: New York State Medicaid Program Physician – Procedure Codes Section 2 – Medicine, Drugs and Drug Administration (Revised 4/1/09), p 20: *"The following codes are used to report the encounter(s) by the supervising practitioner with the patient when designated as "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and **performance of periodic reassessments.**"*(emphasis added).

[https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect2\\_2009-1.pdf](https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect2_2009-1.pdf)

**Vaccine administration services** were covered and reimbursed by New York State Medicaid as of 7/1/09. Refer to item #5 of the Addendum, Documentation of Vaccine Administration Rates in Effect 7/1/09, for more details.

**4. Physician Services – Vaccine Administration**

Since the VFC Regional Maximum is the "lesser of" rate for children, New York will reimburse \$25.10 to qualified physicians.

TN #13-04

Approval Date May 30, 2013

Supersedes TN NEW

Effective Date January 1, 2013

## Attachment to Addendum

## Crosswalk of Vaccine Product Codes to Administration Codes

Vaccine Code	Administration Code
90585	90471, 90472
90586	90471, 90472
90632	90460, 90471, 90472
90633	90460, 90471, 90472
90636	90460, 90471, 90472
90645	90471, 90472
90646	90471, 90472
90647	90460, 90471, 90472
90648	90460, 90471, 90472
90649	90460, 90471, 90472
90650	90460, 90471, 90472
90654	90471, 90472
90655	90460
90656	90460, 90471, 90472
90657	90460
90658	90460, 90471, 90472
90660	90460, 90473, 90474
90662	90471, 90472
90669	90460, 90471, 90472
90670	90460, 90471, 90472
90675	90471, 90472
90676	90471, 90472
90680	90460, 90473, 90474
90681	90460, 90473, 90474
90690	90473, 90474
90691	90471, 90472
90692	90471, 90472
90696	90460
90698	90460, 90471, 90472
90700	90460
90702	90471, 90472
90703	90471, 90472
90704	90471, 90472
90705	90471, 90472
90706	90471, 90472
90707	90460, 90471, 90472
90708	90471, 90472
90710	90460
90712	90473, 90474
90713	90460, 90471, 90472
90714	90460, 90471, 90472
90715	90460, 90471, 90472
90716	90460, 90471, 90472
90717	90471, 90472
90720	90471, 90472
90721	90460, 90471, 90472
90723	90460, 90471, 90472
90725	90471, 90472
90732	90460, 90471, 90472
90733	90471, 90472
90734	90460, 90471, 90472
90735	90471, 90472
90736	90471, 90472
90738	90471, 90472
90740	90471, 90472
90743	90460, 90471, 90472
90744	90460, 90471, 90472
90746	90460, 90471, 90472
90747	90471, 90472
90748	90460, 90471, 90472

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**Addendum (continued)**

**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**5. Documentation of Vaccine Administration Rates in Effect 7/1/09**

The documentation is available from the: New York State Medicaid Program Physician – Procedure Codes Section 3 Drugs and Drug Administration (Revised 4/1/09), page 5:

**VFC:** *“For dates of service on or after 7/1/03 when immunization materials are supplied by the Vaccine for Children Program (VFC), bill using the procedure code that represents the immunization(s) administered and **append modifier –SL State Supplied Vaccine** to receive the VFC administration fee.”*

**Adults/non-VFC:** *“The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen. For immunizations not supplied by the VFC Program insert acquisition cost per dose plus a two dollar (\$2.00) administration fee in amount charged field on claim form.”*

[https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect3\\_2009-1.pdf](https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect3_2009-1.pdf)

For further illustration, the following crosswalk is provided for reference between vaccine immunization administration codes activated for 1/1/13 and New York State Medicaid **billing instructions for the service on 7/1/09:**

90460 Immunization administration through 18 years of age via any route:  
Reported vaccine immunization code plus SL modifier for reimbursement of VFC supplied vaccine(s).

90471 Percutaneous, intradermal, subcutaneous, intramuscular administration, one vaccine: Included in payment for vaccine code for adults; add \$2.00 administration fee to the charge for the vaccine immunization code.

90472 Percutaneous, intradermal, subcutaneous, intramuscular administration, each additional vaccine: Included in payment for vaccine code for adults; add \$2.00 administration fee to the charge for the vaccine immunization code.

90473 Oral or nasal administration; 1 vaccine: Included in payment for vaccine code for adults; add \$2.00 administration fee to the charge for the vaccine immunization code.

90474 Oral or nasal administration, each additional vaccine: Included in payment for vaccine code for adults; add \$2.00 administration fee to the charge for the vaccine immunization code.

TN #13-04

Approval Date May 30, 2013

Supersedes TN NEW

Effective Date January 1, 2013

New York  
Page 1.16

Addendum (continued)

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

**6. Effective Date of Payment**

Physicians were notified of the effective date of the payment for the primary care rate increase in the December 2012 Medicaid Update, available at:

[http://www.health.ny.gov/health\\_care/medicaid/program/update/2012/dec12mu.pdf](http://www.health.ny.gov/health_care/medicaid/program/update/2012/dec12mu.pdf)

When the SPA is approved, the fee schedule for qualified physicians will be available at

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>

TN #13-04

Approval Date May 30, 2013

Supersedes TN NEW

Effective Date January 1, 2013

**New York  
1(A)**

**Statewide Patient Centered Medical Home – Physicians and/or Nurse Practitioners**

Fee schedules developed by the Department of Health and approved by the Division of Budget will be augmented by incentive payments to physicians and/or nurse practitioners certified by the Department as patient centered medical homes.

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain physicians' and nurse practitioners' practices as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

To improve access to high quality primary care services the statewide Medicaid Patient Centered Medical Home initiative will provide incentive payments to providers who meet "medical home" standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance's Physician Practice Connections ® -- Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Physicians and/or nurse practitioners achieving NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to physicians' and/or nurse practitioners' practices that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of "medical home" recognition: Levels 1, 2 and 3. Eligible providers will receive a per visit incentive payment commensurate with their level of "medical home" recognition. Incentive payments will be added to claims from NCOA recognized providers for visits with evaluation and management codes identified by the Department as "primary care."

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of "medical home" incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to practitioners' offices to arrive at a per-visit incentive payment amount for each level of medical home recognition.

TN #09-49-A

Supersedes TN NEW

Approval Date May 13, 2010

Effective Date December 1, 2009

New York  
1(A)(i)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on and after that date. All rates are published on the State Department of Health's website.

Once a physician and/or nurse practitioner practice advances to a higher level of "medical home" recognition he/she will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A physician and/or nurse practitioner practice may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments physicians' and/or nurse practitioners' practices must (a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and b) provide data to the Department of Health to permit the Commissioner to evaluate the impact of patient centered medical homes on quality, outcomes and cost.

TN #09-49-A  
Supersedes TN NEW

Approval Date May 13, 2010  
Effective Date December 1, 2009

**New York**  
**1(A)(i)(1)**

**Advanced Primary Care – Physicians and/or Nurse Practitioners**

Fee schedules developed by the Department of Health and approved by the Division of Budget will be augmented by incentive payments to physicians and/or nurse practitioners recognized by the Department as Advanced Primary Care (APC) practices.

Effective for periods on and after January 1, 2017, the Commissioner of Health is authorized to recognize physicians' and nurse practitioners' practices as advanced primary care practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

To improve access to high quality primary care services, the Medicaid Advanced Primary Care initiative will provide incentive payments to Physicians and/or Nurse Practitioners that meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes.

Per visit incentive payments will be made to physicians' and/or nurse practitioners' practices that meet the Department standards for recognition as an advanced primary care practice. There are three levels that correspond to providers' capabilities: Levels 1, 2, and 3. Eligible providers will receive a per-visit incentive payment commensurate with their level of Advanced Primary Care recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for Medicaid FFS. Incentive payment amounts were determined based on historic data from an established incentive payment paid to primary care providers. Factors that were part of the determination included average primary care visits per year, panel size, and level of advanced primary care practice transformation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website, [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/docs/ffs\\_incentive\\_payment\\_rates.pdf](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/ffs_incentive_payment_rates.pdf).

To maintain eligibility for incentive payments physicians' and/or nurse practitioners' practices must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

TN                   #17-0024-A                  

Approval Date           6/14/2018                  

Supersedes TN           #NEW                  

Effective Date           01/01/2017

**New York  
1(A)(ii)**

**Adirondack Medical Home Multipayor Program – Physicians and/or Nurse Practitioners**

Fee schedules developed by the Department of Health and approved by the Division of the Budget will be augmented by incentive payments to physicians and/or nurse practitioner practices certified by the Department as participants in the Adirondack Medical Home Multipayor Program.

Effective for periods on and after December 1, 2009, certain clinicians and clinics in the upper northeastern region of New York State will be certified as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D of Article 28 of the Public Health Law (PHL).

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to physicians and/or nurse practitioner practices that meet “medical home” standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance (NCOA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC® - PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of physicians and/or nurse practitioner practices to certified medical homes. Within one year, providers in the Multipayor Program must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants in order to continue to receive the incentive payment. Eligible providers will receive the same incentive payment commensurate with the following levels of “medical home” designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program physicians and /or nurse practitioner practices for visits with Evaluation and Management codes identified by the Department of Health as “primary care”.

TN #09-56-A

Supersedes TN NEW

Approval Date July 19, 2010

Effective Date December 1, 2009

New York  
1(A)(iii)

The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Mutlipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services provided on or after that date. All rates are published on the Department of Health public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While physician and/or nurse practitioner practices are participating in the Multipayor Program they are precluded from receiving incentive payments from the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

**[E-prescription**

An e-prescription financial incentive will be paid to physicians for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.]

TN     #14-08     Approval Date     May 5, 2014      
Supersedes TN     #09-56-A     Effective Date     April 1, 2014

New York  
1(a)

**Dental Services (including dentures)**

Payments are limited to the lower of the usual and customary charge to the public or the fee schedule developed by the Department of Health and approved by the Division of the Budget.

**Podiatrists**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

**Optometrists**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

**Chiropractor's Services**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

**Nurse Midwives**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Effective September 1, 2012, reimbursement will be provided to nurse midwives for breastfeeding health education and counseling services. Nurse midwives must be currently registered and licensed by the State in accordance with 42 CFR 440.60(a) and also International Board Certified Lactation Consultants (IBCLC). Date of implementation will occur on the first day of the month following 30 days after Federal approval of this provision of the State Plan.

**Nurse Practitioners**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Effective September 1, 2012, reimbursement will be provided to nurse practitioners for breastfeeding health education and counseling services. Nurse practitioners must be currently registered and licensed by the State in accordance with 42 CFR 440.60(a) and also International Board Certified Lactation Consultants (IBCLC). Date of implementation will occur on the first day of the month following 30 days after Federal approval of this provision of the State Plan.

**Other Practitioner Services**

**Clinical Psychologists**

Fee schedule developed by the Department of Health and approved by the Division of the Budget.

**Outpatient Hospital Services/Emergency Room Services**

For those facilities certified under Article 28 of the State Public Health Law: The Department of Health promulgates prospective, all inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor

TN #12-16

Approval Date December 28, 2012

Supersedes TN #95-25

Effective Date September 1, 2012

Page 1(a)(i)

[Reserved]

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: New York**

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE**

**Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only)**

Reimbursement for EPSDT NP-LBHP as outlined in Item 6.d(i). per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date. Additionally, the agency's rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. All rates are published on the Department of Health website:

[www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/bh\\_kids\\_ffs\\_rates.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/bh_kids_ffs_rates.pdf)

[www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/1.31.19\\_fpss\\_bh\\_kids\\_ffs\\_rates.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/1.31.19_fpss_bh_kids_ffs_rates.pdf)

TN # #19-0003 Approval Date 02/07/2019

Supersedes TN # 18-0052 Effective Date 01/01/2019

[Reserved]

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**STATE: New York**

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE**

**Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only - cont.)**

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

TN # #19-0003 Approval Date 02/07/2019

Supersedes TN # 18-0052 Effective Date 01/01/2019

Page 1(a)(iii)

[Reserved]

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT****STATE: New York****METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE****Rehabilitative Services (EPSDT only)**

Reimbursement for EPSDT Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date. Additionally, the agency's rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. All rates are published on the Department of Health website:

[www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/bh\\_kids\\_ffs\\_rates.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/bh_kids_ffs_rates.pdf)

[www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/1.31.19\\_fpss\\_bh\\_kids\\_ffs\\_rates.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/1.31.19_fpss_bh_kids_ffs_rates.pdf)

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

TN # #19-0003 Approval Date 02/07/2019

Supersedes TN # 18-0053 Effective Date 01/01/2019

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: New York**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EPSDT services provided as Tuberculosis/Directly Observed Therapy (TB/DOT) Services

Effective for dates of service on or after July 1, 2018, payments for Tuberculosis Directly Observed Therapy (TB/DOT) shall be based on fees established by the Department of Health.

Reimbursement for TB/DOT therapy is at the following rates:

Upstate

Rate code 5317 (Level I) equal to \$33.92

Rate code 5318 (Level II) equal to \$82.58

Downstate

Rate code 5312 (Level I) equal to \$38.82

Rate code 5313 (Level II) equal to \$95.90

Please note that for Level I the Local Health Department (LHD) is serving TB patients for purposes other than DOT on a routine basis. Level II means the LHD is serving patients who would not otherwise be seen.

LHDs bill through their Diagnostic and Treatment Center category of service 0160.

TN # #18-0039

Approval Date June 13, 2019

Supersedes TN # New

Effective Date July 1, 2018

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: New York**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EPSDT provided as EPSDT Early Intervention (EI) Services

Early and periodic screening, diagnostic and treatment services (EPSDT) for individuals under 21 years of age, and treatment of conditions found.

EPSDT EI services are delivered by Department of Health-approved early intervention service providers in each county of the State or the City of New York and include the following Medicaid services as described in Item 6.d(i) of Section 3.1-A and 3.1-B of the Medicaid State Plan.

- 1) Screening Services, 2) Evaluation Services, 3) Audiology Services, 4) Nursing Services, 5) Nutrition Services, 6) Occupational Therapy Services, 7) Physical Therapy Services, 8) Psychological Services, 9) Social Work Services, 10) Special Instruction/Developmental, Services, 11) Speech-Language Pathology Services, 12) Medical Equipment and Appliances, 13) Vision Services, 14) Applied Behavioral Analysis Services, 15) Transportation Services.

Fees established by the Department of Health and in effect on July 1, 2018 will be used to pay for EPSDT EI services furnished on or after July 1, 2018. The fees are available on the Department of Health’s website at the following links:

EPSDT EI Services (other than DME and transportation):  
[www.health.ny.gov/community/infants\\_children/early\\_intervention/service\\_rates.htm](http://www.health.ny.gov/community/infants_children/early_intervention/service_rates.htm)

EPSDT EI transportation services:  
[www.oms.nysed.gov/medicaid/resources/transportation\\_rates/sshsp\\_special\\_trans\\_rates\\_august\\_5\\_2013.pdf](http://www.oms.nysed.gov/medicaid/resources/transportation_rates/sshsp_special_trans_rates_august_5_2013.pdf)

Medical equipment and appliances are reimbursed in accordance with the methodology in place for Durable Medical Equipment on page 6(a)(viii) of the State Plan.

**TN # #18-0039 Approval Date June 13, 2019**

**Supersedes TN # New Effective Date July 1, 2018**

New York  
Page 1(a)(iii)(3)

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: New York**

**Applied Behavior Analysis**

Effective for services on or after October 1, 2019, rates established by the Commissioner of Health and approved by the Director of the Budget will reflect Applied Behavior Analysis (ABA) costs on a per hour basis when medically necessary ABA services have taken place.

Rates for the assessment and delivery of ABA services will be the amount billed by the provider not to exceed \$29.00 per hour. Services less than 60 minutes are not eligible for reimbursement.

TN 19-0046

Supersedes TN NEW

Approval Date December 17, 2019

Effective Date October 1, 2019

New York  
1(a)(iv)

**E-prescription**

An e-prescription financial incentive will be paid to physicians for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for physicians will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

An e-prescription financial incentive will be paid to dentists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for dentists will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

TN #14-08

Supersedes TN #09-53

Approval Date May 5, 2014

Effective Date April 1, 2014

**New York  
1(a)(v)**

An e-prescription financial incentive will be paid to podiatrists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for podiatrists will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

TN #14-08

Approval Date May 5, 2014

Supersedes TN #09-53

Effective Date April 1, 2014

**New York  
1(a)(vi)**

An e-prescription financial incentive will be paid to optometrists for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for optometrists will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

TN #14-08  
Supersedes TN #09-53

Approval Date May 5, 2014  
Effective Date April 1, 2014

**New York  
1(a)(vii)**

An e-prescription financial incentive will be paid to nurse midwives for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for nurse midwives will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

TN #14-08  
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Effective Date April 1, 2014

**New York  
1(a)(viii)**

An e-prescription financial incentive will be paid to nurse practitioners for the purpose of encouraging the electronic transmission of prescriptions and fiscal orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at 80 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for nurse practitioners will cease and reimbursement at 80 cents per electronic prescription/fiscal order will end.

TN #14-08  
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Effective Date April 1, 2014

**New York  
1(b)**

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of \$150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, will be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services will be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, will be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of \$95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component will be \$125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component will be \$140 per visit; and during the period January 1, 2009 through March 31, 2010 emergency department services will be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the capital costs per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

**TN**     #19-0042    

**Supersedes TN**   #17-0034  

**Approval Date**     September 26, 2019    

**Effective Date**     April 1, 2019

**New York**  
**1(b)(i)**

For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health [shall] will apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor [shall] will be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health [shall] will apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% [shall] will be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period [shall] will be no greater than zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospitals provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

**New York**  
**1(b)(i)(1)**

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

TN #11-66  
Supersedes TN NEW

Approval Date August 6, 2012  
Effective Date April 1, 2011

New York  
1(b)(i)(1)(a)

**Exempt acute care children's hospitals**

1. Exempt acute care children's hospitals.

Hospitals shall qualify for outpatient reimbursement for specialty day hospital services as exempt acute care children's hospitals for periods on and after December 1, 2009, only if:

a. Such hospitals were, as of December 31, 2008, designated as exempt acute care children's hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act; and

b. Such hospitals filed a discrete 2007 institutional cost report on or before December 1, 2008, including such adjustments as the Commissioner deems appropriate, reflecting reported Medicaid discharges of greater than 50 percent of total discharges.

2. The operating component of the rate for dates of service occurring on and after December 1, 2009; the base period reported operating costs shall be divided by the base period total visits to establish an all-inclusive operating cost per visit. The base period used to establish the operating component of rates of payment for outpatient services for facilities subject to this section shall be updated no less frequently than every two years and each such hospital shall submit such additional data as the Commissioner may require.

3. The non-operating component of the rate for dates of service occurring on and after December 1, 2009; the base period reported non-operating costs used to establish the non-operating component of rates of payment, such as capital costs, for outpatient services for facilities subject to this section shall reflect the current methodology in accordance with the Outpatient Hospital Services/Emergency Services reimbursement section of this Attachment.

TN #09-67

Supersedes TN NEW

Approval Date August 22, 2011

Effective Date December 1, 2009

**New York**  
**1(b)(ii)**

**Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services**

Hospital-Based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services. For dates of service on and after December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and until March 31, 2010, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services, as modified by the APG methodology.

Reimbursement for providers designated as preferred primary care providers or for hospital based programs providing specialty clinic services is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system. Federally Qualified Health Centers (FQHCs) may choose to be paid under the APG methodology, or may choose to continue to receive payment under the existing prospective payment system (PPS) rate methodology. The payment methodology selected by the FQHC will apply to all claims submitted. PAC rates will continue to be available as a payment mechanism only for those FQHCs that opt to continue using them instead of switching to APG payments. In addition, FQHCs may apply for temporary rate adjustments under the alternate payment methodology as described in the sections entitled "Mergers, acquisitions, consolidations, restructurings, and closings." FQHCs that are granted such adjustments will be listed in the section "Mergers, acquisitions, consolidations, restructurings, and closings" for hospital-based outpatient or freestanding clinics, whichever is applicable.

Under the PAC reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service, a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

TN     #11-0026    

Supersedes TN     #08-0032    

Approval Date     June 9, 2015    

Effective Date     April 1, 2012

**New York  
1(b)(iii)**

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

TN   #08-32  

Approval Date   September 9, 2011  

Supersedes TN   #07-12  

Effective Date   April 1, 2008

**New York  
1(c)**

[medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.]

**Ordered Ambulatory Services (specific services performed by a hospital on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient)**

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services will not exceed the combined payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

TN     #08-32    

Supersedes TN     #06-45    

Approval Date     September 9, 2011    

Effective Date     April 1, 2008

**New York  
1(c)(i)**

[payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.]

**Trend Factors**

Notwithstanding any inconsistent provision of this state plan, effective April 1, 2000, in those instances when trend factors are used in determining rates of payment for hospital outpatient services, diagnostic and treatment centers unless otherwise subject to the rate freeze set forth herein, certified home health agencies, and personal care services, the Commissioner of Health shall apply trend factors in accordance with the following:

- (1) For rate periods on and after April first, two thousand, the Commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services whose rate of payment are established by the commissioners of the Department of Mental Hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.
- (2) In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget outlook after June first of the rate year prior to the year for which rates are being developed.
- (3) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the U.S. Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in number two of this section and any difference will be included in the prospective trend factor for the current year.

Nothing in this section is intended to produce a change in any existing provision of law establishing maximum reimbursement rates.

TN     #08-32      
Supersedes TN     #05-21    

Approval Date     September 9, 2011      
Effective Date     April 1, 2008

New York  
1(c)(i)(A)

**Statewide Patient Centered Medical Home - Hospital Based Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinics as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service (FFS).

Clinic shall mean a general hospital providing outpatient care, licensed under Article 28 of the Public Health Law.

To improve access to high quality primary care services, the statewide Medicaid Patient Centered Medical Home initiative will provide incentive payments to Clinics that meet "medical home" standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance's Physician Practice Connections ® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Clinics achieving NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to Clinics that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of "medical home" recognition: Levels 1, 2 and 3. Eligible Clinics will receive a per visit incentive payment commensurate with their level of "medical home" recognition. Incentive payments will be added to claims from NCOA recognized Clinics for visits with evaluation and management codes identified by the Department as "primary care."

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Supersedes TN NEW

Approval Date September 23, 2011  
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**New York**  
**1(c)(i)(B)**

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of "medical home" incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to general hospitals providing outpatient care, free standing diagnostic and treatment centers, and Federally Qualified Health Centers to arrive at a per-visit incentive payment amount for each level of medical home recognition.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

The "medical home" recognition level for Clinics is site-specific. Once a Clinic advances to a higher level of "medical home" recognition it will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A Clinic may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments, Clinics must: (a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and (b) provide data to the Department of Health to permit the Commissioner to evaluate the effect of patient centered medical homes on quality, outcomes, and cost.

TN #09-49-B

Supersedes TN NEW

Approval Date September 23, 2011

Effective Date December 1, 2009

**New York**  
**1(c)(i)(B.1)**

**Advanced Primary Care – Hospital Based Clinics**

Effective for periods on and after January 1, 2017, the Commissioner of Health is authorized to recognize certain clinics as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

Clinic shall mean a general hospital providing outpatient care, licensed under Article 28 of Public Health Law.

To improve access to high quality primary care services, the Medicaid Advanced Primary Care initiative will provide incentive payments to Hospital Based Clinics that meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes.

Per visit incentive payments will be made to Clinics that meet the Department standards for recognition as an Advanced Primary Care practice. There are three levels that correspond to providers' capabilities: Levels 1, 2, and 3. Eligible providers will receive a per-visit incentive payment commensurate with their level of Advanced Primary Care recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Clinics is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for Medicaid FFS. Incentive payment amounts were determined based on historic data from an incentive payment paid to primary care providers. Factors that were part of the determination included average primary care visits per year, panel size, and level of advanced primary care practice transformation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website, [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/docs/ffs\\_incentive\\_payment\\_rates.pdf](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/ffs_incentive_payment_rates.pdf).

To maintain eligibility for incentive payments, Clinics must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

TN                   #17-0024-B                  

Approval Date           06/14/2018                  

Supersedes TN           #NEW                  

Effective Date           01/01/2017

New York  
1(c)(i)(C)

**Adirondack Medical Home Multipayor Program – Hospital-Based Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service.

**Clinic** shall mean a general hospital providing outpatient care, licensed under Article 28 of the PHL.

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to clinics that meet “medical home” standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance’s (NCQA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of these clinic practices to certified medical homes. Within one year, providers in the Multipayor program must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants in order to continue to receive the incentive payment. Eligible providers will receive the same incentive payment commensurate with the following levels of “medical home” designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program clinics for visits with Evaluation and Management codes identified by the Department of Health as “primary care.”

The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide “medical home” patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount, the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics

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New York  
1(c)(i)(D)

and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, state- developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services on or after that date. All Medicaid rates are published on the Department of Health's public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While clinics and clinicians are participating in the Multipayer Program, they are precluded from receiving incentive payments under the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

TN #09-56-B  
Supersedes TN NEW

Approval Date September 23, 2011  
Effective Date December 1, 2009

New York  
1(c)(i)(E)

**Statewide Patient Centered Medical Home – Freestanding Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinics as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

Clinic shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of the Public Health Law.

To improve access to high quality primary care services, the statewide Patient Centered Medicaid Medical Home initiative will provide incentive payments to Clinics meeting “medical home” standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance’s Physician Practice Connections ® -- Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Clinics achieving the NCOA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to Clinics that meet the Department standards for certification as a patient centered medical homes, consistent with the NCOA PPC®-PCMH™ Program. There are three levels of “medical home” recognition: Levels 1, 2 and 3. Eligible Clinics will receive a per visit incentive payment commensurate with their level of “medical home” recognition. Incentive payments will be added to claims from NCOA recognized Clinics for visits with evaluation and management codes identified by the Department as “primary care.”

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of “medical home” incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by

TN #09-49-C  
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**New York**  
**1(c)(i)(F)**

programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to general hospitals providing outpatient care, free standing diagnostic and treatment centers, and Federally Qualified Health Centers to arrive at a per-visit incentive payment amount for each level of medical home recognition.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on and after that date. All rates are published on the State Department of Health's website.

The "medical home" recognition for clinics is site-specific. Once a Clinic advances to a higher level of "medical home" designation it will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A Clinic may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments, Clinics must (a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and (b) provide data to the Department to permit the Commissioner to evaluate the impact of patient centered medical homes on quality, outcomes and cost.

TN #09-49-C  
Supersedes TN NEW

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New York  
1(c)(i)(F.1)

**Advanced Primary Care – Freestanding Clinics**

Effective for periods on and after January 1, 2017, the Commissioner of Health is authorized to recognize certain clinics as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

Clinic shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of Public Health Law.

To improve access to high quality primary care services, the Medicaid Advanced Primary Care initiative will provide incentive payments to Freestanding Clinics that meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes.

Per visit incentive payments will be made to Clinics that meet the Department standards for recognition as an advanced primary care practice. There are three levels that correspond to providers' capabilities: Levels 1, 2, and 3. Eligible providers will receive a per-visit incentive payment commensurate with their level of Advanced Primary Care recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Clinics is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for Medicaid FFS. Incentive payment amounts were determined based on historic data from an established incentive payment paid to primary care providers. Factors that were part of the determination included: average primary care visits per year, panel size, and level of advanced primary care practice transformation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website, [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/docs/ffs\\_incentive\\_payment\\_rates.pdf](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/ffs_incentive_payment_rates.pdf).

To maintain eligibility for incentive payments, Clinics must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

TN                   #17-0024 - C                  

Approval Date           06/14/2018                  

Supersedes TN           #NEW                  

Effective Date           01/01/2017

**New York  
1(c)(i)(G)**

**Adirondack Medical Home Multipayor Program – Freestanding Clinics**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D of Article 28 of the Public Health Law (PHL).

**Clinic** shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to clinics that meet “medical home” standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance’s (NCQA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of these clinic practices to certified medical homes. Within one year, providers in the Multipayor Program must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants. Eligible providers will receive the same incentive payment commensurate with the following levels of “medical home” designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program clinics for visits with Evaluation and Management codes identified by the Department of Health as “primary care”.

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New York  
1(c)(i)(H)

The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services provided on or after that date. All rates are published on the Department of Health's Public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While clinics and clinicians are participating in the Multipayor Program, they are precluded from receiving incentive payments from the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

TN #09-56-C  
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New York  
1(c)(i)(I)

**Statewide Patient Centered Medical Home – Federally Qualified Health Centers**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinics as patient centered medical homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

A Federally Qualified Health Center shall mean a general hospital providing outpatient care or a free standing diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

To improve access to high quality primary care services, the statewide Medicaid Patient Centered Medical Home initiative will provide incentive payments to Federally Qualified Health Centers that meet “medical home” standards established by the Department. Those standards will be consistent with the National Committee for Quality Assurance’s (NCQA) Physician Practice Connections ® -- Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program. Federally Qualified Health Centers achieving the NCQA PPC®-PCMH™ recognition will be eligible for incentive payments for providing services to Medicaid FFS patients.

Per visit incentive payments will be made to Federally Qualified Health Centers that meet the Department standards for certification as a patient centered medical homes, consistent with the NCQA PPC®-PCMH™ Program. There are three levels of “medical home” recognition: Levels 1, 2 and 3. Eligible Federally Qualified Health Centers will receive a per visit incentive payment commensurate with their level of “medical home” recognition. Incentive payments will be added to claims from NCQA recognized Federally Qualified Health Centers for visits with evaluation and management codes identified by the Department as “primary care.”

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New York  
1(c)(i)(J)

To determine appropriate incentive payment amounts, the NY Medicaid Program conducted a review of "medical home" incentive payments nationally. Most programs paid medical home incentive payments on a per member per month (PMPM) basis. To work in the fee-for-service payment context, PMPM benchmark amounts used by programs in several other states (\$2, \$4, and \$6) were converted to per-visit payment amounts by first multiplying the PMPM payment by twelve (12) to calculate an annual per member payment, and then dividing the annual amount by the average number of annual primary care visits to general hospitals providing outpatient care, free standing diagnostic and treatment centers, and Federally Qualified Health Centers to arrive at a per-visit incentive payment amount for each level of medical home recognition.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as patient centered medical homes. The agency's fee schedule rates were set as of December 1, 2009 and are effective for services provided on and after that date. All rates are published on the State Department of Health's website.

The "medical home" recognition level for Federally Qualified Health Centers is site-specific. Once a Federally Qualified Health Center advances to a higher level of "medical home" recognition it will no longer be eligible for the lower level incentive payment per Evaluation and Management visit. A Federally Qualified Health Center may only receive one level of incentive payment at a time for each eligible visit. Medical home incentive payments are only applicable to claims when Medicaid is the primary payer.

To maintain eligibility for incentive payments, Federally Qualified Health Centers must (a) renew their "patient centered medical home" certification at a frequency determined by the Commissioner; and b) provide data to the Department of Health to permit the Commissioner to evaluate the effect of patient centered medical homes on quality, outcomes and cost.

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**New York**  
**1(c)(i)(J.1)**

**Advanced Primary Care – Federally Qualified Health Centers**

Effective for periods on and after January 1, 2017 the Commissioner of Health is authorized to recognize certain clinics as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

A Federally Qualified Health Center shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of Public Health Law that is designated as a Federally Qualified Health Center pursuant to section 1861 (aa) of the Social Security Act.

To improve access to high quality primary care services, the Medicaid Advanced Primary Care initiative will provide incentive payments to Federally Qualified Health Centers that meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes.

Per visit incentive payments will be made to Federally Qualified Health Centers that meet the Department standards for recognition as an advanced primary care practice. There are three levels that correspond to providers' capabilities: Levels 1, 2, and 3. Eligible providers will receive a per-visit incentive payment commensurate with their level of Advanced Primary Care recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Federally Qualified Health Centers is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for Medicaid FFS. Incentive payment amounts were determined based on historic data from an incentive payment paid to primary care providers. Factors that were part of the determination included average primary care visits per year, panel size, and level of advanced primary care practice transformation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website, [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/docs/ffs\\_incentive\\_payment\\_rates.pdf](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/ffs_incentive_payment_rates.pdf).

To maintain eligibility for incentive payments, Federally Qualified Health Centers must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

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**New York**  
**1(c)(i)(K)**

**Adirondack Medical Home Multipayor Program – Federally Qualified Health Centers (FQHCs)**

Effective for periods on and after December 1, 2009, the Commissioner of Health is authorized to certify certain clinicians and clinics in the upper northeastern region of New York State as health care homes to improve health outcomes and efficiency through patient care continuity and coordination of health services. Certified providers will be eligible for incentive payments for services provided to recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; and enrollees eligible for and enrolled in Family Health Plus organizations pursuant to Title 11-D pursuant to Article 28 of the Public Health Law (PHL).

**A Federally Qualified Health Center** shall mean a general hospital providing outpatient care or a free-standing diagnostic and treatment center licensed under Article 28 of the Public Health Law that is designated as a Federally Qualified Health Center pursuant to Section 1861(aa) of the Social Security Act.

The Adirondack Medical Home Multipayor Program is a primary care medical home collaborative of health care service providers including hospitals, diagnostic and treatment centers and private practices serving residents and eligible recipients in the counties of Clinton, Essex, Franklin, Hamilton, Saratoga and Warren. Incentive payments to FQHCs that meet “medical home” standards will be established jointly by the State Department of Health, participating health care service providers and payors. Medical home certification includes, but is not limited to, existing standards developed by national accrediting and professional organizations, including the National Committee for Quality Assurance’s (NCQA) Physician Practice Connections® - Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program.

Under this program, incentive payments will be made for one year to participating providers to support conversion of these FQHC practices to certified medical homes. Within one year, providers in the Multipayor Program must achieve either Level 2 or Level 3 including additional criteria (referred to as Level 2 Plus and Level 3 Plus) as determined by the program participants. Eligible providers will receive the same incentive payment commensurate with the following levels of “medical home” designation: conversion support; Level 2 Plus; or Level 3 Plus. There will be no incentive payment for Level 1 designation. Incentive payments will be added to claims from program FQHCs for visits with Evaluation and Management codes identified by the Department of Health as “primary care”.

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**New York**  
**1(c)(i)(L)**

The incentive amount was determined by the Department of Health and participating payors based on a market analysis of the cost to support the conversion of a practice to provide "medical home" patient care and management information systems related to meeting the objectives of this initiative. The participating payors agreed to a per member per month (PMPM) incentive payment of \$7. To calculate the per-visit incentive payment amount, the PMPM was multiplied by twelve (12) to calculate an annual per member payment (\$84) and then this annual amount was divided by the average number of annual primary care visits to clinics and practitioners' offices to arrive at a per visit incentive payment. The average annual visit rate, based on two years of claims data (January 1, 2007 – December 31, 2008) for a specific list of providers who agreed to participate in the Multipayor Program, was 3 visits per year. Therefore, the per visit incentive payment is \$28. The incentive amount will be approved by the Division of the Budget.

Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of primary care "medical home" services in the Multipayor Program. The agency's fee schedule rate was set as of December 1, 2009 and is effective for services provided on or after that date. All Medicaid rates are published on the Department of Health's Public website.

Patient and health care services participation in the Adirondack Medical Home Multipayor Program is on a voluntary basis. While FQHCs are participating in the Multipayor Program, they are precluded from receiving incentive payments under the statewide patient centered medical home program established pursuant to section 364-m of the Social Services Law.

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New York  
1(c)(ii)

**Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law**

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, [and] on and after April 1, 2003 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

TN   #11-21  

Approval Date   August 31, 2012  

Supersedes TN   #09-23-A  

Effective Date   April 1, 2011

**New York**  
**1(d)**

The rates include a capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. For the period October 1, 2004 through December 31, 2004, freestanding clinic MMTP services shall be reimbursed on a uniform weekly fee per enrolled patient at the rate of \$173.13. For the period beginning on January 1, 2005 and thereafter, the uniform fixed weekly fee for MMTP services will equal 100% of the weekly rate for hospital based MMTP service providers. Payment rates for renal dialysis services of \$150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

**Additional Funding for Diagnostic and Treatment Centers for the period October 1, 1999 through December 31, 1999**

Rates for diagnostic and treatment centers for the period October 1, 1999 through December 31, 1999 shall include, in the aggregate, the sum of fourteen million dollars (\$14,000,000) which shall be added to rates of payment based on an apportionment of such amount using a ratio of each individual providers estimated Medicaid expenditures to total estimated Medicaid expenditures for diagnostic and treatment centers, as determined by the Commissioner, for the October 1, 1999 through September 30, 2000 rate period.

**Additional Funding for Diagnostic and Treatment Centers Providing Services to Persons with Developmental Disabilities**

For the period July 1, 2000, through March 31, 2001 and annual state fiscal periods thereafter, fee-for-service rates of payment for medical assistance services provided to patients eligible for federal financial participation under title XIX of the federal social security act by diagnostic and treatment centers licensed under article 28 of the public health law that provide services to individuals with developmental disabilities as their principal mission, shall be increased by

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**New York  
1(d)(i)**

annual amounts of two million two hundred eighty thousand dollars (\$2,280,000) in the aggregate. Each such diagnostic and treatment center shall receive a proportionate share of these funds based upon the ratio of its medical assistance units of service to the total medical assistance units of service of all such facilities during the base year. The base year shall be the calendar year immediately proceeding each annual period. There shall be no reconciliation of the amount added to rates of payment pursuant to this section to reflect the actual number of Medicaid units of service for affected providers for the period July 1, 2000 to March 31, 2001 and annual state fiscal periods thereafter.

**Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers**

**Services for medically supervised chemical dependence treatment and medically supervised withdrawal services**

For dates of service beginning on July 1, 2002, facilities providing these services shall be reimbursed at their existing rate for provision of comprehensive diagnostic and treatment center services as described in the paragraphs of the section of this plan titled Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law; Including Federally Qualified Health Centers.

**Designated Preferred Primary Care Provider for Freestanding Diagnostic and Treatment Centers**

Freestanding Diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add-on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities. The per visit rate add-on is calculated by dividing the related capital cost by current patient visit volume.

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New York  
1(e)

The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits. This supplemental bad debt and charity care allowance shall be in effect until December 31, 1996.

For services provided on or after April 1, 1995, by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994, based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995, for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

TN #07-06

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New York  
1(e)(1)

**Ambulatory Patient Group System: Hospital-Based Outpatient**

For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through December 31, [2018] 2019, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

If a clinic is certified by the Office of People with Developmental Disabilities (OPWDD), reimbursement will be as specified in the OPWDD section of the State Plan.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems. When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

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New York  
1(e)(2)

**APG Reimbursement Methodology – Hospital Outpatient**

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at [http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm). In addition, prior period information associated with these links is available upon request to the Department of Health.

**Contact Information:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm) Click on "Contacts."

**3M APG Crosswalk, version 3.14; updated as of [01/01/19 and 04/01/19] 07/01/19 and 10/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/crosswalk/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm)

<http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html> Click on "Accept" at bottom of page to gain access.

**APG Alternative Payment Fee Schedule; updated as of 01/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Alternative Payment Fee Schedule."

**APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/bundling/](http://www.health.ny.gov/health_care/medicaid/rates/bundling/) Click on "2019"

**APG 3M Definitions Manual Versions; updated as of [01/01/19 and 04/01/18] 07/01/19 and 10/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/crosswalk/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm)

**APG Investments by Rate Period; updated as of 01/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Investments by Rate Period."

**APG Relative Weights; updated as of [01/01/19] 07/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

**Associated Ancillaries; updated as of 07/01/15:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm) Click on "Ancillary Policy."

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**New York  
1(e)(2.1)**

**Carve-outs; updated as of 10/01/12:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Carve Outs."

**Coding Improvement Factors (CIF); updated as of 07/01/12:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "CIFs by Rate Period."

**If Stand Alone, Do Not Pay APGs; updated as of 01/01/15:**

[http://www.health.state.ny.us/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm) Click on "If Stand Alone, Do Not Pay APGs."

**If Stand Alone, Do Not Pay Procedures; updated as of 01/01/19:**

[http://www.health.state.ny.us/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm) Click on "If Stand Alone, Do Not Pay Procedures."

**Modifiers; updated as of 07/01/18:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Modifiers."

**Never Pay APGs; updated as of 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Never Pay APGs."

**Never Pay Procedures; updated as of [07/01/18] 07/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Never Pay Procedures."

**No-Blend APGs; updated as of 04/01/10:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Blend APGs."

**No-Blend Procedures; updated as of 01/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Blend Procedures."

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New York  
1(e)(2.2)

**No Capital Add-on APGs; updated as of 07/01/13:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Capital Add-on APGs."

**No Capital Add-on Procedures; updated as of 07/01/17:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Capital Add-on Procedures."

**Non-50% Discounting APG List; updated as of 07/01/17:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Non-50% Discounting APG List."

**Rate Codes Carved Out of APGs; updated as of 01/01/15:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Rate Codes Carved Out of APGs for Article 28 facilities."

**Rate Codes Subsumed by APGs; updated as of 10/01/12:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Rate Codes Subsumed by APGs – Hospital Article 28."

**Statewide Base Rate APGs; updated as of [01/01/14] 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Statewide Base Rate APGs."

**Packaged Ancillaries in APGs; updated as of [01/01/12] 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Packaged Ancillaries in APGs."

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Supersedes TN       #17-0055      

Approval Date           05/22/2019          

Effective Date           01/01/2019

**New York  
1(e)(3)**

**Hospital-Based APG Base Rate Table**

Peer Group	Region	Rate Start Date	Base Rate Updated as of 05/01/12
Ambulatory Surgery Services	Downstate	12/01/08	\$195.59
Ambulatory Surgery Services	Upstate	12/01/08	\$151.09
Clinic*	Downstate	12/01/08	\$183.53
Clinic*	Upstate	12/01/08	\$140.52
Clinic Episode*	Downstate	07/01/09	\$183.53
Clinic Episode*	Upstate	07/01/09	\$140.52
Clinic MR/DD/TBI <sup>*(1)</sup>	Downstate	07/01/10	\$220.23
Clinic MR/DD/TBI <sup>*(1)</sup>	Upstate	07/01/10	\$168.63
Clinic MR/DD/TBI Episode <sup>*(1)</sup>	Downstate	07/01/10	\$220.23
Clinic MR/DD/TBI Episode <sup>*(1)</sup>	Upstate	07/01/10	\$168.63
Emergency Department	Downstate	01/01/09	\$197.38
Emergency Department	Upstate	01/01/09	\$154.15
<u>Statewide Base Price<sup>(2)</sup></u>	<u>Statewide</u>	<u>01/01/11</u>	<u>\$160.00</u>

\*For Clinic (effective 12/1/08) & School-Based Health Center (SBHC) (effective 4/1/09), while they share the same base payment rates, please note that their rate codes and effective dates differ.

<sup>(2)</sup> Statewide Base Price is not a service but used for APGs which do not have a payment differentiation for upstate and downstate providers.

Hospital-based Article 28 Medicaid rates can also be found at the Department of Health's website at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm)

TN           #14-0001          

Supersedes TN           #12-0031          

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Effective Date           January 1, 2014

**New York  
1(e)(4)**

**Freestanding Diagnostic and Treatment Center APG Base Rate Table**

<b>Peer Group</b>	<b>Region</b>	<b>Rate Start Date</b>	<b>Base Rate Effective 09/1/2009</b>
General Clinic	Downstate	09/01/09	\$212.07
General Clinic	Upstate	09/01/09	\$174.74
General Clinic MR/DD/TBI	Downstate	09/01/09	\$254.48
General Clinic MR/DD/TBI	Upstate	09/01/09	\$209.69
Dental School	Downstate	09/01/09	\$268.35
Dental School	Upstate	09/01/09	\$223.22
Renal	Downstate	09/01/09	\$235.70
Renal	Upstate	09/01/09	\$196.06
Ambulatory Surgery	Downstate	09/01/09	\$ 88.69
Ambulatory Surgery	Upstate	09/01/09	\$ 86.39]

TN   #09-66  

Supersedes TN   #09-62  

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Effective Date   December 1, 2009

**New York  
1(e)(5)**

**Dually Licensed Article 28 & Article 31 Hospital-Based APG Base Rate Table**

<u>Peer Group</u>	<u>Region</u>	<u>Rate Start Date</u>	<u>Base Rate as of 10/01/10</u>
<u>Mental Health Clinic</u>	<u>Downstate</u>	<u>10/1/10</u>	<u>\$181.16</u>
<u>Mental Health Clinic</u>	<u>Upstate</u>	<u>10/1/10</u>	<u>\$139.25</u>

Quality Improvement Supplement – Hospital-based clinics are not eligible for the Quality Improvement Supplement.

Hospital-based mental health clinic Medicaid blend rates can be found on the Office of Mental Health website at:

[http://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](http://www.omh.ny.gov/omhweb/medicaid_reimbursement/)

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Effective Date July 1, 2010

**New York  
1(e)(6)**

**Dually Licensed Article 28 & Article 32 Hospital-Based APG Base Rate Table**

Chemical Dependence Outpatient Clinic	Downstate	10/1/10	<del>[\$201.55]</del> <u>\$181.72</u>
Chemical Dependence Outpatient Clinic	Upstate	10/1/10	<del>[\$154.92]</del> <u>\$146.57</u>
Opioid Treatment Program (Clinic)	Downstate	1/3/11	\$180.99
Opioid Treatment Program (Clinic)	Upstate	1/3/11	\$157.14
<u>Outpatient Rehabilitation Clinic</u>	<u>Downstate</u>	<u>1/1/11</u>	<u>\$151.20</u>
<u>Outpatient Rehabilitation Clinic</u>	<u>Upstate</u>	<u>1/1/11</u>	<u>\$116.23</u>

Hospital-based OASAS clinic Medicaid rates can be found on the Office of Alcoholism and Substance Abuse website at:

<https://www.oasas.ny.gov/admin/hcf/FFS/RegionAPGBaseRate.cfm>

TN 10-0041

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Supersedes TN 10-0017

Effective Date: Jan 1, 2016

**New York  
1(e)(7)**

**Licensed Article 31 Hospital-Based APG Base Rate Table**

<b><u>Peer Group</u></b>	<b><u>Region</u></b>	<b><u>Rate Start Date</u></b>	<b><u>Base Rate effective 05/01/16</u></b>
<u>State-operated Mental Health Clinic</u>	<u>Statewide</u>	<u>10/01/10</u>	<u>\$410.96</u>

Quality Improvement Supplement – Licensed Article 31 Hospital-based clinics are not eligible for the Quality Improvement Supplement.

Licensed Article 31 Hospital-Based clinic Medicaid rates can also be found on the Office of Mental Health Website at: [https://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://www.omh.ny.gov/omhweb/medicaid_reimbursement/)

**TN   #16-0040**

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**Supersedes TN   NEW**

**Effective Date:   05/01/2016**

New York  
1(f)**Ambulatory Patient Group System – Hospital Outpatient**

**The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.** Links to detailed APG Reimbursement Methodology lists are located in the APG Reimbursement Methodology - Hospital Outpatient section.

**Allowed APG Weight** shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting.

**Ambulatory Patient Group (APG)** shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of [ICD-9-CM] ICD-10-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M Health Information Systems' grouping logic outlined in the APG Definitions Manual. A link to the APG Definitions Manual versions and effective dates is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**APG Relative Weight** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs. A link to the APG relative weights for all periods is available in the APG Reimbursement Methodology- Hospital Outpatient section.

TN     # 15-0019    Approval Date February 17, 2016Supersedes TN     #09-0065-A    Effective Date October 1, 2015



New York  
1(g)(1)

**Discounting** shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting [is always] will be at the rate of 50% until January 1, 2010, with the exception of those discounts listed in the link to the Non-50% Discounting APG List provided in the APG Reimbursement Methodology – Hospital Outpatient Section.

"Episode" shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a hospital-based outpatient clinic, ambulatory surgery center, or an emergency department to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.

**Final APG Weight** shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable for bundling, packaging, and discounting.

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New York  
1(h)

“**HCPCS Codes**” are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

**International Classification of Diseases, [9<sup>th</sup>] 10<sup>th</sup> Revision-Clinical Modification ([ICD-9-CM]) ICD-10-CM** is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

**Modifier** shall mean a HCPCS Level II code used in APGs, based on its meaning in the HCPCS lexicon, to modify the payment for a specific procedure code or APG.

**Never Pay APGs** shall mean an APG where all the procedure codes that map to the APG are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay APG file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**Never pay procedures** shall mean procedure codes that are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay Procedures file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**No-blend APG** shall mean an APG that has its entire payment calculated under the APG reimbursement methodology without regard to the historical average operating payment per visit for the provider. A link to a list of no-blend APGs for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

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**New York  
1(h)(1)**

**Packaging** [shall] will mean those circumstances in which payment for routine ancillary services or drugs [shall] will be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software. A link to a list of the uniform packaging APGs for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**"Peer Group"** [shall] will mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. The [sixteen] seventeen hospital peer groups are:

1. Clinic – Upstate;
2. Clinic – Downstate;
3. Ambulatory Surgery Services – Upstate;
4. Ambulatory Surgery Services – Downstate;
5. Emergency Department – Upstate;
6. Emergency Department – Downstate;
7. Clinic Mental Retardation, Developmental Disability, Traumatic Brain Injured – Upstate
8. Clinic Mental Retardation, Developmental Disability, Traumatic Brain Injured – Downstate
9. Opioid Treatment Program (Clinic) – Upstate
10. Opioid Treatment Program (Clinic) – Downstate
11. Mental Health Clinic – Upstate;
12. Mental Health Clinic – Downstate;
13. Chemical Dependence Outpatient Clinic – Upstate;
14. Chemical Dependence Outpatient Clinic - Downstate.
15. Outpatient Rehabilitation Clinic – Upstate; [and]
16. Outpatient rehabilitation Clinic – Downstate; and
17. State-operated Mental Health Clinic.

**"Procedure-based Weight"** [shall] will mean a numeric value that reflects the relative expected average resource utilization (cost) for a given HCPCS/CPT code as compared to the expected average resource utilization for other HCPCS/CPT codes or APGs. If a procedure code has not been assigned a procedure-based weight, the APG relative weight for the APG to which that procedure code groups will be used as the basis for reimbursement for that procedure code (subject to the consolidation, discounting and packaging logic).

**"Region"** [shall] will mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region [shall] will consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region [shall] will consist of all other counties in New York State.

**"APG Visit"** [shall] will mean a unit of service consisting of all the APG services and associated ancillary services performed for a patient that are coded on the same claim and share a common date of service.

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**New York  
1(h)(2)**

**["Episode"** shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a hospital-based outpatient clinic, ambulatory surgery center, or an emergency department to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.]

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Effective Date     April 1, 2010

**New York  
1(i)**

**Reimbursement Methodology – Hospital Outpatient**

- I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., “APG weight”) is used.
- II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.
- a. The APG relative weights will be updated no less frequently than every [seven] eight years. These APG and weights are set as of December 1, 2008, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – Reimbursement Components section.
  - b. The APG relative weights will be reweighted prospectively. The initial reweighting will be based on Medicaid claims data from the December 1, 2008 through September 30, 2009 period. Subsequent reweighting’s will be based on Medicaid claims data from the most recent twelve-month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.
  - c. The Department will correct material errors of any given APG relative weight. Such corrections will make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights will be made on a prospective basis.
- III. Case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices will be calculated by running applicable claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix. The initial calculation of case mix indices for periods prior to January 1, 2010, will be based on Medicaid data from the December 1, 2008, through April 30, 2009 period. The January 1, 2010, calculation of case-mix indices will be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent calculations will be based on Medicaid claims data from the most recent twelve-month period.

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**New York**  
**1(j)**

- III. The APG base rates [shall] will be updated at least annually. Updates for periods prior to January 1, 2010 will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, update will be based on claims data for the period December 1, 2008, through September 30, 2009. Subsequent updates will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate billing data. APG base rates [shall] will be rebased each time the APG relative weights are reweighted.
- a. If it is determined by the Department that an APG base rate is materially incorrect, the Department [shall] will correct that base rate prospectively so as to align aggregate reimbursement with total available funding.
- IV. APG base rates [shall] will initially be calculated using the total operating reimbursement for services and associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments [shall] will also reflect an investment of \$178 million on an annualized basis for periods prior to December 1, 2009, [and] \$270 million on an annualized basis for the period December 1, 2009, through April 30, 2012, and \$245 million for the period May 1, 2012, through March 31, 2013, and \$245 million on an annualized basis for periods thereafter. A link to the allocation of all APG investments across peer groups for all periods is available in the APG Reimbursement Methodology – Hospital Outpatient section. The case mix index [shall] will initially be calculated using 2005 claims data.
- a. Re-estimations of total operating reimbursement and associated ancillaries and the estimated number of visits [shall] will be calculated based on historical claims data. Re-estimations for periods prior to January 1, 2010, will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, re-estimation [shall] will be based on claims data from the December 1, 2008, through September 30, 2009, period. Subsequent re-estimations will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate data.
- b. The estimated case mix index [shall] will be calculated using the appropriate version of the 3M APG software based on claims data. Re-estimations for periods prior to January 1, 2009, will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, re-estimation [shall] will be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent re-estimations will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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**New York  
1(j.1)**

- c. APG base rates shall be adjusted for the following to reflect policy changes for services, not reimbursed as a discrete peer group in APGs or reimbursed prior to APGs on discrete rate codes, which are carved in to or out of APGs. The adjustment to the base rate is to maintain budget neutrality on overall Medicaid expenditures.
- (i) Effective beginning January 1, 2011 and thereafter, \$5M will be removed from the clinic base rates for the carve in of occupational, physical and speech therapy from ordered ambulatory providing for payment using the APG reimbursement method;
- (a) For Article 28 hospitals offering occupational, physical and speech therapy services that do not have a clinic rate, these providers will submit claims using the ordered ambulatory fee schedule.
- (ii) Effective beginning April 1, 2011 and thereafter, \$30M will be removed for physician costs from the clinic and emergency department base rates to allow providers to submit a separate claim for physicians services to the physician fee schedule.
- d. APG base rates shall be adjusted for the following to reflect policy changes for services, not reimbursed as a discrete peer group in APGs or reimbursed prior to APGs on discrete rate codes, which are carved out of APGs. The adjustment to the base rate is to remove costs for a discontinuation of payment.
- (i) Effective beginning January 1, 2011 and thereafter, \$2M will be removed from the clinic base rates for the removal of the Community Support Program from APG reimbursement.

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Supersedes TN     New    

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**New York**  
**1(j)(i)**

**VI. Rates for new facilities during the transition period**

- (1) General hospital outpatient clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:
- (2) For the period December 1, 2008 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as computed in accordance with this Attachment;
- (3) E[f]or the period [January 1, 2010] December 1, 2009 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment;
- (4) E[f]or the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment;
- (5) E[f]or periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment.
- (6) E[f]or the purposes of this subdivision, the historical 2007 regional average payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for general hospital outpatient clinic claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology except those specifically excluded pursuant to §86-8.10 of this Subpart, [divided] by the total visits on claims paid under such rate codes.
- (7) The phase-in described in the preceding paragraphs [(2) through (5)] is also applicable to hospital-based outpatient clinics in operation prior to January 1, 2008.

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**New York  
1(k)**

**APG Rate Computation – Hospital Outpatient**

The following is a description of the methodology to be utilized in calculating rates of payment for hospital outpatient department, ambulatory surgery, and emergency department services under the Ambulatory Patient Group classification and reimbursement system.

- I. Claims containing [ICD-9-CM] ICD-10-CM diagnostic and CPT-4/HCCPS procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.
- II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.
- III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.
- IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For hospital outpatient and emergency services, capital will continue to be paid as an add-on using the existing, previously approved methodology. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2005 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2005 calendar year.
- V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., outpatient department, ambulatory surgery, and emergency department services) during the 2007 calendar year and associated ancillary payments will be added to an investment of \$178 million on an annualized basis for periods through November 30, 2009, and \$270 million on an annualized basis for periods thereafter to form the numerator. A link to the base rates can be found in the APG Reimbursement Methodology – Hospital Outpatient section.

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Supersedes TN <u>#09-0065-B</u>	Effective Date <u>October 01, 2015</u>

**New York  
1(k)(1)**

VI. The base rates will be adjusted for the carve in or out of services, not reimbursed as a discrete peer group, as described in the APG Base Rate Calculation section.

The peer group-specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

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Supersedes TN#: 09-0065-B      Effective Date: Jan 1, 2011

**New York  
1(I)**

The following is an example of a sample APG base rate calculation:

a. 2007 Peer Group Reimbursement	\$51,000,000
b. Additional Investment	\$25,000,000
c. Case Mix Index	8.1610
d. Coding Improvement Factor	1.05
e. 2007 Base Year Visits	50,000

$$(\$51,000,000 + \$25,000,000) / (8.1610 \times 1.05 \times 50,000) = \$177.38 \text{ (Base Rate)}$$

**VII. Rates for existing facilities during the transition period**

During the transition period, reimbursement for hospital based outpatient department services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending [December 31] November 30, 2009) 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. For the period December 1, 2009, through December 31, 2010 [During 2010], the blend will be 50/50. During 2011, the blend will be 75/25. Hospital outpatient department payments will be based upon 100% of the APG operating component beginning on January 1, 2012. Both the emergency department and ambulatory surgery services will move to 100% APG payment upon implementation with no transition period. [Per the enabling statute, as new services the Education APGs, and the Extended Hours APGs are not subject to the blend requirement.

Effective for dates of service on and after September 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a general hospital outpatient department shall be reimbursed entirely on the APG methodology.] A link to a list of APGs that are not subject to the blend is available in the APG Reimbursement Methodology – Hospital Outpatient section.

TN #09-65-A

Supersedes TN #09-62

Approval Date February 6, 2013

Effective Date December 1, 2009

**New York**  
**1(I)(i)**

[Effective September 1, 2009, immunization services provided in a general hospital outpatient department, when no other medical services are provided during that patient visit, shall be reimbursed entirely on the APG methodology.]

Effective for dates of service on and after January 1, 2009, payments to general hospital outpatient departments for the following services shall be based on fees or rates established by the Department of Health: (1) wheelchair evaluations, (2) eyeglass dispensing, and (3) individual psychotherapy services provided by licensed social workers to persons under the age of 21, and to persons requiring such services as a result of or related to pregnancy or giving birth. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's alternative payment fee schedule rates for the services listed in this paragraph were set September 1, 2009 and are effective for services provided on or after that date. A link to the APG alternative rates for all periods is available in the APG Reimbursement Methodology – Hospital Outpatient section.[The rates are published on the Department of Health web-site at the following link:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/docs/apg\\_alternative\\_payment\\_fee\\_schedule.pdf](http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/apg_alternative_payment_fee_schedule.pdf)]

**VIII. Rates for services provided in hospital outpatient facilities located outside of New York State shall be as follows:**

- APG rates in effect for similar services for providers located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth; in the Pennsylvania county of Pike; and in the Connecticut counties of Fairfield and Litchfield; and rates in effect for similar services for providers located in the upstate region of New York State shall apply with regard to all other out-of-state providers.
- In the event the Department determines that an out-of-state provider is providing services which are not available within New York State, the Department may negotiate payment rates and conditions with such a provider up to but not in excess of the provider's usual and customary charges. Prior approval by the Department shall be required with regard to services provided by such providers.

TN   #09-65-A  

Supersedes TN   #09-62  

Approval Date   February 6, 2013  

Effective Date   December 1, 2009

New York  
1(l)(ii)

- For APG reimbursement to out-of-state hospitals, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

**System updating**

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable [ICD-9-CM] ICD-10-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.

TN #15-0019

Approval Date February 17, 2016

Supersedes TN #10-0005

Effective Date October 1, 2015

**New York  
1(m)**

**- RESERVED -**

[The following shall be excluded from the APG reimbursement system:

- Drugs and other pharmaceutical products and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007, and as set forth by the Department in written billing instructions issued to providers.
- HIV counseling and testing visits, HIV counseling (no testing), post-test HIV counseling visits (positive results), day health care service (HIV).
- TB/directly observed therapy - downstate levels 1 and 2, TB/directly observed therapy.
- Upstate levels 1 and 2, AIDS clinic therapeutic visits in general hospital outpatient clinics.
- Child rehabilitation services provided under rate code 2887 in general hospital outpatient clinics.
- Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.
- Visits solely for the purpose of receiving ordered ambulatory services.
- Visits solely for the purpose of receiving pharmacy services.
- Visits solely for the purpose of receiving education or training services, except with regard to services authorized pursuant to clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving services from licensed social workers, except with regard to psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving group services, except with regard to clinical group psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system and provided, however, that reimbursement for such group services shall be determined in accordance with state regulation.
- Offsite services, defined as medical services provided by a facility's outpatient staff at locations other than those operated by and under the facility's licensure under Article 28 of the Public Health Law, or visits related to the provision of such offsite services, except with regard to offsite services provided by Federally Qualified Health Centers or Rural Health Centers.]

TN   #10-05  

Approval Date   November 7, 2013  

Supersedes TN   #08-39  

Effective Date   April 1, 2010

New York  
1(m)(i)

Effective for hospital outpatient services, on or after July 1, 2013, the administration of a Long-Acting Reversible Contraceptive (LARC) will be carved out of the APG reimbursement methodology when it is provided on the same Date of Service (DOS) as an abortion. The facility will be reimbursed with state funds only for the abortion procedure through APGs which is a prospective payment system that pays based on a facility's base rate and the service intensity weight of the procedure(s) rendered. The facility will submit a separate claim that will pay \$208 which will cover the cost of the LARC insertion (\$158) and the associated Evaluation and Management services (\$50). The facility will submit a third claim to be reimbursed for the cost of the LARC device at the provider's actual acquisition cost.

TN     #13-0039    

Supersedes TN   NEW  

Approval Date   November 29, 2017  

Effective Date   July 1, 2013

**New York  
1(n)**

[- RESERVED -]

Effective May 1, 2016, the statewide APG base rate for the State-operated Mental Health Clinic peer group will be updated annually and calculated as follows. There will be one base rate for all clinics within this peer group, regardless if the clinic serves adults or children and youth.

(1) **Definitions** applicable to this section:

- (i) **Valid Visit** – A recipient and / or collateral visit for clinic procedures for varying durations. Multiple reimbursable clinic procedures for a recipient and / or collateral per day will be counted as a single valid visit.
- (ii) **Average Ambulatory Patient Group (APG) Procedure Weight** – The APG methodology assigns a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. The Average APG procedure weight is the average of APG weights for Medicaid reimbursed visits to state-operated mental health clinics in 2014-15.

(2) **Computation of Rates:**

- (i) The Office of Mental Health will report Psychiatric Hospital costs on form 2552 in accordance with the Centers for Medicare and Medicaid Services instructions for completing Medicare Hospital Cost Reports.
- (ii) OMH will use the total State-operated mental health adult clinic costs added to the State-operated mental health children & youth clinic costs from the filed Medicare Hospital Cost Report for 2014-15 divided by total valid visits for State-operated mental health clinics for both adult and children & youth from the same reporting year.
- (iii) The total per visit clinic cost will be trended forward to the rate year based on the Consumer Price Index for all urban consumers (CPI-U).
- (iv) The result of section (3)(iii) is divided by the average APG procedure weight resulting in the cost-based base rate for State-operated mental health clinics for the year.

TN     #16-0040    

Supersedes TN     #10-0005    

Approval Date     11/22/2019    

Effective Date     05/01/2016

**New York  
1(o)**

**- RESERVED -**

[The following APGs shall not be eligible for reimbursement when they are presented as the only APG or APGs applicable to a patient visit or when the only other APGs presented with them are one or more of the APGs listed in the list of APGs not eligible for reimbursement:

- 280 VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY
- 284 MYELOGRAPHY
- 285 MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
- 286 MAMMOGRAPHY
- 287 DIGESTIVE RADIOLOGY
- 288 DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES
- 289 VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES
- 290 PET SCANS
- 291 BONE DENSITOMETRY
- 298 CAT SCAN - BACK
- 299 CAT SCAN – BRAIN
- 300 CAT SCAN – ABDOMEN
- 301 CAT SCAN – OTHER
- 302 ANGIOGRAPHY, OTHER
- 303 ANGIOGRAPHY, CEREBRAL
- 330 LEVEL I DIAGNOSTIC NUCLEAR MEDICINE
- 331 LEVEL II DIAGNOSTIC NUCLEAR MEDICINE
- 332 LEVEL III DIAGNOSTIC NUCLEAR MEDICINE
- 380 ANESTHESIA
- 390 LEVEL I PATHOLOGY
- 391 LEVEL II PATHOLOGY
- 392 PAP SMEARS
- 393 BLOOD AND TISSUE TYPING
- 394 LEVEL I IMMUNOLOGY TESTS
- 395 LEVEL II IMMUNOLOGY TESTS
- 396 LEVEL I MICROBIOLOGY TESTS
- 397 LEVEL II MICROBIOLOGY TESTS
- 398 LEVEL I ENDOCRINOLOGY TESTS
- 399 LEVEL II ENDOCRINOLOGY TESTS
- 400 LEVEL I CHEMISTRY TESTS
- 401 LEVEL II CHEMISTRY TESTS
- 402 BASIC CHEMISTRY TESTS
- 403 ORGAN OR DISEASE ORIENTED PANELS
- 404 TOXICOLOGY TESTS
- 405 THERAPEUTIC DRUG MONITORING]

TN #10-05

Approval Date November 7, 2013

Supersedes TN #08-39

Effective Date April 1, 2010

New York  
1(p)

[- RESERVED -]

Reimbursement information for some Hospital Outpatient Services that are licensed by the Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS) is located in later pages of this section which contain the reimbursement information for the same or similar services that are provided by Freestanding Clinics.

TN #10-0018 Approval Date November 1, 2017

Supersedes TN #10-0005 Effective Date July 1, 2010

**New York**  
**1(p)(i)**

**Behavioral Health Utilization Controls – Hospital-based Clinics**

Effective April 1, 2011, the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) will establish utilization thresholds for their hospital-based clinics. These thresholds will target unusually high utilization with payment reductions and will be established by the licensing state agency as follows:

For Article 31 clinics licensed by OMH in or operated by general hospitals licensed under Article 28 of the Public Health Law, Medicaid payments shall be subject to the following reductions:

- (1) For persons 21 years of age or older at the start of the state fiscal year, payment for the 31st through 50th visits in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 25% reduction in the otherwise applicable payment amount.
- (2) For persons 21 years of age or older at the start of the state fiscal year, payment for visits in excess of 50 in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.
- (3) For persons less than 21 years of age at the start of the state fiscal year, payment for visits in excess of 50 in that state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.
- (4) Off-site visits (rate codes 1519 and 1525), medical visits (rate codes 1588 and 1591) and crisis visits (rate codes 1576 and 1582), when billed under their applicable rate codes, will be disregarded in computing the number of visits pursuant to the preceding paragraphs. For off-site visits provided by OMH-licensed clinics to homeless individuals, Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OMH-licensed clinics to other than homeless individuals may be reimbursed with State-only funding and will not be claimed for federal financial participation.

TN #11-28

Supersedes TN NEW

Approval Date August 15, 2012

Effective Date April 1, 2011

**New York  
1(p)(ii)**

For hospital-based Article 32 clinics licensed by OASAS, Medicaid payments shall be subject to the following per person reductions:

- (1) Payment for the 76th through 95th visits in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 25% reduction in the otherwise applicable payment amount.
- (2) Payment for visits in excess of 95 in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.

TN #11-28

Supersedes TN NEW

Approval Date August 15, 2012

Effective Date April 1, 2011

**New York  
1(q)**

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Hospital-Based Outpatient**

A temporary rate adjustment will be provided to eligible providers of outpatient services that are subject to or impacted by the closure, merger, and acquisition, consolidation, or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed:

**Hospital-Based Outpatient Services:**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
<u>A.O. Fox Memorial Hospital</u>	<u>\$3,031,209</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$2,529,235</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$1,705,835</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Clifton-Fine Hospital</u>	<u>\$1,225,000</u>	<u>01/01/2014 – 03/31/2014</u>
<u>Cortland Memorial Hospital</u>	<u>\$577,633</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$1,114,173</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$496,666</u>	<u>04/01/2015 – 03/31/2016</u>

TN   #13-0070

Approval Date   October 13, 2016

Supersedes TN   #11-0026-A

Effective Date   January 01, 2014

**New York  
1(q)(i)**

**Hospital-Based Outpatient Services (Continued):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
Delaware Valley Hospital, Inc.	\$221,650	01/01/2014 – 03/31/2014
	\$164,400	04/01/2014 – 03/31/2015
	\$66,200	04/01/2015 – 03/31/2016
Ellenville Regional Hospital	\$219,780	01/01/2014 – 03/31/2014
	\$224,176	04/01/2014 – 03/31/2015
	\$699,788	04/01/2015 – 03/31/2016
Oswego Hospital	\$300,000	01/01/2013 – 03/31/2013
	\$750,000	01/01/2014 – 03/31/2014
	\$500,000	04/01/2014 – 03/31/2015
River Hospital	\$1,444,695	02/01/2014 – 03/31/2014
Schuyler Hospital	\$216,113	01/01/2014 – 03/31/2014
	\$215,574	04/01/2014 – 03/31/2015
	\$225,143	04/01/2015 – 03/31/2016

TN #14-0013

Supersedes TN #13-0070

Approval Date October 17, 2016

Effective Date February 01, 2014

**New York  
1(q)(ii)**

**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Bassett Hospital of Schoharie County-Cobleskill Regional Hospital</u>	<u>\$372,500</u>	<u>07/01/2019 – 3/31/2020</u>
	<u>\$372,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Carthage Area Hospital</u>	<u>\$325,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$520,000</u>	<u>10/01/2015 - 03/31/2016</u>
	<u>\$520,000</u>	<u>04/01/2016 - 03/31/2017</u>
	<u>\$532,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$532,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$532,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$532,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Catskill Regional Medical Center – Hermann Division</u>	<u>\$275,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$240,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$327,500</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$327,500</u>	<u>04/01/2016 - 03/31/2017</u>
	<u>\$310,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$310,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$310,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$310,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Clifton-Fine Hospital</u>	<u>\$350,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$325,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$520,000</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$520,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$532,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$532,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$532,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$532,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Community Memorial Hospital</u>	<u>\$240,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$384,000</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$384,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$372,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$372,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$372,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$372,500</u>	<u>04/01/2020 – 03/31/2021</u>

TN   #19-0050Approval Date   December 20, 2019Supersedes TN   #17-0061Effective Date   July 1, 2019

**New York  
1(q)(iii)**

**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Cuba Memorial Hospital</u>	\$315,000	<u>02/01/2014 – 03/31/2014</u>
	\$445,000	<u>11/01/2014 – 03/31/2015</u>
	\$550,000	<u>10/01/2015 – 03/31/2016</u>
	\$550,000	<u>04/01/2016 – 03/31/2017</u>
	\$532,500	<u>08/01/2017 – 03/31/2018</u>
	\$532,500	<u>04/01/2018 – 03/31/2019</u>
	\$532,500	<u>07/01/2019 – 03/31/2020</u>
	\$532,500	<u>04/01/2020 – 03/31/2021</u>
<u>Delaware Valley Hospital</u>	\$246,000	<u>02/01/2014 – 03/31/2014</u>
	\$240,000	<u>11/01/2014 – 03/31/2015</u>
	\$327,500	<u>10/01/2015 – 03/31/2016</u>
	\$327,500	<u>04/01/2016 – 03/31/2017</u>
	\$310,000	<u>08/01/2017 – 03/31/2018</u>
	\$310,000	<u>04/01/2018 – 03/31/2019</u>
	\$310,000	<u>07/01/2019 – 03/31/2020</u>
	\$310,000	<u>04/01/2020 – 03/31/2021</u>
<u>Elizabethtown Community Hospital</u>	\$410,000	<u>02/01/2014 – 03/31/2014</u>
	\$240,000	<u>11/01/2014 – 03/31/2015</u>
	\$327,500	<u>10/01/2015 – 03/31/2016</u>
	\$327,500	<u>04/01/2016 – 03/31/2017</u>
	\$310,000	<u>08/01/2017 – 03/31/2018</u>
	\$310,000	<u>04/01/2018 – 03/31/2019</u>
	\$310,000	<u>07/01/2019 – 03/31/2020</u>
	\$310,000	<u>04/01/2020 – 03/31/2021</u>
<u>Ellenville Regional Hospital</u>	\$384,800	<u>02/01/2014 – 03/31/2014</u>
	\$240,000	<u>11/01/2014 – 03/31/2015</u>
	\$327,500	<u>10/01/2015 – 03/31/2016</u>
	\$327,500	<u>04/01/2016 – 03/31/2017</u>
	\$310,000	<u>08/01/2017 – 03/31/2018</u>
	\$310,000	<u>04/01/2018 – 03/31/2019</u>
	\$310,000	<u>07/01/2019 – 03/31/2020</u>
	\$310,000	<u>04/01/2020 – 03/31/2021</u>

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**New York  
1(q)(iv)**

**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Gouverneur Hospital, Inc.</u>	<u>\$300,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$240,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$327,500</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$327,500</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$372,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$372,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$372,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$372,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Lewis County General Hospital</u>	<u>\$370,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$325,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$520,000</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$520,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$532,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$532,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$532,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$532,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Little Falls Hospital</u>	<u>\$342,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$240,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$327,500</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$327,500</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$372,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$372,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$372,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$372,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Margaretville Memorial Hospital</u>	<u>\$128,600</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$325,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$520,000</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$520,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$532,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$532,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$532,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$532,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Medina Memorial Hospital</u>	\$480,000	<u>10/01/2015 – 03/31/2016</u>
	\$480,000	<u>04/01/2016 – 03/31/2017</u>
	\$432,000	<u>08/01/2017 – 03/31/2018</u>
	\$432,000	<u>04/01/2018 – 03/31/2019</u>
	\$432,000	<u>07/01/2019 – 03/31/2020</u>
	\$432,000	<u>04/01/2020 – 03/31/2021</u>
<u>Moses Ludington Hospital</u>	\$359,800	<u>02/01/2014 – 03/31/2014</u>
	\$325,000	<u>11/01/2014 – 03/31/2015</u>
	\$390,000	<u>10/01/2015 – 03/31/2016</u>
	\$390,000	<u>04/01/2016 – 03/31/2017</u>
	\$372,500	<u>08/01/2017 – 03/31/2018</u>
	\$372,500	<u>04/01/2018 – 03/31/2019</u>
<u>O'Connor Hospital</u>	\$363,800	<u>02/01/2014 – 03/31/2014</u>
	\$240,000	<u>11/01/2014 – 03/31/2015</u>
	\$327,500	<u>10/01/2015 – 03/31/2016</u>
	\$327,500	<u>04/01/2016 – 03/31/2017</u>
	\$310,000	<u>08/01/2017 – 03/31/2018</u>
	\$310,000	<u>04/01/2018 – 03/31/2019</u>
	\$310,000	<u>07/01/2019 – 03/31/2020</u>
	\$310,000	<u>04/01/2020 – 03/31/2021</u>
<u>River Hospital</u>	\$482,000	<u>02/01/2014 – 03/31/2014</u>
	\$445,000	<u>11/01/2014 – 03/31/2015</u>
	\$550,000	<u>10/01/2015 – 03/31/2016</u>
	\$550,000	<u>04/01/2016 – 03/31/2017</u>
	\$532,500	<u>08/01/2017 – 03/31/2018</u>
	\$532,500	<u>04/01/2018 – 03/31/2019</u>
	\$532,500	<u>07/01/2019 – 03/31/2020</u>
	\$532,500	<u>04/01/2020 – 03/31/2021</u>
<u>Schuyler Hospital</u>	\$453,000	<u>02/01/2014 – 03/31/2014</u>
	\$240,000	<u>11/01/2014 – 03/31/2015</u>
	\$384,000	<u>10/01/2015 – 03/31/2016</u>
	\$384,000	<u>04/01/2016 – 03/31/2017</u>
	\$462,500	<u>08/01/2017 – 03/31/2018</u>
	\$462,500	<u>04/01/2018 – 03/31/2019</u>
	\$462,500	<u>07/01/2019 – 03/31/2020</u>
	\$462,500	<u>04/01/2020 – 03/31/2021</u>

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**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Soldiers &amp; Sailors Memorial Hospital</u>	<u>\$220,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$325,000</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$390,000</u>	<u>10/01/2015 – 03/31/2016</u>
	<u>\$390,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$372,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$372,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$372,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$372,500</u>	<u>04/01/2020 – 03/31/2021</u>

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- c. Temporary rate adjustments have been approved for the following essential community providers in the amounts and for the effective periods listed:

**Essential Community Providers:**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>A.O. Fox Memorial Hospital</u>	<u>\$255,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$255,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$328,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$328,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Adirondack Medical Center</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$ 78,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$ 78,500</u>	<u>04/01/2018 - 03/31/2019</u>
	<u>\$ 78,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$ 78,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Alice Hyde Hospital Association</u>	<u>\$130,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$130,000</u>	<u>04/01/2016 - 03/31/2017</u>
	<u>\$208,000</u>	<u>08/01/2017 - 03/31/2018</u>
	<u>\$208,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$208,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$208,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Auburn Community Hospital</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$ 78,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$ 78,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$ 78,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$ 78,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Bassett Hospital of Schoharie County-Cobleskill Regional Hospital</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$103,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$103,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Brooks Memorial Hospital</u>	<u>\$245,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$245,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$303,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$303,500</u>	<u>04/01/2018 - 03/31/2019</u>
	<u>\$303,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$303,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**Essential Community Providers (cont'd)**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Canton Potsdam Hospital</u>	<u>\$ 65,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 65,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$ 58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$ 58,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$ 58,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$ 58,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Carthage Area Hospital</u>	<u>\$275,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$275,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Catskill Regional Hospital Medical Center</u>	<u>\$255,000</u>	<u>03/01/2016 - 03/31/2016</u>
	<u>\$255,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$328,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$328,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Catskill Regional Medical Center – Hermann Division</u>	<u>\$ 85,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 85,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$128,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$128,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Cayuga Medical Center-Ithaca</u>	<u>\$120,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$120,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$153,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$153,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**Essential Community Providers (cont'd)**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Champlain Valley Physicians Hospital</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$103,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$103,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Chenango Memorial Hospital</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$103,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$103,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Claxton Hepburn Medical Center</u>	<u>\$ 85,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 85,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$128,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$128,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Clifton-Fine Hospital</u>	<u>\$275,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$275,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Cobleskill Regional Hospital</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Columbia Memorial Hospital</u>	<u>\$120,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$120,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$153,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$153,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Community Memorial Hospital</u>	<u>\$130,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$130,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$208,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$208,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$208,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$208,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Corning Hospital</u>	<u>\$ 65,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 65,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$ 58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$ 58,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$ 58,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$ 58,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Cortland Memorial Hospital</u>	<u>\$255,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$255,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$328,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$328,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Cuba Memorial Hospital</u>	<u>\$245,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$245,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$328,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$328,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Delaware Valley Hospital</u>	<u>\$ 85,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 85,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$128,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$128,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Elizabethtown Community Hospital</u>	<u>\$ 85,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 85,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$128,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$128,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Ellenville Regional Hospital</u>	\$ 85,000	03/01/2016 – 03/31/2016
	\$ 85,000	04/01/2016 – 03/31/2017
	\$128,500	08/01/2017 – 03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
	\$128,500	07/01/2019 – 03/31/2020
	\$128,500	04/01/2020 – 03/31/2021
<u>Gouvernor Hospital, Inc.</u>	\$275,000	03/01/2016 - 03/31/2016
	\$275,000	04/01/2016 – 03/31/2017
	\$247,500	08/01/2017 – 03/31/2018
	\$247,500	04/01/2018 – 03/31/2019
	\$247,500	07/01/2019 – 03/31/2020
	\$247,500	04/01/2020 – 03/31/2021
<u>Ira Davenport Memorial Hospital</u>	\$275,000	03/01/2016 - 03/31/2016
	\$275,000	04/01/2016 – 03/31/2017
	\$353,500	08/01/2017 – 03/31/2018
	\$353,500	04/01/2018 – 03/31/2019
	\$353,500	07/01/2019 – 03/31/2020
	\$353,500	04/01/2020 – 03/31/2021
<u>Jones Memorial Hospital</u>	\$120,000	03/01/2016 – 03/31/2016
	\$120,000	04/01/2016 – 03/31/2017
	\$192,000	08/01/2017 – 03/31/2018
	\$192,000	04/01/2018 – 03/31/2019
	\$192,000	07/01/2019 – 03/31/2020
	\$192,000	04/01/2020 – 03/31/2021
<u>Lewis County General Hospital</u>	\$245,000	03/01/2016 - 03/31/2016
	\$610,000	04/01/2016 – 03/31/2017
	\$328,500	08/01/2017 – 03/31/2018
	\$328,500	04/01/2018 – 03/31/2019
	\$328,500	07/01/2019 – 03/31/2020
	\$328,500	04/01/2020 – 03/31/2021
<u>Little Falls Hospital</u>	\$ 85,000	03/01/2016 – 03/31/2016
	\$1,185,000	04/01/2016 – 03/31/2017
	\$136,000	08/01/2017 – 03/31/2018
	\$136,000	04/01/2018 – 03/31/2019
	\$136,000	07/01/2019 – 03/31/2020
	\$136,000	04/01/2020 – 03/31/2021

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**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Margaretville Memorial Hospital</u>	<u>\$255,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$255,000</u>	<u>04/01/2016 - 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Mary Imogene Bassett Hospital</u>	<u>\$ 65,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 65,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$104,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$104,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$104,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$104,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Massena Memorial Hospital</u>	<u>\$205,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$205,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$203,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$203,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$203,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$203,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Medina Memorial Hospital</u>	<u>\$ 85,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 85,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$136,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$136,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$136,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$136,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Moses-Ludington Hospital</u>	<u>\$205,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$205,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$253,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$253,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$253,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$253,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Nathan Littauer Hospital</u>	<u>\$ 75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$103,500</u>	<u>08/01/2017 - 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/0018 – 03/31/2019</u>
	<u>\$103,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$103,500</u>	<u>04/01/2020 – 03/31/2021</u>

TN #19-0051Approval Date December 20, 2019Supersedes TN #17-0062Effective Date July 1, 2019

**New York  
1(q)(xi)**

**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Nicholas H Noyes Memorial Hospital</u>	\$ 85,000	03/01/2016 – 03/31/2016
	\$ 85,000	04/01/2016 -03/31/2017
	\$103,500	08/01/2017 – 03/31/2018
	\$103,500	04/01/2018 – 03/31/2019
	\$103,500	07/01/2019 – 03/31/2020
	\$103,500	04/01/2020 – 03/31/2021
<u>Northern Dutchess Hospital</u>	\$ 65,000	03/01/2016 – 03/31/2016
	\$ 65,000	04/01/2016 – 03/31/2017
	\$ 58,500	08/01/2017 – 03/31/2018
	\$ 58,500	04/01/2018 - 03/31/2019
	\$ 58,500	07/01/2019 – 03/31/2020
	\$ 58,500	04/01/2020 – 03/31/2021
<u>O'Connor Hospital</u>	\$105,000	03/01/2016 - 03/31/2016
	\$105,000	04/01/2016 – 03/31/2017
	\$128,500	08/01/2017 – 03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
	\$128,500	07/01/2019 – 03/31/2020
	\$128,500	04/01/2020 – 03/31/2021
<u>Olean General Hospital-Main</u>	\$ 85,000	03/01/2016 - 03/31/2016
	\$ 85,000	04/01/2016 – 03/31/2017
	\$103,500	08/01/2017 – 03/31/2018
	\$103,500	04/01/2018 – 03/31/2019
	\$103,500	07/01/2019 – 03/31/2020
	\$103,500	04/01/2020 – 03/31/2021
<u>Oneida Healthcare</u>	\$120,000	03/01/2016 – 03/31/2016
	\$120,000	04/01/2016 – 03/31/2017
	\$153,500	08/01/2017 – 03/31/2018
	\$153,500	04/01/2018 – 03/31/2019
	\$153,500	07/01/2019 – 03/31/2020
	\$153,500	04/01/2020 – 03/31/2021
<u>Oswego Hospital</u>	\$ 85,000	03/01/2016 – 03/31/2016
	\$ 85,000	04/01/2016 – 03/31/2017
	\$136,000	08/01/2017 – 03/31/2018
	\$136,000	04/01/2018 – 03/31/2019
	\$136,000	07/01/2019 – 03/31/2020
	\$136,000	04/01/2020 - 03/31/2021

TN #19-0051Approval Date December 20, 2019Supersedes TN #17-0062Effective Date July 1, 2019

**New York  
1(q)(xii)**

**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>River Hospital</u>	<u>\$275,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$275,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$328,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$328,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Samaritan Medical Center</u>	<u>\$ 65,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$ 65,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$58,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$58,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Schuyler Hospital</u>	<u>\$150,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$150,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$240,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$240,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$240,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$240,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Soldiers and Sailors Memorial Hospital</u>	<u>\$120,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$495,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$192,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$192,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$192,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$192,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>St. James Mercy Hospital</u>	<u>\$255,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$255,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>St. Mary's Healthcare</u>	<u>\$105,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$105,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$153,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$153,500</u>	<u>04/01/2020 – 03/31/2021</u>

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**New York  
1(q)(xiii)**

**Essential Community Providers (cont'd):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>TLC Health Network</u>	<u>\$275,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$275,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Tri Town Regional Hospital</u>	<u>\$65,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$65,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$58,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$58,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>United Memorial Medical Center – North Street Division</u>	<u>\$75,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$75,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$103,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$103,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Westfield Memorial Hospital</u>	<u>\$275,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$275,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$353,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$353,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Wyoming County Community Hospital</u>	<u>\$130,000</u>	<u>03/01/2016 - 03/31/2016</u>
	<u>\$130,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$208,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$208,000</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$208,000</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$208,000</u>	<u>04/01/2020 – 03/31/2021</u>
<u>WCA Hospital</u>	<u>\$120,000</u>	<u>03/01/2016 – 03/31/2016</u>
	<u>\$120,000</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$228,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$228,500</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$228,500</u>	<u>07/01/2019 – 03/31/2020</u>
	<u>\$228,500</u>	<u>04/01/2020 – 03/31/2021</u>

TN #19-0051Approval Date December 20, 2019Supersedes TN NEWEffective Date July 1, 2019

**New York  
1(r)**

**[RESERVED]**

**Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs):**

Rural hospitals will qualify for additional outpatient reimbursement as critical access hospitals for the period October 1, 2017 through March 31, 2018, only if such hospitals are designated as critical access hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act. The gross Medicaid expenditure amount for the period October 1, 2017 through March 31, 2018 is \$20,000,000.

The distribution method for the period October 1, 2017 through March 31, 2018 is based upon a minimum rate adjustment of \$400,000 per hospital, with the remaining funds being proportionally distributed based upon each hospital's share of the total Medicaid Outpatient visits, as reported in their 2015 Institutional Cost Report.

Eligible providers, the amount of the rate adjustment, and the duration of the adjustment will be listed in the table which follows. The adjustment for the effective period will be paid quarterly with the amount of each quarterly payment being made in equal installments. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

The following rate adjustments have been approved for the following providers in the amounts and for the effective periods listed:

**Hospital-Based Outpatient Services:**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Carthage Area Hospital</u>	<u>\$2,574,839</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Catskill Regional Medical Center – Hermann Division</u>	<u>\$524,464</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Clifton-Fine Hospital</u>	<u>\$597,381</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Community Memorial Hospital</u>	<u>\$1,634,972</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Cuba Memorial Hospital</u>	<u>\$680,929</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Delaware Valley Hospital</u>	<u>\$1,036,816</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Elizabethtown Community Hospital</u>	<u>\$962,825</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Ellenville Regional Hospital</u>	<u>\$1,124,553</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Gouverneur Hospital, Inc.</u>	<u>\$1,171,589</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Lewis County General Hospital</u>	<u>\$2,239,786</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Little Falls Hospital</u>	<u>\$1,305,718</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Margaretville Memorial Hospital</u>	<u>\$525,323</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Moses-Ludington Hospital</u>	<u>\$622,295</u>	<u>10/01/2017 – 03/31/2018</u>
<u>O'Connor Hospital</u>	<u>\$682,218</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Orleans Community Health</u>	<u>\$708,099</u>	<u>10/01/2017 – 03/31/2018</u>
<u>River Hospital</u>	<u>\$1,178,462</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Schuyler Hospital</u>	<u>\$1,436,517</u>	<u>10/01/2017 – 03/31/2018</u>
<u>Soldiers &amp; Sailors Memorial Hospital</u>	<u>\$993,216</u>	<u>10/01/2017 – 03/31/2018</u>

**TN #17-0069** \_\_\_\_\_

**Supersedes TN #13-0002** \_\_\_\_\_

**Approval Date** 11/21/2019 \_\_\_\_\_

**Effective Date** 10/01/2017 \_\_\_\_\_

New York  
1(s)

RESERVED

TN #13-0002 \_\_\_\_\_

Approval Date June 12, 2018

Supersedes TN New

Effective Date January 1, 2018

**New York  
1(t)**

**Integrated Licensing Program – Hospital-based Clinics Licensed by the New York State Office of Mental Health (OMH)**

Effective January 1, 2013 through December 31, 2017, the new Integrated Licensing Program (ILP) reimbursement methodology is established for authorized providers providing integrated physical health, behavioral and/or substance abuse services in hospital-based clinic sites licensed pursuant to Article 31 of the Public Health Law. The following providers' hospital outpatient departments are authorized to participate in the ILP:

- Flushing Hospital Medical Center (NPI 1154461622, Loc Code 006)
- Mercy Medical Center (NPI 1659330173, Loc Code 006); and
- Montefiore Medical Center (NPI 1952476988, Loc Code 061)

For the time period in which the ILP is in effect, authorized providers have access to a new clinic base rate that is equal to 105% of the facility's usual base rate; with the new base rate reimbursed only at authorized sites where integrated physical, behavioral and/or substance services were available. Payment amounts are determined via the usual Ambulatory Patient Group reimbursement methodology, utilizing the applicable base rate and the procedure(s) and diagnose(s) codes submitted on each claim.

The goal of the Integrated Licensing Program was to facilitate and promote the availability of physical, behavioral and/or substance abuse services at authorized hospital-based clinic sites, in order to: economize the number of visits for patients with co-morbidities; provide more comprehensive, integrated care; improve health outcomes and decrease rates of utilization of emergency room and inpatient services. Individuals with serious mental illness and/or addictions at these sites had the opportunity to receive an integrated array of care at the same location to address a range of physical, mental, and/or behavioral healthcare needs.

TN #13-0002 \_\_\_\_\_

Supersedes TN   New  

Approval Date   June 12, 2018  

Effective Date   January 1, 2018

## New York

2

**Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).**

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate. Payment for these services are in compliance with 42 CFR 447.325.

**[AIDS/HIV] Adult Day Health Care Services For Persons with HIV/AIDS and Other High-need Populations Diagnostic And Treatment Centers**

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV and other high-need populations by a free standing ambulatory care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service [and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services.] in accordance with clients' comprehensive care plans. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated unless one or more services are provided in accordance with a client's comprehensive care plan [if these two requirements are not met].

**Core services include:**

- Medical visits
- Nursing visits

TN #17-0006  
Supersedes TN #07-06

Approval Date December 11, 2017  
Effective Date September 1, 2017

**New York  
2(a)**

- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

**Health related (non-core) services include:**

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided to patients diagnosed with HIV/AIDS and to other high-need populations on and after January 1, 2007, medical assistance rates of payment to diagnostic and treatment centers shall be increased up to an annual amount of \$2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

Effective for adult day health care services rendered on and after January 1, 2007 through December 31, 2009, and for adult day health care services provided to patients diagnosed with HIV/AIDS and to other high-need populations on and after April 1, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology. Such adjustments shall be applied to the operational cost component of the rate.

Effective April 1, 2011 through June 30, 2011, rates of payment for adult day health care services provided to patients with AIDS or other HIV related illnesses shall be increased by an additional aggregate amount of \$1,156,650 to be allocated proportionally among such providers based on the Medicaid visits as reported in the most recently available cost report submitted to the State by January 1, 2011.

New York  
2(a)(i)

**Hospital Based Ambulatory Surgery Facilities Certified Under Article 28 of the Public Health Law**

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates of payment in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through November 30, 2008, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

For dates of service beginning December 1, 2008, for hospital outpatient ambulatory surgery services, services shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

**[Freestanding-Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Surgery Centers**

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through March 31, 2011, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.]

TN     #11-21    

Supersedes TN     #08-29    

Approval Date     August 31, 2012    

Effective Date     April 1, 2011

New York  
2(a)(ii)

**Freestanding-Diagnostic and Treatment Center[s]Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Surgery Centers – Products of Ambulatory Surgery Payment Groups**

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through [March] August 31, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. [The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.]

For dates of service beginning September 1, 2009, for freestanding-diagnostic and treatment ambulatory surgery facilities, services will be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

TN #08-29

Supersedes TN NEW

Approval Date May 18, 2011

Effective Date April 1, 2008

New York  
2(b)

**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law**

**Services for AIDS and HIV positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective. For dates of service beginning on December 1, 2008 through March 31, 2010, the discrete services for comprehensive initial visit, post-test HIV counseling (negative result), and monitoring – asymptomatic HIV disease shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

TN     #09-23-A    

Approval Date     December 22, 2011    

Supersedes TN     #07-06    

Effective Date     April 1, 2009

New York  
2(b.1)

**Freestanding Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law [A]as Freestanding  
Diagnostic and Treatment Centers**

**Services for AIDS and HIV positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2009] 2011, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

TN #09-23-A

Approval Date December 22, 2011

Supersedes TN NEW

Effective Date April 1, 2009

**New York  
2(b)(i)**

**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law**

**Services for medically supervised chemical dependence treatment and medically supervised withdrawal services**

For dates of service beginning on July 1, 2002, for those facilities certified under Article 28 of the State Public Health Law, the Department of Health promulgates prospective, all-inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor (two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained in the Trend Factor section in this Attachment.

TN     #08-32    

Approval Date     September 9, 2011    

Supersedes TN     #07-12    

Effective Date     April 1, 2008

**New York  
2(b)(ii)**

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% [shall] will be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period [shall] will be no greater than zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date September 26, 2019**

**Supersedes TN #17-0034** \_\_\_\_\_

**Effective Date April 1, 2019** \_\_\_\_\_

**New York  
2(c)**

**Hospital Based Outpatient Department**

**Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments**

**Services for Pregnant Women**

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007, as calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

TN     #09-46    

Supersedes TN   #09-19  

Approval Date     January 10, 2012    

Effective Date     April 1, 2009

**New York  
2(c.1)**

For dates of service beginning on December 1, 2008 through March 31, 2010, for hospital outpatient clinic services, the operating component of rates shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

TN #09-46  
Supersedes TN NEW

Approval Date January 10, 2012  
Effective Date April 1, 2009

New York  
2(c)(A)

**Freestanding Diagnostic and Treatment Centers**

**Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers**

**Services for Pregnant Women**

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the previously approved trend factor methodology contained in the Trend Factor section of this Attachment.

The reimbursement methodology identified on this page regarding freestanding diagnostic & treatment centers sunsets June 30, 2010. Reimbursement as of July 1, 2010 will use the Ambulatory Patient Group (APG) methodology identified in the APG section of the State Plan.

TN #10-0018 Approval Date November 1, 2017  
Supersedes TN #07-0012 Effective Date July 1, 2010

**New York  
2(c)(i)**

**Comprehensive Primary Care Services**

**Voluntary Non-Profit and Publicly Sponsored Diagnostic and Treatment Centers  
Certified Under Article 28 of the Public Health Law**

An allowance will be established annually and added to Medicaid rates of payment for certified agencies, which can demonstrate a financial shortfall as a result of providing comprehensive primary care services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related-out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publicly-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies. Notwithstanding any inconsistent provisions of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with this paragraph shall apply only for services provided on or before December 31, 1996.

The methodology described in the following paragraphs pertains to diagnostic and treatments centers, which received an allowance for financing losses resulting from the provision of comprehensive primary care services to a disproportionate share of uninsured low-income patients during the period from July 1, 1990 through December 31, 1996. This allowance is described in the previous paragraph. For the period July 1, 2003 through December 31, 2003, qualified diagnostic and treatment centers shall receive an uncompensated care rate adjustment of not less than one-half the amount that would have been received for any losses associated with the delivery of bad debt and charity care for calendar year 1995.

For the period January 1, 2004 through December 31, 2004, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the above paragraph. For the period January 1, 2005 through June 30, 2005, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the above paragraph.

Any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with the above shall be reallocated by the Commissioner for distributions to the other classifications based on remaining need.

TN   #03-32  

Supersedes TN   #96-25  

Approval Date   June 18, 2004  

Effective Date   July 1, 2003

New York  
2(c)(i)(a)

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

TN #03-32  
Supersedes TN NEW

Approval Date June 18, 2004  
Effective Date July 1, 2003

**New York  
2(c)(ii)**

**Transitional Supplemental Payments**

For the periods February 1, 2002 through March 31, 2002, October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, the Commissioner of Health shall make supplemental medical assistance payments to qualified voluntary not-for-profit health care providers that are: freestanding diagnostic and treatment centers (D&TCs) that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding diagnostic and treatment centers that operate approved programs under the state Prenatal Care Assistance Program, or licensed freestanding family planning clinics. These supplemental payments reflect additional costs associated with the transition to Managed Care and are for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation. These providers will be eligible to receive a supplemental payment if the following criteria are met. The provider's number of Medicaid visits in the base year (2000) equals or exceeds 25 percent of its total number of visits and its number of visits for Medicaid Managed Care enrollees equals or exceeds three percent of its total number of Medicaid visits during the base year. Providers meeting these criteria shall receive a supplemental payment equal to a proportional share of the total funds available not to exceed fourteen million dollars for the period February 1, 2002 through March 31, 2002, nine million eight hundred twenty-four thousand dollars for the period October 1, 2002 through December 31, 2002, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2003 through December 31, 2003, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period April 1, 2005 through June 30, 2005, twenty nine million four hundred seventy-two thousand dollars (\$29,472,000) for the period October 1, 2006 through December 31, 2006, and nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2007 through December 31, 2007. This share shall be based upon the ratio of a provider's visits from medical assistance recipients enrolled in Managed Care during the 2000 base year to the total number of visits to all such qualified providers by medical assistance recipients enrolled in managed care during the base year. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment.

TN   #08-40  

Approval Date   February 10, 2011  

Supersedes TN   #07-46  

Effective Date   October 1, 2008

New York  
2(c)(iii)

**Electronic Health Record Systems Supplemental Payments**

For the period October 1, 2008 through December 31, 2008, seven million three hundred eighty eight thousand dollars (\$7,388,000) and for the period October 1, 2009 through December 31, 2009, seven million three hundred eighty eight thousand dollars (\$7,388,000) shall be available to eligible covered providers as medical assistance payments for services provided to Medicaid beneficiaries to reflect additional costs associated with the development, training, maintenance, and support of electronic health record systems that meet such standards no later than January 1, 2008, as established by the Commissioner of Health. The State will conduct a survey and perform independent verification. Electronic health records standards are: the exchanging of health information with other computer systems according to national standards; be certified by the Certification Commission for Health Information Technology; be capable of and used for supporting electronic prescribing; and be capable of and used for providing relevant information to the clinicians to assist with decision making. Providers will be eligible to receive a supplemental payment for the period October 1, 2008 through December 31, 2008, and October 1, 2009 through December 31, 2009, if this criterion is met. In addition to meeting the electronic record standards criterion, a provider's number of Medicaid visits for patient care services during the base year must equal or exceed twenty-five percent of its total number of visits for patient care services in the base year or its number of Medicaid visits combined with its number of uninsured visits for patient care services in the base year equals or exceeds thirty percent of its total number of visits for patient care services during the base year. Each qualified provider shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated, based upon the ratio of its visits from Medicaid recipients during the base year to the total number of Medicaid visits to all such qualified providers during the base year. The base year will be two years prior to the rate year, and the Commissioner of Health shall utilize data to determine Medicaid and uninsured visits reported by covered providers on certified 2006 AHCF-1 cost reports submitted to the Department of Health for such base year.

TN #09-31

Approval Date April 18, 2011

Supersedes TN #08-40

Effective Date October 1, 2009

New York  
2(c)(iii)(a)

**Supplemental Payments – Dental Clinic – February 1, 2002 through March 31, 2002**

Notwithstanding the provisions of the preceding section, for the period February 1, 2002 through March 31, 2002, facilities licensed under article twenty-eight of the public health law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to five hundred thousand dollars, in the aggregate, for use as supplemental payments pursuant to the preceding section. These funds shall be allocated for distribution to such facilities pursuant to the statutorily defined methodology contained in §364-j-2 of the Social Services Law. Payments may be added to rates of payment or made as aggregate payments to eligible facilities for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

TN     #08-40     Approval Date     February 10, 2011      
Supersedes TN     #07-46     Effective Date     October 1, 2008

**New York  
2(c)(iii)(b)**

**Supplemental Payments - Dental Clinic - October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, [and] October 1, 2008 through December 31, 2008, and October 1, 2009 through December 31, 2009.**

Notwithstanding the provisions of the first paragraph of this section titled Transitional Supplemental Payments, for the periods October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, facilities licensed under article twenty-eight of the Public Health Law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to two hundred twenty-five thousand dollars in the aggregate for the period October 1, 2002 through December 31, 2002, for the period October 1, 2003 through December 31, 2003, up to two hundred twenty-four thousand dollars in the aggregate, for the period April 1, 2005 through June 30, 2005, up to two hundred twenty-four thousand dollars in the aggregate, for the period October 1, 2006 through December 31, 2006, up to six hundred seventy-two thousand dollars (\$672,000) in the aggregate, and for the period October 1, 2007 through December 31, 2007, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; and for the period October 1, 2008 through December 31, 2008, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; and for the period October 1, 2009 through December 31, 2009, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; for use as supplemental payments pursuant to the first paragraph of this section titled Transitional Supplemental Payments. Forty percent of these funds shall be allocated for equal distribution based upon the facilities losses reported from self-pay and free visits multiplied by the facility specific Medicaid payment rate for the applicable year. This amount shall be offset by any payments received from such patients during the applicable period. Sixty percent, plus any funds allocated but not distributed under provisions of the previous sentence, shall be allocated according to the following scale.

% of eligible BD&CC visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 – 30%	75%
30%+	100%

TN   #09-31   Approval Date   April 18, 2011    
Supersedes TN   #08-40   Effective Date   October 1, 2009

**New York**  
**2(c)(iii)(c)**

The allocated amounts will be added to rates of payment[s] for eligible facilities for services rendered to Medicaid beneficiaries for the effective periods. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

TN   #08-40    
Supersedes TN   New  

Approval Date   February 10, 2011    
Effective Date   October 1, 2008

**New York  
2(c)(iv)**

**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics**

Prospective Payment System Reimbursement as of January 1, 2001 for and Rural Health Clinics including FQHCs located on Native American reservations and operated by Native American tribes or Tribal Organizations pursuant to applicable Federal Law and for which State licensure is not required.

For services provided on and after January 1, 2001 and prior to October 1, 2001, all-inclusive rates shall be calculated by the Department of Health, based on the lower of the facilities' allowable operating cost per visit or the peer group ceiling plus allowable capital cost per visit. The base for this calculation shall be the average of cost data submitted by facilities for both the 1999 and 2000 base years.

For each twelve month period following September 30, 2001, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September 30th of the prior period as increased by the percentage increase in the Medicare Economic Index and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility. Effective May 1, 2015 and each October 1 thereafter, rates of payment for the group psychotherapy and individual off-site services will be increased by the percentage increase in the Medicare Economic Index.

Supplementary increases in Medicaid rates of payment for these providers which is paid for the purpose of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility, in accordance with the provisions of the Workforce Recruitment and Retention section of this Attachment, are in addition to the standard Medicaid operating cost component calculation. As such, they are not subject to trend adjustments. These supplementary increases shall be in effect through June 30, 2005.

Rates of payments to facilities which first qualify as federally qualified health centers on or after October 1, 2000 shall be computed as above provided, however, that the operating cost component of such rates shall reflect an average of the operating cost components of rates of payments issued to other FQHC facilities during the same rate period and in the same geographic region, and with similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data for such facility as reported to the Department of Health. Effective May 1, 2011, the geographic regions will consist of the Downstate Region, which includes the five counties comprising New York City and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess and the Upstate Region, which includes all counties in the State other than those counties included in the Downstate Region. For each twelve-month period following the rate period in which such facilities commence operation, the operating cost components of rates of payment for such facilities shall be computed as described above.

For services provided on and after April, 1, 2016 the cost of long acting reversible contraceptives (LARC) will be separated from the PPS reimbursement. Reimbursement for LARC will be based on actual acquisition cost. The facility must submit a separate claim to be reimbursed for the actual acquisition cost of the LARC device.

TN #16-0028

Approval Date: July 25, 2016

Supersedes TN #15-0039

Effective Date: April 01, 2016

New York  
2(c)(iv.1)

For services provided on or after January 1, 2001, until such time as the new methodology is implemented, facilities shall be paid via the methodology in place as of December 31, 2000. The difference between the two methodologies shall be calculated and the sum shall be paid, on a per visit basis, in the fiscal year immediately following implementation of this new methodology.

For services provided on or after January 1, 2001 by FQHC's participating in managed care, supplemental payments will be made to these FQHC's that will be equal to 100% of the difference between the facilities reasonable cost per visit rate and the amount per visit reimbursed by the managed care plan.

The reimbursement methodology that the Department of Health will use for FQHCs located out-of-state will be the currently approved FQHC rate of the provider's home state.

TN #15-0039

Approval Date May 20, 2016

Supersedes TN #11-0059

Effective Date May 1, 2015

New York  
2(c)(iv)(a)

Diagnostic and treatment centers eligible for rates of payment as a Federally Qualified or Rural Health Center, which were also certified by the Department of Health as a preferred primary care provider as of December 31, 2000, and receiving rates of payment through the Products of Ambulatory Care reimbursement system as of such date, may elect to continue to be reimbursed via this alternative method of reimbursement. In no event shall rates of payment to these facilities be less than those computed as described on page 2(c)(iv) of this plan.

Effective on and after January 1, 2006, individual and group psychotherapy services provided to Medicaid patients by a licensed psychiatrist, psychologist, clinical social worker or master social worker at Federally Qualified and Rural Health Centers (FQHC/RHC) shall be reimbursed by the Department of Health. As of January 1, 2006, Federally Qualified and Rural Health Centers shall also be reimbursed for the provision of off-site primary care services provided to existing FQHC/RHC patients in need of professional services available at the FQHC/RHC, but, due to the individual's medical condition, are unable to receive the services on the premises of the center. An existing patient is defined as a registered patient with the FQHC/RHC prior to being admitted to the hospital or nursing home or requiring other offsite services. These services, provided by a physician, physician assistant, nurse practitioner, or nurse mid-wife, may be rendered at the off-site location only for the duration of the limiting illness. Rates of payment for group psychotherapy and off-site services shall be calculated by the Department of Health using elements of the Resource Based Relative Value Scale promulgated by the federal Centers for Medicare and Medicaid Services using the following methodology. For each relevant CPT procedure code, the work, practice expense, and geographic cost index (GPCI). The downstate average GPCI is based on the average of Manhattan, New York City & Long Island, and Queens indices. The upstate average GPCI consists of Poughkeepsie and Rest of State Indices. These are then summed and multiplied by the conversion factor to arrive at a regional price for each service. Rates of payment for group psychotherapy services shall not include a component for case management services. Rates of payment for individual psychotherapy services shall be made at the general FQHC rate calculated in accordance with the approved methodology contained on Page 2(c)(iv) of this Attachment.

Effective on and after April 1, 2008, rates of payment may be established based on alternative rate-setting methodologies for Federally Qualified and Rural Health Centers provided such methodologies, contained on plain pages 1(f) through 1(p) for hospital providers, and on pages 2(h) through 2(t) for freestanding clinic providers, are authorized by State law, agreed to by both the New York State Commissioner of Health and the applicable facility, and do not result in aggregate payments lower than the payments calculated under the existing approved methodology for such facility.

TN     #08-36     Approval Date     May 26, 2009      
Supersedes TN     #06-11     Effective Date     December 1, 2008

New York  
2(c)(iv)(a)(1)

Effective on and after January 1, 2015, the Department of Health shall reimburse FOHC/RHCs for Collaborative Care Services provided to Medicaid patients diagnosed with depression pursuant to the methodology for Collaborate Care Services for Freestanding Clinics outlined in Attachment 4.19-B. Effective on and after January 1, 2018, the Department of Health shall reimburse FOHC/RHCs for Collaborative Care Services provided to Medicaid patients with other mental illness diagnoses at the rates of payment then in effect for Collaborate Care Services provided to Medicaid patients diagnosed with depression. Rates of payment for Collaborative Care Services will be increased annually on October 1 by the percentage increase in the Medicare Economic Index.

TN #14-0027  
Supersedes TN NEW

Approval Date November 28, 2017  
Effective Date January 1, 2015

New York  
2(c)(iv)(b)

For providers choosing to be reimbursed under the Ambulatory Patient Group (APG) methodology, the Department will reconcile amounts actually paid in a calendar year through APG; to that which would have been paid through the PPS methodology. Adjustments will be made based upon this comparison to ensure that providers are not paid less than they would have under PPS. Reconciliation by DOH will include any FQHC providers which elect APGs or any alternate payment methodology to PPS and includes all Medicaid eligible services regardless of which State Agency is the licensing authority for the service.

TN #10-0018

Approval Date November 1, 2017

Supersedes TN #08-0036

Effective Date July 1, 2010

**New York  
2(c)(iv)(c)**

**Minimum Wage – Article 28 FOHCs**

Effective January 1, 2017, and every January 1, thereafter until the minimum wage reaches the statutorily described per hour wage as shown below, a minimum wage add-on will be developed and used to adjust Article 28 FOHC rate as an alternative payment method (APM) rate.

<u>Minimum Wage (MW) Region</u>	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>	<u>12/31/2020</u>	<u>12/31/2021</u>
<u>New York City (Large employers)</u>	<u>\$11.00</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>New York City (Small employers)</u>	<u>\$10.50</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester counties</u>	<u>\$10.00</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$9.70</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

The minimum wage add-on and the APM rate will be posted to Health Commerce System (HCS: [https://commerce.health.state.ny.us/public/hcs\\_login.html](https://commerce.health.state.ny.us/public/hcs_login.html)). An Article 28 FOHC's PPS threshold rate will be adjusted by a minimum wage add-on based on the following:

- a. 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 wage.
  - i. Minimum wage cost development based on survey data collected.
    1. Survey data will be collected for Article 28 FOHC specific wage data.
    2. Article 28 FOHCs will report by specified wage bands, the total count of FTEs and total hours paid to employees earning less than the statutory minimum wage applicable for each MW Region.
    3. Article 28 FOHCs will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
    4. 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 Article 28 FOHC has reported total hours paid. To this result, the Article 28 FOHC's average fringe benefit percentage is applied and added to the costs.
  - ii. Minimum wage cost development based on the AHCF cost report data.
    1. The average hourly wages of employees in occupational titles where the reported average hourly wage is below the regional statutory minimum wage are identified.
    2. The total payroll hours of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the AHCF cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.

TN #17-0013  
Supersedes TN New

Approval Date December 26, 2017  
Effective Date January 1, 2017

**New York  
2(c)(iv)(d)**

3. The facility's fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
  4. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.
- b. The 2017 minimum wage costs will be developed based on collected survey data received and attested to by Article 28 FOHCs. If an Article 28 FOHC did not submit a survey, its minimum wage costs will be calculated based on 2014 Ambulatory Health Care Facility (AHCF) Cost Report wage data. If an Article 28 FOHC fails to submit both the survey and the 2014 AHCF cost report, its minimum wage add-on will not be calculated.
  - c. In the subsequent years until the minimum wage is completely implemented statewide, the Department will survey Article 28 FOHCs utilizing the methodology employed in year one. If an Article 28 FOHC fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the use of the personnel wage data reported on the statewide latest available AHCF cost report. If an Article 28 FOHC fails to submit both the survey and the latest AHCF cost report, its minimum wage add-on will not be calculated. Once the costs are included in the development of FOHC PPS rate, the minimum wage add-on will be excluded from the rate.
  - d. A minimum wage add-on will be developed by multiplying minimum wage costs pursuant to "a." above by a percentage of Medicaid visits to total visits, divided by total Medicaid visits for such services.
  - e. Minimum Wage Reconciliation - After the end of each calendar year, the Department of Health will survey Article 28 FOHCs 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 the Article 28 FOHCs will have two weeks to complete the survey or request an extension if an FOHC 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 Article 28 FOHC's minimum wage add-on for the calendar year covered by the survey will be recouped.
    - i. Total annual minimum wage funding paid to the Article 28 FOHC (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 an Article 28 FOHC's total services.

TN #17-0013Approval Date December 26, 2017Supersedes TN NewEffective Date January 1, 2017

**New York  
2(c)(iv)(e)**

- ii. Medicaid's share of the total amount the Article 28 FOHC was obligated to pay to bring salaries up to the minimum wage for the calendar year. (This information will be completed by the Article 28 FOHC.)
- iii. Minimum wage funds to be recouped or additional funds to be received by the Article 28 FOHC. (This information will be completed by the provider.) This will be the difference between the amount paid to the Article 28 FOHC for the Medicaid share of the minimum wage law increase requirement and the corresponding amount the Article 28 FOHCs determined it was actually obligated to pay.
- iv. The State agency will review Article 28 FOHCs' 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.

- f. Since the costs will be at a current year dollar value, the minimum wage add-on will not be adjusted by the Medicare Economic Index (MEI).
- g. As this is an APM rate, providers will be required to agree to the implementation of this rate. However, this rate will not need to be subject to the comparison of the PPS FOHC rate, since this APM rate will be an increase to the PPS FOHC rate.
- h. For the purpose of comparing the Ambulatory Patient Group (APG) payment method rate that is being used as an APM for an FOHC provider, the APM PPS FOHC rate will be used in the rate comparison. This is due to the APG rate used in the comparison also having been increased by the MW add-on.

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New York  
2(c)(v)

Reserved

**[Hospital Outpatient Payment Adjustment**

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002, for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for public general hospitals other than those operated by the State of New York or the State University of New York, which experienced free patient visits in excess of 20 percent of their total self-pay and free patient visits based on data reported on Exhibit 33 of their 1999 Institutional Cost Report and which experienced uninsured outpatient losses in excess of 75% of their total inpatient and outpatient uninsured losses based on data reported on Exhibit 47 of their 1999 Institutional Cost Report, and are located in a city with a population of over one million. The amount to be paid will be thirty seven million dollars for the period beginning January 1, 2002 and ending March 31, 2002 and one hundred fifty-one million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005.

For state fiscal year beginning April 1, 2005 and ending March 31, 2006, the amount to be paid will be \$222,781,000. For state fiscal year beginning April 1, 2006 and ending March 31, 2007, the amount to be paid will be \$229,953,000. For state fiscal year beginning April 1, 2007 and ending March 31, 2008, the amount to be paid will be \$211,865,219. For state fiscal year beginning April 1, 2008 and ending March 31, 2009, the amount to be paid will be \$183,365,199. For state fiscal year beginning April 1, 2009 and ending March 31, 2010, the amount to be paid will be \$179,191,153. For state fiscal year beginning April 1, 2010 and ending March 31, 2011, the amount to be paid will be \$153,834,433.

For state fiscal year beginning April 1, 2011 and ending March 31, 2012, the amount to be paid will be \$55,223,767. For state fiscal year beginning April 1, 2012 through March 31, 2013, the amount to be paid will be \$45,880,761. For state fiscal year beginning April 1, 2013 through March 31, 2014, the amount to be paid will be \$101,247,036. For state fiscal year beginning April 1, 2014 through March 31, 2015, the amount to be paid will be \$105,802,261. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all Medicaid outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.]

TN #15-0023

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Effective Date April 1, 2015

**New York  
2(c)(v.1)**

**Hospital Outpatient Supplemental Payment Adjustment – Public General Hospitals**

The State will provide a supplemental payment for hospital outpatient and emergency room services provided by eligible public general hospitals. To be eligible, the hospital must (1) be a public general hospital, (2) not be operated by the State of New York or the State University of New York, and (3) be located in a city with a population over one million.

For state fiscal year beginning April 1, 2011 and ending March 31, 2012, the amount of the supplemental payment will be \$98,610,666. For state fiscal year beginning April 1, 2012 and ending March 31, 2013, the amount of the supplemental payment will be \$107,953,672. For state fiscal year beginning April 1, 2013 and ending March 31, 2014, the amount of the supplemental payment will be \$22,101,480. For state fiscal year beginning April 1, 2014 and ending March 31, 2015, the amount of the supplemental payment will be \$26,898,232. For state fiscal year beginning April 1, 2015 and ending March 31, 2016, the amount of the supplemental payment will be \$161,521,405. For state fiscal year beginning April 1, 2016 and ending March 31, 2017, the amount of the supplemental payment will be \$ 112,980,827. For state fiscal year beginning April 1, 2017 and ending March 31, 2018, the amount of the supplemental payment will be \$111,305,328. For state fiscal year beginning April 1, 2018 and ending March 31, 2019, the amount of the supplemental payment will be \$105,303,666. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all Medicaid outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such supplemental payments under this section will be made in a single lump-sum payment.

TN   #18-0027  

Approval Date   December 10, 2019  

Supersedes TN   #17-0009  

Effective Date   April 01, 2018

New York  
2(c)(v.1)(a)

**UPL Hospital Outpatient Settlement Supplemental Payment Adjustment – Public General Hospitals**

After receiving CMS approval of its UPL demonstration, the State will provide an additional supplemental payment for hospital outpatient and emergency room services provided by eligible public general hospitals. To be eligible, the hospital must have qualified for the additional supplemental payment authorized on page (2)(c)(v.1)

For state fiscal year beginning April 1, 2011 and ending March 31, 2012, the amount of the supplemental payment will be \$14,884,309. For state fiscal year beginning April 1, 2012 and ending March 31, 2013, the amount of the supplemental payment will be \$4,337,791. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all Medicaid outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such supplemental payments under this section will be made in a single lump-sum payment.

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Supersedes TN # NEW Effective Date: Jan 1, 2016

**New York  
2(c)(v.2)**

**Hospital Outpatient Supplemental Payments – Non-government Owned or Operated General Hospitals**

Effective for the period April 1, [2017] 2018 through March 31, [2018] 2019, supplemental payments are authorized for certain general hospitals for outpatient services furnished in the [2017] 2018 calendar year. Payments under this provision [shall] will not exceed [\$22,883,791] \$86,067,926.

To receive payment under this provision, a general hospital, as defined in Attachment 4.19-A of the state plan, must meet all of the following:

- (i) must be non-government owned or operated;
- (ii) must operate an emergency room; and
- (iii) must have received an Indigent Care Pool payment for the [2017] 2018 rate year; and/or must have a facility specific projected disproportionate share hospital payment ceiling for the [2017] 2018 rate year that is greater than zero.

The amount paid to each eligible hospital [shall] will be determined based on an allocation methodology utilizing data reported in eligible hospitals' most recent Institutional Cost Report submitted to the New York State Department of Health as of October 1, [2016] 2017:

- (a) Thirty percent of the payments under this provision [shall] will be allocated to eligible general hospitals classified as a safety net hospital, based on each hospital's proportionate share of all safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

For this purpose, a safety net hospital is defined as an eligible general hospital having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

- (b) Seventy percent of the payments under this provision [shall] will be allocated to eligible general hospitals based on each hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

Eligible Hospitals [shall] will receive payment under (a) and/or (b), as eligible, with each hospital's payment made in a lump sum distribution that is proportionately allocable across the hospital's share of the [\$350,032,365] \$413,942,892 in in outpatient services reimbursed all eligible hospitals in the [2017] 2018 calendar year.

**TN #18-0030**

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**Effective Date April 01, 2018**

**New York  
2(c)(vi)**

**Hospital Outpatient Payment Adjustment**

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002 [and ending March 31, 2005], for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for government general hospitals other than those operated by the State of New York or the State University of New York, which experienced free patient visits in excess of 20 percent of their total self-pay and free patient visits based on data reported on Exhibit 33 of their 1999 Institutional Cost Report and which experienced uninsured outpatient losses in excess of 75% of their total inpatient and outpatient uninsured losses based on data reported on Exhibit 47 of their 1999 Institutional Cost Report, and are located in a city with a population of over one million. The amount to be paid will be up to thirty four million dollars for the period beginning January 1, 2002 [through] and ending March 31, 2002 and [up to] one hundred thirty six million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002 and ending March 31, 2005, for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for government general hospitals operated by a county of the state of New York, which shall not include a city with a population over one million, and including those government hospitals located in the counties of Westchester and Nassau. The amount to be paid will be up to an aggregate of fifteen million dollars for the period January 1, 2002 through March 31, 2002, and up to an aggregate of sixty million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. Medical assistance payments for outpatient services will be made for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act. The allocation of aggregate payments among qualifying hospitals shall be based on each such hospital's proportionate share of the sum of all estimated differences in outpatient medical assistance payments and one hundred fifty percent of a reasonable estimate of the amount that would have been paid for such services under Medicare payment principles for the respective periods. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #05-26

Approval Date March 18, 2010

Supersedes TN #03-31

Effective Date April 1, 2005

**New York  
2(c)(vii)**

**Workforce Recruitment And Retention**

Effective for dates of service beginning on April 1, 2002 and ending on March 31, 2008, medical assistance rates of payment shall be adjusted for comprehensive freestanding diagnostic and treatment centers that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding clinics that provide services to clients with developmental disabilities as their principal mission, licensed facilities authorized to provide dental services and sponsored by a university or dental school, licensed freestanding family planning clinics, and freestanding diagnostic and treatment centers operating an approved program under the prenatal care assistance program to include costs associated with the recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. For the period April 1, 2002 through December 31, 2002, the aggregate amount of thirteen million dollars will be available for this purpose. The aggregate amount of thirteen million dollars will also be available each year for the periods January 1, 2003 through December 31, 2006. For the period January 1, 2007 through June 30, 2007 the aggregate amount of six million five hundred thousand dollars will be available for this purpose. For the period July 1, 2007 through March 31, 2008, nine million seven hundred fifty thousand dollars will be available. For the period April 1, 2008 through March 31, 2009, thirteen million dollars will be available. For the period April 1, 2009 through March 31, 2010, thirteen million dollars will be available. For the period April 1, 2010 through March 31, 2011, thirteen million dollars will be available. Payments will be made as adjustments to the rates of payment allocated proportionately based upon each diagnostic and treatment center's total annual gross salary and fringe benefit costs as reported in their 1999 cost report submitted to the Department of Health prior to November 21, 2001. These amounts shall be included as a reimbursable cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year. For the periods on and after July 1, 2007, payments will be made as adjustments to the rates of payment and the available funding allocated proportionately based upon each diagnostic and treatment center's total reported Medicaid visits as reported in their 2004 cost report submitted to the Department of Health prior to January 31, 2007, to the total of such Medicaid visits for all diagnostic and treatment centers.

The Commissioner of Health shall increase medical assistance rates of payment [for eligible diagnostic and treatment centers] by three percent for services provided on and after December first, two thousand two for purposes of improving recruitment and retention of non-supervisory

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New York  
2(c)(viii)

workers or any worker with direct patient care responsibility for]. Eligible diagnostic and treatment center shall mean a] voluntary, not-for-profit diagnostic and treatment centers that received medical assistance rates of payment reflecting assignment to (1) limited primary care or (2) drug free peer groups and that provides primary health care services to a patient population primarily comprised of substance abuse patients and that [is] are ineligible for an adjustment to medical assistance rates of payment under the first paragraph of this section of the plan.

Diagnostic and treatment centers which have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

The Commissioner shall increase medical assistance rates of payment by three percent for services provided on and after December first, two thousand two by freestanding methadone maintenance service and program providers; subject to provisions of the following paragraph. Freestanding methadone maintenance services and program providers which are eligible for rate adjustments pursuant to this paragraph and which are also eligible for rate adjustments pursuant to the first paragraph of this section of the plan shall, on or before July first, two thousand two, submit, amendments to their 1999 AHCF-1 cost report segregating wages and fringe benefit costs associated with methadone maintenance services, for the purpose of excluding such wages and fringe benefits from awards determined on and after January 1, 2003, pursuant to the first paragraph of this section of the plan titled Workforce Recruitment And Retention.

Freestanding methadone maintenance service and program providers which have their rates adjusted in accordance with the above shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. The Commissioner is authorized to audit each freestanding methadone maintenance services and program provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

TN #08-30 Approval Date July 26, 2010  
Supersedes TN #07-33 Effective Date April 1, 2008

New York  
2(d)

**TYPE OF SERVICE**

Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]

**METHOD OF REIMBURSEMENT**

The [products] Products of Ambulatory Care (PACS) Reimbursement Program uses a prospective reimbursement method associated with resource use patterns to insure that ambulatory services are economically and efficiently provided, and to provide incentives to foster continuity of care and treatment for patients. All participating providers, both hospital based clinics and freestanding diagnostic and treatment centers, are placed under a uniform, prospective, modified priced based system. The methodology is based upon the assignment of an ambulatory care visit into one of 24 mutually exclusive PAC groups. Under the reimbursement method, facility specific payment rates are established for each of the 24 PAC groups. Each rate in the payment model is comprise of two components – a case mix related price component and a facility component. The price component includes values for labor, ancillaries and medical supplies for which values are based upon current market prices. The facility specific cost components include pharmacy, facility, teaching and capital costs, and are based on a providers reported historical costs subject to ceiling limitations where applicable. Pharmacy and routine capital costs are fully reimbursed, although they are subject to desk audit adjustments.

The PAC payment method is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals and diagnostic and treatment centers. There are unique

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Effective Date     August 1, 1991

New York  
2(e)

**TYPE OF SERVICE**

Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]

**METHOD OF REIMBURSEMENT**

features present in the PACS reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the submission of patient encounter data by providers to the New York State Department of Health, financial responsibility by providers for selected laboratory and other ancillary procedures and Medicaid Revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Hospital-based clinics and freestanding diagnostic and treatment centers seeking PACs reimbursement are required to enter into a Memorandum of Participation with the New York State Department of Health.

TN #91-63

Supersedes TN #90-38

Approval Date October 31, 1991

Effective Date August 1, 1991

New York  
2(f)

Reserved

[Type of Service      Method of Reimbursement

Medically Supervised, Ambulatory Substance Abuse Treatment Services (Facilities certified under Article 23 of Mental Hygiene Law)

Prospective, provider-specific, all inclusive rates calculated by the State Division of Substance Abuse Services (DSAS):

- 1) For providers which have at least twelve months of previous history of operation as a medically supervised, ambulatory substance abuse treatment program, the rate is based on historical costs per visit held to Ceiling limitations mutually agreed upon by DSAS and DSS and trended forward to the current rate period to adjust for inflation or deflation; or,
- 2) providers which have less than twelve months history of operation as a medically supervised ambulatory substance abuse treatment program, a temporary prospective rate is calculated first taking the weighted average of all the rates calculated in (1) above, and then taking a percentage of that amount to arrive at the temporary prospective rates for all providers with less than twelve months history. A final rate will be calculated, based on actual costs from the first twelve months of operation under the temporary prospective rate, according to (1) above.

All rates are in effect for a two year period. Rates are subject to the approval of SDSS and Division of Budget. Rates are promulgated by SDSS.]

TN   #02-16  

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Supersedes TN   #91-59  

Effective Date   July 1, 2002

New York  
2(g)

**Comprehensive Diagnostic and Treatment Center Indigent Care Program**

For periods on and after July 1, 2003, the Commissioner of Health shall adjust medical assistance rates of payment to assist in meeting losses resulting from uncompensated care.

Eligible diagnostic and treatment centers shall mean voluntary non-profit and publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate losses from disproportionate share of uncompensated care during a base period two years prior to the grant period.

Uncompensated care need means losses from reported self-pay and free visits multiplied by the facility's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

A diagnostic and treatment center qualifying for a distribution or a rate adjustment shall provide assurances satisfactory to the Commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

To be eligible for an allocation of funds or a rate adjustment, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The Commissioner may retrospectively reduce the allocations of funds or the rate adjustments to a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the applicable period in the delivery of comprehensive primary health care services to uncompensated care residents of the community.

TN #03-32

Supersedes TN NEW

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**New York  
2(g)(i)**

For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payments for the following categories of eligible comprehensive voluntary diagnostic and treatment centers (D&TCs) for the following periods in the following aggregate amounts:

**Voluntary Non-Profit D&TCs**

- A. For the period July 1, 2003 through December 31, 2003, up to seven million five hundred thousand dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to fifteen million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to seven million five hundred thousand dollars.

**Public D&TCs, other than those operated by the New York City Health and Hospitals Corp.**

- A. For the period July 1, 2003 through December 31, 2003, up to nine million dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to eighteen million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to nine million dollars.

**Public D&TCs Operated by the New York City Health and Hospitals Corporation**

- A. For the period July 1, 2003 through December 31, 2003, up to six million dollars;
- B. For the period January 1, 2004 through December 31, 2004, up to twelve million dollars;
- C. For the period January 1, 2005 through June 30, 2005, up to six million dollars.

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**New York  
2(g)(ii)**

**Methodology**

A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center in each of the following categories; voluntary non-profit Diagnostic and Treatment Centers (D&TCs), public D&TCs other than those operated by the New York City Health And Hospitals Corporation, and public D&TCs operated by the New York City Health And Hospitals Corporation. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

<u>Percent of eligible bad debt and charity care clinic visits to total visits</u>	<u>Percent of nominal financial loss coverage</u>
<u>up to 15%</u>	<u>50%</u>
<u>15-30%</u>	<u>75%</u>
<u>over 30%</u>	<u>100%</u>

The uncompensated care rate adjustments for each eligible diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for diagnostic and treatment centers within the applicable category to the total statewide nominal payment amounts for all eligible diagnostic and treatment centers within the applicable category applied to the nominal payment amount for each such diagnostic and treatment center.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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New York  
2(g)(iii)

**Non-Hospital Based Freestanding or Local Health Department Operated  
General Medical Clinics**

Non-hospital based freestanding or local health department operated general clinics sponsored by municipalities that received state aid for the 1989-90 state fiscal year in support of non-hospital based free-standing or local health department operated general medical clinics shall receive an uncompensated care rate adjustment for the period July 1, 2003 through December 31, 2003, of not less than one-half the amount received in the 1989-90 state fiscal year for general medical clinics.

For the period January 1, 2004 through December 31, 2004, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to the previous paragraph.

For the period January 1, 2005 through June 30, 2005, each such eligible general clinic shall receive an uncompensated care rate adjustment of not less than the amount calculated pursuant to the first paragraph.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible general clinics and shall not be subject to subsequent adjustment or reconciliation.

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New York  
2(g)(iv)

**Diagnostic And Treatment Centers With Less Than Two Years Operating Experience**

For periods on and after July 1, 2003, funds shall be made available for adjustments to rates of payment for eligible diagnostic and treatment centers with less than two years of operating experience, and diagnostic and treatment centers which have received certificate of need approval on applications which indicate a significant increase in uninsured visits, for the following periods and in the following aggregate amounts:

- For the period July 1, 2003 through December 31, 2003, up to one million five hundred thousand dollars;
- For the period January 1, 2004 through December 31, 2004, up to three million dollars;
- For the period January 1, 2005 through June 30, 2005, up to one million five hundred thousand dollars.

To be eligible for a rate adjustment, a diagnostic and treatment center shall be a voluntary non-profit or publicly sponsored diagnostic and treatment center providing a comprehensive range of primary health care services and be eligible to receive a Medicaid budgeted rate prior to April first of the applicable rate adjustment period after which time, the Department shall issue rate adjustments pursuant to the information provided in this plan for such periods. Rate adjustments made pursuant to this section shall be allocated based upon each eligible facility's proportional share of costs for services rendered to uninsured patients which have otherwise not been used for establishing distributions to the total of all qualifying facilities. For the purposes of this section, costs shall be measured by multiplying each facility's Medicaid budgeted rate by the estimated number of visits reported for services anticipated to be rendered to uninsured patients meeting the aforementioned criteria, less any anticipated patient service revenues received from such uninsured patients, during the applicable rate adjustment period.

Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation.

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Supersedes TN NEW

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New York  
2(g)(1)

**APG Reimbursement Methodology – Freestanding Clinics**

For the purposes of sections pertaining to the Ambulatory Patient Group, and excepted as otherwise noted, the term freestanding clinics shall mean freestanding Diagnostic and Treatment Centers (D&TCs) and shall include freestanding ambulatory surgery centers.

For dates of service beginning September 1, 2009 through December 31, [2018] 2019, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

TN           #19-0010          

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**New York  
2(g)(2)**

**APG Reimbursement Methodology – Freestanding Clinics**

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at [http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm). In addition, prior period information associated with these links is available upon request to the Department of Health.

**Contact Information:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm) Click on "Contacts."

**3M APG Crosswalk\*:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm) Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

**APG Alternative Payment Fee Schedule; updated as of 01/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Alternative Payment Fee Schedule."

**APG Consolidation Logic; logic is from version 3.14.19.1, updated as of 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/bundling/](http://www.health.ny.gov/health_care/medicaid/rates/bundling/) Click on "2019"

**APG 3M Definitions Manual; version 3.14 updated as of [01/01/19 and 04/01/19] 07/01/19 and 10/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "3M Versions and Crosswalk."

**APG Investments by Rate Period; updated as of 07/01/10:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Investments by Rate Period."

**APG Relative Weights; updated as of [01/01/19] 07/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

**Associated Ancillaries; updated as of 07/01/15:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm) Click on "Ancillary Policy."

\*Older 3M APG crosswalk versions available upon request.

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2(g)(3)**

**Carve-outs; updated as of 10/01/12. The full list of carve-outs is contained in Never Pay APGs and Never Pay Procedures:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Carve Outs."

**Coding Improvement Factors (CIF); updated as of 04/01/12 and 07/01/12:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "CIFs by Rate Period."

**If Stand Alone, Do Not Pay APGs; updated 01/01/15:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "If Stand Alone, Do Not Pay APGs."

**If Stand Alone, Do Not Pay Procedures; updated 01/01/19:**

[http://www.health.state.ny.us/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm) Click on "If Stand Alone, Do Not Pay Procedures."

**Modifiers; updated as of 07/01/18:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Modifiers."

**Never Pay APGs; updated as of 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Never Pay APGs."

**Never Pay Procedures; updated as of [07/01/18] 07/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Never Pay Procedures."

**No-Blend APGs; updated as of 04/01/10:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Blend APGs."

**No-Blend Procedures; updated as of 01/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No-Blend Procedures."

**No Capital Add-on APGs; updated as of 10/1/12 and 01/01/13:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Capital Add-on APGs."

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New York  
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**No Capital Add-on Procedures; updated as of 07/01/17:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "No Capital Add-on Procedures."

**Non-50% Discounting APG List; updated as of 07/01/17:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Non-50% Discounting APG List."

**Rate Codes Carved Out of APGs; updated as of 01/01/15:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Rate Codes Carved Out of APGs for Article 28 facilities."

**Rate Codes Subsumed by APGs; updated as of 01/01/11 and 07/01/11:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Rate Codes Subsumed by APGs – Freestanding Article 28."

**Statewide Base Rate APGs; updated as of [01/01/14] 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Statewide Base Rate APGs."

**Packaged Ancillaries in APGs; updated as of [01/01/12] 01/01/19:**

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm) Click on "Packaged Ancillaries in APGs."

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**New York  
2(g)(4)**

**Freestanding Clinic and Ambulatory Surgery Centers APG Base Rate Table**

<b>Peer Group</b>	<b>Region</b>	<b>Rate Start Date</b>	<b>Base Rate Updated as of [01/01/12] <u>07/01/12</u></b>
Academic Dental	Downstate	09/01/09	\$155.38
Academic Dental	Upstate	09/01/09	\$147.64
Ambulatory Surgery Centers	Downstate	09/01/09	\$113.92
Ambulatory Surgery Centers	Upstate	09/01/09	\$99.15
Clinic <sup>2</sup>	Downstate	09/01/09	[\$162.19] <u>\$165.64</u>
Clinic <sup>2</sup>	Upstate	09/01/09	[\$135.92] <u>\$138.81</u>
Clinic MR/DD/TBI <sup>1</sup>	Downstate	09/01/09	[\$194.62] <u>\$198.76</u>
Clinic MR/DD/TBI <sup>1</sup>	Upstate	09/01/09	[\$163.11] <u>\$166.58</u>
Renal	Downstate	09/01/09	\$141.29
Renal	Upstate	09/01/09	\$126.82
School-Based Health Center (SBHC) <sup>2</sup>	Downstate	09/01/09	[\$162.19] <u>\$165.64</u>
School-Based Health Center (SBHC) <sup>2</sup>	Upstate	09/01/09	[\$135.92] <u>\$138.81</u>
Statewide Base Price	Statewide	01/01/11	\$160.00

<sup>1</sup>Mentally retarded/developmentally disabled/traumatic brain injured.

<sup>2</sup>For Clinic and School-Based Health Center (SBHC), while they share the same base payment rates, please note that their rate codes differ.

<sup>3</sup>Statewide Base Price is not a service but used for APGs which do not have a payment differentiation for upstate and downstate providers.

Freestanding Clinic and Ambulatory Surgery Center Medicaid rates can be found at the Department of Health's website at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm)

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New York  
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**Ambulatory Patient Group System - Freestanding Clinics**

**The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.** Links to detailed APG reimbursement methodology lists are located in the APG Reimbursement Methodology – Freestanding Clinics section.

**Allowed APG Weight** shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting.

**Ambulatory Patient Group (APG)** shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of [ICD-9-CM] ICD-10-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M's grouping logic outlined in the APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M. A link to the APG Definitions Manual versions and effective dates is available in the APG Reimbursement Methodology – Freestanding Clinics section.

**APG Relative Weight** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

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2(i)

**Associated Ancillaries** shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. The ancillary policy for freestanding clinics has been delayed from September 1, 2009, to July 1, 2011. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

**APG Software** shall mean the New York State-specific version of the APG computer software developed and published by 3M Health Information Systems (3M) to process HCPCS/CPT-4 and [ICD-9-CM] ICD-10-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software can perform the computations by accessing the APG definitions manual, which is available on the 3M web site. The appropriate link can also be found on the NYS DOH website.

**Base Rate** shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

**Carve-outs** shall mean certain procedures which are not paid using the APG reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. If the procedure is not reimbursable thru the APG methodology or on the fee schedules as stated, they are not reimbursable in Medicaid. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**Case Mix Index** is the actual or estimated average final APG weight for a defined group of APG visits.

**Coding Improvement Factor** is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. A link to the coding improvement factors for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

**Consolidation/Bundling** shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual, a link to which is provided in the APG Reimbursement Methodology – Freestanding Clinics section.

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2(i)(1)**

**Current Procedural Terminology-fourth edition (CPT-4)** is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and the HCPCS is maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

**Discounting** shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting will be at the rate of 50% until January 1, 2010, with the exception of those discounts listed in the link to the Non-50% Discounting APG List provided in the APG Reimbursement Methodology – Freestanding Clinic Section.

"Episode" shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a freestanding clinic or an ambulatory surgery center to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.

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**New York  
2(j)**

**Final APG Weight** shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable for bundling, packaging, and discounting.

**“HCPCS Codes”** are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

**International Classification of Diseases, [9<sup>th</sup>] 10<sup>th</sup> Revision-Clinical Modification ([ICD-9-CM] ICD-10-CM)** is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

**Modifier** shall mean a HCPCS Level II code used in APGs, based on its meaning in the HCPCS lexicon, to modify the payment for a specific procedure code or APG.

**Never Pay APGs** shall mean an APG where all the procedure codes that map to the APG are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay APG file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**Never pay procedures** shall mean procedure codes that are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay Procedures file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**No-blend APG** shall mean an APG that has its entire payment calculated under the APG reimbursement methodology without regard to the historical average operating payment per visit for the provider. A link to a list of no-blend APGs for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

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**New York  
2(j)(1)**

**Packaging** shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software. A link to the list of uniform packaging APGs for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

**“Peer Group”** shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. There are ten [DTC] freestanding clinic peer groups for initial APG implementation: General Clinic/School-Based Health Centers upstate; General Clinic/School-Based Health Centers downstate; Academic Dental upstate; Academic Dental downstate; Ambulatory Surgery Centers upstate; Ambulatory Surgery Centers downstate; Renal upstate; Renal downstate; Mental Retardation, Developmental Disability, Traumatic Brain Injured upstate(MR/DD/TBI); and Mental Retardation, Developmental Disability, Traumatic Brain Injured downstate.

**“Procedure-based Weight”** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a given HCPCS/CPT code as compared to the expected average resource utilization for other HCPCS/CPT codes or APGs. If a procedure code has not been assigned a procedure-based weight, the APG relative weight for the APG to which that procedure code groups will be used as the basis for reimbursement for that procedure code (subject to the consolidation, discounting and packaging logic).

**“Region”** shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

**“APG Visit”** shall mean a unit of service consisting of all the APG services and associated ancillary services performed for a patient that are coded on the same claim and share a common [on a single] date of service [and related ancillary services].

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[New York  
2(j)(i)]

**["Episode"** shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a freestanding clinic or an ambulatory surgery center to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.]

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New York  
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Reimbursement Methodology – Freestanding Clinics

- I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.
- II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.
  - a. The APG relative weights will be updated no less frequently than every [seven] eight years based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – Freestanding Clinics section.
  - b. The APG relative weights shall be re-weighted prospectively. The initial reweighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re-weightings will be based on Medicaid hospital claims data from the most recent twelve-month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.
  - c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.
- III. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. Recalculations of case mix indices for periods prior to January 1, 2010, will be based on freestanding D&TC and ambulatory surgery center Medicaid data for 2007. Such revisions for the period commencing January 1, 2010, will be based on such data from the January 1, 2009 through November 15, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve month period.

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- IV. The APG base rates shall be updated at least annually. [The initial u] Updates for periods prior to January 1, 2010, will be based on claims data from 2007. The update commencing January 1, 2010, [the September] will be based on claims data from the January 1, 2009 through November [30] 15, 2009 period, and subsequent updates will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.
- a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. [APG payments shall also reflect an investment of \$13.54 million for dates of service from September 1, 2009 through March 31, 2010, and \$12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.]
- V. [For the period September 1, 2009 to November 30, 2009, the] APG base rates shall initially be calculated using the total operating reimbursement for services and [related] associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of [\$13.54] \$9.375 million for dates of service from September 1, 2009 through [March 31, 2010] November 30, 2009, and [\$12.5] \$50 million for each annual period thereafter. A link to the allocation of all APG investments across peer groups for all periods is available in the APG Reimbursement Methodology – Freestanding Clinic section. The case mix index shall initially be calculated using 2005 claims data.
- a. [For all rate periods subsequent to November 30, 2009, estimated] The calculation of total operating reimbursement for services and [related] associated ancillaries and the [estimated] number of visits shall be calculated based on historical claims data. Calculations for periods prior to January 1, 2010, shall be based on Medicaid claims data for 2007. Calculations for the period commencing January 1, 2010, shall be based on Medicaid claims data for the period January 1, 2009 [The initial re-estimation will be based on claims data from the September 1, 2009] through November [30] 15, 2009[, and s] Subsequent [modifications] calculations will be based on Medicaid freestanding clinic and ambulatory surgery center claims data from the most recent twelve-month period[, ] and will be based on complete and accurate data.
- b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. This initial estimate will be adjusted prior to January 1, 2010, based on Medicaid freestanding [D&TC] clinic and ambulatory surgery center claims data from 2007 [the September 1, 2009 through November 30, 2009 period]. For January 1, 2010, the case mix index will be recalculated using January 1, 2009, to November 15, 2009, claims data. [and] Any subsequent modifications will be based on Medicaid freestanding [D&TC] clinic and ambulatory surgery center claims data from the most recent twelve-month period[, ] and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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**New York  
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- VI. Rates for new freestanding D&TC clinics during the transition period
- a. Freestanding D&TC clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to the Public Health Law are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:
  - b. For the period September 1, 2009 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - c. For the period December 1, 2009, [January 1, 2010] through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility-specific Medicaid reimbursement paid for freestanding D&TC clinic claims for each peer group, as defined [on Page 2(j) of this plan amendment] in the list of definitions under the Ambulatory Patient Group Reimbursement System – Freestanding Clinic section, paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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**New York  
2(n)**

- VII. Rates for new freestanding ambulatory surgery centers during the transition period
- a. Freestanding ambulatory surgery centers which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available, shall have the capital cost component of their rates computed in accordance with the methodology described in [item IV on page 2(o) of this plan amendment] the APG Rate Computation – Freestanding Clinics section and shall have the operating cost component of their rates computed in accordance with the following:
  - b. For the period September 1, 2009 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - c. For the period December 1, 2009, [January 1, 2010] through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;
  - e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section; and
  - f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for freestanding ambulatory surgery centers services claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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New York  
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**APG Rate Computation – Freestanding Clinics**

The following is a description of the methodology to be utilized in calculating rates of payment for freestanding clinics and ambulatory surgery center services under the Ambulatory Patient Group classification and reimbursement system.

- I. Claims containing ICD-10 diagnostic and CPT-4/HCPCS procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.
- II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.
- III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.
- IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For freestanding clinic services, capital will continue to be paid as an add-on using the existing, previously approved methodology. Beginning January 1, 2016, and every January 1 thereafter, the capital add-on for Article 28 freestanding clinic services shall be the result of dividing the total allowable capital costs associated with Article 28 services by the Article 28 total number of visits or procedures. The allowable capital costs and visits or procedures will be based on the 2-year prior certified Ambulatory Health Care Facility (AHCF) annual cost report submitted to the Department of Health. If a clinic fails to file a base year AHCF cost report with the required documents, the clinic will receive no capital add-on for Article 28 freestanding clinic services for the rate period. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2007 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2007 calendar year.
- V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., freestanding clinic and ambulatory surgery center services) during the 2007 calendar year and associated ancillary payments will be added to an investment of \$9.375 million for dates of service from September 1, 2009 through November 30, 2009, and \$50 million for each annualized period thereafter to form the numerator. A link to the base rates can be found in the APG Reimbursement Methodology – Freestanding Clinics section. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

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**New York  
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The following is an example of a sample APG base rate calculation:

a. 2007 Peer Group Reimbursement	\$51,000,000
b. Additional Investment	\$25,000,000
c. Case Mix Index	8.1610
d. Coding Improvement Factor	1.05
e. 2007 Base Year Visits	50,000

$$(\$51,000,000 + \$25,000,000) / (8.1610 \times 1.05 \times 50,000) = \$177.38 \text{ (Base Rate)}$$

- VI. During the transition period, reimbursement for freestanding clinic and ambulatory surgery center services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending [December 31] November 30, 2009) 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. [During 2010] For the period December 1, 2009, through December 31, 2010, the blend will be 50/50. During 2011, the blend will be 75/25. Payments will be based upon 100% of the APG operating component beginning on January 1, 2012. [Per the enabling statute, as new services the Education APGs and the Extended Hours APGs are not subject to the blend requirement.

Effective for dates of service on and after September 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a freestanding clinic shall be reimbursed entirely on the APG methodology.] A link to the list of APGs that are not subject to the blend is available in the APG Reimbursement Methodology – Freestanding Clinics section.

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New York  
2(p)(i)

Effective for dates of service on and after September 1, 2009, payments to freestanding clinics for the following services shall be based on fees or rates established by the Department of Health: (1) wheelchair evaluations, (2) eyeglass dispensing, and (3) individual psychotherapy services provided by licensed social workers to persons under the age of 21, and to persons requiring such services as a result of or related to pregnancy or giving birth, and (4) individual psychotherapy services provided by licensed social workers at freestanding clinics that provided, billed for, and received payment for these services between January 1, 2007 through December 31, 2007. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. A link to the APG alternative rates for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

VII. Rates for services provided in freestanding clinic and ambulatory surgery center facilities located outside of New York State shall be as follows:

- APG rates in effect for similar services for providers located in the downstate region of New York State shall apply to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth; in the Pennsylvania county of Pike; and in the Connecticut counties of Fairfield and Litchfield; and rates in effect for similar services for providers located in the upstate region of New York State shall apply to all other out-of-state providers.
- In the event the Department determines that an out-of-state provider is providing services which are not available within New York State, the Department may negotiate payment rates and conditions with such a provider up to, but not in excess of, the provider's usual and customary charges. Prior approval by the Department shall be required with regard to services provided by such providers.
- For the purpose of APG reimbursement to out-of-state providers, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

**System updating**

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable [ICD-9-CM] ICD-10-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.

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Approval Date     February 16, 2016    

Effective Date     October 01, 2015

**New York  
2(p)(ii)**

**Minimum Wage – Article 28 Freestanding Clinics**

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 the Ambulatory Patient Group (APG) rate for freestanding clinics and ambulatory surgery centers under Article 28.

<u>Minimum Wage (MW) Region</u>	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>	<u>12/31/2020</u>	<u>12/31/2021</u>
<u>New York City (Large employers)</u>	<u>\$11.00</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>New York City (Small employers)</u>	<u>\$10.50</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester counties</u>	<u>\$10.00</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$9.70</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

The minimum wage add-on and the adjusted APG rate will be posted to Health Commerce System (HCS: [https://commerce.health.state.ny.us/public/hcs\\_login.html](https://commerce.health.state.ny.us/public/hcs_login.html)). The minimum wage add-on will be developed and implemented as follows:

- a. 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 wage.
  - i. Minimum wage cost development based on survey data collected.
    1. Survey data will be collected for facility specific wage data.
    2. Facilities will report by specified wage bands, the total count of FTEs and total hours paid to employees earning less than the statutory minimum wage applicable for each MW Region.
    3. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
    4. 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 AHCF cost report data.
    1. The average hourly wages of employees in occupational titles where the reported average hourly wage is below the regional statutory minimum wage are identified.
    2. The total payroll hours of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the AHCF cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.
    3. The facility's fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
    4. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.

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Effective Date January 1, 2017

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- b. The 2017 minimum wage costs will be developed based on collected survey data received and attested to by clinics and ambulatory surgery centers. If a clinic or ambulatory surgery center did not submit a survey, its minimum wage costs will be calculated based on 2014 Ambulatory Health Care Facility (AHCF) Cost Report wage data. If a clinic or ambulatory surgery center fails to submit both the survey and the 2014 AHCF cost report, its minimum wage add-on will not be calculated.
- c. In the subsequent years until the minimum wage is completely implemented statewide, the Department will survey clinics and ambulatory surgery centers utilizing the methodology employed in year one. If a clinic or ambulatory surgery center fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the use of the personnel wage data reported on the statewide latest available AHCF cost report. If a clinic or ambulatory surgery center fails to submit both the survey and the latest AHCF cost report, its minimum wage add-on will not be calculated. Once the costs are included in the development of the upstate/downstate APG base rate, the minimum wage add-on will be excluded from the rate.
- d. A minimum wage add-on will be developed by multiplying minimum wage costs pursuant to "a." above by a percentage of Medicaid visits to total visits, divided by total Medicaid visits for such services.
- e. 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.
- i. 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.
  - ii. 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.)
  - iii. 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

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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.

- iv. 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.

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[The following shall be excluded from the APG reimbursement system:

- Drugs and other pharmaceutical products and implantable family planning devices for which separate and distinct outpatient billing and payment were authorized by the Department as of December 31, 2007, and as set forth by the Department in written billing instructions issued to providers.
- HIV counseling and testing visits, HIV counseling (no testing), post-test HIV counseling visits (positive results), day health care service (HIV).
- TB/directly observed therapy - downstate levels 1 and 2, TB/directly observed therapy.
- Upstate levels 1 and 2, AIDS clinic therapeutic visits in general hospital outpatient clinics.
- Child rehabilitation services provided under rate code 2887 in general hospital outpatient clinics.
- Medicaid obstetrical and maternity services (MOMS) provided under rate code 1604.
- Visits solely for the purpose of receiving ordered ambulatory services.
- Visits solely for the purpose of receiving pharmacy services.
- Visits solely for the purpose of receiving education or training services, except with regard to services authorized pursuant to clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving services from licensed social workers, except with regard to psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system, or as authorized pursuant to clauses (C) and (D) of subparagraph (ii) of paragraph (f) of subdivision 2-a of §2807 of the Public Health Law.
- Visits solely for the purpose of receiving group services, except with regard to clinical group psychotherapy services provided by Federally Qualified Health Centers or Rural Health Centers choosing to participate in the APG system and provided, however, that reimbursement for such group services shall be determined in accordance with state regulation.
- Offsite services, defined as medical services provided by a facility's outpatient staff at locations other than those operated by and under the facility's licensure under Article 28 of the Public Health Law, or visits related to the provision of such offsite services, except with regard to offsite services provided by Federally Qualified Health Centers or Rural Health Centers.]

TN #10-06

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New York  
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Effective for freestanding clinic and ambulatory surgery centers, on or after July 1, 2013, the administration of a Long-Acting Reversible Contraceptive (LARC) will be carved out of the APG reimbursement methodology when it is provided on the same Date of Service (DOS) as an abortion. The facility will be reimbursed with state funds only for the abortion procedure through APGs which is a prospective payment system that pays based on a facility's base rate and the service intensity weight of the procedure(s) rendered. The facility will submit a separate claim that will pay \$208 which will cover the cost of the LARC insertion (\$158) and the associated Evaluation and Management services (\$50). The facility will submit a third claim to be reimbursed for the cost of the LARC device at the provider's actual acquisition cost. The cost of the physician's professional services is carved out of the ambulatory surgery center payments; the physician is permitted to submit separate claim for those professional services rendered in an ambulatory surgery center. Physician payments will be made per the fee schedule posted online at <https://www.emedny.org/ProviderManuals/Physician/index.aspx>.

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[-RESERVED-]

**Ambulatory Patient Group Reimbursement Methodology – Freestanding Office of Alcoholism and Substance Abuse (OASAS) Certified Chemical Dependence and Opioid Treatment Clinics certified pursuant to Mental Hygiene Law Article 32 and not operated by a Hospital**

Ambulatory Patient Group (APG) reimbursement for freestanding chemical dependence clinics (including those certified as outpatient clinics and outpatient rehabilitation clinics) and freestanding opioid treatment clinics (OASAS clinics) certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and not operated by a hospital will begin on July 1, 2011. The initial base rates for freestanding OASAS clinics will be calculated using paid 2008 Medicaid claims data for OASAS freestanding clinics. The initial update will be based on claims data from 2010 Medicaid claims for OASAS freestanding clinics. Beginning 2012, the base rates will be updated at least every two years, will be based on Medicaid claims data from the most recent 12 month period and will be based on complete and accurate billing data. Freestanding OASAS clinics will not receive a capital add-on. Freestanding OASAS clinics do not include OASAS clinics operated by a hospital.

There are 6 OASAS freestanding clinic peer groups for initial APG implementation. The peer groups are divided into two regions, downstate and upstate. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the rest of the State. The peer groups are as follows: Upstate freestanding chemical dependence clinics; Downstate freestanding chemical dependence clinics; Upstate freestanding chemical dependence outpatient rehab clinics; Downstate freestanding chemical dependence outpatient rehab clinics; Upstate freestanding opioid treatment clinics; Downstate freestanding opioid treatment clinics. This information is also available on the OASAS website at:

<http://www.oasas.ny.gov/admin/hcf/FFS/RegionAPGBaseRate.cfm>

**I. Reimbursement Methodology**

The list of definitions in the APG System: Freestanding Clinics section will apply to the methodology for OASAS freestanding clinics.

The calculation of the case mix index will be used in the periodic determination of the APG base rates to assure that prospective aggregate disbursements remain within available resources. Every provider reports Medicaid claims by actual services delivered by procedure. The initial case mix index will be based on 2008 Medicaid claims data for OASAS free standing clinics. The total volume of service type multiplied by the service weight and added to the other aggregated volume per service weight will determine initial case mix. Thereafter, case mix will continue to be determined by actual volume of reported services to yield the actual case mix ratio.

In an APG payment environment, payments are determined by multiplying a dollar base rate (varies by peer group) by the weight for each procedure. The weight is a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. Procedure weights are the same for all freestanding clinic providers regardless of peer group.

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**II. Transition**

Freestanding clinics are those clinics certified by OASAS pursuant to New York State Mental Hygiene Law Article 32 and not operated by a hospital. OASAS will promulgate the APG base rates for all freestanding OASAS clinics. The base rates for all OASAS clinic peer groups can be found in the section entitled Base Rates for Office of Alcoholism and Substance Abuse Outpatient Treatment Programs.

All freestanding OASAS clinics will transition to full payment under the APG methodology over a multi-year period. Freestanding OASAS clinics will transition beginning July 1, 2011 and ending January 1, 2014 as described in the following paragraphs:

There will be a transition to APG reimbursement as identified in the transition schedule below. Provider reimbursement during the identified transition period will be a blended payment consisting of a percentage of the individual provider's rate in effect on June 30, 2011 and a percentage of APG payment. The APG payment will be the product of the base rate multiplied by the relative weights of the delivered procedure and/or services. A link to the APG base rates in effect during the transition and after completion of the transition by provider can be found at:

<https://www.oasas.ny.gov/admin/hcf/FFS/index.cfm>

Payments to Freestanding OASAS clinics will be made pursuant to the following transition schedule:

- a. Beginning on July 1, 2011 and ending on June 30, 2012, payment will reflect a blend of 75% of the existing provider rate in effect on June 30, 2011 and 25% of the APG payment;
- b. Beginning on July 1, 2012 and ending on June 30, 2013, payment will reflect a blend of 50% of the existing provider rate in effect on June 30, 2011 and 50% of the APG payment;
- c. Beginning on July 1, 2013 and ending on December 31, 2013, payment will reflect a blend of 25% of the existing provider rate in effect on June 30, 2011 and 75% of the APG payment; and
- d. Beginning on January 1, 2014, all subsequent payments will reflect full APG reimbursement.

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2(r.2)**III. Rates for new freestanding OASAS certified clinics during the transition period.**

Clinics that begin operation on or after July 1, 2011 ("new clinics") will be reimbursed in accordance with the transition phase-in schedule identified in the transition section. An appropriate threshold fee will be established for such new clinics and be blended with the APG rate according to the same phase-in percentages as clinics that existed prior to July 1, 2011. New clinics do not have historical volume on which their legacy rate can be determined. A legacy rate for new clinics will use an average legacy rate, which will be determined using all of the legacy fees for providers in the new clinic's peer group. The new clinic's reimbursement rate during the transition period will follow the transition schedule.

**IV. Off-site visits provided by OASAS licensed clinics to homeless individuals.**

Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Medicaid claims will not be submitted by OASAS licensed clinics for off-site services provided to individuals who do not meet the exception in 42 CFR 440.90(b).

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**APG Peer Group Base Rates for freestanding OASAS licensed chemical dependence and opioid treatment programs**

<u>Upstate</u>	<u>\$147.59</u>	<u>Effective: 07/01/2011</u>
<u>Downstate</u>	<u>\$172.69</u>	<u>Effective: 07/01/2011</u>
<u>Upstate</u>	<u>\$147.59</u>	<u>Effective: 07/01/2011</u>
<u>Downstate</u>	<u>\$172.69</u>	<u>Effective: 07/01/2011</u>
<u>Upstate</u>	<u>\$136.04</u>	<u>Effective: 07/01/2011</u>
<u>Downstate</u>	<u>\$159.17</u>	<u>Effective: 07/01/2011</u>

**Base Rates and blend rates for all OASAS chemical dependence medically supervised outpatient clinics:**

<http://www.oasas.ny.gov/admin/hcf/FFS> Click on "Regional APG Base Rates."

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**APG Reimbursement Methodology – Freestanding (Non-[Article 28] Hospital) OMH Licensed Mental Health Clinics**

Ambulatory Patient Group (APG) reimbursement for all freestanding mental health clinics licensed by the New York State Office of Mental Health (OMH) will begin October 1, 2010. The initial base rates for mental health clinics will be calculated by the OMH using historical Article 31 claims data as reported in the data warehouse, from the base period of July 1, 2008 to June 30, 2009. This base period will be used as the basis for calculations for all rates going forward from October 1, 2010.

There are [four] three mental health clinic peer groups for initial APG implementation: Upstate freestanding clinics; Downstate freestanding clinics; and freestanding mental health clinics operated by a county's designated local governmental unit [, and State-operated mental health clinics].

Assignment to a peer group is based on the corporate information related to the licensure of the owner's primary location. Clinics that are owned by hospitals will receive the hospital base rate. Clinics owned by a free-standing (non[-Article 28 ]hospital) entity will receive the freestanding clinic base rate.

APG is an alternative reimbursement methodology to the Prospective Payment System (PPS) methodology and is subject to the minimum payment annual reconciliation for Federally Qualified Health Centers as described in the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics section of this Attachment.

**I. Definitions:** The list of definitions in the APG System freestanding clinic section of this attachment will also apply to the methodology for OMH clinics except as follows:

- **After hours** is considered to be services outside the time period 8:00 am – 6:00 pm for weekdays or any time during weekends. Weekends are considered to be Saturday and Sunday.
- **Provider blend rate** is the combination of the provider's average per-visit Medicaid reimbursement for clinic services for the period July 1, 2008 through June 30, 2009, plus the provider's supplemental payments for Comprehensive Outpatient Program Services (COPS) and the Community Service Program (CSP) in effect as of June 30, 2009.
- **Supplemental payment** means payment that is in addition to the operating rate, which operating rate during the transition period will be composed of both an APG component and a pre-APG (legacy) component. The supplemental payments included in the pre-APG (legacy) component consist of Comprehensive Outpatient Services (COPS) payments and Community Support Program (CSP) payments.

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**II. Reimbursement Methodology**

Under the APG payment methodology, payments are determined by multiplying a dollar base rate, varying by peer group, by the weight for each procedure. The weight is a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. Procedure weights are the same for all freestanding clinic providers regardless of peer group. They are also the same for the same procedure regardless of the licensure of the clinic delivering the reimbursable procedure.

The statewide case mix of .8675 will be used in the determination of the APG base rates. The statewide case mix was calculated by determining the specific service mix that would exist within the OMH clinic, applying the pre-existing APG and procedure-specific weights and calculating the weighted average based on service volume based on each procedure code.

**III. Transition**

OMH will promulgate the APG base rates and blend rates in accordance with the methodology describe herein for all freestanding OMH-licensed mental health clinics.

Facilities will transition to the APG methodology according to the terms of the Transition Schedule detailed in the APG Reimbursement Methodology – OMH Licensed Mental Health Clinics section of this Attachment.

**IV. Transition Schedule**

Excluding new sites as described in paragraph V of this section, all freestanding OMH-licensed mental health clinics will transition to full payment under the APG methodology over a multi-year period beginning October 1, 2010 as follows:

The first year of the transition to full payment under the APG methodology, October 1, 2010 to September 30, 2011, the payments for visits to OMH-licensed, freestanding mental health clinics will be comprised of 25% of the APG rate plus 75% of the individual provider's blend rate.

In the second year, October 1, 2011, to September 30, 2012, the payments to OMH-licensed, freestanding mental health clinics will be comprised of 50% of the APG rate and 50% of the blend rate.

In the third year, October 1, 2012, to September 30, 2013, the payments to OMH-licensed, freestanding mental health clinics will be comprised of 75% of the APG rate and 25% of the blend rate.

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In the fourth year, beginning October 1, 2013, the entire payment to OMH-licensed, freestanding mental health clinics will be comprised of the APG rate.

**V. Rates for new OMH-licensed mental health clinics during the transition period.**

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- [1. The APG transition period for OMH-licensed mental health clinics is October 1, 2010, through September 30, 2013.
2. For any clinic for which an initial operating certificate was issued during the transition period, the base rate will be the same as the base rate for other members of the peer group to which such clinic is assigned by OMH. The provider blend rate for any such clinic will be the lowest blend rate paid to any other member of the peer group, excluding all clinics with licenses with a duration of six months or less. The relocation of a clinic operated by the same agency provider, the assumption of the operation or control of an existing clinic by a different agency provider, or an increase in capacity of an existing clinic, will not be treated as a new clinic for these purposes.
3. The base rate for the new site(s) for providers assuming operation of clinic site(s) previously operated by another provider will be based on the peer group previously assigned to that clinic site; blend rate adjustment, if any, will be based on whether the provider assuming operation of the clinic site is currently operating one or more clinic sites in the same peer group. If the provider is currently operating one or more such clinics, the blend will be the visit-volume weighted average of the calculated blend rates of the agency provider's current clinic sites and the newly assumed location. If the provider that is acquiring a site does not currently operate any sites, the base rate of the new site is determined by the peer group to which it is assigned and the blend rate for the new site will be the same as it was when operated by the previous provider.
4. Freestanding (non-Article 28 hospital) mental health clinic provider Medicaid blend rates can be found on the Office of Mental Health website at:

[https://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://www.omh.ny.gov/omhweb/medicaid_reimbursement/)

Click on "Blend Rates –Provider-Specific" then click on "Non-hospital Fee-for Service Clinic Blend Rates"]

**VI. Rates for new OMH-licensed mental health clinics after the transition period.**

For any clinic for which an initial operating certificate was issued after the transition period, the base rate will be the same as the base rate for other members of the peer group to which such clinic is assigned by OMH.

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**VII. Off-Site Visits Provided By OMH Licensed Clinics to Homeless Individuals.**

Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OMH licensed clinics to other than homeless individuals will be reimbursed with State-only funding and federal financial participation will not be claimed.

**VIII. Quality Improvement (QI) Program**

An enhanced APG peer group base rate is available for providers participating in the OMH quality improvement program. To become eligible for this enhancement, providers must complete a Memorandum of Agreement agreeing to the terms and conditions under which the enhanced APG peer group base rate will be paid, develop and submit a quality improvement plan that is subsequently approved by the OMH, identify the process or outcome indicators that will be monitored, and submit the QI findings and results to the OMH.

Providers that discontinue their involvement in the QI program will revert to the APG peer group base rate for their region that does not include the enhancement.

**IX. APG Peer Group Base Rates for all OMH-Licensed Freestanding Mental Health Clinics**

Peer Group	Base Rates Effective <u>04/01/16</u>
Upstate freestanding clinics without quality improvement enhancement	<u>\$136.90</u>
Downstate freestanding clinics without quality improvement enhancement	<u>\$152.08</u>
Freestanding mental health clinics operated by a county's designated local governmental unit without quality improvement enhancement	<u>\$190.80</u>
Upstate freestanding clinics including quality improvement enhancement	<u>\$142.16</u>
Downstate freestanding clinics including quality improvement enhancement	<u>\$157.92</u>
Freestanding mental health clinics operated by a county's designated local governmental unit including quality improvement enhancement	<u>\$198.12</u>
State-operated mental health clinics ( <u>Effective until 04/30/16</u> )	<u>\$247.42</u>

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**X. Minimum Wage Rate Increases for Non-State-operated Freestanding OMH-Licensed Mental Health Clinics**

Effective January 1, 2018 and every January 1 thereafter until the minimum wage reaches the state statutorily described per hour wage shown below, a minimum wage increase percentage will be developed and applied to the APG base rates for all peer groups of freestanding OMH-licensed Mental Health Clinics, except State-operated Mental Health Clinics.

<u>Minimum Wage Region</u>	<u>12/31/17</u>	<u>12/31/18</u>	<u>12/31/19</u>	<u>12/31/20</u>	<u>12/31/21</u>
<u>New York City (Large employers)</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>New York City (Small employers)</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

Rates adjusted by the minimum wage increase percentage will be posted to the OMH Medicaid Reimbursement website at [https://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://www.omh.ny.gov/omhweb/medicaid_reimbursement/). The minimum wage increase percentage will be developed and implemented as follows:

- a. Minimum wage costs mean the additional costs for salary and fringe benefits incurred beginning January 1, 2018, and thereafter, as a result of New York State statutory increases to minimum wage. Minimum wage costs for 2018 are developed based on the most current available CFR cost report data and updated annually thereafter through 2022. For 2018, the State used 2014-2015 CFR cost report data and adjusted any wages reported therein below the 12/31/16 minimum wage up to such statutory minimum wage prior to calculating the minimum wage increase percentage.
  - i. The average hourly wages of employees in occupational titles where the calculated average hourly wage, after controlling for overtime, is below the regional statutory minimum wage are identified.
  - ii. The total payroll hours of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the CFR cost report is then subtracted from the projected payroll resulting in the expected minimum wage cost increase attributable to salary.
  - iii. Fringe benefit costs are identified on the CFR and the statewide average fringe benefit percentage is calculated.
  - iv. The fringe benefit percentage is applied to the increased minimum wage costs attributable to salary and the result is then added to the minimum wage cost increase attributable to salary, resulting in total minimum wage costs.
  - v. The total minimum wage cost is divided by total operating expenditures reported in the CFR cost report to derive a minimum wage increase percentage.
- b. APG base rates are adjusted annually to account for minimum wage costs by multiplying the APG base rates then in effect by the minimum wage increase percentage as determined pursuant to section (a), above.

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- c. After the end of each CFR reporting year beginning in 2018, OMH will review providers' CFR submissions to ensure the average hourly wages of employees in all occupational titles comply with minimum wage standards. OMH may reconcile and recoup minimum wage rate increases paid to providers that do not submit their CFRs according to established reporting deadlines or that are found not to be in compliance with wage standards if the Office of Mental Health deems such recoupment to be cost effective. In addition, OMH will investigate provider compliance with applicable labor laws and refer noncompliant providers to the Office of the Medicaid Inspector General.

**XI. Direct Support, Direct Care and Clinical Professionals Compensation Increases for Non-State-operated Freestanding OMH-Licensed Mental Health Clinics**

Effective on both January 1, 2018 and April 1, 2018, a direct care compensation increase will be developed and implemented for Direct Support and Direct Care Professionals. Also, effective April 1, 2018, a clinical compensation increase will be developed and implemented for Clinical Professionals. Such increases will apply to all peer groups of freestanding OMH-licensed Mental Health Clinics, except State-operated Mental Health Clinics. Employee wage information is based on 2014-2015 CFR cost report data.

- a. Rate increases effective January 1, 2018 are calculated as follows:
- i. The total wages of employees in Direct Support and Direct Care Professional occupational titles (adjusted by any applicable minimum wage increases) are increased by 3.25%.
  - ii. Such wage increase is divided by the total operating expenditures reported in the CFR to derive a direct care compensation factor.
  - iii. APG base rates are adjusted for direct care compensation by multiplying the APG base rates then in effect by the direct care compensation factor calculated pursuant to subsection a(ii).
- b. Rate increases effective April 1, 2018 are calculated as follows:
- i. The total wages of employees in Direct Support and Direct Care Professional occupational titles (adjusted by any applicable minimum wage increases and the increase specified in subsection (a)(i), above) are increased by 3.25%.
  - ii. The total wages of employees in Clinical Professional occupational titles are increased by 3.25%.
  - iii. Wage increases calculated pursuant to subsections (b)(i) and (ii), above are combined and then the sum is divided by the total operating expenditures reported in the CFR to derive a direct care and clinical compensation factor.
  - iv. APG base rates are adjusted for direct care and clinical compensation by multiplying the APG base rates then in effect by the direct care and clinical compensation factor calculated pursuant to subsection b(iii).

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**Ambulatory Patient Group (APG) Reimbursement Methodology - Office for People With Developmental Disabilities' (OPWDD) Freestanding (non-hospital based) Clinics certified pursuant to Mental Hygiene Law Article 16.**

- I. Implementation date:** For service dates beginning July 1, 2011, for clinics certified or operated by New York State OPWDD (i.e., Article 16 clinics), services will be reimbursed using the Ambulatory Patient Group (APG) methodology. Website links to the various components of the APG methodology can be found at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm)

- (1) Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90 (b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OPWDD licensed clinics to other than homeless individuals will be reimbursed with State-only funding and federal financial participation will not be claimed.

**II. Definitions: The list of definitions in the Ambulatory Patient Group System: Freestanding Clinics section will apply to the methodology for OPWDD freestanding clinics except as follows:**

- (1) **Average legacy Rate.** The average legacy rate represents the provider-specific historical operating component reimbursement under the previous OPWDD clinic rate methodology. Each Provider's specific average legacy rate can be found at the link below.

[http://health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/apg/2011-07-01\\_legacy.htm](http://health.ny.gov/health_care/medicaid/rates/mental_hygiene/apg/2011-07-01_legacy.htm)

- (2) **OPWDD Peer Groups are defined as:**

- (i) Peer Group A. Except for clinics described in Peer Group C, Peer Group A will be comprised of clinics that have the certified main clinic site located in the counties of New York, Bronx, Kings, Queens, Richmond, Nassau and Suffolk.
- (ii) Peer Group B. Except for clinics described in Peer Group C, Peer Group B will be comprised of clinics that have the certified main clinic site located in a county other than those identified in Peer Group A.
- (iii) Peer Group C. Peer Group C will be comprised of clinic facilities operated by an educational institution providing graduate medical education which places residents and fellows at no fewer than two major hospital systems and which clinic's physicians have admitting and/or courtesy privileges at same hospital systems. Additionally, the educational institution operating the clinic facility must hold the following federal designations as of July 1, 2011:
- (a) University Center for Excellence in Developmental Disabilities (UCEDD) by the United States Department of Health and Human Services' Administration on Developmental Disabilities (ADD); and

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(b) National Institutes for Health's (NIH's) Eunice Kennedy Shriver National Institute of Child Health and Human Development Intellectual and Developmental Disability Research Center (IDDRC); and

(c) Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration of the United States Public Health Service, Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training program.

### **III. Reimbursement Methodology—Operating and APG Rate Computation**

**Operating:** For dates of service beginning July 1, 2011, the operating component of rates shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the APG classification and reimbursement system. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

There will be a three and one half year transition period to the new APG reimbursement methodology. During this transition period, the operating component payment will be calculated as a blend of the new APG methodology calculation and the clinic-specific legacy rates established based on the former reimbursement methodology. The transition blend formula is described in subpart 3 of this Section. Beginning January 1, 2014 and thereafter, 100% of the operating component payment will be based on the APG methodology. Per the enabling statute, new services are not subject to the blend requirement. A comprehensive list of "No Blend" APGs are posted on the APG website:

[http://www.health.ny.gov/health\\_care/medicaid/rates/apg](http://www.health.ny.gov/health_care/medicaid/rates/apg)

Click on "Reimbursement Components" then click on "No Blend APGs"

The APG patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**APG Rate Computation:** The following is a description of the methodology to be utilized in calculating rates of payment under the APG classification and reimbursement system.

Claims containing diagnostic and procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format. Procedures will be coded using the CPT-4

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code set. Diagnoses will be coded using the ICD-9-CM code set until September 30, 2015 and then the ICD-10 code set thereafter.

Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.

Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.

The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim.

A separate base rate calculation shall be calculated for each peer group established jointly by OPWDD and the Department of Health. All Medicaid reimbursement paid to Article 16 clinic facilities in the peer group during the period April 1 2009 to March 31, 2010 will form the numerator. The peer group specific case mix index multiplied by the coding improvement factor and the peer group base year (4/1/09-3/31/10) visits will form the denominator. Dividing the numerator by the denominator yields the peer group base rate.

The following is an example of a sample APG base rate calculation:

a.	<u>2007 Peer Group Reimbursement</u>	<u>\$51,000,000</u>
b.	<u>Case Mix Index</u>	<u>8.1610</u>
c.	<u>Coding Improvement Factor</u>	<u>1.05</u>
d.	<u>2007 Base Year Visits</u>	<u>50,000</u>

$$\text{\$51,000,000} / (8.1610 \times 1.05 \times 50,000) = \text{\$119.03 (Base Rate)}$$

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**The APG Rate Computation as described above for DOH-licensed Article 28 free-standing clinics will also apply to OPWDD-licensed Article 16 clinics, except for the following:**

- (1) **Case mix.** The initial case mix index is based on paid OPWDD Article 16 Medicaid claims data from April 1, 2009 through March 31, 2010. The APG peer group base rates are based on the following case mix values: Peer Group A= .59, Peer Group B= .52, and Peer Group C= .86.
- (2) **Healthcare Common Procedure Coding System (HCPCS) modifier codes impact the calculation of allowed APG payment for OPWDD clinic services in the same manner as DOH-certified freestanding clinics, with the following exception:**
- (i) Article 16 clinics permit Rehabilitation Counselors to deliver certain vocation-related procedures that might otherwise be limited to licensed Occupational and Physical Therapists. The specific procedure codes that rehabilitation counselors deliver are limited to:
- 97003-97004 – Evaluations and Re-evaluations until December 31, 2016;  
97165-97168 – Evaluation and Re-evaluation beginning January 1, 2017;  
97530 – Therapeutic Activities;  
97532 – Development of Cognitive Skills;  
97535 – Self-care/home management training;  
97537 – Community/work reintegration training; or  
97150 – Therapeutic Procedures, group
- (ii) Providers are instructed to include procedure modifier codes HO and HN modifiers on rehabilitation counseling services only. The HO and HN modifiers are not added to procedures delivered by Occupational Therapists (OTs), Occupational Therapist Assistants, (OTAs), Physical Therapists (PTs), and Physical Therapist Assistants (PTAs). When these specific services are delivered by a Rehabilitation Counselor, these modifiers will discount the payment to 75% of the rate. The discount is intended to reflect the lower staff costs associated with this title.
- (iii) OPWDD clinics are prohibited from attaching modifier codes AF, AG, SA, and U4 to their claims. The additional cost factors represented by these modifiers are considered “already included” within OPWDD base rates. The link for APG modifier codes can be found at the following webpage:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/modifiers.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers.htm)

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**(3) Transition:**

(i) During the transition, the average legacy rate established for each clinic will be reimbursed as per the schedule located on the following webpage:

[http://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/apg/2011-07-01\\_legacy.htm](http://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/apg/2011-07-01_legacy.htm)

(ii) OPWDD transition schedule for the operating component of the rate:

(a) July 1, 2011 through June 30, 2012 - Blend of 75% average legacy rate and 25% APG;

(b) July 1, 2012 through June 30, 2013 - Blend of 50% average legacy rate and 50% APG;

(c) July 1, 2013 through December 31, 2013 - Blend of 25% average legacy rate and 75% APG; and

(d) Beginning on January 1, 2014, all subsequent payments will consist of 100% APG

**(4) APG payments for Article 16 clinics certified or operated by OPWDD will not reflect any additional investments beyond the APG payment.**

**(5) Article 16 (OPWDD) Clinics follow the same reimbursement policy guidance as Article 28 (DOH) Clinics, with the following exceptions:**

(i) Nutrition therapy services, whether delivered alone or with other services during the same visit, shall be reimbursed through the APG methodology.

(ii) Wheelchair evaluation services shall be reimbursed through the APG payment methodology.

(iii) Unlike Article 28 clinics, reimbursement of psychotherapy and developmental testing services delivered by licensed Social Workers within their scope of practice under state law shall not be limited to recipients who are dually eligible for Medicare. In an Article 16 clinic, a licensed social worker may deliver reimbursable services to Medicaid-only enrollees. All such psychotherapy and developmental testing services shall be reimbursed using the APG methodology.

(iv) Self-management education and training services, when delivered at certified clinic locations, will be reimbursed through the APG methodology. Such services may also be reimbursed when delivered at certified clinic locations to family members and other unpaid collateral caregivers for the purpose of enhancing, augmenting, and/or reinforcing ongoing treatment and clinical services to the patients. Self-management, education and training services are under APG 428 (Patient Education – Individual) and APG 429 (Patient Education – Group). These APGs presently include services described by CPT codes 98960-98962 and G0108-G0109.

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- (v) Article 16 (OPWDD) clinics may offer a wider variety of services delivered in group settings than Article 28 (DOH) clinics. The following Article 16 clinic services can be delivered in group setting and reimbursed through the APG payment methodology:
- (a) Group Physical and Occupational Therapy (APG 274)
  - (b) Group Speech Therapy (APG 275)
  - (c) Group Psychotherapy (APG 310)
  - (d) Group Self-Management Education Services (APG 429)
  - (e) Nutrition therapy services (APG 118). In the case of nutrition therapy services, when claimed using HCPCS codes that specifically permit group services.
- (vi) When explicitly ordered and referred by a physician, Article 16 clinics may use registered nurses (in addition to physicians, physician assistants, and nurse practitioners) to deliver preventive counseling services (procedure codes 99401-99404 and 99411-99412) within the scope of their competence. Such preventive counseling services need not be provided on the same day as a physician medical service.
- (vii) Article 16 clinic facilities are not certified to provide laboratory and radiological services. As such the Article 28 ancillary services policy, which includes the costs of laboratory and radiology services within medical visit APG reimbursement, will not apply to Article 16 clinic facilities. In very limited instances such services are ordered by an Article 16 physician, the patient will be referred to an external provider and the ancillary service will be separately billed to Medicaid.

**IV. Capital Costs:**

If a visit includes a service which maps to an APG that allows a capital add-on, there will be a capital add-on to the operating component of the APG payment for the visit.

- (1) For each visit, the capital cost component will be a fixed amount equal to the capital cost component of the clinic's regular visit fee in effect on June 30, 2011 and can be found at the following webpage:

[http://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/apg/2011-07-01\\_capital\\_add\\_on.htm](http://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/apg/2011-07-01_capital_add_on.htm)

- (2) A capital add-on is allowable for most APG claims and is payable on a per-visit basis. If the visit entails a specific APG or APG Procedure as a standalone, meaning that it is the only visit listed on the claim, then capital will not be reimbursed for this visit. The links for the "No Capital Add-on APG List" and the "No Capital Add-on Procedure List" can be found at the following webpage:

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on](http://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on)  
[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on\\_procedures](http://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on_procedures)

**V. New Clinics:**

Clinics that began or will begin operation on or after July 1, 2011 will be reimbursed in accordance with the OPWDD transition schedule, except that the average legacy rate across all OPWDD clinics, in the amount of \$107.82, will be used in place of a clinic-specific rate when calculating the reimbursement during the transition period. These new clinics will be assigned a peer group, based on their geographical location, and receive a rate which is calculated the same as other clinics using a percentage of the state wide average legacy rate and the peer group APG. The aforementioned methodology includes the capital add-on rate of \$6.16 for new clinics that was in effect on June 30, 2011.

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**VI. APG Base Rates for OPWDD certified or operated clinics.**

<b>Peer Group</b>	<b>Base Rate</b>	<b>Effective Date of Base Rate</b>
Peer Group A	\$180.95	7/1/11
Peer Group B	\$186.99	7/1/11
Peer Group C	\$270.50	7/1/11
Peer Group A	\$182.21	4/1/15
Peer Group B	\$189.07	4/1/15
Peer Group C	\$272.70	4/1/15
Peer Group A	\$182.57	4/1/16
Peer Group B	\$189.45	4/1/16
Peer Group C	\$273.24	4/1/16
<u>Peer Group A</u>	<u>\$184.65</u>	<u>4/1/18</u>
<u>Peer Group B</u>	<u>\$192.90</u>	<u>4/1/18</u>
<u>Peer Group C</u>	<u>\$276.88</u>	<u>4/1/18</u>

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3. The facility's fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
  4. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.
  5. Overtime will be applied based on prior years historical experience.
- b. The 2018 minimum wage costs will be developed based on collected survey data received and attested to by clinics. If a clinic did not submit a survey, its minimum wage costs will be calculated based on 2016 CFR cost report wage data. If a clinic fails to submit both the survey and the 2016 CFR cost report, its minimum wage add-on will not be calculated.
  - c. In the subsequent years until the minimum wage is completely implemented statewide, the Department will survey clinics utilizing the methodology employed in year one. If a clinic fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the use of the personnel wage data reported on the statewide latest available CFR. If a clinic fails to submit both the survey and the latest CFR, its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the upstate/downstate APG base rate, the minimum wage add-on will be excluded from the rate.
  - d. A minimum wage add-on will be developed by dividing minimum wage costs, pursuant to subdivision (a) above, by the total clinic visits as reported in the provider's 2016 CFR cost report to determine an average add-on cost per visit. The add-on will be paid over Medicaid clinic visits.
  - e. 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 the annual minimum wage add-on reimbursement provided for in subdivision (d) above. 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.
    - i. 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. The Medicaid share of the annual minimum wage funding will be supplied in the reconciliation survey by the Department of Health. Medicaid's share is defined as 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.

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- ii. 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.)
- iii. 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 equal the difference between the amount paid to the provider for the Medicaid share of the minimum wage law increase requirement and the actual amount the provider was obligated to pay.
- iv. The Department 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.
- v. The provider's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.

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**Upper Payment Limit**

The State, in order to comply with the Upper Payment Limit (UPL) regulations at 42 CFR 447.321, will mandate the following for all clinics licensed by the NY State Department of Health, Office of Mental Health, [Office of Mental Retardation and] Office for People with Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services.

- All clinic providers will prepare and file cost reports. For clinics with costs of \$100,000 or more, [T]the cost reports must be independently audited for cost and visits [data]. Those clinics that do not submit an independently audited cost report with costs below \$100,000 will be given no UPL margin in the UPL calculations. If a clinic fails to submit an Ambulatory Health Care Facility (AHCF) or Consolidated Fiscal Report (CFR) cost report, or the cost report is incomplete, the payments will be included in the Medicaid side of the UPL calculation without any proxy for costs;
- The State will issue notices to all clinic providers no later than December 31, 2009, that providers must maintain beneficiary "threshold visit" data for all payers, in a format that will be independently audited and reported on the provider's annual cost report and/or as a supplemental report for all cost reporting periods beginning on or after January 1, 2010;
- All clinic claims will be subjected to appropriate eMedNY payment edits, which will deny a claim for incorrect and/or inaccurate billing and coding information, starting no later than December 31, 2009;
- The aggregate UPL for each category of clinic (private, state owned or operated, non-state government owned or operated) will be calculated using an average cost per visit or such other method that may be authorized by federal statute or regulation;
- All costs must be costs that would be allowable using Medicare cost reporting and allocation principles;
- The State will remove all costs and payments associated with services that do not meet the definition of a clinic as described in 42 CFR 440.90, for example, transportation, in-home services, etc.;
- The State will provide a progress report to Centers for Medicare and Medicaid Services (CMS) by June 30, 2011 on eMedNY editing, claims coding, and the cost reporting process;
- The State will submit an addendum to the July 12, 2012 progress report by September 30, 2013 to include the status of providers who submitted 2010 and 2011 audited cost reports, and such audited reports will be provided to CMS based on CMS' sample; and
- The State will submit a full UPL for calendar year 2018 using [2011] 2017 cost data by [December] March 31, [2013]2018. However, if the state makes the following corrective

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actions to address data deficiencies sooner than this time frame it may submit a UPL for CMS review and approval for the period in which the deficiencies were corrected:

- a) Add a page to the Consolidated Fiscal Report (CFR) with utilization statistics by payer similar to Exhibit 1 G&S Information D of the AHCF cost report in order to help ensure total visits are reported for all payers;
- b) Update the CFR instructions to define an Opioid Treatment Program (OTP, formerly referred to as Methadone Maintenance Treatment Program (MMTP)) threshold visit to ensure concurrence with Medicaid visits per Medicaid Management Information System (MMIS);
- c) The State will review, and if applicable, update the instructions for all other services to ensure threshold visits per cost report are consistent with Medicaid per the MMIS;
- d) The State will review the reporting of costs and threshold visits in the cost report for ordered ambulatory services and billing units in MMIS to ensure that ancillary services can be separately identified for ordered ambulatory facilities. If the distinction cannot be made, they are to be considered services for patients in the clinic and, as such, the UPL should include all ancillary costs and applicable MMIS payments with no corresponding visit count; and
- e) The costs for ancillary services that are provided by the same clinic that provided the medical visit (as opposed to ordered ambulatory ancillary services in paragraph d) will be included in the costs on the clinic's cost report. Only one "threshold visit" will be reported that corresponds to the costs provided for the entire visit (medical visit plus ancillary services).

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**New York  
2(v)**

**Upper Payment Limit (UPL) Payments for Diagnostic and Treatment Centers (DTCs)**

**1. New York City Health and Hospitals Corporation (HHC) operated DTCs**

Effective for the period [August 1, 2010] April 1, 2011 through March 31, 2012 [2011], the Department of Health will increase medical assistance rates of payment for diagnostic and treatment center (DTC) services provided by public DTCs operated by the New York City Health and Hospitals Corporation (HHC), at the annual election of the social services district in which an eligible DTC is physically located. The amount to be paid will be \$12.6 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible HHC diagnostic and treatment center.

**2. County Operated DTCs and mental hygiene clinics**

Effective for the period [August 1, 2010] April 1, 2011 through March 31, 2012 [2011], the Department of Health will increase the medical assistance rates of payment for county operated DTCs and mental hygiene clinics, excluding those facilities operated by the New York City HHC. Local social services districts may, on an annual basis, decline such increased payments within thirty days following receipt of notification. The amount to be paid will be \$5.4 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible county operated diagnostic and treatment center and mental hygiene clinic.

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**New York  
2(w)**

**Behavioral Health Utilization Controls – Freestanding Clinics**

Effective April 1, 2011, each of the New York State mental hygiene agencies - the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People with Developmental Disabilities (OPWDD) - will establish utilization thresholds for their freestanding clinics. These thresholds will target unusually high utilization with payment reductions and will be established by the licensing state agency as follows:

For Article 16 clinics licensed by OPWDD, Medicaid payments shall be subject to the following reductions:

Service categories and corresponding peer-based monthly utilization thresholds are established as follows: nutrition/dietetics, 2.08; speech language pathology, 4.33; occupational therapy, 4.08; physical therapy, 5.25; rehabilitation counseling, 3.25; individual psychotherapy, 3.08; and group psychotherapy, 3.17.

Using Medicaid paid claim history, OPWDD will annually compare each Article 16 clinic's monthly utilization rates for the applicable utilization look-back period (as defined later in this section) to the established threshold values for each service category. If the service category threshold was exceeded, OPWDD will calculate the number of visits paid in excess of the threshold value. For the purposes of this section, each unique paid Article 16 Medicaid claim for service rendered during the applicable utilization look-back period shall constitute a "visit." The service category monthly utilization rate and excess paid visits shall be calculated for each clinic as follows:

**Service Category Visits** shall be the number of paid Medicaid visits within the service category rendered by the clinic during the look-back period. Visits associated with Medicaid recipients who received fewer than four paid visits in a service category during the look-back period will be excluded from this calculation.

**Service Category Recipient Months** shall be the count of unique individuals for whom a claim was paid for services rendered during each specific calendar month of the look-back period. For example, a Medicaid recipient who received paid physical therapy services during each month of a twelve month look-back period contributes 12 recipient months to the clinic's total recipient months. A Medicaid recipient who received paid physical therapy services in only three calendar months within the same twelve month look-back period contributes three recipient months to the clinic's total recipient months. Medicaid recipients who received fewer than four paid visits within the service category during the look-back period shall be excluded and will contribute zero recipient months to the clinic's total recipient months.

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**Service Category Monthly Utilization Rate** shall be equal to the service category visits divided by the service category recipient months.

**Service Category Excess Visits.** If the clinic's service category monthly utilization rate was below the established threshold, the service category excess visits shall be zero. Otherwise, the service category excess visits shall be equal to the difference between service category monthly utilization rate and the service category threshold, multiplied by the service category recipient months. That is, excess visits = (monthly utilization rate – threshold) \* recipient months.

Each clinic's excess visits will be summed across all service categories and calculated as a percentage of total paid Article 16 Medicaid visits (claims) for the look-back period. For this purpose, the divisor, "total paid Article 16 Medicaid visits," shall be a count of **all** unique claims paid under Article 16 rate codes during the look-back period; it may include visits for services for which threshold values have not been established (e.g., psychological and developmental testing visits). The reimbursement rates of clinics with excess visits shall be reduced by a uniform percentage as follows:

<b><u>Total Excess Visits As % Of Total Paid Visits</u></b>	<b><u>Percent Rate Reduction</u></b>
<u>15.1% or more</u>	<u>5.00%</u>
<u>10.1% to 15.0%</u>	<u>4.25%</u>
<u>5.1% to 10.0%</u>	<u>3.50%</u>
<u>1.0% to 5.0%</u>	<u>2.75%</u>
<u>Less than 1.0%</u>	<u>0.00%</u>

For the period April 1, 2011, to June 30, 2011, the percentage rate reductions shall be applied to the rates established for each of the twelve visit types authorized by OPWDD regulations during that period. For the period beginning July 1, 2011, onward, the percentage rate reductions shall be applied to the clinic's Article 16 APG base rate, Article 16 APG average legacy fee, and the Article 16 APG capital add-on.

Utilization look-back periods associated with each rate reduction period shall be as follows:

<b><u>Rate Reduction Period (State Fiscal Year)</u></b>	<b><u>Utilization Look-back Period</u></b>
<u>4/1/2011 to 3/31/2012</u>	<u>1/1/2009 to 12/31/2009</u>
<u>4/1/2012 to 3/31/2013</u>	<u>7/1/2011 to 12/31/2011</u>
<u>4/1/2013 to 3/31/2014</u>	<u>10/1/2011 to 9/30/2012</u>

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New York  
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Beginning state fiscal year 2014-2015, and each subsequent state fiscal year thereafter, the utilization look-back period shall be the period used in the preceding state fiscal year advanced by twelve months.

For the period April 1, 2011, through March 31, 2012, OPWDD may waive the reimbursement rate reductions described here, provided, however, that the waiver will be subject to retroactive revocation upon a determination by OPWDD, in consultation with the Department of Health, that the clinic has not complied with the terms of such waiver. Such terms are:

- (i) In order to receive a waiver, a clinic must submit to OPWDD a request for a waiver and a utilization reduction plan. OPWDD's decision on the waiver will be based on whether the clinic's utilization reduction plan shows a reduction in the clinic's planned state fiscal year 2011-2012 Medicaid visits by an amount equal to the paid visits in excess of the utilization thresholds and whether the clinic is operating in conformance with all applicable statutes, rules and regulations. For purposes of this section, a clinic's planned state fiscal year 2011-2012 visits cannot exceed its paid Medicaid visits in calendar year 2010.
- (ii) OPWDD will compare the actual paid and planned visits between April 1, 2011 and March 31, 2012 for each clinic granted a waiver. If a clinic fails to achieve the reduction in utilization in accordance with its utilization reduction plan, OPWDD will revoke the waiver and reduce the clinic's reimbursement rates for state fiscal year 2011-12 as computed in accordance with the provisions of this section, provided, however, that such reduction computation will incorporate and reflect any utilization reduction that the clinic did achieve while operating under the waiver.

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**New York  
2(w)(iii)**

For freestanding Article 31 clinics licensed by OMH and Article 31 clinics in or operated by Diagnostic and Treatment Centers licensed under Article 28 of the Public Health Law, Medicaid payments shall be subject to the following reductions:

- (1) For persons 21 years of age or older at the start of the state fiscal year, payment for the 31st through 50th visits in a state fiscal year at one or more clinics operated by the same agency will be subject to a 25% reduction in the otherwise applicable payment amount.
- (2) For persons 21 years of age or older at the start of the state fiscal year, payment for visits in excess of 50 in a state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.
- (3) For persons less than 21 years of age at the start of the state fiscal year, payment for visits in excess of 50 in that state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.
- (4) Off-site visits (rate codes 1519 and 1525), medical visits (rate codes 1588 and 1591) and crisis visits (rate codes 1576 and 1582), when billed under their applicable rate codes, will be disregarded in computing the number of visits pursuant to the preceding paragraphs. For off-site visits provided by OMH-licensed clinics to homeless individuals, Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OMH-licensed clinics to other than homeless individuals may be reimbursed with State-only funding and will not be claimed for federal financial participation.

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**New York  
2(w)(iv)**

For freestanding Article 32 clinics licensed by OASAS, Medicaid payments will be subject to the following per person reductions:

- (1) Payment for the 76th through 95th visits in a state fiscal year at one or more clinics operated by the same agency will be subject to a 25% reduction in the otherwise applicable payment amount.
- (2) Payment for visits in excess of 95 in a state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.

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New York  
2(w)(v)

**Integrated Licensing Program – Freestanding Clinics Licensed by the Office of Mental Health (OMH)**

Effective January 1, 2013 through December 31, 2017, the new Integrated Licensing Program (ILP) reimbursement methodology is established for authorized providers providing integrated physical health, behavioral and/or substance abuse services at freestanding clinic sites licensed pursuant to Article 31 of the Public Health Law. The following providers' hospital outpatient departments are authorized to participate in the ILP:

- Citizen Advocates, Inc (NPI 1780619064, Loc Code 003, 004, 005, 015, 016)
- The Institute for Community Living (NPI 1558494930, Loc Code 004)

For the time period in which the ILP is in effect, authorized providers have access to a new clinic base rate that is equal to 105% of the facility's usual base rate; with the new base rate reimbursed only at authorized sites where integrated physical, behavioral and/or substance services were available. Payment amounts are determined via the usual Ambulatory Patient Group reimbursement methodology, utilizing the applicable base rate and the procedure(s) and diagnose(s) codes submitted on each claim.

The goal of the Integrated Licensing Program was to facilitate and promote the availability of physical, behavioral and/or substance abuse services at authorized hospital-based clinic sites, in order to: economize the number of visits for patients with co-morbidities; provide more comprehensive, integrated care; improve health outcomes and decrease rates of utilization of emergency room and inpatient services. Individuals with serious mental illness and/or addictions at these sites had the opportunity to receive an integrated array of care at the same location to address a range of physical, mental, and/or behavioral healthcare needs.

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New York  
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**Lactation Consultation Services**

Effective September 1, 2012, reimbursement will be provided to free-standing clinics and hospital outpatient departments for breastfeeding health education and counseling services based upon the Ambulatory Patient Group (APG) reimbursement methodology. Date of implementation will occur on the first day of the month following 30 days after Federal approval of this provision of the State Plan. Procedure codes (S9445 and S9446) have been added to the fee schedules and the APG payment methodology.

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Supersedes TN NEW

Effective Date September 1, 2012



New York  
2(z)(vi)

**Integrated Licensing Program – Freestanding Clinics Licensed by the Office of Alcoholism and Substance Abuse Services (OASAS)**

Effective January 1, 2013 through December 31, 2017, the new Integrated Licensing Program (ILP) reimbursement methodology is established for authorized providers providing integrated physical health, behavioral and/or substance abuse services at freestanding clinic sites licensed pursuant to Article 32 of the Public Health Law. The following providers' freestanding clinic sites are authorized to participate in the ILP:

- Mental Health Service of Erie County (NPI 1265607022, Loc Code 021)

For the time period in which the ILP is in effect, authorized providers have access to a new clinic base rate that is equal to 105% of the facility's usual base rate; with the new base rate reimbursed at authorized sites where integrated physical, behavioral and/or substance services were available. Payment amounts are determined via the usual Ambulatory Patient Group reimbursement methodology, utilizing the applicable base rate and the procedure(s) and diagnose(s) codes submitted on each claim.

The goal of the Integrated Licensing Program was to facilitate and promote the availability of physical, behavioral and/or substance abuse services at authorized clinic sites, in order to: economize the number of visits for patients with co-morbidities; provide more comprehensive, integrated care; improve health outcomes and decrease rates of utilization of emergency room and inpatient services. Individuals with serious mental illness and/or addictions at these sites had the opportunity to receive an integrated array of care at the same location to address a range of physical, mental, and/or behavioral healthcare needs.

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**New York  
2(a)**

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – FOHC’s**

A temporary rate adjustment will be provided to eligible freestanding clinic providers that are subject to or impacted by the closure, merger, and acquisition, consolidation, or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider’s temporary rate adjustment prior to the end of the specified timeframe. Once a provider’s temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed:

**Federally Qualified Health Centers (FOHCs):**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
Hudson River Healthcare	\$126,464	04/01/2012 - 03/31/2013
	\$218,361	04/01/2013 - 03/31/2014
	\$219,873	04/01/2014 - 03/31/2015

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**New York  
2(a)(1)**

**Federally Qualified Health Centers (FQHCs):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>AHRC Health Care, Inc. (d/b/a ACCESS Community Health Center)</u>	<u>\$74,937</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$299,749</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$160,152</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Anthony L. Jordan Health Center</u>	<u>\$40,268</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$161,073</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$81,295</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Asian &amp; Pacific Islander Coalition on HIV/AIDS, Inc. (d/b/a APICHA Community Health Center)</u>	<u>\$67,633</u>	<u>01/01/14 – 03/31/2014</u>
	<u>\$88,661</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$92,118</u>	<u>04/01/2015 – 03/31/2016</u>
<u>East Hill Family Medical Inc.</u>	<u>\$35,217</u>	<u>01/01/2014 – 03/31/2014</u>
<u>Morris Heights Health Center, Inc.</u>	<u>\$99,387</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$97,725</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$96,557</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Mount Vernon Neighborhood Health Center Network</u>	<u>\$38,713</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$41,170</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$43,000</u>	<u>04/01/2015 – 03/31/2016</u>
<u>The Floating Hospital</u>	<u>\$29,476</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$29,476</u>	<u>04/01/2014 -03/31/2015</u>

TN #13-0074

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**New York  
2(a)(2)**

**Federally Qualified Health Centers (FQHCs):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>The Institute for Family Health</u>	<u>\$409,456</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$359,858</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$78,346</u>	<u>04/01/2015 – 03/31/2016</u>

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Effective Date January 1, 2014

**New York  
2(a)(3)**

**Federally Qualified Health Centers (FQHCs):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Finger Lakes Migrant Health Care Project (d/b/a Finger Lakes Community Health)</u>	<u>\$18,835</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$75,342</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$75,342</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Rochester Primary Care Network Inc./Rushville Health Center, Inc. – Finger Lake Region</u>	<u>\$23,482</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$93,926</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$93,926</u>	<u>04/01/2015 – 03/31/2016</u>

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**New York  
2(am)**

**Federally Qualified Health Centers (FQHCs) Safety Net Payment**

1. For the period July 28, 2016, through March 31, 2017, \$127,600,000 of additional payments, and for annual state fiscal years thereafter, \$92,650,000 of additional payments will be made to eligible Medicaid safety net Federally Qualified Health Centers (FQHCs) to sustain access to services. The amount of \$92,650,000 is subject to modification by the transfers described in paragraphs (2) and (3) of this section.
  - a. "Eligible Medicaid safety net Federally Qualified Health Centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care services; provide at least 5% of their annual visits to uninsured individuals; have a process in place to collect payment from third party payers; and received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).
  - b. The base year data used for the period commencing on July 28, 2016 through March 31, 2017 will be the 2014 certified cost report and will be advanced one year thereafter for each subsequent period. In order to be included in the distribution calculation, a provider must timely submit a certified cost report for the base year used in the distribution calculation.
  - c. New providers which do not have a full year cost or visit experience in the base year used for the distribution may qualify to be included in the distribution as follows:
    - i. The provider meets the criteria in paragraph (1)(a).
    - ii. The provider must be eligible to receive a Medicaid rate in New York State.
    - iii. The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.
    - iv. The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in paragraphs (1)(c)(i) through (1)(c)(iii) (herein after referred to as paragraph (1)(c)) or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.
    - v. The distribution method applied to a new provider that qualifies to be included in the distribution based on paragraph (1)(c) of this section will be in accordance with the distribution method for other providers in this section. However, the annual distribution for a provider that qualifies based on paragraph (1)(c) of this section will not exceed \$100,000.
    - vi. The distribution for a provider that qualifies based on paragraph (1)(c) of this section will be included in the total safety net distribution amount as described in paragraph (1) of this section.

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Effective Date     July 28, 2016



**New York  
2(am)(1.1)**

**Federally Qualified Health Centers (FQHCs) Safety Net Payment**

- i. The transfer of funds will occur at the same time the newly designated FQHC provider is included in this FQHCs Safety Net Payment section distribution.
  - ii. Due to the transfer of the newly designated FQHC's funds to this FQHCs Safety Net Payment section, the total value of the additional payment, as described in paragraph (1) of this section for the additional annual payment, will increase.
- c. In no event will the sum of the total safety net distribution amount of the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment State Only program exceed \$151,500,000 for the period July 28, 2016, through March 31, 2017, and \$110,000,000 for the annual state fiscal periods thereafter.
- i. At the time each state fiscal year distribution is developed, the Department of Health will report to the Centers for Medicare and Medicaid Services the providers that have received or lost FQHC designation and the funds transferring between the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment State Only program.
3. In the event that a provider that is included in this FQHCs Safety Net Payment section loses its FQHC designation, the FQHCs Safety Net Payment distribution to the provider, that was calculated for the state fiscal year in which the date falls of when the provider lost its FQHC designation, will be reduced as follows:
- a. The distribution pertaining to the Medicaid managed care visits and the distribution pertaining to the Federal Financial Participation portion of the Medicaid fee-for-service visits applied to the tier add-on payment will no longer be paid to the provider as of the date the FQHC loses its designation. The remaining portion of the distribution pertaining to the Medicaid fee-for-service visits after the Federal Financial Participation will be paid as a State Only payment.
  - b. The amount of the reduction of the distribution to the provider will be calculated based on the number of days remaining in the distribution period from the date the FQHC loses its designation.
  - c. The funds from paragraphs 3(a) and 3(b) will be preserved until the fourth quarterly aggregate payment as the provider may regain their FQHC designation during the same state fiscal year and would then be entitled to their distribution from the date they regained the FQHC designation.
  - d. In the event the provider does not regain their FQHC status, any remaining funds pertaining to the Medicaid managed care visits from paragraphs (3)(a) and 3(b) of this section will be redistributed to the other eligible FQHC providers based on the proportion of their distribution to the total distribution and included in the fourth quarterly aggregate payment. The remaining funds pertaining to the Federal Financial Participation portion of the Medicaid fee-for-service visits will not be redistributed.

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New York  
2(am)(1.2)

**Federally Qualified Health Centers (FOHCs) Safety Net Payment**

- e. The provider will be removed from the distribution calculated in the FOHC Safety Net Payment section and included in section for the D&TCs Safety Net Payment State Only program in the first state fiscal year distribution calculation subsequent to the date they lost their FOHC designation.
  
- f. The funds allocated to the provider in this FOHC Safety Net Payment section will be transferred to the D&TC Safety Net Payment State Only program based on the portion of the distribution pertaining to the Medicaid fee-for-service visits applied to the tier add-on payment. The transfer of funds will be at the same time the provider is included in the D&TC Safety Net Payment State Only program distribution, as stated in paragraph (3)(e) of this section, decreasing the total value of the additional payment as described on paragraph (1) of this section.

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## New York

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**TYPE OF SERVICE - METHOD OF REIMBURSEMENT****Ambulatory Services in Facilities Certified Under Article 16 of the State Mental Hygiene Law:****OPW[MR]DD Clinic Treatment Program**

(Programs certified by OPW[MR]DD pursuant to 14 NYCRR Part 679)

For freestanding outpatient providers, OPW[MR]DD will establish statewide cost related flat fees. Fees will be assigned based on provider specific actual base year costs of budgets which correspond to the fiscal cycle of the provider. All fees are subject to approval by the Division of the Budget.

The above provision sunsets effective June 30, 2011. Effective July 1, 2011, these facilities will be reimbursed under the APG methodology, see: APG Reimbursement Methodology section.

**OPW[MR]DD Clinic Day Treatment Program**

(Programs certified by OPW[MR]DD pursuant to 14 NYCRR Part 690)

The below reimbursement methodology as outlined in *Fee Setting* 1-11 below, sunsets effective December 31, 2016.

Site specific, variable, per diem fees, which are cost related and developed as follows:

**Fee Setting**

- (1) For the purpose of setting the Day Treatment fee, units of service shall include the total number of half day units of service (more than three hours but less than five hours), the number of full day units of service (five hours or more) and less than half day units of service (such as in the amount of one and a half hour (1 1/2)). Units of service are billable in the above amounts. Billable services include the initial contact visit, enrollment for completing a preliminary screening, and services for individuals formally admitted to the Day Treatment program.
  - (i) Units of service for the fee setting calculation shall utilize projected or actual units of service as follows:
    - (a) For non-State operated Day Treatment programs in Regions II or III, including those programs in Region I designated or elected to a Region II or III reporting year-end and fiscal cycle, the April 1, 1991 through December 31, 1991 fee setting calculation shall utilize actual units of service from the January 1, 1988 through December 31, 1988 cost report. For non-State operated Day Treatment programs in Region I, including those programs in Region II and III designated or elected to a Region I reporting year-end and fiscal cycle, the July 1, 1991

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to June 30, 1992 fee setting calculation shall utilize actual units of service from the July 1, 1988 through June 30, 1989 cost report. For State operated Day Treatment programs, the April 1, 1991 through March 31, 1992 fee setting calculation may utilize actual units of service from the April 1, 1989 through March 31, 1990 cost report.

- (b) For the January 1, 1992 through December 31, 1992, April 1, 1992 through March 31, 1993 and July 1, 1992 through June 30, 1993 fee setting calculations, and thereafter actual units of service shall be from the [most recent] cost report submitted two years prior to the period for which the fee is being set. For programs for which OMRDD has not received such cost report at the time of the fee-setting calculation, OMRDD shall utilize the units of service paid for through the Medicaid Management Information System (MMIS) during the required cost report period.
- (c) Projected units of service shall mean the estimated monthly attendance multiplied by the expected number of days the program will be open for each month. This computation shall be made for each month, [and] summed for the number of months in the fee period and annualized. Projected units of service will be used in the absence of actually units of service from cost reports identified above. Projected units of service will be required upon issuance of an operating certificate for a new site or an amended operating certificate reflecting a change in capacity. Projected units of service shall be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the issuance of an operating certificate for a new site occurred, is used for fee-setting purposes. Projected units of service shall also be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the change in capacity occurred, is utilized for fee-setting purposes. If the estimated units of service have not been received by OMRDD by the date required, OMRDD shall utilize the units of service paid for through the MMIS, beginning with the program's initial certification or the first full month since the change in certified capacity occurred. If the available MMIS units of service are for less than a twelve month period, they shall be annualized for fee-setting purposes.
- (2) The fee for Day Treatment programs shall be a fixed amount plus operating, capital and transportation component add-ons. The fixed amount and operating component add-ons shall reflect base period costs and shall be subject to trend factors as approved by the commissioner. All dollar amounts cited herein shall reflect costs for the base period of January 1, 1988 through December 31, 1988.

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Approval Date     May 6, 1997    

Supersedes TN     #93-09    

Effective Date     January 1, 1997

**New York**  
**3a1**

- (i) The operating component add-ons shall be case mix, case mix intensity, salary, staff training and utilities. In addition, non-state operated Day Treatment programs that have submitted cost reports that contain full year costs for the periods January 1, 1988 through December 31, 1988, and July 1, 1988 through June 30, 1989, and state operated Day Treatment programs which have submitted cost reports that contain full year costs for the period April 1, 1989 through March 31, 1990 shall be eligible to qualify for either a cap adjustment component add-on or an allocation adjustment component add-on. In addition, non-state operated Day Treatment programs in Region II and II that participated in the Salary Enhancement plan pursuant to previously approved State Plan Amendment 88-48 shall also receive a salary enhancement cost adjustment component add-on. Operating component add-ons shall reflect base year costs and shall be subject to a trend factor.
- (ii) The capital component shall include property, equipment, and start-up costs. The capital component will not be subject to trend factor.
- (iii) Non-state operated Day Treatment programs in Regions II and III including those non-state operated Day Treatment programs in Region I designated or elected to a Region II or III reporting year end and fiscal cycle shall also receive an annualization cost component add-on for the period April 1, 1991 through December 31, 1991.
- (iv) The fixed amount shall be \$36.67. Effective July 1, 1996, the product of the administration component of the fixed fee times the units of service shall be reduced by an efficiency adjustment as described in this Attachment at subsection (9).
- (v) Effective July 1, 1996, there shall be a separate transportation component add-on to the program's fee as described in this Attachment at subsection (10).
- (vi) The operating component add-ons shall be computed. Such component add-ons shall be added to the fixed amount.
  - (a) **Case Mix Component** – The Developmental Disabilities Profile (DDP) shall be completed for each person attending the Day Treatment program. The individual's adaptive, maladaptive, and health/medical DDP scores shall be assigned as appropriate to its corresponding DDP percentile level grouping. The case mix component add-on will be calculated utilizing the

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highest DDP score for each individual. Corrected or updated DDP scores shall be implemented in accordance with paragraph (5) of Attachment 4.19-B Page 3h of this State Plan. The total number of persons assigned to each percentile level grouping shall be multiplied by the dollar amount associated with that percentile level grouping. Total dollars for each percentile level shall be summed together and divided by the number of persons for whom there are DDP scores.

- (b) Case Mix Intensity Component Add-On:** The highest single DDP percentile ranking for each individual program participant in any one of the three DDP scoring categories, adaptive, maladaptive and health/medical, shall be summed and divided by the total number of program participants with DDP scores, yielding an average percentile level grouping for each program. The Day Treatment program shall receive the per person dollar amount associated with the identified average percentile level grouping.
- (c) Staff Training Component** – The add-on shall be \$.32.
- (d) The Utilities Component** shall be the amount of utilities as reported in the appropriate cost report identified in paragraph (1), divided by the units of service.
- (1)** The utilities amount shall reflect the costs on an annual basis trended by an amount to be determined by the commissioner.
- (2)** A day treatment program shall receive the statewide median for utilities if the most recent cost report identified by paragraph (1) is not available, or does not cover the full period of the cost report.
- (3)** Utilities may be updated to reflect actual costs and/or cost increases due to expansion of the physical plant.
- (e) Salary Component** – The salary component of the fee shall be computed as follows:
- (1)** An agency specific salary per FTE shall be computed for each agency. The agency specific salary per FTE shall be calculated as follows: For non-State operated Day Treatment programs that filed full year cost reports for either the January 1, 1988 through December 31, 1988 or July 1, 1988 through June 30, 1989, the total

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through December 31, 1986, whichever cost report period is applicable, or did not have a full 12 months of operation during the applicable period shall receive the regional average for utilities. For state operated programs the utilities adjustment shall be 1.0987. Reported utilities shall be from the cost report for the period April 1, 1985 through March 31, 1986. Day Treatment programs that did not submit a full cost report for the period April 1, 1985 through March 31, 1986 or did not have a full 12 months of operation during that period shall receive the regional average for utilities.

- (f) **Start-Up Component** – This add-on shall be the amount of those cost incurred from the period the provider receives approval pursuant to the certification of need process, for a facility to become a Day Treatment program, to the date the first client is admitted. OMRDD, may at the discretion of the commissioner, reimburse a facility for all allowable start-up costs incurred in the preparation of the facility during that six month period prior to the date of the first client admission.
  - (1) A facility may apply to the commissioner for an extension of the six month reimbursable start-up period, provided the facility can demonstrate why such an extension is necessary. However, under no circumstances shall a facility be allowed reimbursement of start-up costs for any period of time exceeding 18 months prior to the date of the first client admission.

TN   #89-33    
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Approval Date   March 5, 1991    
Effective Date   July 1, 1989

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agency Day Treatment non contracted personal service costs for each Day Treatment program shall be divided by the total reported agency Day Treatment FTEs for each program and then multiplied by .9533 in order to reflect a median Day Treatment salary for each agency. The non contracted personal service costs reported on the January 1, 1988 through December 31, 1988 cost report shall be inclusive of 9 months of salary enhancement for programs that participated in the salary enhancement program of previously approved State Plan Amendment 88-48. For State operated Day Treatment programs that filed full year cost reports for the period April 1, 1989 through March 31, 1990, the statewide Day Treatment non contracted personal service costs for all state operated Day Treatment programs shall be divided by the total reported Day Treatment FTEs for all state operated Day Treatment programs and then multiplied by .9533 in order to reflect a median Day Treatment salary. The agency salary for all State operated and non-State operated programs that did not file full year cost reports, will be adjusted to reflect the agency salary or other existing Day Treatment programs operated by the provider. If the provider does not operate other Day Treatment programs, the Day Treatment agency salary shall be equal to the agency salary of ICF/DDs and/or Community Residences operated by the providers. Day Treatment agency salaries derived from other Day Treatment programs or ICF/DD and/or Community Residence programs operated by the provider shall be adjusted by .9533 to reflect a median Day Treatment agency salary. If the provider does not operate any other Day Treatment, ICF/DD or Community Residence programs, the agency salary per FTE shall be equal to the Day Treatment Statewide median salary of \$16,799. Day Treatment programs that have not filed full year cost reports for the periods identified above, will be considered to be in a Deficit (1) in accordance with item (3) below.

- (2) The agency salary per FTE shall be compared to the Day Treatment Statewide median salary of \$16,799.
- (3) Surplus/Deficit (1) – A surplus/deficit analysis shall be computed for each Day Treatment program that filed 12 month cost reports for January 1, 1988 through December 31, 1988, July 1, 1988 through June 30,

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1989, and April 1, 1989 through March 31, 1990. For non-State operated Day Treatment programs in Regions II and III and those programs in Region I elected to or designated to a Region II and III year end and fiscal cycle, the January 1, 1990 Day Treatment fixed amount and operating cost components in effect as of October 1, 1990, shall be detrended and compared to the operating costs from the January 1, 1988 through December 31, 1988 cost report. For non-State operated Day Treatment programs in Region I and those programs in Regions II and III elected to or designated to a Region I year end and fiscal cycle, the July 1, 1990 Day Treatment fixed amount and operating cost components in effect as of October 1, 1990, shall be detrended and compared to the operating costs from the July 1, 1988 through June 30, 1989 cost report. For State operated Day Treatment programs, the April 1, 1990 Day Treatment fixed amount and operating cost components, shall be detrended and compared to the operating costs from the April 1, 1989 through March 31, 1990 cost report. The surplus or deficit derived from this analysis shall be titled Surplus/Deficit (I). The Surplus/Deficit I shall not be computed for budget-based sites.

- (4) Salary component add-ons in accordance with the schedule identified below shall be added to fixed amount for each Day Treatment site.
- (i) If the agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 50th percentile of the statewide Day Treatment industry and the Day Treatment program is experiencing a Surplus (I) in accordance with item (2)(v)(e)(3) above, the salary component shall be \$6.10.
  - (ii) If the agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 50th percentile of the Day Treatment industry and the Day Treatment program is experiencing a Deficit (I) in accordance with item (2)(v)(e)(3) above, the salary component shall be \$6.10 plus the amount of costs equal to the agency salary per FTE divided by the Statewide salary of \$16,799 multiplied by \$29.09, minus \$29.09. 21.2 percent fringe is added to this amount.

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- (iii) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is greater than the 40th percentile or equal to the Day Treatment Statewide salary of \$16,799, the salary component add on shall be \$6.10.
- (iv) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 30th percentile or less than the 40th percentile of the Day Treatment industry, the salary component add on shall be \$3.89.
- (v) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 20th percentile or less than the 30th percentile of the Day Treatment industry, the salary component add on shall be \$2.37.
- (vi) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is equal to or greater than the 10th percentile or less than the 20th percentile of the Day Treatment industry, the salary component add on shall be \$1.50.
- (vii) If the adjusted agency salary per FTE pursuant to item (2)(v)(e)(1) above is less than the 10th percentile of the Day Treatment industry, the salary component add on shall be \$0.

**(f) Salary Enhancement Cost Adjustment Component Add-On** – The fixed amount for non-State operated Day Treatment programs that participated in the salary enhancement plan pursuant to previously approved State Plan Amendment 88-48 during the period April 1, 1988 through December 31, 1988 and submitted a 12 month cost report for the same period, shall receive a salary enhancement cost adjustment component add-on. Budget based Day Treatment programs in Regions II and III whose agency salary per FTE pursuant to item (2)(v)(e)(1) above, is equal to the agency salary of other existing Day Treatment programs operated by the same provider shall also receive the salary enhancement cost adjustment component add-on. The salary enhancement cost adjustment component may be revised to reflect additional FTEs for programs that have experienced a capacity change resulting in the issuance of a new operating certificate.

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Effective Date     April 1, 1991

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- (1) The salary enhancement cost adjustment component shall be calculated as follows:
- (i) For Day Treatment programs in Region II, the total number of direct care and support FTEs shall be multiplied by 25 percent of \$1,900 and increased by a fringe benefit factor of .212 percent and divided by the units of service pursuant to paragraph (1).
  - (ii) For Day Treatment programs in Region III, the total number of direct care and support FTEs shall be multiplied by 25 percent of \$1,690 and increased by a fringe benefit factor of .212 percent and divided by the units of service pursuant to paragraph (1).
- (g) Cap adjustment component add-on and allocation adjustment component add on.**
- (1) In order to determine eligibility for either the Cap Adjustment Component add-on or the Allocation component add-on, a surplus/deficit analysis shall be computed for each Day Treatment program using operating fees determined in accordance with subparagraphs (2)(iv) and (v)(a) – (f) [.]and the actual units of service from the appropriate 1988 cost report [.]for non state operated programs and the April 1, 1989 through March 31, 1990 cost report units of service for state operated programs. As appropriate, operating fee revenues shall be compared to appropriate adjusted program specific operating costs from either the January 1, 1988 through December 31, 1988 or July 1, 1988 through June 30, 1989 or the April 1, 1989 through March 31, 1990 cost reports. The surplus or deficit derived from this analysis shall be titled Surplus/Deficit (II).
- (2) Day Treatment programs determined to be in a Deficit (II) pursuant to subclause (1) above that received salary components in accordance with items subclause (2)(v)(e)(4)(i) shall receive a cap adjustment component equal to the Deficit (II) divided by the units of service.
- (3) Day Treatment programs determined to be in a Deficit (II) pursuant to clause (1), that received salary components in accordance with items (2)(v)(e)(4)(iii) through (vii) shall receive an allocation component equal to \$3.07.

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## New York

## 3g

**(h)** **The capital component add-on** shall be the amount of allowable capital costs and start-up costs divided by the units of service figure. Such allowable capital costs and start-up costs must be in accordance with subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan. [may include the cost of principal and interest payments on loan from the NYS Facilities Development Corporation (hereinafter referred to as FDC) pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, net of the portion of such payments attributable to operating costs; provided that the reimbursement of FDC loan payments is an allowance in lieu of reimbursement of interest and depreciation associated with the mortgaged property and/or in lieu of reimbursable start-up costs and in lieu of reimbursement for other underlying allowable costs for which the FDC loan was received. A provider which receives an FDC loan pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, does not have the option of having included in the calculation of its rate otherwise allowable interest, depreciation, start-up costs, or the loan's underlying costs instead of the allowance representing principal and interest. Capital costs and s] Start-up costs shall be from the best available and documented data that reflects the cost expected to be incurred during the fee period. [For property acquired or leased on or after January 1, 1986 prior approval by Office of Mental Retardation and Developmental Disabilities and the Division of the Budget shall be required in order for such property costs to be reimbursed in the fee.] At the onset of each fee period, the OMRDD shall review the capital component add-on for substantial material changes. If said changes are allowable, the capital component shall be revised.

- (3) For the January 1, 1991 to December 31, 1991, April 1, 1991 to March 31, 1992 and the July 1, 1991 to June 31, 1992 fee periods, the final fee shall be equal to the capital component calculated in accordance with (h) above plus the greater of (i) or (ii) below. For the January 1, 1992 to December 31, 1992, April 1, 1992 to March 31, 1993 and the July 1, 1992 to June 31, 1993 fee periods, and thereafter, the final fee shall be equal to the property and equipment component calculated in accordance with clause (h) of this state plan plus subparagraph (ii) of this paragraph:
- (i) For non-State operated programs in Region I and those non-State operated programs designated or elected to a region I year end and fiscal reporting cycle, 99.5 percent of the fixed fee and operating components contained in the June 30, 1991 fee trended to the July 1, 1991 to June 30, 1992 fee period. For non-State operated programs in Regions II and III and those non-State operated programs designated or elected to a Region II and III year end and fiscal reporting cycle, 99.5 percent of the fixed fee and operating components contained in the December 31, 1990 fee trended to the January 1, 1991 to December 31, 1991 fee period. For State operated programs, 99.5 percent of the fixed fee and operating components contained in the March 31, 1991 fee trended to the April 1, 1991 through March 31, 1992 fee.

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**New York**  
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- (ii) The fixed fee and operating components determined in accordance with subsection (2) of this State Plan trended to the appropriate fee period.
- (4) The final adjusted fee shall be equal to the final fee determined in subsection (3) above except as provided below as follows:
- (i) Non-state operated Day Treatment programs in Regions II and III including those programs in Region I designated or elected to a Region II and III year-end reporting and fiscal cycle shall receive the annualization component add-on for the period April 1, 1991 to December 31, 1991. The annualization component add-on shall be equal to the difference between the fee in effect on March 31, 1991 and the April 1, 1991 final fee calculated pursuant to subsection (3) for the period January 1, 1991 to March 31, 1991 divided by the units of service pursuant to subsection (1). The annualization component add-on shall be added to the final fee determined in accordance with subsection (3) above, and the resulting fee shall be considered the final adjusted fee.
  - (ii) The final adjust fee for non-state operated Day Treatment programs in Region I and those facilities designated or elected to a Region I year-end fiscal cycle and state operated Day Treatment programs shall be equal to the final fee determined in accordance with subsection (3) above.
  - (iii) For eligible facilities, the final fee shall be adjusted to include an amount in accordance with subsections (10) and (11).
- (5) The commissioner may make corrections to the fees based upon the following:
- (i) Errors which occurred in the computation of the fee.
  - (ii) Final audit findings.
  - (iii) The Day Treatment provider may request corrections to the fee within 90 days of receipt of the fee. Such corrections are limited to errors in the cost report and corrections to the DDP. If corrections to the DDP would result in an increase to the final adjusted fee, the commissioner may independently review the corrected DDPs. During the period when the commissioner is reviewing the provider-submitted revised DDP data, the DDP in the fee at the time of review shall remain in effect. Should the commissioner's review verify the provider-submitted revisions to the DDP data, said revised DDP data shall be utilized for fee-setting purposes retroactive to the first day of the fee period. The case mix component add-on and the case mix intensity component add-on may be recalculated only if there is a 10 percent or greater change in participants resulting from either a change in certified capacity or a turnover in program participants, or a correction to the DDP score approved by the commissioner. Day Treatment providers must report to OMRDD Rate Setting all participant changes greater than 10 percent.

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- (iv) Corrections to the transportation component add-on pursuant to subsection (10) of Attachment 4.19-B of this State Plan.
- (v) Adjustment to actual units of service.
  - (a) OMRDD may, upon request from a Day Treatment provider, adjust the units of service used for the program's calculation for the prior fee period to actual units of service delivered during such fee period. However, such adjustment will be limited to situations where the Day Treatment provider demonstrated the Day Treatment program was in a deficit situation for the prior fee period and had for reasons beyond its control not been able to deliver the units of service used to calculate the fee for the prior fee period.
  - (b) The Day Treatment provider must request adjustments to the program's actual units of service within [90] 150 days of the close of the [fee] fiscal reporting period for which the said adjustment is sought.
- (6) All fees and any corrections to fees shall not be considered final unless approved by the director of the Division of Budget.
- (7) To encourage the closure of developmental centers, the commissioner will consider proposals to allow the variable costs associated with the closed center or center to become part of the operating expenses of new or existing state operated Day Treatment programs. The commissioner will allow a reasonable incentive plan for the reimbursement of the increased costs referred to above in state operated Day Treatment programs if it is coupled with the closure of a developmental center. An incentive plan would provide for the reimbursement in total of closure related increased costs in the state operated Day Treatment programs without adjustments or offsets.
  - (i) The following reimbursement schedule will be used for proposals approved by the commissioner:
    - (a) 100% reimbursement of the increased cost for at least one full fee period but less than two full fee periods.
    - (b) 75% reimbursement of the increased cost for the second full fee period following the period defined in subsection (7)(i)(a) above.
    - (c) 50% reimbursement of the increased cost for the third full fee period.
    - (d) 25% of the increased cost for the fourth full fee period.

TN #97-09 Approval Date May 6, 1997  
Supersedes TN #96-39 Effective Date January 1, 1997

New York  
3h2

- (ii) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.
  - (a) In order to have the cost of a former developmental center employee included in the incentive plan, the state operated [facility] Day Treatment program applying for a fee adjustment pursuant to subsection (7) must hire such employee within twelve months of the official closing date of the developmental center.
  - (b) Salaries and fringe benefit amounts paid to eligible employees by the new program may not exceed the average salary and fringe amounts paid to comparable employees currently on that [facility's] payroll.
  - (c) Any claim made under this provision is subject to audit as noted in section (5)(ii).
- (iii) Incentive plan applications shall be made in writing to the commissioner.
  - (a) The application shall identify the employees, their job titles, salary levels, date hired, and the B/DDSO of previous employment.
  - (b) OMRDD may request such additional information as it deems necessary.
- (8) To accelerate the closure and to encourage a reduction in the size of developmental centers, the commissioner will consider proposals to allow the variable costs associated with a developmental center to become part of the operating expenses of new and existing state operated Day Treatment programs. The variable costs associated with the developmental center will be allowed for the transition which is the period beginning on the date an official announcement to close a [facility or facilities] center or centers and ending on the date of actual closure. Also variable costs associated with the conversion of beds which is a substantial material change in the [facility] center census will be allowed. The commissioner will allow a reasonable incentive for the reimbursement of the increased costs referred to above in the state operated [community facilities] Day Treatment programs during the transition and/or conversion period.
  - (i) The commissioner will allow the following reimbursement for approved proposals:

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3h3

- (a) 75% reimbursement of the increased costs incurred during the transition[a] closure period. On the effective date of closure, reimbursement of increased costs will be considered under subsection (7).
  - (b) 75% reimbursement of the increased costs incurred during the conversion period. The conversion period will be for at least one full fee period but less than two full fee periods. If during the conversion period, an official announcement of closure occurs, the reimbursement of increased costs may be considered under subsection (7)(i)(a).
- (ii) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.
- (a) In order to have the cost of a former developmental center employee included in the incentive plan, the [community facility] Day Treatment program applying for a fee adjustment pursuant to subsection (7)(iv) must hire such employee during the transition[a] and conversion periods.
  - (b) Salaries and fringe benefit amounts paid to eligible employees by the [facility] Day Treatment program cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that [facility's] program's payroll.
  - (c) Any claim made under this provision is subject to audit as noted in section (5)(ii).
- (iii) Incentive plan applications from the provider shall be made in writing to the commissioner.

TN #96-39

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**New York**  
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- (9) Effective July 1, 1996, there shall be an efficiency adjustment as described herein and applied as a reduction to the fixed component of the fee.
- (i) The efficiency adjustment shall be a percentage reduction based on the \$10.12 associated with administration in the fixed component of the fee. Except as provided for in (ii) of subsection (9) of this section, all cost and revenue information, used to determine the efficiency adjustment percentages, shall be based on reported cost and revenue information for the calendar 1992 or 1992-93 cost reporting year. Each provider shall be assigned a percentage value from the table at subclause (3) of this clause, based on total program cost, a program surplus/deficit group designation and an administration percentage group designation.
- (a) Determination of program surplus/deficit group. A determination shall be made as to whether each provider has a program surplus or deficit, for the combined total of all community residence and Day Treatment programs and all residential habilitation and day habilitation services. Surplus/deficit shall equal gross revenue (less any prior period adjustments) minus allowable costs.
- (1) For those providers with a reported deficit, this deficit shall be considered the final deficit amount for the purpose of this calculation.
- (2) For those providers with a reported program surplus, a certain portion of that surplus shall be exempted to establish an adjusted surplus. The adjusted surplus shall be the reported surplus minus the exempt amount. Exempt amounts shall be determined as follows. For providers whose total program costs are:
- (i) less than \$1 million, the exempt amount shall be \$10,000.
- (ii) between \$1 million and less than \$3 million, the exempt amount shall be \$22,500.
- (iii) between \$3 million and \$7 million, the exempt amount shall be \$35,000.
- (iv) over \$7 million, the exempt amount shall be \$40,000.

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New York  
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- (3) The reported deficit or the adjusted surplus shall be given one of the following designations used to determine the efficiency adjustment percentage in the table at the end of this section:
  - (i) S2 if the adjusted surplus is equal to or greater than \$200,000.
  - (ii) S1 if the adjusted surplus is from \$20,000 to \$199,999.
  - (iii) BE if the reported deficit is not greater than (\$19,999) or the adjusted surplus is not greater than \$19,999 (BE-break even).
  - (iv) D1 if the reported deficit is from (\$20,000) to (\$199,999).
  - (v) D2 if the reported deficit is equal to or greater than (\$200,000).
  
- (b) Determination of a calculated administration percentage group. A determination shall be made of a provider's calculated administration cost, where administration percentage shall equal administration divided by the result of total operating cost minus the sum of capital costs and administration. There shall be five group designations that express the calculated administration percentage as a departure from the average percentage for all provider agencies. Those percentages centered around the average are designated with the abbreviation AVG. There are also two group designations for percentages over the average, abbreviated OA2 and OA1 and two designations for under the average, abbreviated UA2 and UA1. These abbreviations appear in the table of percentages at the end of this section as well as in the following regional tables. Each provider's assignment to one of the five group designations shall be based on the provider's calculated administration percentage, total program cost and elected or assigned region (refer to subdivision (a) of this section). Each provider's administration percentage group designation shall be determined using the following tables.

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**New York  
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**REGION ONE**

Program Cost in Millions of Dollars (< less than: > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.3100 PLUS</u>	<u>.4500 PLUS</u>	<u>.4500 PLUS</u>	<u>.4500 PLUS</u>	<b><u>OA2</u></b>
<u>.2600 .3099</u>	<u>.3500 .4499</u>	<u>.3500 .4499</u>	<u>.3500 .4499</u>	<b><u>OA1</u></b>
<u>.2300 .2599</u>	<u>.3200 .3499</u>	<u>.3200 .3499</u>	<u>.2800 .3499</u>	<b><u>AVG</u></b>
<u>.1900 .2299</u>	<u>.2500 .3199</u>	<u>.2400 .3199</u>	<u>.2400 .2799</u>	<b><u>UA1</u></b>
<u>.0000 .1899</u>	<u>.0000 .2499</u>	<u>.0000 .2399</u>	<u>.0000 .2399</u>	<b><u>UA2</u></b>

**REGION TWO**

Program Cost in Millions of Dollars (< less than: > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.3100 PLUS</u>	<u>.4500 PLUS</u>	<u>.3500 PLUS</u>	<u>.3500 PLUS</u>	<b><u>OA2</u></b>
<u>.2900 .3099</u>	<u>.3500 .4499</u>	<u>.2800 .3499</u>	<u>.2500 .3499</u>	<b><u>OA1</u></b>
<u>.2150 .2899</u>	<u>.3200 .3499</u>	<u>.2500 .2799</u>	<u>.1900 .2499</u>	<b><u>AVG</u></b>
<u>.1900 .2149</u>	<u>.2500 .3199</u>	<u>.2000 .2499</u>	<u>.1700 .1899</u>	<b><u>UA1</u></b>
<u>.0000 .1899</u>	<u>.0000 .2499</u>	<u>.0000 .1999</u>	<u>.0000 .1699</u>	<b><u>UA2</u></b>

**REGION THREE**

Program Cost in Millions of Dollars (< less than: > greater than)

<u>&lt; \$1</u>	<u>\$1 to &lt; \$3</u>	<u>\$3 to \$7</u>	<u>&gt; \$7</u>	<u>Group</u>
<u>Administration Percentage</u>				
<u>.4200 PLUS</u>	<u>.3500 PLUS</u>	<u>.2800 PLUS</u>	<u>.4200 PLUS</u>	<b><u>OA2</u></b>
<u>.3300 .4199</u>	<u>.2700 .3499</u>	<u>.2550 .2799</u>	<u>.3300 .4199</u>	<b><u>OA1</u></b>
<u>.2400 .3299</u>	<u>.2250 .2699</u>	<u>.2300 .2549</u>	<u>.2400 .3299</u>	<b><u>AVG</u></b>
<u>.1851 .2399</u>	<u>.1900 .2249</u>	<u>.2100 .2299</u>	<u>.1851 .2399</u>	<b><u>UA1</u></b>
<u>.0000 .1850</u>	<u>.0000 .1899</u>	<u>.0000 .2099</u>	<u>.0000 .1850</u>	<b><u>UA2</u></b>

TN #96-39

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Effective Date July 1, 1996

New York  
3h7

(c) Determination of the efficiency adjustment percentage. Each provider shall be assigned an efficiency adjustment percentage value from the following table, based on the surplus/deficit group designation and the administration percentage group designation. The amount associated with the administration component of the fixed fee shall be determined by multiplying the administration component of the fixed fee times the units of service. The resulting total amount shall then be reduced by an efficiency adjustment percentage.

	<u>S2</u>	<u>S1</u>	<u>BE</u>	<u>D1</u>	<u>D2</u>
<u>OA2</u>	17.00 %	16.00 %	15.00 %	14.00 %	13.00 %
<u>OA1</u>	16.25 %	15.25 %	14.25 %	13.25 %	12.25 %
<u>AV</u>	15.50 %	14.50 %	13.50 %	12.50 %	11.50 %
<u>UA1</u>	14.75 %	13.75 %	12.75 %	11.75 %	10.75 %
<u>UA2</u>	14.00 %	13.00 %	12.00 %	11.00 %	10.00 %

(1) If a provider agency opens a new Day Treatment program subsequent to the 1992 or 1992-93 cost reporting period, the cell value designated for the new Day Treatment program, shall be the same cell value as that which is designated for all of the provider's other Day Treatment programs, and for which 1992 or 1992-93 cost data available.

(2) New agencies operating Day Treatment programs subsequent to the 1992 or 1992-93 cost reporting period shall be assigned the center cell value, i.e., AVG-BE, in the table found in this subclause.

(ii) A provider may request that OMRDD use a more recent cost reporting period, as an alternative to the 1992 or 1992-93 reporting period, to determine the efficiency adjustment percentage as described herein. Approval to use an alternative reporting period shall be granted if, upon a fiscal review by the commissioner, it is determined that the cost report for the alternative reporting period more accurately reflects the provider's current financial status. For the purpose of determining the efficiency adjustment percentage only, providers may submit corrections to their 1992 or 1992-93 cost report. Such corrections shall be certified by a certified public accountant. Providers may request the use of an alternative reporting period or may submit corrections to their 1992 or 1992-93 cost report only once. Such requests or corrections shall be made in writing and received by OMRDD by December 31, 1996. Providers shall also have until December 31, 1996 to notify OMRDD of errors made in calculating the efficiency adjustment.

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Supersedes TN NEW

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Effective Date July 1, 1996

New York  
3h8

- (10) Effective July 1, 1996, there shall be a separate transportation component add-on to the program's fee. This component add-on for each Day Treatment program shall be determined using the following methodology.
- (i) Using a payment/rate data sample from calendar years 1995 and 1996, the weighted transportation average shall be calculated by dividing the aggregate transportation payments by the aggregate transportation units of service on a program specific basis. One round trip shall equal one unit of service.
    - (a) The weighted transportation average for each Day Treatment program shall be ranked among all Day Treatment programs statewide.
      - (i) If a program's weighted transportation average is \$11.16 or less, the weighted transportation average shall be held 100 percent harmless.
      - (ii) If a program's weighted transportation average exceeds \$11.16, forty percent of the weighted transportation average shall be held harmless.
    - (b) After deducting the forty percent to be held harmless, the net weighted transportation average for each program (i.e., the remaining 60 percent of the weighted transportation average) shall be re-ranked. Based on the new percentile rankings, a percentage offset shall be deducted from the net weighted transportation average. A program's percentage offset shall be determined by locating its net weighted transportation average (i.e., the remaining 60 percent of the weighted transportation average) in the following table.

<u>PERCENTILE RANK</u>	<u>NET WEIGHTED TRANSPORTATION AVERAGE</u>	<u>PERCENTAGE OFFSET</u>
<u>5 or &lt;</u>	<u>\$0 - \$7.26</u>	<u>5</u>
<u>6 to 9</u>	<u>\$7.27 - \$8.13</u>	<u>7.5</u>
<u>10 to 29</u>	<u>\$8.14 - \$10.20</u>	<u>10</u>
<u>30 to 49</u>	<u>\$10.21 - \$13.32</u>	<u>12.5</u>
<u>50 to 59</u>	<u>\$13.33 - \$13.80</u>	<u>15</u>
<u>60 to 69</u>	<u>\$13.81 - \$14.01</u>	<u>16.5</u>
<u>70 to 79</u>	<u>\$14.02 - \$14.97</u>	<u>20</u>
<u>80 to 84</u>	<u>\$14.98 - \$15.77</u>	<u>22.5</u>
<u>85 or &gt;</u>	<u>Over \$15.77</u>	<u>25</u>

TN #96-39  
Supersedes TN NEW

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Effective Date July 1, 1996

**New York**  
**3h9**

- (c) The amount remaining after the application of the percentage offset (the sixty percent of the weighted transportation average reduced by the offset percentage in the table above) shall be added to the hold harmless amount to determine a program's modified weighted transportation average.
- (1) If the modified weighted transportation average falls below \$11.16, the modified weighted transportation average shall be adjusted to \$11.16.
- (2) If the modified weighted transportation average exceeds \$30.00, the modified weighted transportation average shall be adjusted to \$30.00.
- (d) The modified weighted transportation average shall be multiplied by the total to and from Day Treatment transportation units and divided by the total Day Treatment units of service to create a Day Treatment transportation component add-on. This shall be a separate component added to the Day Treatment fee.
- (ii) If an agency currently providing Day Treatment does not have to and from transportation payment/rate data available for a particular program for the period used to calculate the modified weighted transportation averages, or if a provider agency opens a new Day Treatment program, the modified weighted transportation average shall be equal to the lesser of:
- (a) the new program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the new Day Treatment program, or
- (b) the average of the modified weighted transportation averages for all other Day Treatment programs operated by the provider agency.
- (iii) If a provider agency does not currently operate a Day Treatment program and opens a new Day Treatment program, or if a provider agency does not have to and from transportation payment/rate data for any of its Day Treatment programs for the period used to calculate the modified weighted transportation averages, the modified weighted transportation average shall be equal to the lesser of:
- (a) the new program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the Day Treatment program, or
- (b) the average of the modified weighted transportation averages for all day habilitation programs operated by the provider agency in accordance with the State's Home and Community Based Services Waiver for persons with mental retardation and developmental disabilities.

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Effective Date July 1, 1996

New York  
3h10

(iv) If the provider agency does not operate any Day Treatment program or day habilitation program, the modified weighted transportation average shall be equal to the lesser of the new Day Treatment program's budgeted amount for transportation based on the transportation requirements of the person(s) to be transported to and from the Day Treatment program or 75 percent of the regional modified weighted transportation average associated with transporting individuals to and from Day Treatment programs. The table below shows the regional modified weighted transportation averages:

<u>REGION</u>	<u>AVERAGE</u>	<u>75 PERCENT OF AVERAGE</u>
1	\$21.37	\$16.03
2	\$21.17	\$15.88
3	\$15.97	\$11.98

(v) Providers that operated only day habilitation programs, under the Home and Community Based Services Waiver, prior to July 1, 1996, and opened a Day Treatment program for the first time between July 1, 1996 and September 26, 1996 and received a 75 percent of the regional modified weighted transportation average for day treatment transportation as the transportation add-on component to the Day Treatment fee, shall receive a one time fee adjustment based on the methodological change that became effective September 26, 1996 as described paragraph (10)(iii) above. The one time fee adjustment shall be either:

- (a) a one time fee increase if the provider's fee effective July 1, 1996 was lower than the new fee effective September 26, 1996, because the lesser of the need-based budgeted transportation amount or the average of the provider agency's day habilitation modified weighted transportation averages is greater than 75 percent of the regional modified weighted average for transportation to and from day treatment, or
- (b) a one time fee decrease if the provider's fee effective July 1, 1996 was higher than the new fee effective September 26, 1996, because the lesser of the need-based budgeted transportation amount or the average of the provider agency's day habilitation modified weighted transportation averages is less than 75 percent of the regional modified weighted average for transportation to and from day treatment.

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New York  
3h11

- (11) (i) Effective January 1, 1999 for non-state operated facilities, a cost of living add-on may be included in the final adjusted fee. This add-on will be an increase to the fee due to a 2.5 percent increase in salaries and salary related fringe benefits. Inclusion of the add-on is subject to a resolution of the facility's governing body that funding received will be used solely to effect a 2.5 percent increase beginning with the lowest paid employees. To be deemed reimbursable, both the resolution and an implementation plan must be submitted by the facility and approved by the Commissioner.
- (ii) Effective January 1, 1999, for state operated facilities, a cost of living add-on will be included in the final adjusted fee. This add-on will be the full annual amount of 2.5 percent of the salaries and salary related fringe benefits included in the final fee.
- (iii) Facilities certified as day treatment facilities on or after May 20, 1999 shall be deemed to have met the requirements for an approved cost of living add-on described in paragraphs (i) and (ii) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (iv) Effective July 1, 2000 non-state operated facilities may be eligible for a salary enhancement add-on to be included in their final net fee. This add-on will recognize the costs of a \$750 annual salary increase per full time equivalent, plus salary related fringe benefits, for direct care and support workers. Inclusion of the add-on is subject to a resolution of the facility's governing body that funding received will be used solely to effect this increase. To be deemed reimbursable, both the resolution and an implementation plan must be submitted by the facility and approved by the commissioner.

TN     #00-35    

Approval Date     June 6, 2001    

Supersedes TN     #99-20    

Effective Date     July 1, 2000

**New York**  
**3h12**

- (v) Effective July 1, 2000, for state operated facilities, a salary enhancement add-on will be included in the final adjusted fee. This add-on will be the full annual amount of \$750 per full time equivalent, plus salary related fringe benefits, for the direct care and support full time equivalent included in the final fee.
- (vi) Facilities initially certified as day treatment facilities on or After April 1, 2001 shall be deemed to have met the requirements for an approved salary enhancement add-on described in subparagraphs (iv) and (v) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (vii) Effective January 1, 2003, non-state operated facilities may be eligible for a cost of living adjustment (COLA) add-on of three percent to be included in their final adjusted fee. This add-on is a three percent increase to the personal service portion of allowed reimbursement, for expenditures related to recruitment and retention of staff for the period of April 1, 2002 through March 31, 2003. On or after January 1, 2003, eligible facilities will receive an amount that they would have received if the COLA add-on were added to the final adjusted fee on December 1, 2002. The provider is required to submit to OMRDD a Letter of Attestation, signed by the Executive Director and President or equivalent of the governing body, which details how the COLA is expended.
- (viii) Effective January 1, 2003, for state operated facilities, a cost of living adjustment (COLA) add-on of three percent is included in the final adjusted fee. This add-on is a three percent increase to the personal service portion of allowed reimbursement, for expenditures related to recruitment and retention of staff for the period of April 1, 2002 through March 31, 2003. On or after January 1, 2003 facilities will receive an amount that they would have received if the COLA add-on were added to the final adjusted fee on December 1, 2002.
- (ix) Facilities certified on or after April 1, 2003 shall be deemed to have met the requirements for an approved COLA add-on described in subparagraphs (vii) and (viii) of this paragraph, and a corresponding factor shall be included in the final adjusted fee.
- (x) The day treatment facility shall be responsible for the cost of services which:
  - (a) are necessary to meet the needs of consumers while attending the program, and
  - (b) which prior to August 1, 2004 could have been met by home health aide or personal care services separately billed to Medicaid.

TN   #05-08    
Supersedes TN   ---  

Approval Date   December 12, 2005    
Effective Date   January 5, 2005

**New York  
3h12.1**

**OPWDD Freestanding Clinic – Day Treatment**

Effective January 1, 2017, reimbursement fees for Ambulatory Services in Facilities Certified Under Article 16 of the Mental Health Law Clinic Day Treatment program providers are as follows:

<u>Corp Name</u>	<u>Site</u>	<u>Rate Codes</u>				
		<u>4170 Full Day</u>	<u>4171 Half Day</u>	<u>4172 Collocated Model</u>	<u>4173 Intake</u>	<u>4174 Diagnosis &amp; Evaluation</u>
<u>Family Residence &amp; Essential Enterprises</u>	<u>28 Research Way</u>	<u>\$128.16</u>	<u>\$64.08</u>	<u>\$0.00</u>	<u>\$128.16</u>	<u>\$128.16</u>
<u>Family Residence &amp; Essential Enterprises</u>	<u>120 Plant Avenue</u>	<u>\$203.94</u>	<u>\$101.97</u>	<u>\$0.00</u>	<u>\$203.94</u>	<u>\$203.94</u>
<u>Monroe County ARC</u>	<u>1651 Lyell Avenue</u>	<u>\$0.00</u>	<u>\$0.00</u>	<u>\$36.84</u>	<u>\$0.00</u>	<u>\$0.00</u>
<u>Otsego County ARC</u>	<u>3 Chenango Road</u>	<u>\$98.49</u>	<u>\$49.25</u>	<u>\$0.00</u>	<u>\$98.49</u>	<u>\$98.49</u>
<u>Rehabilitation Center of Cattaraugus</u>	<u>3799 South Nine Mile Road</u>	<u>\$106.52</u>	<u>\$53.26</u>	<u>\$0.00</u>	<u>\$106.52</u>	<u>\$106.52</u>
<u>UCP Nassau</u>	<u>380 Washington Avenue</u>	<u>\$169.06</u>	<u>\$84.53</u>	<u>\$0.00</u>	<u>\$169.06</u>	<u>\$169.06</u>
<u>UCP Putnam &amp; Southern Dutchess Counties</u>	<u>40 Jon Barret Road</u>	<u>\$141.54</u>	<u>\$70.77</u>	<u>\$0.00</u>	<u>\$141.54</u>	<u>\$141.54</u>
<u>UCP Niagara</u>	<u>2103 Mckenna Avenue</u>	<u>\$0.00</u>	<u>\$0.00</u>	<u>\$35.06</u>	<u>\$0.00</u>	<u>\$0.00</u>
<u>UCP Suffolk</u>	<u>250 Marcus Boulevard</u>	<u>\$151.05</u>	<u>\$75.53</u>	<u>\$0.00</u>	<u>\$151.05</u>	<u>\$151.05</u>
<u>UCP Westchester</u>	<u>1186 King Street</u>	<u>\$191.36</u>	<u>\$95.68</u>	<u>\$0.00</u>	<u>\$191.36</u>	<u>\$191.36</u>

TN #10-0018

Approval Date November 1, 2017

Supersedes TN NEW

Effective Date July 1, 2010

**New York**  
**Page 3(h.13)**

Effective July 1, 2018 the following fees will be in effect for the Targeted Case Management Service. The Basic HCBS Plan Support-initial fee is a one-time payment made in the first month of service for the individual. One unit of Basic HCBS Plan Support-on-going may be billed per quarter (up to four units per year). A provider may not bill both an initial and an on-going fee in the same quarter. In order to be reimbursed for a billable unit, the CCO/HH provider must, at a minimum, provide at least one of the monitoring, or follow-up activities, or conduct a face to face visit.

<u>Rate Code</u>	<u>Rate Code Definition</u>	<u>Locator Code</u>	<u>Fee</u>
<u>1904</u>	<u>Basic HCBS Plan Support- on going</u>	<u>03/04</u>	<u>\$247.25</u>
<u>1906</u>	<u>Basic HCBS Plan Support- initial</u>	<u>03/04</u>	<u>\$741.74</u>

TN # 18-0058  
Supersedes TN # 12-0030

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**New York  
Page 3(h.14)**

**Rate Setting**

1. The method of reimbursement for Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD) will be a fee established by OPWDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget. The fee schedule to be paid is as follows:

<u>LEVEL OF INVOLVMENT</u>	<u>LEVEL</u>	<u>UPSTATE FEE</u>	<u>DOWNSTATE FEE</u>	<u>UNIT OF SERVICE</u>
<u>Stable</u>	<u>1</u>	<u>\$56.29</u>	<u>\$64.77</u>	<u>Monthly</u>
<u>Mild</u>	<u>2</u>	<u>\$375.27</u>	<u>\$431.77</u>	<u>Monthly</u>
<u>Moderate</u>	<u>3</u>	<u>\$405.29</u>	<u>\$466.31</u>	<u>Monthly</u>
<u>Intensive</u>	<u>4</u>	<u>\$799.33</u>	<u>\$919.65</u>	<u>Monthly</u>

i. Billing Standards

- a. Stable – periodic (quarterly) intervention - At least one month in each quarter requires the delivery and documentation of a face-to-face service.
- b. Mild – monthly intervention - Provider may bill the monthly unit of service when CSIDD services are rendered and at a minimum one face-to-face service is delivered in the month.
- c. Moderate – multiple outreach per month - Provider may bill the monthly unit of service when CSIDD services are rendered and documents more than one face-to per service per month.
- d. Intensive – weekly or more outreach - Provider may bill the monthly unit of service when CSIDD services are rendered and face-to-face services are provided on a weekly basis.

ii. Reporting requirements

- a. Providers will be required to complete cost reports on an annual basis.

TN                   #19-0014                  Supersedes TN           #18-0058          Approval Date           December 16, 2019          Effective Date           January 01, 2019

**New York  
3(i)**

**Type of Service****Office of Alcoholism and Substance Abuse Services (OASAS) Outpatient Services**

**Chemical Dependence Medically Supervised Treatment and Chemical Dependence Medically Supervised Freestanding Clinic and Hospital Outpatient Withdrawal Services**

For dates of service beginning on July 1, 2002, facilities certified solely under article 32 of the Mental Hygiene Law will be reimbursed based upon per visit fees developed by the Department of Health and approved by the Division of the Budget. Fees will be prospective, all-inclusive, and will be based upon reported historical cost and visit data supplied by providers. Operating and capital cost data is submitted annually on the facility Consolidated Fiscal Report (CFR). Fees are regionally adjusted to reflect geographic cost variation and are based upon 1998 base year cost data trended to this initial level. The above reimbursement methodology sunsets effective May 31, 2017.

Effective June 1, 2017, OASAS providers receive a daily fee which recognizes regional costs differences reflected in a fee table. All fees and rates are subject to the approval of the Division of the Budget. The fees can be found on the OASAS website at:

<https://www.oasas.ny.gov/admin/hcf/FFS/MedSuprOtptWthdrl.cfm#top>

**OMH [Outpatient Programs] Licensed Freestanding Clinic and Outpatient Hospital Services Under 14 NYCRR Parts [579 and 585: (to be phased out)] 587, 588 and 599**

**Clinic, Day and Continuing Treatment Programs**

For freestanding outpatient providers OMH will establish regional fee schedules which recognizes regional cost differences. For hospital-based providers, OMH will establish cost-related rates subject to ceiling limitations. All fees and rates are subject to the approval of the Division of the Budget.

The above reimbursement methodology identified in this paragraph sunsets effective May 31, 2017.

In addition to these fees, a provider which has been recommended by the local governmental unit and designated by the New York State Office of Mental Health can receive a supplemental rate for clinic and/or day treatment programs to cover the cost of additional rehabilitative services provided by its community support program(s). Such rates shall be calculated by dividing the cost of community support program services determined to be eligible for Medicaid reimbursement by the number of services provided to recipients who are eligible for Medicaid.

The supplemental reimbursement rate identified in this paragraph sunsets effective October 31, 2013.

TN <u>  #10-0018  </u>	Approval Date <u>  November 1, 2017  </u>
Supersedes TN <u>  #02-0016  </u>	Effective Date <u>  July 1, 2010  </u>

**New York  
3(j)**

**[Type of Service]**

**OMH [Outpatient Programs] Licensed Freestanding Clinic and Outpatient Hospital Services [Under 14 NYCRR Parts 587 and 588**

**(to replace existing programs licensed under 14 NYCRR Parts 585 and 579]**

**Method of Reimbursement**

[For Freestanding outpatient providers OMH will establish regional fee schedules which recognize regional cost differences. For hospital based providers, OMH will establish cost related rates subject to ceiling limitations. All fees and rates are subject to the approval of the Division of the Budget.]

**Clinic Treatment for Adults, Clinic Treatment for Children, Clinic and Continuing Day Treatment Programs**

Continuing Day Treatment fees will be tiered so that a client's reimbursement will vary depending on their service utilization during a month. The fee will decrease when a client reaches specified, uniform monthly utilization levels. Freestanding outpatient providers will have three fees representing three utilization levels. Hospital based providers will have two.

In addition to these fees, a provider of Freestanding Clinic or Outpatient Hospital Services which has been recommended by the local governmental unit and designated by the New York State Office of Mental Health can receive a supplemental rate for clinic and/or continuing day treatment programs to cover the cost of additional rehabilitative services provided by its community support program(s). Such rates shall be calculated by dividing the cost of community support program services determined to be eligible for Medicaid reimbursement by the number of services provided to recipients who are eligible for Medicaid.

OMH will also set project specific fees for approved projects which examine innovative program and administrative configurations, subject to the approval of the Division of the Budget.

The reimbursement methodology identified in this paragraph sunsets effective May 31, 2017.

**Continuing Day Treatment Services: Reimbursement Methodology for Freestanding Clinics**

**Effective June 1, 2017**

**Definitions**

- **Group Collateral** – A unit of service in which services are provided to collaterals of more than one individual at the same time. Group Collateral Visit shall not include more than 12 individuals and collaterals. Reimbursement for group collateral visits of 30 minutes or more is provided for each individual for whom at least one collateral is present.

- **Regions** –

**Downstate:** Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester Counties

**Western:** Allegheny, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tompkins, Wayne, Wyoming and Yates Counties

**Upstate:** Albany, Broome, Cayuga, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Orange, Oswego, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Tioga, Warren and Washington Counties

Providers with program sites located in different regions receive reimbursement based on the region where the services are provided.

TN # 10-0018

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Supersedes TN # 98-0028

Effective Date July 1, 2010

**New York  
3(j.1)**

▪ **Units of Service –**

Half Day – minimum two hours

Full Day – minimum four hours

Collateral Visit – minimum of 30 minutes

Preadmission and Group Collateral Visits – minimum of one hour

Crisis Visit – any duration

Cumulative hours are calculated on a monthly basis. A Half Day visit counts as two hours and a Full Day counts as four hours towards an individual's monthly cumulative hours. Time spent during a crisis, collateral, group collateral, or preadmission visit is excluded from the calculation of monthly cumulative hours. Time spent during a crisis, collateral, group collateral, or preadmission visit is also excluded from the minimum service hours necessary for Half Day and Full Day visits.

When the hours of any single visit include more than one rate because the individual surpassed the monthly utilization amount within a single visit, reimbursement is at the rate applicable to the first hour of such visit.

Effective June 1, 2017, reimbursement rates for non-State-operated Continuing Day Treatment Services Providers licensed solely pursuant to Article 31 of the Mental Hygiene Law are as follows:

**Regional Continuing Day Treatment Rates for Freestanding Clinic (Non-State Operated)**

<b><u>Rate Code</u></b>	<b><u>Description</u></b>	<b><u>Downstate Region</u></b>	<b><u>Western Region</u></b>	<b><u>Upstate Region</u></b>
4310	Half Day 1-40 Cumulative Hours	<u>\$31.10</u>	<u>\$28.02</u>	<u>\$27.53</u>
4311	Half Day 41-64 Cumulative Hours	<u>\$23.33</u>	<u>\$23.35</u>	<u>\$23.37</u>
4312	Half Day 65+ Cumulative Hours	<u>\$17.19</u>	<u>\$17.21</u>	<u>\$17.22</u>
4316	Full Day 1-40 Cumulative Hours	<u>\$62.20</u>	<u>\$56.03</u>	<u>\$55.03</u>
4317	Full Day 41-64 Cumulative Hours	<u>\$46.65</u>	<u>\$46.69</u>	<u>\$46.73</u>
4318	Full Day 65+ Cumulative Hours	<u>\$34.37</u>	<u>\$34.40</u>	<u>\$34.43</u>
4325	Collateral Visit	<u>\$31.10</u>	<u>\$28.02</u>	<u>\$27.53</u>
4331	Group Collateral Visit	<u>\$31.10</u>	<u>\$28.02</u>	<u>\$27.53</u>
4337	Crisis Visit	<u>\$31.10</u>	<u>\$28.02</u>	<u>\$27.53</u>
4346	Preadmission Visit	<u>\$31.10</u>	<u>\$28.02</u>	<u>\$27.53</u>

TN 16-0041 Approval Date 11/22/2019

Supersedes TN #10-0018 Effective Date 04/01/2016

**New York  
3(j.1a)**

Effective June 1, 2017, reimbursement rates for State-operated Continuing Day Treatment Services providers licensed solely pursuant to Article 31 of the Mental Hygiene Law are as follows:

**Statewide Continuing Day Treatment Rates for Freestanding Clinics (State-Operated)**

<u>Rate Code</u>	<u>Description</u>	<u>Statewide Rate</u>
<u>4310</u>	<u>Half Day 1-40 Cumulative Hours</u>	<u>\$137.00</u>
<u>4311</u>	<u>Half Day 41-64 Cumulative Hours</u>	<u>\$102.75</u>
<u>4312</u>	<u>Half Day 65+ Cumulative Hours</u>	<u>\$75.35</u>
<u>4316</u>	<u>Full Day 1-40 Cumulative Hours</u>	<u>\$274.00</u>
<u>4317</u>	<u>Full Day 41-64 Cumulative Hours</u>	<u>\$205.50</u>
<u>4318</u>	<u>Full Day 65+ Cumulative Hours</u>	<u>\$150.70</u>
<u>4325</u>	<u>Collateral Visit</u>	<u>\$137.00</u>
<u>4331</u>	<u>Group Collateral Visit</u>	<u>\$137.00</u>
<u>4337</u>	<u>Crisis Visit</u>	<u>\$137.00</u>
<u>4346</u>	<u>Preadmission Visit</u>	<u>\$137.00</u>

TN #10-0018

Approval Date November 1, 2017

Supersedes TN NEW

Effective Date July 1, 2010

**New York  
3(j.2)**

**Continuing Day Treatment Services:****Reimbursement Methodology for Outpatient Hospital Services****Effective June 1, 2017****Definitions:**

- **Group Collateral** - A unit of service in which services are provided to collaterals of more than one individual at the same time. Group Collateral Visit shall not include more than 12 individuals and collaterals. Reimbursement for group collateral visits of 30 minutes or more is provided for each individual for whom at least one collateral is present.
- **Units of Service** - Half Day – Minimum two hours  
Full Day – Minimum four hours  
Collateral Visit – minimum of 30 minutes  
Preadmission and Group Collateral Visits – minimum of one hour  
Crisis Visit – any duration

Cumulative hours are calculated on a monthly basis. A Half Day visit counts as two hours and a Full Day counts as four hours towards an individual's monthly cumulative hours. Time spent during a crisis, collateral, group collateral, or preadmission visit is excluded from the calculation of monthly cumulative hours. Time spent during a crisis, collateral, group collateral, or preadmission visit is also excluded from the minimum service hours necessary for Half Day and Full Day visits.

When the hours of any single visit include more than one rate because the individual surpassed the monthly utilization amount within a single visit, reimbursement is at the rate applicable to the first hour of such visit.

Effective June 1, 2017, reimbursement for Continuing Day Treatment Services providers licensed pursuant to Article 31 of the Mental Hygiene Law and Article 28 of the Public Health Law, are as follows:

**Statewide Continuing Day Treatment Rates for Hospital-based Outpatient Providers (Non-State Operated)**

<b><u>Rate Code</u></b>	<b><u>Description</u></b>	<b><u>Statewide Rate</u></b>
4310	Half Day 1-40 Cumulative Hours	<u>\$41.73</u>
4311	Half Day 41+ Cumulative Hours	<u>\$31.30</u>
4316	Full Day 1-40 Cumulative Hours	<u>\$62.28</u>
4317	Full Day 41+ Cumulative Hours	<u>\$46.71</u>
4325	Collateral Visit	<u>\$41.73</u>
4331	Group Collateral Visit	<u>\$41.73</u>
4337	Crisis Visit	<u>\$41.73</u>
4346	Preadmission Visit	<u>\$41.73</u>

TN 16-0041  
Supersedes TN #10-0018

Approval Date 11/22/2019  
Effective Date 04/01/2016

New York  
3(j.2a)

Reimbursement will include a per-visit payment for the cost of capital, which will be determined by dividing the provider's total allowable capital costs as reported on the Institutional Cost Report (ICR) for its licensed outpatient Mental Health Clinic, Continuing Day Treatment and Day Treatment Services for children, by the sum of the total annual number of visits for all of such services. The per-visit capital payment will be updated annually and will be developed using the costs and visits based on an ICR that is 2-years prior to the rate year. The allowable capital, as reported on the ICR, will also be adjusted prior to the rate add-on development to exclude costs related to statutory exclusions as follows: (1) forty-four percent of the costs of major moveable equipment and (2) staff housing.

TN #10-0018 Approval Date November 1, 2017

Supersedes TN NEW Effective Date July 1, 2010

New York  
3J-A

**Type of Service**

**Method of Reimbursement**

Clinic Treatment for Adults, Clinic  
Treatment for Children, Clinic and Continuing  
Day Treatment Programs

Effective April 1, 2000, OMH will increase the fees paid to certain not-for-profit freestanding clinic and outpatient hospital [and] non-residential programs which are not eligible for reimbursement as comprehensive outpatient programs under the regulations of the Office of Mental Health; and will also increase fees for programs which are designated as comprehensive outpatient programs but absent such fee increase would not be reimbursed at a rate equivalent to the non-comprehensive programs. In return for these fee increases, the non-comprehensive programs will be required to perform additional case management functions, must agree to provide emergency response services for cases deemed "critical", participate in conjunction with other mental health providers in the local planning process set forth in State laws and regulations and provide other additional services as required by OMH. In no instance will these programs be required to perform services greater than those performed by programs designated as comprehensive outpatient programs. The method of reimbursement identified on the page sunsets October 31, 2013.

TN #10-0018

Approval Date November 1, 2017

Supersedes TN #00-0023

Effective Date July 1, 2010

**New York  
3k**

[Type of Service]

**Partial Hospitalization – Freestanding Clinic and Outpatient Hospital Services**

**[Method of] Reimbursement Methodology for Freestanding Clinic and Outpatient Hospital Services**

OMH will establish regional fee schedules which recognize regional cost differences. All fees are subject to approval by the Division of the Budget. There will be limits on the number of service hours reimbursed per individual for each service episode and for a calendar year. This reimbursement methodology sunsets effective May 31, 2017.

**[Comprehensive Outpatient Programs – 14 NYCRR Part 592**

OMH will develop provider specific rate supplements to fees for outpatient mental health programs licensed exclusively by OMH and rates promulgated by OMH for outpatient mental health programs operated by general hospitals and licensed by OMH based upon expenditures approved by OMH to outpatient programs licensed pursuant to 14 NYCRR Parts 585 and 587 which are designated by county mental health departments or OMH.]

Effective June 1, 2017, reimbursement rates for non-State-operated freestanding clinic and outpatient hospital Partial Hospitalization Services providers are as follows:

**Definitions:**

- **Group Collateral** - A unit of service in which services are provided to collaterals of more than one individual at the same time. Group Collateral Visit shall not include more than 12 individuals and collaterals. Reimbursement for group collateral visits is provided for each individual for whom at least one collateral is present.
- **Regions - Long Island:** Nassau and Suffolk counties.  
  - New York City:** Bronx, Kings, New York, Queens, and Richmond counties.
  - Hudson River:** Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington and Westchester counties.
  - Central New York:** Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Fulton, Franklin, Hamilton, Herkimer, Jefferson, Madison, Montgomery, Lewis, Oneida, Onondaga, Oswego, Otsego and St. Lawrence counties.
  - Western New York:** Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates counties.

Providers with program sites located in different regions receive reimbursement based on the region where the services are provided.

- **Units of Service - Partial Hospitalization:**

Service hours shall be determined by rounding to the nearest full hour once the minimum billable period has been reached. No rounding is permitted for crisis or preadmission service hours.

TN #10-0018 Approval Date November 1, 2017

Supersedes TN #92-0030 Effective Date July 1, 2010

**New York  
3k(1)**

**Regional Partial Hospitalization Rates for Freestanding Clinic and Outpatient Hospital**

**Partial Hospitalization Services effective June 1, 2017**

Rate Code	Description	Long Island Region	NYC Region	Hudson River Region	Central Region	Western Region
4349	Service Duration 4 hours	\$116.62	\$153.20	\$128.66	\$88.67	\$109.34
4350	Service Duration 5 hours	\$145.78	\$191.51	\$160.82	\$110.84	\$136.67
4351	Service Duration 6 hours	\$174.93	\$229.81	\$192.99	\$133.01	\$164.01
4352	Service Duration 7 hours	\$204.09	\$268.11	\$225.15	\$155.18	\$191.34
4353	Collateral 1 hour	\$29.16	\$38.30	\$32.16	\$22.17	\$27.33
4354	Collateral 2 hours	\$58.31	\$76.60	\$64.33	\$44.34	\$54.67
4355	Group Collateral 1 hour	\$29.16	\$38.30	\$32.16	\$22.17	\$27.33
4356	Group Collateral 2 hours	\$58.31	\$76.60	\$64.33	\$44.34	\$54.67

**Crisis effective June 1, 2017**

Rate Code	Description	Long Island Region	NYC Region	Hudson River Region	Central Region	Western Region
4357	Crisis 1 hour	\$29.16	\$38.30	\$32.16	\$22.17	\$27.33
4358	Crisis 2 hours	\$58.31	\$76.60	\$64.33	\$44.34	\$54.67
4359	Crisis 3 hours	\$87.47	\$114.90	\$96.49	\$66.50	\$82.00
4360	Crisis 4 hours	\$116.62	\$153.20	\$128.66	\$88.67	\$109.34
4361	Crisis 5 hours	\$145.78	\$191.51	\$160.82	\$110.84	\$136.67
4362	Crisis 6 hours	\$174.93	\$229.81	\$192.99	\$133.01	\$164.01
4363	Crisis 7 hours	\$204.09	\$268.11	\$225.15	\$155.18	\$191.34

**Preadmission effective June 1, 2017**

Rate Code	Description	Long Island Region	NYC Region	Hudson River Region	Central Region	Western Region
4357	Preadmission 1 hour	\$29.16	\$38.30	\$32.16	\$22.17	\$27.33
4358	Preadmission 2 hours	\$58.31	\$76.60	\$64.33	\$44.34	\$54.67
4359	Preadmission 3 hours	\$87.47	\$114.90	\$96.49	\$66.50	\$82.00
4349	Preadmission 4 hours	\$116.62	\$153.20	\$128.66	\$88.67	\$109.34
4350	Preadmission 5 hours	\$145.78	\$191.51	\$160.82	\$110.84	\$136.67
4351	Preadmission 6 hours	\$174.93	\$229.81	\$192.99	\$133.01	\$164.01
4352	Preadmission 7 hours	\$204.09	\$268.11	\$225.15	\$155.18	\$191.34

TN 16-0041 Approval Date 11/22/2019

Supersedes TN #10-0018 Effective Date 04/01/2016

**New York  
3k(2)**

**Comprehensive Outpatient Programs – 14 NYCRR Part 592 - Reimbursement Methodology**

OMH will develop provider specific rate supplements to fees for outpatient mental health programs licensed exclusively by OMH and rates promulgated by OMH for outpatient mental health programs operated by general hospitals and licensed by OMH based upon expenditures approved by OMH to outpatient programs licensed pursuant to 14 NYCRR Parts 585 and 587 which are designated by county mental health departments or OMH. The method of reimbursement identified in this paragraph sunsets on October 31, 2013.

**Day Treatment Services for Children:**

**Reimbursement Methodology for Freestanding Clinics**

**Definitions:**

- **Regions** – New York City: Bronx, Kings, New York, Queens, and Richmond counties.  
Rest of State: All other counties in the State of New York
- **Units of Service** – Full Day, including Preadmission Full Day – More than five hours  
Half Day, including Preadmission Half Day – Three to five hours  
Brief Day – At least one but less than three hours  
Collateral Visit – minimum of 30 minutes  
Crisis Visit – minimum of 30 minutes

Crisis and collateral visits are excluded from the calculation of the service hours required for full, half, and brief days.

Effective June 1, 2017, reimbursement rates for non-State operated Day Treatment Services for Children providers licensed solely pursuant to Article 31 of the Mental Hygiene Law are as follows:

**Regional Day Treatment Services for Children Rates for Freestanding Clinic (Non-State Operated)**

<b>Rate Code</b>	<b>Description</b>	<b>New York City</b>	<b>Rest of State</b>
4060	Full Day	\$98.56	\$95.27
4061	Half Day	\$49.29	\$47.64
4062	Brief Day	\$32.86	\$31.70
4064	Crisis Visit	\$98.56	\$95.27
4065	Preadmission Full Day	\$98.56	\$95.27
4066	Collateral Visit	\$32.86	\$31.70
4067	Preadmission Half Day	\$49.29	\$47.64

TN 16-0041 Approval Date 11/22/2019

Supersedes TN #10-0018 Effective Date 04/01/2016

**New York  
3k(3)**

Effective June 1, 2017, reimbursement rates for State-operated Day Treatment Services for Children providers licensed solely pursuant to Article 31 of the Mental Hygiene Law are as follows:

**Statewide Day Treatment Services for Children Rates for State-Operated Providers**

<u>Rate Code</u>	<u>Description</u>	<u>Statewide Rate</u>
<u>4060</u>	<u>Full Day</u>	<u>\$375.00</u>
<u>4061</u>	<u>Half Day</u>	<u>\$187.85</u>
<u>4062</u>	<u>Brief Day</u>	<u>\$124.55</u>
<u>4064</u>	<u>Crisis Service</u>	<u>\$375.00</u>
<u>4065</u>	<u>Preadmission Full Day</u>	<u>\$375.00</u>
<u>4066</u>	<u>Collateral</u>	<u>\$124.55</u>
<u>4067</u>	<u>Preadmission Half Day</u>	<u>\$187.50</u>

**Day Treatment Services for Children:**

**Reimbursement Methodology for Outpatient Hospital Services**

Effective June 1, 2017, reimbursement rates for hospital-based Day Treatment Services for Children providers licensed pursuant to Article 31 of the Mental Hygiene Law and Article 28 of the Public Health Law, are as follows:

**Definitions:**

- **Regions** – New York City: Bronx, Kings, New York, Queens, and Richmond counties.  
Rest of State: All other counties in the State of New York
- **Units of Service** – Full Day, including Preadmission Full Day – More than five hours  
Half Day, including Preadmission Half Day – Three to five hours  
Brief Day – At least one but less than three hours  
Collateral Visit – minimum of 30 minutes  
Crisis Visit – minimum of 30 minutes

Crisis and collateral visits are excluded from the calculation of the service hours required for full, half, and brief days.

TN #10-0018

Approval Date November 1, 2017

Supersedes TN NEW

Effective Date July 1, 2010

**New York  
3k(4)**

**Regional Day Treatment for Children Rates for Outpatient Hospital Services  
(Non-State Operated)**

<b>Rate Code</b>	<b>Description</b>	<b>New York City</b>	<b>Rest of State</b>
4060	Full Day	<u>\$98.56</u>	<u>\$95.27</u>
4061	Half Day	<u>\$49.29</u>	<u>\$47.64</u>
4062	Brief Day	<u>\$32.86</u>	<u>\$31.70</u>
4064	Crisis Visit	<u>\$98.56</u>	<u>\$95.27</u>
4065	Pre-Admission Full Day	<u>\$98.56</u>	<u>\$95.27</u>
4066	Collateral Visit	<u>\$32.86</u>	<u>\$31.70</u>
4067	Pre-Admission Half Day	<u>\$49.29</u>	<u>\$47.64</u>

Reimbursement will include a per-visit payment for the cost of capital, which will be determined by dividing the provider's total allowable capital costs, as reported on the Institutional Cost Report (ICR) for its licensed outpatient Mental Health Clinic, Continuing Day Treatment and Day Treatment Services for children, by the sum of the total annual number of visits for all of such services. The per-visit capital payment will be updated annually and will be developed using the costs and visits based on an ICR that is 2-years prior to the rate year. The allowable capital, as reported on the ICR, will also be adjusted prior to the rate add-on development to exclude costs related to statutory exclusions as follows: (1) forty-four percent of the costs of major moveable equipment and (2) staff housing.

TN 16-0041 Approval Date 11/22/2019

Supersedes TN #10-0018 Effective Date 04/01/2016

**New York  
3k(5)**

**Effective January 1, 2018:**

**Reimbursement Methodology for Non-State-operated OMH-Licensed Freestanding Clinic and Outpatient Hospital Services, including Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children.**

**I. Minimum Wage Rate Increases**

Effective January 1, 2018 and every January 1 thereafter until the minimum wage reaches the state statutorily described per hour wage shown below, a minimum wage increase percentage will be developed and applied to the rates for OMH-licensed Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children, except rates for State-operated Services.

<u>Minimum Wage Region</u>	<u>12/31/17</u>	<u>12/31/18</u>	<u>12/31/19</u>	<u>12/31/20</u>	<u>12/31/21</u>
<u>New York City (Large employers)</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>New York City (Small employers)</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester counties</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

Rates adjusted by the minimum wage increase percentage will be posted to the OMH Medicaid Reimbursement website at [https://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://www.omh.ny.gov/omhweb/medicaid_reimbursement/). The minimum wage increase percentage will be developed and implemented as follows:

- a. Minimum wage costs mean the additional costs for salary and fringe benefits incurred beginning January 1, 2018, and thereafter, as a result of New York State statutory increases to minimum wage. Minimum wage costs for 2018 for each type of service are developed based on the most current available CFR cost report data and updated annually thereafter through 2022. For 2018, the State used 2014-2015 CFR cost report data and adjusted any wages reported therein below the 12/31/16 minimum wage up to such statutory minimum wage prior to calculating the minimum wage increase percentage.
  - i. The average hourly wages of employees in occupational titles where the calculated average hourly wage, after controlling for overtime, is below the regional statutory minimum wage are identified.
  - ii. The total payroll hours of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the CFR cost report is then subtracted from the projected payroll resulting in the expected minimum wage cost increase attributable to salary.
  - iii. Fringe benefit costs are identified on the CFR and the statewide average fringe benefit percentage is calculated.
  - iv. The fringe benefit percentage is applied to the increased minimum wage costs attributable to salary and the result is then added to the minimum wage cost increase attributable to salary, resulting in total minimum wage costs.
  - v. The total minimum wage cost is divided by total operating expenditures reported in the CFR cost report to derive a minimum wage increase percentage.

**TN #18-0009 Approval Date November 22, 2019**  
**Supersedes TN NEW Effective Date January 1, 2018**

**New York  
3k(6)**

- b. Rates for Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children are adjusted for minimum wage costs by multiplying rates then in effect by the minimum wage increase percentage as determined pursuant to section (a), above.
- c. After the end of each CFR reporting year beginning in 2018, the Office of Mental Health will review providers' CFR submissions to ensure the average hourly wages of employees in all occupational titles comply with minimum wage standards. OMH may reconcile and recoup minimum wage rate increases paid to providers that do not submit their CFRs according to established reporting deadlines or that are found not to be in compliance with wage standards if the Office of Mental Health deems such recoupment to be cost effective. In addition, OMH will investigate provider compliance with applicable labor laws and refer noncompliant providers to the Office of the Medicaid Inspector General.

**II. Direct Support, Direct Care and Clinical Professionals Compensation Increases**

Effective on both January 1, 2018 and April 1, 2018, a direct care compensation increase will be developed and implemented for Direct Support and Direct Care Professionals. Also, effective April 1, 2018, a clinical compensation increase will be developed and implemented for Clinical Professionals. Such increases will apply to the rates for OMH-licensed Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children, except rates for State-operated. Employee wage information is based on 2014-2015 CFR cost report data.

- a. Rate increases effective January 1, 2018 are calculated as follows:
- i. The total wages of employees in Direct Support and Direct Care Professional occupational titles (adjusted by any applicable minimum wage increases) are increased by 3.25%.
  - ii. Such wage increase is divided by the total operating expenditures reported in the CFR to derive a direct care compensation factor.
  - iii. Rates for Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children are adjusted for direct care compensation by multiplying the rates then in effect by the direct care compensation factor calculated pursuant to subsection a(ii).
- b. Rate increases effective April 1, 2018 are calculated as follows:
- i. The total wages of employees in Direct Support and Direct Care Professional occupational titles (adjusted by any applicable minimum wage increases and the increase specified in subsection (a)(i), above) are increased by 3.25%.
  - ii. The total wages of employees in Clinical Professional occupational titles are increased by 3.25%.
  - iii. Wage increases calculated pursuant to subsections (b)(i) and (ii), above are combined and then the sum is divided by the total operating expenditures reported in the CFR to derive a direct care and clinical compensation factor.
  - iv. Rates for Partial Hospitalization and Continuing Day Treatment Services and Day Treatment Services for Children are adjusted for direct care and clinical compensation by multiplying the rates then in effect by the direct care and clinical compensation factor calculated pursuant to subsection b(iii).

TN #18-0009

Approval Date November 22, 2019

Supersedes TN NEW

Effective Date January 1, 2018

**New York**  
**3L**

**TYPE OF SERVICE**

<b>Intensive Psychiatric Rehabilitation Treatment</b>	OMH will develop a flat fee to be approved by the Division of Budget. There will be limits on the number of monthly and calendar year service hours that may be reimbursed per individual. Off-site service reimbursement will all be limited to a percentage of each program's total service hours.
<b>Rehabilitative Services for Residents of Community-based Residential Programs Licensed by the Office of Mental Health</b>	OMH will develop monthly and half-monthly rates for OMH licensed community-based residences of sixteen (16) or fewer beds to provide physician-prescribed rehabilitation services for seriously mentally ill individuals in residences. OMH will develop rates for services provided to eligible residents of congregate-type community residences for both children and adults, apartment-based community residences for adults, family-based treatment programs for children and teaching family homes for children. Rehabilitation services will not include didactic education, vocational services, and room and board.
<b>Program Type 1:</b> 1) Community Residences	
<b>Program Categories</b> a) congregate-type b) apartment-based	
<b>Program Type 2:</b> 1) Family Based Treatment	
<b>Program Type 3</b> 1) Teaching Family Homes	
	Providers of rehabilitation services shall be assigned an individual provider monthly rate based upon their cumulative approved costs for all sites divided by the maximum capacity for their sites divided by 12 months, divided by the specific utilization factor established by the Office of Mental Health for beds in adult congregate programs (85%), adult apartment programs (83%) or for children's residential services programs (82%). Rates for a half month service shall be 50% of the monthly rate. The rate calculated under this methodology will be reduced by \$4 for a full month and \$2 for a half month rate to account for payment for the four Individual Rehabilitation Services at a cost of \$1.00 per service required for a full month and two Individual Rehabilitation Services at a cost of \$1.00 per service required for a half month.
	The rate methodology for rehabilitation services provided in residential programs operated by the Office of Mental Health shall be the same as for other licensed providers except that there shall be one statewide rate which shall be the lower of the calculated rate or the highest rate approved for other providers.

TN   #96-21  Supersedes TN   #94-27  Approval Date   September 23, 1996  Effective Date   May 1, 1996

**New York  
3L-1**

RESERVED

**[Type of Service**

Personalized Recovery Oriented Services:  
(PROS)  
Community Rehabilitation and Support

Providers will be reimbursed through a regionally based, tiered monthly case payment, based on the number of hours of service provided to the individual and his/her collaterals. PROS programs that offer Clinical Treatment as part of the service package will be reimbursed at a higher rate than programs which do not. Programs which do not provide clinical treatment will be expected to provide clinical linkages. PROS clients will be given free choice as to whether they wish to receive clinical treatment through the PROS. PROS providers will need to abide by certain program and billing restrictions if they currently operate a clinic and/or choose to offer optional clinical treatment services within the PROS.

Intensive Rehabilitation

If the client receives Intensive Rehabilitation from a comprehensive PROS, a regionally based monthly case payment will be paid in addition to the Community Rehabilitation and Support case payment. If the client attends a limited license PROS, an Intensive Rehabilitation case payment will be paid.

Ongoing Rehabilitation and Support

If the client receives Ongoing Rehabilitation and Support from a comprehensive PROS, a regionally based monthly case payment will be paid in addition to the Community Rehabilitation and Support case payment. If the client attends a limited license PROS, the Ongoing Rehabilitation and Support case payment will be paid. A program which bills for Intensive Rehabilitation cannot also bill for Ongoing Rehabilitation and Support.]

**New York  
3L-2**

**TYPE OF SERVICE****Personalized Recovery Oriented Services (PROS)**

PROS provider agencies will be reimbursed for Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR) and Ongoing Rehabilitation and Support (ORS) services. A PROS provider agency that has obtained approval from the Office of Mental Health to provide Clinical Treatment Services will be reimbursed for Clinical Treatment Services provided to individuals enrolled in PROS. PROS are provided by provider agencies licensed by the Office of Mental Health. Individual practitioners are not eligible for reimbursement. Only properly documented services provided to eligible individuals who are either enrolled in PROS or in pre-admission status, or to collaterals of an individual enrolled in PROS, will be reimbursed.

Rates of payment for PROS services shall be the same for governmental and non-governmental providers.

**Monthly Base Rate:**

PROS will be reimbursed a tiered regional monthly case payment based on units of service provided to the individual and his/her collaterals. One unit is equal to one hour. Units are accumulated in intervals of 15 minutes.

Daily services provided during the calendar month determine the monthly base rate tier as follows:

- Tier 1: 2 -12 units;
- Tier 2: 13 – 27 units;
- Tier 3: 28 – 43 units;
- Tier 4: 44 – 60 units; and
- Tier 5: 61 or more units per month.

A minimum of two units must be provided during a calendar month for PROS monthly base rate reimbursement. Units are determined by a combination of the number of PROS service components delivered to an individual or collateral during the course of a day and the duration of participation in structured or supervised activities. Participation is measured in 15-minute increments. Increments of less than 15 minutes are rounded down to the nearest quarter hour to determine the program participation for the day.

A minimum of one PROS service component must be delivered to an individual or collateral per day in order to accumulate units. If one PROS service component is delivered, a maximum of two units may be accumulated in a day. If two PROS service components are delivered, a maximum of four units may be accumulated in a day. If three or more PROS service components are delivered, a maximum of five units may be accumulated in a day. The number of PROS units per individual per day cannot exceed five.

**TN #16-0041**  
**Supersedes TN NEW**

**Approval Date** 11/22/2019  
**Effective Date** 04/01/2016

New York  
3L-3

Services provided to an individual must be at least 15 continuous minutes in duration. Services provided in a group format must be at least 30 continuous minutes in duration.

**Capital Reimbursement:**

For a PROS provider that is operated by a hospital licensed pursuant to Article 28 of the Public Health Law, there is an allowance added to the monthly base rate for the cost of capital, which is determined by the application of the principles of cost-finding for the Medicare program. The capital payment is a monthly add-on and is determined by dividing all allowable capital costs of the provider's PROS, after deducting any exclusions, by the annual number of service months for all enrollees of the PROS. Both factors are extracted from the Institutional Cost Report (ICR) submitted annually by hospitals to the New York State Department of Health. The capital payment is updated on a two year rate cycle. The Commissioner of the New York State Office of Mental Health may impose a cap on the revenues generated from the capital add-on.

**Clinical Treatment:**

PROS providers that offer Clinical Treatment receive additional reimbursement for providing Clinical Treatment Services to individuals enrolled in PROS. Reimbursement will be a regional monthly add-on payment. In order to receive reimbursement, the provider must be eligible for the monthly base rate and a minimum of one Clinical Treatment service must be provided during the month. Additionally, individuals enrolled in PROS Clinical Treatment must have, at a minimum, one face-to-face contact with a psychiatrist or psychiatric nurse practitioner every three months or more frequently as clinically appropriate.

TN #16-0041

Approval Date 11/22/2019

Supersedes TN NEW

Effective Date 04/01/2016

New York  
3L-4

**Intensive Rehabilitation (IR):**

In addition to the monthly base rate (and reimbursement for Clinical Treatment, if applicable), PROS providers shall receive an additional monthly add-on for providing at least one IR service to an individual who has received at least six units during the month.

In instances where a PROS provider provides IR services to an individual, but CRS services are provided by another PROS provider or no CRS services are provided in the month, the minimum six units required will be limited to the provision of IR services and only the IR add-on will be reimbursed.

The maximum number of IR add-on payments to a PROS provider shall not exceed 50 percent of that provider's total number of monthly base rate claims reimbursed in the same calendar year.

**Ongoing Rehabilitation and Support (ORS):**

In addition to the monthly base rate (and reimbursement for Clinical Treatment, if applicable), PROS providers shall receive an additional monthly add-on for providing ORS services. Reimbursement requires a minimum of two face-to-face contacts per month, which must occur on two separate days. A minimum contact is 30 continuous minutes in duration. The 30 continuous minutes may be split between the individual and the collateral. At least one visit per month must be with the individual only.

The ORS or IR add-on payment can be claimed independently or in addition to the base rate (and Clinical Treatment, if applicable). ORS and IR will not be reimbursed in the same month for the same individual.

**Pre-admission Screening Services:**

PROS providers will be reimbursed at a regional monthly case payment for an individual in pre-admission status. Reimbursement for an individual in pre-admission status is limited to the pre-admission rate. If the individual receives pre-admission screening services during the month of admission, the base rate is calculated using the entire month but no reimbursement is permitted to Clinical Treatment, IR or ORS.

Reimbursement for pre-admission screening services is limited to two consecutive months.

**PROS Rates of Payment:** PROS rates of payment are available on the OMH website at: [http://www.omh.ny.gov/omhweb/medicaid\\_reimbursement/](http://www.omh.ny.gov/omhweb/medicaid_reimbursement/)

TN   #16-0041  

Approval Date   11/22/2019  

Supersedes TN   NEW  

Effective Date   04/01/2016

New York  
3M

**Assertive Community  
Treatment (ACT)**

Services will be provided primarily in the community by a licensed multi-disciplinary team under the supervision of a psychiatrist which meets with the recipient or the recipient's significant others a minimum of six times per month for full ACT payment, or two times per month for ACT step-down payment. For full ACT payment, at least three of the six contacts must be with the Medicaid recipient. For ACT step-down services, both of the two required contacts must be with the client.

Monthly fees as approved by Division of the Budget will be set by dividing total gross approved costs by twelve months and the number of clients and will include a vacancy factor of 10% OMH will consult with DOH regarding any changes to the fees.

TN   #01-01  

Supersedes TN   NEW  

Approval Date   May 29, 2001  

Effective Date   January 1, 2001

## New York

4

**Laboratory Services**

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates for services listed in this paragraph were set as of June 1, 2010 and are effective for services provided on or after that date. All rates are published on the Department of Health website at the following link:

[https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory\\_Fee\\_Schedule.xls](https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory_Fee_Schedule.xls)

**[Home Health Services/Certified Home Health Agencies**

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.]

TN #08-32 Approval Date September 9, 2011  
Supersedes TN #07-06 Effective Date April 1, 2008

**New York  
4(1)**

**Home Health Services/Certified Home Health Agencies**

Prospective, cost based hourly and per visit rates for five services [shall] will be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period [shall] will be no greater than zero. For rates of payment effective for services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date** September 26, 2019

**Supersedes TN** #17-0034

**Effective Date** April 1, 2019

**New York  
4(2)**

Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, will not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period will be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, will be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

**TN #19-0042** \_\_\_\_\_  
**Supersedes TN #17-0034** \_\_\_\_\_

**Approval Date** September 26, 2019  
**Effective Date** April 1, 2019

**New York  
4(3)**

**Certified home health care agency ceilings.**

- (a) Effective for services provided on and after April 1, 2011 through March 31, 2012, Medicaid payments for certified home health care agencies (agencies), except for such services provided to children under eighteen years of age, shall reflect ceiling limitations determined in accordance with this section. Ceilings for each agency shall be based on a blend of:
- (1) the agency's 2009 average per patient Medicaid claims, weighted at 51 percent, and
  - (2) the 2009 statewide average per patient Medicaid claims for all agencies, as adjusted by the regional wage index factor and by each agency's patient case mix index, and weighted at 49 percent.
- (b) Effective for rate periods on and after April 1, 2011, the Department shall determine, based on 2009 claims data, each agency's projected average per patient Medicaid claim for the period April 1, 2011 through March 31, 2012, as compared to the applicable ceiling, computed pursuant to this section. To the extent that each agency's projected average claim exceeds such ceiling, the Department shall reduce such agency's payments for periods on and after April 1, 2011 by the amount that exceeds such ceiling.
- (c) The regional wage index factor (WIF) will be computed in accordance with the following and applied to the portion of the statewide average per-patient Medicaid claim attributable to labor costs:
- (1) Average wages will be determined for agency service occupations for each of the 10 labor market regions as defined by the New York State Department of Labor.
  - (2) The average wages in each region will be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories as reported in the most recently available agency cost report submissions.

TN #11-50

Approval Date August 25, 2011

Supersedes TN NEW

Effective Date April 1, 2011

**New York**  
**4(4)**

- (3) Based on the average wages as determined pursuant to this subdivision, as weighted pursuant to this subdivision, an index will be determined for each region, based on a comparison of the weighted average regional wages to the statewide average wages.
- (4) The Department will adjust the regional WIFs proportionately, if necessary, to assure that the application of the WIFs is revenue-neutral on a statewide basis.
- (d) Agency specific case mix indexes (CMIs) will be calculated for each agency and applied to the statewide average CMI. Computation of such CMIs will utilize the episodic payment system grouper and will reflect:
- (1) 2009 adjusted agency Medicaid claims as grouped into 60 day episodes of patient care;
  - (2) data for each agency patient as derived from the federal Outcome Assessment Information Set (OASIS) and as reflecting the assignment of such patients to OASIS resource groups;
  - (3) the assignment of a relative weight to each OASIS resource group;
  - (4) the assignment of each agency's CMI index based on the sum of the weights for all of its grouped episodes of care divided by the number of episodes.
- (e) Ceiling limitations determined pursuant to this section will be subject to retroactive adjustment and reconciliation. In determining payment adjustments based on such reconciliation, adjusted agency ceilings will be established. Such adjusted ceilings will be based on a blend of:
- (1) an agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at 51 percent, and;
  - (2) the 2009 statewide average per-patient Medicaid claims adjusted by a regional WIF and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at 49 percent. Such adjusted agency ceiling will be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when an agency's actual per-patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess will be due from each

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**New York**  
**4(5)**

such agency to the state and will be recouped through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, and such agency's actual per-patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling will be remitted to each such agency by the Department in a lump sum amount.

- (f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.
- (g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than \$200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to \$200 million. Such reconciliation will not be subject to subsequent adjustment.
- (h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.
- (i) Effective May 2, 2012[,] through March 31, 2019, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age and [effective May 2, 2012] except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department, will be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences. Effective May 2, 2012[,] through March 31, 2019, such case mix adjustments will include an adjustment factor for CHHAs providing care to Medicaid-eligible patients, more than 50%, but no fewer than two hundred, of whom are eligible for OPWDD services.

The initial statewide episodic base price to be effective May 2, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

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New York  
4(6)

February of 2010, will be included in the base price calculation. Low utilization episodes of care, as defined below, shall be excluded from the base price calculation. For high utilization episodes of care, costs in excess of outlier thresholds shall be excluded from the base price calculation. The remaining costs will be divided by the number of episodes to determine the unadjusted base price. The resulting base price shall be subject to further adjustment as is required to comply with the aggregate savings mandated by paragraph (b) of subdivision 13 of section 3614 of the Public Health Law (PHL). The applicable base year for determining the episodic base price will be updated not less frequently than every three years.

The case mix index applicable to each episodic claim, excluding low utilization claims, shall be based on patient information contained in the federal Outcome Assessment Information Set (OASIS). The patient shall be assigned to a resource group based on data which includes, but is not limited to, clinical and functional information, age group, and the reason for the assessment. A case mix index shall be calculated for each resource group based on the relative cost of paid claims during the base period.

To determine the case mix adjustment factor for agencies providing care to Medicaid-eligible patients of whom more than 50%, and no fewer than 200, are eligible for OPWDD services, total Medicaid claims reimbursement received by each qualified agency during the statutory base year for the Episodic Payment System (calendar year 2009 and subsequently determined base years) will be compared to the projected total reimbursement that would result from applying the episodic methodology to the same services billed in the base year. If the projected episodic reimbursement is less than the actual base year reimbursement, the percentage difference will be applied to the case mix index for all of the agency's episodic claims in order to equalize the traditional fee-for-service and estimated episodic reimbursement totals. All of the provider's episodic rates (which consist of case mix index multiplied by the statewide base price) will be increased by this percentage.

A regional wage index will be calculated for each of the ten labor market regions in New York as defined by the New York State Department of Labor. Average wages will be determined for the health care service occupations applicable to certified home health agencies. The average wages in each region shall be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories reported in the most recently available agency Medicaid cost report submissions. Weighted average wages for each region will be compared to the statewide average wages to determine an index for each region. The wage index will be applied to the portion of each payment which is attributable to labor costs. If necessary, the Department will adjust the regional index values proportionately to assure that the application of the index values is revenue-neutral on a statewide basis.

Payments for low utilization cases shall be based on the statewide weighted average of fee-for-service rates for services provided by certified home health agencies, as adjusted by the applicable regional wage index factor. Low utilization cases will be defined as 60-day episodes of care with a total cost of \$500 or less, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, calculated prior to the application of the regional wage index factor.

TN #15-0029 Approval Date August 26, 2015  
Supersedes TN #12-0019 Effective Date April 1, 2015

**New York  
4(7)**

Payments for 60-day episodes of care shall be adjusted for high-utilization cases in which total costs, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, exceed outlier cost thresholds determined by the Department for each case mix group. In such cases the provider will receive the adjusted episodic base payment, plus 50% of the total costs which exceed the outlier threshold. Both the base payment and the excess outlier payment will be adjusted by the regional wage index factor. The percentage of excess costs to be reimbursed shall be subject to such further adjustment as deemed necessary to comply with the aggregate savings mandated by PHL section 3614(13)(b).

The outlier threshold for each resource group shall be equal to a specified percentile of all episodic claims totals for the resource group during the base period, excluding low utilization episodes. Such percentiles shall range from the seventieth percentile for groups with the lowest case mix index to the ninetieth percentile for groups with the highest case mix index.

Services provided to maternity patients, defined as patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy, may be reimbursed pursuant to this section without the submission of the patient information contained in the federal Outcome Assessment Information Set (OASIS), provided that providers billing for such services must bill in accordance with such special billing instructions as may be established by the Commissioner, and such patients shall receive a case mix designation based on the lowest acuity resource group.

Payments for episodes of care shall be proportionately reduced to reflect episodes of care totaling less than 60 days provided, however, that CHHAs will receive reimbursement for a full episode of care if the episode totaled less than 60 days and the patient was discharged to the home, to a hospital, or to a hospice, or if the episode ended due to the death of the patient. Payments will be proportionately reduced if the patient transferred to a different CHHA before the end of the 60-day episode.

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Supersedes TN     #11-0051     Effective Date     April 1, 2015

New York  
4(8)

For services provided on and after May 1, 2012[,] through March 31, 2019, please see the website below for detailed information, which includes information related to the following components of payments for 60-day episodes of care including (as posted on March 14, 2012):

- Definition of 60-day episode of care
- Base price
- Resource groups
- Case mix indices
- Outlier thresholds
- Regional wage index factors
- Weighted average rates used to calculate total costs

[www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/index.htm](http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/index.htm)

For periods on and after March 1, 2014, the Commissioner of Health will increase Medicaid rates of payment for services provided by certified home health agencies (CHHA) to address cost increases stemming from the wage increases required by implementation of the provisions of section 3614-c of the Public Health Law.

The payment increase for CHHA episodic rates will equal the difference between the minimum per hour rate and the weighted average home health aide rate reflected in the 2009 episodic expenditure base[,] and subsequently determined episodic base periods. This amount will be further adjusted for accurate application to the episodic bundled payment to insure the adjustment is applied to the estimated home health aide portion of the episodic payment and not to the estimated professional nursing and therapy services portions of the payment. An adjustment is also made to reflect the minimum home health aide rate in the low utilization and outlier components of the rate calculation.

For CHHA non-episodic rates (the payment for qualified individuals under 18 years of age), an add-on will be provided which represents the difference between the home health hourly rate in the current rate and the minimum home health aide hourly rate.

TN #15-0029 Approval Date August 26, 2015  
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**New York**  
**4(8)(1)**

**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 Certified Home Health Agency (CHHA) Rate.

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 (Large Employers)	\$11.00	\$13.00	\$15.00	\$15.00	\$15.00	\$15.00
New York City (Small employers)	\$10.50	\$12.00	\$13.50	\$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	\$12.50

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.
2. The 2017 facility specific minimum wage add-on will be developed based on collected survey data received and attested to by CHHA providers. If a provider does not submit a survey, the minimum wage add-on will be calculated based on the Provider's cost report wage data from two years prior to the period being calculated. If a facility fails to submit both the attested survey and the cost report, the facility's minimum wage add-on will not be calculated.
  - i. Minimum wage cost development based on survey data collected.
    1. Survey data will be collected for facility specific wage data.
    2. 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.
    3. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
    4. 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 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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**New York**  
**4(8)(1)(a)**

3. For pediatric rates the provider specific cost amount will be divided by hours to arrive at a rate per diem add on for Home Health aides which will be applied to only Medicaid hours for purposes of Medicaid reimbursement.

For episodic rates the provider specific cost amount will be divided by patient episodes to arrive at a rate per 60-day episode. This will be applied to only Medicaid episodes 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 provider fails to submit the minimum wage survey the calculation for minimum wage costs will default to the personnel wage data reported on the provider's latest available CHHA cost report. If a provider fails to submit both the survey and the CHHA cost report its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the CHHA 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 the provider may request an extension. 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.

i. 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.

ii. 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.)

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**Supersedes TN**           NEW          

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**New York  
4(8)(1)(b)**

iii. 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.

iv. 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.

CHHA provider rates are available on the following website:

[www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/](http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/)

**TN**           #17-0009          

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**New York  
4(9)**

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Certified Home Health Agencies (CHHAs)**

A temporary rate adjustment will be provided to eligible CHHA providers that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible CHHA providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed.

**Certified Home Health Agencies:**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
Visiting Nurse Association of Long Island, Inc.	\$168,006	01/01/2014 – 03/31/2014
	\$672,020	04/01/2014 – 03/31/2015
	\$672,020	04/01/2015 – 06/30/2015
<u>Jefferson County Public Health Service</u>	<u>\$63,306</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$253,222</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$253,222</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$189,916</u>	<u>04/01/2016 – 12/31/2016</u>

TN #13-0071A

Approval Date August 26, 2015

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Effective Date January 1, 2014

**New York  
4(10)**

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Licensed Home Care Services Agencies (LHCSA)**

A temporary rate adjustment will be provided to eligible LHCSA providers that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible LHCSA providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being [equal to one fourth of] equally divided for the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed.

**Licensed Home Care Services Agencies:**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
North Country Homes	\$1,045,000	02/01/2016 – 3/31/2016
	\$1,621,300	04/01/2016 – 3/31/2017
	\$ 46,200	04/01/2017 – 3/31/2018
	\$ 450,000	07/01/2017 – 03/31/2018
	\$1,500,000	05/10/2018 – 03/31/2019

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Approval Date   August 10, 2018  

Supersedes TN   #17-0051  

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New York  
4(a)

For the rate periods on and after January 1, 2005 through December 31, 2006, and April 1, 2007 through March 31, 2009, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

In addition, separate payment rates for nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall be established based upon regional services prices. Such prices shall be computed based upon average nursing costs per visit calculated by aggregating base year allowable costs and statistics reported by certified home health agencies within each of four state regions, and increased by a case mix adjustment factor which represents the relative ratio of additional resources needed to provide home care nursing services to AIDS patients when compared to the average case mix of home care patients. Such AIDS regional nursing prices will be trended annually.

Effective for services provided on and after April 1, 2011, separate payment rates will no longer be established for nursing services provided to patients diagnosed with AIDS; the rate for nursing services provided to patients diagnosed with AIDS will be the prospective certified home health agency rate for nursing services established for the effective period.

The Commissioner shall adjust medical assistance rates of payment for services provided by AIDS home care programs for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

Rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

Providers which have their rates adjusted for this purpose shall use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers shall be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted

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New York  
4(a)(i)

volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

The Commissioner of Health will additionally adjust rates of payment for AIDS home care service providers, for the purpose of improving recruitment and retention of home health aides or non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each AIDS home care service provider's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. The total aggregate available funding for AIDS home care service providers is as follows:

- For the period June 1, 2006 through December 31, 2006 - \$540,000.
- For the period January 1, 2007 through June 30, 2007 - \$540,000.
- For the period July 1, 2007 through March 31, 2008 - \$1,080,000.
- For the period April 1, 2008 through March 31, 2009 - \$1,080,000.
- For the period April 1, 2009 through March 31, 2010 - \$1,080,000.
- For the period April 1, 2010 through March 31, 2011 - \$1,080,000.
- For the period April 1, 2011 through March 31, 2012 - \$1,080,000.
- For the period April 1, 2012 through March 31, 2013 - \$1,080,000.
- For the period April 1, 2013 through March 31, 2014 - \$1,080,000.
- For the period June 5, 2014 through March 31, 2015 - \$1,080,000.
- For the period April 1, 2015 through March 31, 2016 - \$1,080,000.
- For the period April 1, 2016 through March 31, 2017 - \$1,080,000.
- For the period April 1, 2017 through March 31, 2018 - \$1,080,000.
- For the period April 1, 2018 through March 31, 2019 - \$1,080,000.
- For the period April 1, 2019 through March 31, 2020 - \$1,080,000.

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

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Supersedes TN #14-0025

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New York  
4(a)(i)(A)

Funds received through this program are to be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Each agency receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The Commissioner is authorized to audit each such agency or program to ensure compliance with this written certification and may recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**[Accessibility, Quality, and, Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by AIDS home care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for all eligible providers in an aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Criminal Background Checks for AIDS Home Care Program Providers**

Effective April 1, 2005, AIDS home care program providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record]

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New York  
4(a)(i)(1)

**Accessibility, Quality, and Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by AIDS home care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for all eligible providers in an aggregate of \$16,000,000 annually for the period June 1, 2006 through March 31, 2007, July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Criminal Background Checks for AIDS Home Care Program Providers**

Effective April 1, 2005, AIDS home care program providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record

TN <u>  #11-15  </u>	Approval Date <u>  September 7, 2011  </u>
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**New York**  
**4(a)(i)(2)**

check, including, but not limited to, a finger print card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through [March 31, 2007] August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data is unavailable, payment will be based on budgeted costs and subsequently prospectively adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than [\$13,4000,000] \$5,600,000 for the April 1, 2006 through [March 31, 2007] August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally based on each eligible provider's reported costs for criminal background checks to the total costs of criminal background checks of all eligible providers.

Effective September 1, 2006. AIDS home care program providers shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information consists of both a state and a national criminal history check.

AIDS home care program providers may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and the administrative costs associated with obtaining the fingerprints and completing the fingerprint cards. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period. The proportionate costs for criminal background checks will be allocated to Medicaid based on the percent of Medicaid utilization of services provided to the total services provided for all payers, services being defined as units of service (i.e. hours or visits). The costs allocated to Medicaid will be divided by the Medicaid units of service for the period two years prior to the rate year to constitute the rate add-on.

TN <u>  #06-70  </u>	Approval Date <u>  June 18, 2007  </u>
Supersedes TN <u>  #06-53  </u>	Effective Date <u>  September 1, 2006  </u>

New York  
4(a)(i)(3)

**Personal Emergency Response Services**

Reimbursement for Personal Emergency Response Services (PERS) will be provided under the auspices of SDSS through contractual arrangements between the LDSS and the provider. Locally negotiated rates must include the costs for renting or leasing PERS equipment, the installation, maintenance, and the removal of PERS equipment from the clients home. A second rate must also be negotiated by the local district for a monthly monitoring service charge. These two rates must not exceed the local prevailing rate or the SDSS established cap.

For the period April 1, 1995 through March 31, 1996, the Department of Social Services in consultation with the Department of Health shall establish a state share medical assistance cost savings target for each certified home health agency, which is to be achieved as a result of the agency's development and implementation of personal emergency response services and shared aide efficiency initiatives. The aggregate of such state share targets shall not exceed fifteen million five hundred thousand dollars.

**Services Provided To Medically Fragile Children**

For purposes of this section, a medically fragile child shall mean a child, up to twenty-one years of age, who is at risk of hospitalization or institutionalization for reasons that include but are not limited to the following: children who are technologically-dependent for life or health-sustaining functions; require complex medication regimen or medical interventions to maintain or improve their health status; or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. These children are capable of being cared for at home if provided with appropriate home care services including but not limited to continuous nursing services.

For the period beginning January 1, 2007 and thereafter [through December 31, 2010], rates of payment for continuous nursing services for medically fragile children provided by a certified home health agency, or by registered nurses or licensed practical nurses who are independent providers, shall be established to ensure the availability of such services, and shall be established at a rate that is thirty percent higher than the provider's current rate for private duty nursing services. A certified home health agency that receives such rates for continuous nursing services for medically fragile children shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide these services. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

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Supersedes TN #08-28 Effective Date January 1, 2011

New York  
4(a)(i)(4)

**Home Telehealth Services**

Beginning October 1, 2007, the Commissioner of Health is authorized to establish fees to reimburse the cost of home telehealth services provided by a certified home health agency, including those that provide AIDS home care services.

The Commissioner shall reimburse for telehealth services if such services are provided only in connection with federal Food and Drug Administration approved and interoperable devices, which are incorporated as part of a patient's plan of care.

The purpose of providing telehealth services shall be to assist in the effective monitoring and management of patients whose medical, functional, and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Reimbursement for home telehealth services is to be provided for Medicaid patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute long term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

Rates established by the Commissioner of Health and approved by the Director of the Budget shall reflect telehealth services costs on a daily basis to account for daily variation in the intensity and complexity of patients' telehealth service needs. Such rates shall further reflect the cost of the daily operation and provision of such services including the following functions performed by a participating certified home health agency:

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**New York  
4(a)(i)(5)**

- (i) monitoring of patient vital signs;
- (ii) patient education;
- (iii) medication management;
- (iv) equipment maintenance; and
- (v) review of patient trends and/or other changes in patient condition necessitating professional intervention.

Daily rates for home telehealth services provided to Medicaid patients shall not exceed \$9.65 per day per patient for clients with a class 2 device capable of interoperability and \$11.08 per client per day for clients with a device connected to a home care point of care system. A one time installation fee of \$50 shall also be payable for devices installed in client homes on and after October 1, 2007.

All providers will be required to disallow any cost (nursing or equipment) related to the provision of the telehealth service from the base year cost utilized to determine rates for other cost based CHHA services such as nursing and home health aide.

Effective for services on or after October 1, 2007, the following uniform fees will be paid by governmental and non-governmental providers:

- Installation                      \$50 per installation
- Daily Monitoring – Type 1      \$8.88 per day
- Daily Monitoring – Type 2      \$10.19 per day

TN #07-45

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Supersedes TN NEW

Effective Date October 1, 2007

**New York  
4(a)(i)(6)**

**Telehealth Services – Store and Forward**

The Commissioner of Health is authorized to establish fees, approved by the Director of the Budget, to reimburse the cost of consultations [in the specialty areas of ophthalmology and dermatology] provided via telehealth store and forward technology.

Telehealth store and forward technology involves the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a [qualified physician, nurse practitioner, midwife, or physician assistant,] provider at an originating site to a consulting [physician] provider at a distant site without the patient present. Reimbursement for telehealth store and forward services is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

[The Commissioner shall reimburse for telehealth store and forward technology if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient's plan of care.]

Reimbursement will be made to the consulting [physician] provider. Telehealth store and forward technology is reimbursed at [50] 75% of the applicable [physician] fee for the evaluation and management code that applies. [The physician] Provider fee schedules can be found at

<https://www.emedny.org/ProviderManuals/index.aspx>

[<https://www.emedny.org/ProviderManuals/Physician/>]

TN <u>18-0043</u>	Approval Date <u>07/18/2018</u>
Supersedes TN <u>#16-0015</u>	Effective Date <u>04/01/2018</u>

**New York  
4(a)(i)(7)****Telehealth Services – Remote Patient Monitoring**

Rates established by the Commissioner of Health and approved by the Director of the Budget [shall] will reflect telehealth remote patient monitoring costs on a [daily] monthly basis when medically necessary remote patient monitoring has taken place. A [daily] monthly fee will be paid to the ordering telehealth provider for each [day] month the telehealth remote patient monitoring equipment is used to monitor/manage the patient's care. [This amount will not exceed a designated monthly rate.]

Effective for services on or after [June 1, 2016] April 1, 2018, rates for remote patient monitoring [shall] will be the amount billed by the provider not to exceed \$48.00 per [day] month. The [maximum rate] minimum time that may be billed for remote patient monitoring is 30 minutes per month per patient [shall not exceed \$32.00]. Services less than 30 minutes are not eligible for reimbursement.

TN #18-0043Approval Date 07/18/2018Supersedes TN # 16-0015Effective Date 04/01/2018

New York  
4(a)(ii)

The Department of Health shall calculate an adjustment to the approved rate of payment for the period July 1, 1995 to December 31, 1995, for each such agency by an amount sufficient to achieve its agency-specific savings target, as established by the Department of Social Services, prior to March 31, 1996. Such adjustment shall not be considered a rate change or rate adjustment, but shall serve as an off set of payments to the agency against its liability to the state for savings to be achieved under its agency-specific target, as established by the Department of Social Services.

On or before January 1, 1996, the Department of Social Services shall notify agencies of the progress made toward reaching the specific targets, including information on the number of new clients being served, the types of services provided, and the amount of any state funds which have been offset from their rates and applied to the agency target. Any agency that believes that the offset of its payments was incorrect may request the Commissioner of the Department of Social Services to review its payments by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, the Commissioner of the Department of Social Services finds that the payments were incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any account incorrectly offset, as soon as possible, but in no event later than June 30, 1996.

As soon as practicable after March 31, 1996, the Commissioner of Social Services shall review the total payments made to each such agency; the amount of the offset from payments otherwise due the agency; and the total savings actually achieved by the agency as a result of the agency's development and implementation of personal emergency response systems and share aide efficiencies initiatives. If the Commissioner of Social Services determines that payments to any agency were offset in an amount greater than was necessary to meet its agency-specific savings target given the agency's actual savings achieved, the Commissioner of Social Services shall authorize payment of such amount to such agency, as soon as possible, but in no event later than June 30, 1996. Any agency dissatisfied with the determination of the Commissioner of Social Services may request the Commissioner of Social Services to review its payments, offsets and savings achieved by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, such Commissioner finds that the determination was incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any amount incorrectly offset, as soon as possible, but in no event later than September 30, 1996.

TN     #05-25    

Approval Date     March 22, 2006    

Supersedes TN     #05-20    

Effective Date     April 1, 2005

**New York  
4(a)(iii)**

Effective for the period August 1, 1996 through November 30, 2009, certified home health agencies (CHHAs) will be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period will mean January 1, 1998 through November 30, 1998, the 1999 target period will mean January 1, 1999 through November 30, 1999, the 2000 target period will mean January 1, 2000 through November 30, 2000, the 2001 target period will mean January 1, 2001 through November 30, 2001, the 2002 target period will mean January 1, 2002 through November 30, 2002, the 2003 target period will mean January 1, 2003 through November 30, 2003, the 2004 target period will mean January 1, 2004 through November 30, 2004, the 2005 target period will mean January 1, 2005 through November 30, 2005, the 2006 target period will mean January 1, 2006 through November 30, 2006, the 2007 target period will mean January 1, 2007 through November 30, 2007, the 2008 target period will mean January 1, 2008 through November 30, 2008, and the 2009 target period will mean January 1, 2009 through November 30, 2009, and the 2010 target period will mean January 1, 2010 through November 30, 2010, and the 2011 target period will mean January 1, 2011 through November 30, 2011, and the 2012 target period will mean January 1, 2012 through November 30, 2012 and the 2013 target period will mean January 1, 2013 through November 30, 2013, and the 2014 target period will mean January 1, 2014 through November 30, 2014, and the 2015 target period will mean January 1, 2015 through November 30, 2015, and the 2016 target will mean January 1, 2016 through November 30, 2016, and the 2017 target period will mean January 1, 2017 through November 30, 2017, and the 2018 target will mean January 1, 2018 through November 30, 2018, and the 2019 target period will mean January 1, 2019 through November 30, 2019, and the 2020 target period will mean January 1, 2020 through November 30, 2020, and the 2021 target period will mean January 1, 2021 through November 30, 2021, and for each subsequent target period thereafter the period will mean January through November of the target period year or receive a reduction in their Medicaid payments. For this purpose, regions will consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency will be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group will mean all those CHHAs located within a region. Medicaid revenue percentage will mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

**TN #19-0042**

**Supersedes TN #17-0034**

**Approval Date September 26, 2019**

**Effective Date April 1, 2019**

**New York  
4(a)(iii)(A)**

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate will be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014, prior to February 1, 2015, prior to February 1, 2016, prior to February 1, 2017, prior to February 1, 2018, [and] prior to February 1, 2019, prior to February 1, 2020 and prior to February 1 of each year thereafter, for each regional group, the Commissioner of Health will calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage will be calculated.

For each regional group, the 1996 target Medicaid revenue percentage will be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region;
- and,
- six-tenths of one percentage point for CHHAs located within the upstate region.

**TN**     **#19-0042**      
**Supersedes TN**     **#17-0034**    

**Approval Date**     **September 26, 2019**      
**Effective Date**     **April 1, 2019**

**New York  
4(a)(iv)**

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, and 2019, for each regional group, the target Medicaid revenue percentage for the respective year will be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;  
and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage will be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor will be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, will not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor will be zero. For each regional group, the 1996 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

**TN**     #19-0042    

**Supersedes TN**     #17-0034    

**Approval Date**     September 26, 2019    

**Effective Date**     April 1, 2019

**New York  
4(a)(iv)(1)**

For each regional group reduction, if the 1996 reduction factor will be zero, there will be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health will compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, will be called the reduction factor for such respective year. These amounts, expressed as a percentage, will not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year will be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, the reduction factor for the respective year will be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

**TN**     #19-0042      
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**New York  
4(a)(iv)(2)**

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there will be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region;

five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there will be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion will be multiplied by the applicable 1996 state share reduction amount. This amount will be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, the state share reduction amount for the respective year will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion will be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount will be called the provider specific state share reduction amount for the applicable year.

**New York  
4(a)(v)**

The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, respectively, will be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs will submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health will calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated will be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference will be refunded to the CHHA by the state no later than July 15, 1997. CHHAs will submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA will be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health will reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, will be prorated by the Commissioner of Health for the period April 1, 2007 through March 31, 2009.

**TN**     #19-0042      
**Supersedes TN**     #17-0034    

**Approval Date**     September 26, 2019      
**Effective Date**     April 1, 2019

**New York  
4(a)(vi)**

**Certified Home Health Care Agency – Insurance Costs**

The Commissioner of Health is authorized to provide for increased payments to certified home health agencies to support increased employee fringe benefit costs associated with the agencies' provision of enhanced health care coverage for their employees.

The cost of such health care related increased employee fringe benefits is a reimbursable cost for eligible certified home health agencies. Eligible home care agencies [, as determined by the Commissioner of Health,] are those agencies whose workers are employed in cities within the state which have populations in excess of one million persons [and] or counties within the state which have populations in excess of [one million persons] nine hundred thousand persons if the county is located within the metropolitan commuter transportation district and meet the following conditions: (a) at least fifty percent of the [persons receiving services from] actual total hours of service for the period July 1, 2007 through March 31, 2008 provided by such employers are provided to recipients of medical assistance; and (b) the employer contributes to a group health insurance plan or employer based group health plan on behalf of such employees[; and (c) no benefits are provided under the group health insurance plan or employer based group health plan in excess of the benefits provided to the majority of hospital workers in the community in which the home health care workers are employed].

[Total] Medicaid payments to eligible home care agencies are based on total funds available for this program, allocated proportionately by Medicaid hours of service provided by each eligible provider, [the documented approved costs of the eligible agency for group health insurance premiums paid for their employed home care attendants and allocable to the Medicaid hours of service provided by such employees.] Payments may, in the aggregate, and on an annual basis, be no more than \$58,000,000 provided however, that for the period October 2 through December 31, 2003, the amount will increase by \$105,000,000; and for annual periods [on and after] January 1, 2004 through June 30, 2007, the amount of funding shall be no more than \$163,000,000 in the aggregate. For the period July 1, 2007 through March 31, 2008, the amount of funding shall be \$122,300,000 in the aggregate for all eligible certified home health agencies and personal care providers. Rates of payment shall be adjusted for eligible providers and allocated proportionally [to reflect the Medicaid share of the approved costs] based on the [proportional] relationship of the provider's Medicaid annual hours of service [care rendered to Medicaid beneficiaries] to the total Medicaid annual hours of service [care] rendered [to] by all of the providers [patients]

TN #07-32

Approval Date April 8, 2008

Supersedes TN #05-49

Effective Date July 1, 2007

**New York  
4(a)(vi)(A)**

based upon each provider's actual Medicaid hours of service for which payment has been made by the State's Medicaid Management Information System for the period July 1, 2007 through March 31, 2008.

Eligible providers shall use such funds solely for the purpose of supporting health insurance coverage for their employees and are prohibited from using such funds for any other purpose. The Commissioner is authorized to audit such providers for the purpose of ensuring compliance and shall recoup any funds determined to have been used for purposes other than those authorized.

[The Commissioner may modify the amounts made available for any specific annual period so long as the total amount made available for the period is not exceeded.] The effective period is January 1, 2000 through [June 30, 2007] March 31, 2008.

TN #07-32

Supersedes TN NEW

Approval Date April 8, 2008

Effective Date July 1, 2007

New York  
4(a)(vii)

The Commissioner of Health is authorized to require group health insurance plans and employer based group health plans to report to the Department, insofar as such reporting does not violate any provisions the Federal Employee Retirement Income Security Act (ERISA), at such times and in such manner as the Commissioner shall decide, any information needed [to operate such a demonstration project], including but not limited to, the number of people in such plans who become ineligible each month for the continuation coverage described herein. In addition, every certified health maintenance organization and every insurer licensed by the Superintendent of Insurance shall submit reports in such form and at such times as may be required [to implement this demonstration].

**Recruitment And Retention**

The Commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December 1, 2002.

Rates of payment by governmental agencies for certified home health agency services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

Providers, which have their rates adjusted for this purpose shall use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers shall be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

TN     #05-49     Approval Date     November 21, 2006      
Supersedes TN     #03-57     Effective Date     July 1, 2005

**New York  
4(a)(viii)**

**Criminal Background Checks for Certified Home Health Agencies**

Effective April 1, 2005, certified home health agencies must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record check, including, but not limited to, a finger print card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through [March 31, 2007] August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years, respectively. For new providers or existing providers for which cost report data is unavailable, payment will be based on budgeted costs and subsequently adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than [\$13,400,000] \$5,600,000 for the April 1, 2006 through [March 31, 2007] August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally based on each eligible provider's reported costs for criminal background checks to the total costs of criminal background checks of all eligible providers.

Effective September 1, 2006, certified home health agencies shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information consists of both a state and a national criminal history check.

Certified home health care agencies may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant of law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and the administrative costs associated with obtaining the fingerprints and completing the fingerprint cards. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period. The proportionate costs for criminal background checks will be allocated to Medicaid based on the percent of Medicaid utilization of services provided to the total services provided for all payers, services being defined as units of service (i.e. hours or visits). The costs allocated to Medicaid will be divided by the Medicaid units of service for the period two years prior to the rate year to constitute the rate add-on.

TN <u>#06-70</u>	Approval Date <u>June 18, 2007</u>
Supersedes TN <u>#06-53</u>	Effective Date <u>September 1, 2006</u>

**New York  
4(a)(viii)(1)**

**Recruitment and Retention of Direct Patient Care Personnel**

The Commissioner of Health will additionally adjust rates of payment for certified home health agencies, for purposes of improving recruitment and retention of home health aides or [other] non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each certified home health agency's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. For home health services paid under the episodic payment system, allocation of the recruitment and retention payment is included in episodic payment prices paid under that system. The total aggregate available funding for all eligible certified home health agency providers is as follows:

For the period June 1, 2006 through December 31, 2006 - \$20,100,000.  
 For the period January 1, 2007 through June 30, 2007 - \$20,100,000.  
 For the period July 1, 2007 through March 31, 2008 - \$40,200,000.  
 For the period April 1, 2008 through March 31, 2009 - \$40,200,000.  
 For the period April 1, 2009 through March 31, 2010 - \$40,200,000.  
 For the period April 1, 2010 through March 31, 2011 - \$40,200,000.  
 For the period April 1, 2011 through March 31, 2012 - \$40,200,000.  
 For the period April 1, 2012 through March 31, 2013 - \$40,200,000.  
 For the period April 1, 2013 through March 31, 2014 - \$40,200,000.  
 For the period June 5, 2014 through March 31, 2015 - \$26,736,000.  
 For the period April 1, 2015 through March 31, 2016 - \$26,736,000.  
 For the period April 1, 2016 through March 31, 2017 - \$26,736,000.  
~~For the period April 1, 2017 through March 31, 2018 - \$26,736,000.~~  
~~For the period April 1, 2018 through March 31, 2019 - \$26,736,000.~~  
~~For the period April 1, 2019 through March 31, 2020 - \$26,736,000.~~

Payments made pursuant to this section will not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

TN     #17-0042    

Supersedes TN     #14-0025    

Approval Date     September 26, 2017    

Effective Date     April 1, 2017

**New York  
4(a)(ix)**

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

Funds received through this program are to be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Each agency receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The Commissioner is authorized to audit each such agency or program to ensure compliance with this written certification and may recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Accessibility, Quality, and, Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by certified home health agencies for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased used of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;

TN   #08-31   Approval Date   April 9, 2009    
Supersedes TN   #07-13   Effective Date   April 1, 2008

**New York  
4(a)(x)**

(iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for all eligible providers in an [amount up to an] aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, [and] July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as [determined] calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #08-33 Approval Date March 20, 2009  
Supersedes TN #07-13 Effective Date June 1, 2008

New York  
4(b)

**Home Health Services  
Community and Residential Based  
Certified Home Health Agencies  
Under Article 36 of the Public  
Health Law**

An allowance will be established annually and added to Medicaid rates of payment for certified agencies which can demonstrate a financial shortfall as a result of providing services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publically-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies.

~~[For purposes of establishing rates of payment by governmental agencies for certified home health agencies for rate the periods beginning on or]~~

TN     #95-25     Approval Date     February 11, 1999      
Supersedes TN     #92-25     Effective Date     April 1, 1995

New York  
4(c)

~~[after January first, nineteen hundred ninety five, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as a base year in determining rates of payment, shall not exceed thirty percent of total reimbursable base year operational costs of such provider of services.]~~

TN   #95-25  

Approval Date   February 11, 1999  

Supersedes TN   #93-25  

Effective Date   April 1, 1995

**New York  
4(c)(1)**

**[Type of Service]****[Method of Reimbursement]****Assisted Living Programs**

[In accordance with Public Health law section 3614(6) and 10 NYCRR Subpart 86-7, the Commissioner of Health and subject to approval for the State Director of the Budget, establishes per diem payment rates that] The per diem rates described below are payment-in-full for the [Title XIX] [P]personal [C]care [S]services that the Assisted Living Program (ALP) provides directly or through contracts with [a Long Term Home Health Care Program,] a certified home health agency (CHHA) or other qualified provider[s]; nursing services, home health aide services, physical therapy, occupational therapy, speech therapy and medical supplies and equipment not requiring prior approval, personal emergency response services, and adult day health care provided in a program approved by the Commissioner of Health. In addition to the provision of any of these needed home care services, the ALP is responsible for the overall case management of individuals participating in the program. Case management functions that are the responsibility of the ALP can be found on the eMedNY website at:

[www.emedny.org/ProviderManuals/AssistedLiving/PDFs/ALP\\_Policy\\_Section.pdf](http://www.emedny.org/ProviderManuals/AssistedLiving/PDFs/ALP_Policy_Section.pdf)

Payment rates are established for 1992 for each of sixteen patient classification groups in each of sixteen regions, and the 1992 payment rates [are] were increased by a roll factor for each subsequent year through 2011. The payment rates are related to fifty percent of the amounts which otherwise would have been expended to provide the appropriate level of care in a residential health care facility (RHCF) in the applicable regions and consist of a direct component and other than direct component. For 1992, the direct and other than direct components for each patient classification group in each of sixteen regions are summed and multiplied by fifty percent. For subsequent calendar years through 2011, the 1992 payment rates are increased by the applicable roll factor, pursuant to Department regulations for the Assisted Living Program under the Adjustments to Rate of Payment section and for Residential Health Care Facilities under the Adjustments to Basic Rate section. [Payment rates cannot exceed prevailing charges in the locality.] ALP per diem rates can be found on the Department of Health website at:

[http://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/alp/](http://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/)

**Reimbursement for ALP preadmission assessments:**

The reimbursement rate for preadmission assessments conducted directly by the ALP will be equal to the statewide weighted average rate for CHHA nursing visits in effect on January 1 of the year of the preadmission assessment.

The average CHHA nursing visit reimbursement rates (effective for ALP preadmission assessments) can be found on the Department of Health website at:

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/episodic/eps\\_weighted\\_average\\_rates.htm](https://www.health.ny.gov/facilities/long_term_care/reimbursement/episodic/eps_weighted_average_rates.htm)

TN#:                     #12-0022                          Approval Date:   3/27/18  

Supersedes TN#:                     #97-0010                          Effective Date:   4/26/12

**New York  
4(c)(1.1)**

**Assisted Living Programs**

Beginning January 1, 2017, and every January 1 thereafter until the minimum wage reaches the state statutorily described per hour wage as shown below, the Department will recognize cost increases experienced by ALP providers in accordance with established ALP rate setting methodology. This minimum wage methodology will include an examination of the regional nursing home impact and apply a fifty percent factor. The minimum wage rates as approved are as follows:

	<u>December 31, 2016</u>	<u>December 31, 2017</u>	<u>December 31, 2018</u>	<u>December 31, 2019</u>	<u>December 31, 2020</u>	<u>December 31, 2021</u>
<u>New York City</u>	<u>\$11.00</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk &amp; Westchester</u>	<u>\$10.00</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of State</u>	<u>\$9.70</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Assisted Living Programs. The agency's fee schedule rate was set as of January 1, 2017, and is effective for services provided on or after that date. Rates of payments to Assisted Living Programs are available at:

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/alp/2017-01-01\\_alp\\_min\\_wage\\_rates.htm](https://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/2017-01-01_alp_min_wage_rates.htm)

TN                   #17-0008                   Approval Date           May 17, 2018          

Supersedes TN           NEW           Effective Date           January 01, 2017

New York  
4(c)(1.2)

**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.

- i. 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.
- ii. 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.)
- iii. 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.
- iv. 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.

ALP per diem rates can be found on the Department of Health website at:

[http://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/alp/](http://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/)

TN#:           #17-0008                                Approval Date:   May 17, 2018  

Supersedes TN#:           NEW                                Effective Date:   January 01, 2017

**New York  
4(c)(2)**

Per diem rate add-on for Assisted Living Programs:

Effective April 1, 2013, certain Assisted Living Programs (ALPs) may qualify for an add-on to the per diem rate. ALPs will qualify if the facility:

1. Houses exclusively ALPs beds.
2. Is operated by a not-for-profit corporation.
3. Commenced operation after 1998, and
4. Is in a county with a population of no less than 280,000 persons.

Qualified ALPs receive the following add-on to each RUGS-II category for their respective regional rate:

	2013	2014	2015	2016	2017	2018
Eger	\$49.11	\$48.31	\$48.03	\$47.71	\$47.37	\$47.00
Lott de Salle	\$34.57	\$32.76	\$32.10	\$31.39	\$30.65	\$29.87
No. Riverview	\$9.29	\$7.63	\$7.64	\$7.37	\$7.20	\$7.05
Island	--	\$48.44	\$49.19	\$49.49	\$49.49	\$49.49

Going forward, the add-on amount will be computed using the same methodology as in prior years. The ALP rates and rate add-on for qualified ALPS are available at:

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/alp/](https://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/)

TN#: 13-0045 Approval Date: April 22, 2019

Supersedes TN#: NEW Effective Date: April 1, 2013

**New York  
4(d)**

Outpatient Drug Reimbursement

1. Reimbursement for Prescribed Drugs (including specialty drugs) dispensed by a retail pharmacy; an institutional or long term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program is as follows:
  - a. Reimbursement for Brand Name Drugs is the lower of:
    - i. National Average Drug Acquisition Cost (NADAC) or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC) less 3.3%; plus, the professional dispensing fee in Section 2; or
    - ii. the billing pharmacy's usual and customary price charged to the general public.
  - b. Reimbursement for Generic Drugs is the lower of:
    - i. NADAC or, in the event of no NADAC pricing available, WAC less 17.5%; plus, a professional dispensing fee; or
    - ii. the Federal Upper Limit (FUL) plus the professional dispensing fee in Section 2; or
    - iii. the State Maximum Acquisition Cost (SMAC) plus the professional dispensing fee in Section 2; or
    - iv. the billing pharmacy's usual and customary price charged to the general public.
  - c. Reimbursement for Nonprescription Drugs is the lower of:
    - i. NADAC or, in the event of no NADAC pricing available, WAC; plus, if a covered outpatient drug, the professional dispensing fee in Section 2;
    - ii. the FUL plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
    - iii. the SMAC plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
    - iv. the billing pharmacy's usual and customary price charged to the general public.
2. The professional dispensing fee for covered outpatient drugs, including 340B-purchased drugs, when dispensed by a retail pharmacy; an institutional or long term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program, is [~~\$10.00~~] \$10.08.
3. Payment for drugs dispensed by pharmacies that are acquired at a nominal price as referenced in 42 CFR § 447.502 is at actual acquisition cost plus the professional dispensing fee in Section 2.
4. Payment for drugs dispensed by pharmacies that are acquired via the Federal Supply Schedule is at actual acquisition cost plus the professional dispensing fee in Section 2.

TN           #18-0022          

Approval Date           September 5, 2018          

Supersedes TN           #17-0005          

Effective Date           April 1, 2018

## New York

## 4(d)(1)

- c. Reimbursement for Nonprescription Drugs is the lower of:
- i. NADAC or, in the event of no NADAC pricing available, WAC; plus, if a covered outpatient drug, the professional dispensing fee in Section 2;
  - ii. the FUL plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
  - iii. the SMAC plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
  - iv. the billing pharmacy's usual and customary price charged to the general public.
2. The professional dispensing fee for covered outpatient drugs, including 340B-purchased drugs, when dispensed by a retail pharmacy; an institutional or long term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program, is \$10.00.
3. Payment for drugs dispensed by pharmacies that are acquired at a nominal price as referenced in 42 CFR § 447.502 is at actual acquisition cost plus the professional dispensing fee in Section 2.
4. Payment for drugs dispensed by pharmacies that are acquired via the Federal Supply Schedule is at actual acquisition cost plus the professional dispensing fee in Section 2.
5. Payment for drugs dispensed by the pharmacy of a 340B covered entity as described in section 1927(a)(5)(B) of the Act, or a contract pharmacy under contract with a 340B covered entity as described in section 1927(a)(5)(B) of the Act, shall be as follows:
- a. 340B purchased drugs – actual acquisition cost not to exceed the 340B ceiling price, plus the professional dispensing fee in Section 2;
  - b. Non-340B purchased drugs – in accordance with lower of logic in section 1 plus the professional dispensing fee in Section 2.
6. Payment for clotting factor dispensed by a pharmacy enrolled in the NYS Medicaid FFS Program is at the lower of: SMAC, as described below, not to exceed WAC, plus the professional dispensing fee in Section 2; or the billing pharmacy's usual and customary price charged to the general public.

SMAC is established for clotting factor products using multiple clotting factor pricing resources including but not limited to wholesalers, drug file vendors such as First Data Bank, pharmaceutical manufacturers, and the Hemophilia Services Consortium, Inc. pricing. The Hemophilia Services Consortium, Inc. subcontracts with the New York Blood Center (both not-for-profit corporations) to negotiate with manufacturers and distributors to obtain the best volume discount for the Consortium's safety net hospital.

The SMAC file is stored in a database where valid statistical calculations are used to evaluate and compare the various pricing benchmarks to develop the SMAC price. The SMAC file is updated monthly and applied to all clotting factor products.

Payment for 340B-purchased clotting factor dispensed by a Hemophilia Treatment Center, whether the pharmacy is owned by the covered entity or has a contract pharmacy arrangement, shall be in accordance with Section 5.a.

TN       #17-0005      

Approval Date   December 7, 2017  

Supersedes TN       #NEW      

Effective Date   April 01, 2017



New York  
4(e)

Compound Drugs: Reimbursement is determined by the State Department of Health at the cost of ingredients plus the current dispensing fee.

Exception: Physician Override: Reimbursement for those brand name drugs for which there are generic equivalent drugs for which reimbursement is not to exceed the aggregate of the specified upper limit for the particular drug established by the Centers for Medicare and Medicaid Services, plus a dispensing fee, will be paid at the lower of the estimated acquisition cost, plus a dispensing fee, or at the provider's usual and customary price charged to the general public when the prescriber has obtained a prior authorization when required for the brand-name drug, indicated that the brand name drug is required by placing "daw" (dispense as written) in the box located on prescription form and by writing "brand necessary" or "brand medically necessary" in his/her own handwriting on the face of the prescription.

Where it has been determined that reimbursement plus a dispensing fee does not exceed the aggregate for all drugs under the Federal Upper Limit (FUL) program , the writing by the prescriber of "brand necessary" or "brand medically necessary" will not be required. Prior authorization will not be required for these select drugs.

Indian Health Clinics and tribal clinics which have licensed pharmacies, may submit fee-for-service claims for pharmacy services provided to Native Americans and will be reimbursed at the net acquisition cost for those drugs purchased through the Federal Supply Schedule or at an amount determined by the reimbursement methodology indicated above for all other purchased drugs.

New York  
4(e)(1)

An e-prescription financial incentive will be paid to retail pharmacies for the purpose of encouraging the electronic transmission of prescriptions al orders for select over-the-counter medications and supplies prescribed and dispensed in accordance with State and federal requirements. Reimbursement is determined by the State Department of Health at the cost of ingredients plus a dispensing fee plus 20 cents per electronic prescription/fiscal order dispensed.

Effective April 1, 2014, the e-prescription financial incentive for retail pharmacies will cease and reimbursement at 20 cents per electronic prescription/fiscal order will end.

TN   #14-08   Approval Date   May 5, 2014  

Supersedes TN   #09-53   Effective Date   April 1, 2014

New York  
Page 4(f)

**Type of Service: Pharmacy Medication Therapy**

**Method of Reimbursement:**

Fee schedule developed by the Department of Health and approved by the Division of Budget. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers of medication therapy management services. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the official New York State pharmacy provider manual available and is also available at [http://nyhealth.gov/health\\_care/medicaid/program/mtm/index.htm](http://nyhealth.gov/health_care/medicaid/program/mtm/index.htm). The agency's fee schedule was set as of December 29, 2008 and is effective for services provided on or after January 6, 2010.

Effective April 2, 2012 the Medicaid Medication Therapy Management (MTM) Pilot Program will cease and fee-for-service reimbursement for MTM services will end.

TN   #12-08   Approval Date   June 7, 2012  

Supersedes TN   #09-08   Effective Date   April 2, 2012

**New York  
Page 4(f)(1)**

**Pharmacists as Immunizers**

The [F]fee schedule is developed by the Department of Health and approved by the Division of Budget. State developed fee schedules are the same as the fee schedule established for Physicians. Pharmacies participating in the New York State Medicaid program are reimbursed a vaccine administration fee established at the same rate paid to physicians. The reimbursement to the pharmacy is on behalf of the employed pharmacist, who as the licensed practitioner is the vaccine administrator. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the official New York State pharmacy provider manual, which can be found at:

[http://nyhealth.gov/health\\_care/medicaid/program/pharmacists\\_as\\_immunizers/fact\\_sheet\\_10-14-10.htm](http://nyhealth.gov/health_care/medicaid/program/pharmacists_as_immunizers/fact_sheet_10-14-10.htm)

The agency's fee schedule is effective for services provided on or after October 15, 2009.

**Diabetes Self-Management Training**

The fee schedule is developed by the Department of Health and approved by the Division of Budget. State-developed fee schedules are the same as the fee schedule established for physicians. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the official New York State physician provider manual, which can be found at:

[https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician\\_Manual\\_Fee\\_Schedule\\_Sect2.xls](https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Manual_Fee_Schedule_Sect2.xls)

The agency's fee schedule is effective for services provided on or after July 1, 2011.

Pharmacies participating in the New York State Medicaid program are reimbursed for Diabetes Self-Management Training (DSMT) at the same rate paid to physicians. The reimbursement to the pharmacy, which is accredited by a CMS approved national accreditation organization (NAO) such as the American Diabetes Association (ADA), American Association of Diabetes Educators (AADE) or Indian Health Services (IHS) is on behalf of the employed pharmacist who, as the licensed practitioner, is the DSMT Educator.

TN   #11-73  

Approval Date   December 16, 2011  

Supersedes TN   #09-63  

Effective Date   July 1, 2011

New York  
5

**Nonprescription Drugs**

Reimbursement is the lowest of:

- (1) the usual and customary price charged to the general public;
- (2) the price established by the Commissioner of Health as shown on the NYS List of Medicaid Reimbursable Drugs for that generic category and strength in the package size nearest to that ordered; and,
- (3) Acquisition cost plus dispensing fee.

**Private Duty Nursing**

Fees determined by local districts and reviewed by the Department of Social Services.

The Commissioner of Health shall adjust rates of payment for services provided by private duty nursing providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

TN <u>  #06-53  </u>	Approval Date <u>  April 2, 2007  </u>
Supersedes TN <u>  #99-01  </u>	Effective Date <u>  June 1, 2006  </u>

**New York  
5(a)**

The Commissioner shall increase the rates of payment for all eligible providers in an amount up to an aggregate of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, April 1, 2007 through March 31, 2008, and April 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Services Provided to Medically Fragile Children**

For purposes of this section, a medically fragile child shall mean a child, up to twenty-one years of age, who is at risk of hospitalization or institutionalization for reasons that include but are not limited to the following: children who are technologically-dependent for life or health-sustaining functions; require complex medication regimen or medical interventions to maintain or improve their health status; or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. These children are capable of being cared for at home if provided with appropriate home care services including but not limited to continuous nursing services.

For the period January 1, 2007 through December 31, [2008] 2010, rates of payment for continuous nursing services for medically fragile children shall be established to ensure the availability of such services or programs, and shall be established at a rate that is thirty percent higher than the provider's current rate for private duty nursing services. Providers that receive such rates for continuous nursing services for medically fragile children must use these enhanced rates to increase payments to registered nurses or licensed practical nurses who provide these services to medically fragile children. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Nursing Services (Limited)**

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain nursing services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain

TN <u>  #08-28  </u>	Approval Date <u>  March 24, 2009  </u>
Supersedes TN <u>  #08-33  </u>	Effective Date <u>  January 1, 2009  </u>

**New York  
5(a)(i)**

personal care and nursing services to residents of the adult home or enriched housing program governed by the terms of the limited license. The nursing services for which reimbursement shall be provided are: the administration of subcutaneous and/or Intramuscular injections and application of sterile dressings by a registered professional nurse, including associated nursing tasks, provided however, that the services provided are not services that must otherwise be provided to residents of adult home or enriched housing programs. Regional quarter hour rates are established utilizing average fees established for private duty nursing services for the respective regions.

**Physical Therapy**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Occupational Therapy**

Fee schedule developed by Department of Health and approved by Division of the Budget.

TN #07-01

Approval Date June 25, 2007

Supersedes TN NEW

Effective Date January 1, 2007

**New York  
5(a)(ii)**

**Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD)**

- (A) Payments are made in accordance with a fee schedule developed by the Department of Health and approved by the Division of the Budget. The State-developed fee schedule rates are the same for both governmental and private providers of IPSIDD services which are included under independent practitioner services.
- (1) The IPSIDD fee schedule was set as of April 1, 2016 and is effective for services provided on and after that date. The fee schedules are published on the Department of Health website and can be found at the following links:
- (i) IPSIDD fee schedule effective April 1, 2016 through December 31, 2016:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/ipsidd\\_04-01-16](https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/ipsidd_04-01-16)
  - (ii) IPSIDD fee schedule effective January 1, 2017 through December 31, 2017:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/2017\\_01\\_01\\_ipsidd.htm](https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/2017_01_01_ipsidd.htm)
  - (iii) IPSIDD fee schedule effective January 1, 2018 [and forward] through December 31, 2018:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/2018/2018\\_01\\_01\\_ipsidd.htm](https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/2018/2018_01_01_ipsidd.htm)
  - (iv) IPSIDD fee schedule effective January 1, 2019 and forward:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/mental\\_hygiene/2019/2019\\_01\\_01\\_ipsidd.htm](https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/2019/2019_01_01_ipsidd.htm)
- (2) IPSIDD is available for the following services:
- (i) Occupational Therapy;
  - (ii) Physical Therapy;
  - (iii) Speech and Language Pathology;
  - (iv) Psychotherapy.

TN     #19-0014    

Approval Date     December 16, 2019    

Supersedes TN     #16-0007    

Effective Date     January 01, 2019

New York  
5(b)

**Eyeglasses and Other Visual Services**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Hearing Aid Supplies and Services**

Fee schedule developed by Department of Health and approved by Division of the Budget.

**Prosthetic and Orthotic Appliances**

Payments are limited to the lower of the usual and customary charge to the general public or fee schedule developed by Department of Health and approved by the Division of the Budget.

**Comprehensive Psychiatric Emergency Programs**

Flat fee developed by OMH and approved by the Division of the Budget.

TN #06-53

Approval Date April 2, 2007

Supersedes TN NEW

Effective Date June 1, 2006

New York  
5(b)(1)

**Medical Supplies/Orthopedic Footwear**

Effective dates of service on and after May 1, 2011, payment for orthopedic footwear shall be the lower of; the maximum reimbursable amount as shown in the fee schedule for durable medical equipment, medical/surgical supplied, orthotics and prosthetic appliances and orthopedic footwear (the maximum reimbursable amount will be determined for each item of footwear based on an average cost of products representative of that item); or the usual and customary price charged to the general public for the same or similar products. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of orthopedic footwear. The agency's fee schedule rate was set as of May 1, 2011, and is effective for services provided on or after that date. All rates are published on:

<http://www.emedny.org/ProviderManuals/DME/index.html>

TN #11-36 \_\_\_\_\_

Approval Date August 11, 2011

Supersedes TN NEW

Effective Date May 1, 2011

## New York

6

<u>Type of Service</u>	<u>Method of Reimbursement</u>
Durable Medical Equipment	<p>Purchase: Reimbursement must not exceed the lower of a) the maximum reimbursable amount as shown in the fee schedule for durable medical equipment; the maximum reimbursable amount will be determined for each item of durable medical equipment based on an average cost of products representative of that item; or b) the usual and customary price charged to the general public for same or similar products.</p> <p>When there is no price listed in the fee schedule for durable medical equipment, payment for purchase of durable medical equipment must not exceed the lower of a) acquisition cost as established by invoice detailing the line item cost to the provider from a manufacturer or wholesaler net any rebates, discounts or valuable consideration, mailing, shipping, handling, insurance, or sales tax plus fifty percent; or b) the usual and customary price charged to the general public for the same or similar products.</p> <p>When the primary payor is Medicare, payment for the purchase of durable medical equipment shall be the amount approved by Title XVIII of the Medicare Program.</p> <p>Rental: monthly rental charges are determined by the Department of Health.</p>
Medical/Surgical Supplies	Purchase: reimbursement is determined by the Department of Health at the lower of the maximum reimbursable amount, or at the usual and customary price charged to the general public.
General Formula	Purchase: reimbursement is the lower of the cost to the provider plus 50% or the usual and customary price charged to the general public.
Transportation	<p>[Fees determined by local social services districts and approved by the Division of the Budget and shall not exceed the current local prevailing charge or locally negotiated fee, whichever is lower, with the following exception:</p> <p>For those clients for whom the State retains fiscal and administrative responsibility, fees are determined by the DOH Office of Financial Management using the local social services district fee for a comparable service as the upper limit of payment.]</p> <p><u>In a fee-for-service arrangement, fees will be established by the local social services districts and subsequently approved by the Office of Health Insurance Programs. Fees will be reviewed to ensure they do not exceed the current usual and customary amount charged to the general public. However, there will be extenuating and unique circumstances where a higher fee is necessary to assure safe and appropriate transportation to necessary medical services. In those circumstances, a fee will be negotiated.</u></p>

TN #06-52Approval Date March 29, 2007Supersedes TN #99-29Effective Date June 1, 2006

**New York**  
**6.1**

**Emergency Medical Services Provider Supplemental Payment**

The Department will supplement Medicaid fee-for-service reimbursements made to emergency medical services providers.

For the period July 1, 2006 to March 31, 2007, the aggregate amount of \$3.0 million and for the period April 1, 2007 to March 31, 2008, the aggregate amount of \$6 million will be available. For the period March 26, 2009 through March 31, 2009, the aggregate amount of \$4,512,000 will be available. For the period May 30, 2014 through March 31, 2015, the aggregate amount of \$6 million will be available. Annually, beginning with the period of April 23, 2015 through March 31, 2016, the aggregate amount of \$6 million will be available.

This payment will be based upon a ratio of individual provider payments to total Medicaid provider payments in each quarter of the state fiscal year.

The following methodology applies in each state fiscal year:

- The aggregate amount will be divided by four as a payment will be made in each quarter of the state fiscal year, and further divided as follows:
  - Twenty five percent of the total aggregate amount will be paid to providers within the City of New York.
    - ▶ The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers within the City of New York, and will express that ratio as a percentage.
    - ▶ The Department will then multiply the percentage by one-quarter the supplemental amount available to be disbursed for emergency medical services providers based in the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".
    - ▶ In each quarter of the state fiscal year, these steps shall be repeated.
  - Seventy-five percent of the total aggregate amount will be paid to Medicaid providers outside the City of New York.
    - ▶ The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers outside the City of New York, and will express that ratio as a percentage.
    - ▶ The Department will then multiply the percentage by one quarter the supplemental amount available to be disbursed to providers based outside the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".
    - ▶ In each quarter of the state fiscal year, these steps shall be repeated.

TN #15-0032

Approval Date January 14, 2016

Supersedes TN #14-0023

Effective Date April 23, 2015

**New York  
6(a)**

**Out-of-State Services****Fee-based providers:**

Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.

**HMO's and Prepaid Health Plans**

Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 442.302 and Part 447.361 including all federal requirements for the reimbursement methodology.

**[Personal Care Services**

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for personal care services provided on and after January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for personal care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.]

TN #09-46

Approval Date January 10, 2012

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Effective Date April 1, 2009

**New York  
6(a)(1)**

**Personal Care Services**

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained on page 1(c)(i) in this Attachment.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be zero.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period [shall] will be no greater than zero. For rates of payment effective for services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date September 26, 2019**

**Supersedes TN #17-0034**

**Effective Date April 1, 2019** \_\_\_\_\_

**New York  
6(a)(1)(i)**

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

TN #13-33

Approval Date August 20, 2013

Supersedes TN NEW

Effective Date April 1, 2013

**New York  
6(a)(2)**

Such rates of payment [shall] will be further adjusted to reflect costs associated with the recruitment and retention of non-supervisory workers. For programs providing services in local social service districts which include a city with a population of over one million persons, such rate adjustments will be calculated by allocating the total dollars available for the applicable rate period to each individual provider proportionally based on total claimed hours of services for personal care services provided in the district to recipients of medical assistance. The allocated dollars will be included as a reimbursable cost add-on to the Medicaid rates of payment based on the Medicaid utilization data as adjudicated through the Medicaid Management Information System (MMIS), or any successor entity, utilizing the most recently available total claimed hours of Medicaid services data, as agreed to by New York State and the district.

For payment periods January 1, 2017, and thereafter, the Commissioner of Health will increase the rates of payment for services provided by all Personal Care providers in accordance with the wage chart shown below to address cost increases resulting from increases to the minimum wage in New York State. Final rates for providers can be found on the Department of Health website:

For New York City Personal Care:

[http://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/rate\\_chart.pdf](http://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/rate_chart.pdf)

For non New York City Personal Care:

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/pcr/](https://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/)

**Minimum Wage Chart**

<u>Minimum Wage (MW) Region</u>	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>	<u>12/31/2020</u>	<u>12/31/2021</u>
<u>New York City (Large employers)</u>	<u>\$11.00</u>	<u>\$13.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>New York City (Small employers)</u>	<u>\$10.50</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester counties</u>	<u>\$10.00</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$9.70</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

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 wage. Minimum wage cost development will be based on survey data collected.

1. Survey data will be collected for facility specific wage data.

TN #17-0026

Approval Date February 1, 2018

Supersedes TN #09-0069

Effective Date January 1, 2017

**New York**  
**6(a)(3)**

2. Facilities will report by specified wage bands, the total count of FTEs and total hours paid to employees earning less than the statutory minimum wage applicable for each minimum wage region.
3. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
4. 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.
5. The 2017 minimum wage costs will be developed based on collected survey data received and attested to by Personal Care Agencies. The cost report will not be used because it does not contain wage data at the level of detail needed to calculate a minimum wage adjustment. Therefore, if the providers do not respond to the survey they will not receive a minimum wage add-on.
6. In subsequent years until the minimum wage is completely implemented statewide, the Department will survey Personal Care Agencies (PCA). If a PCA fails to submit the survey its minimum wage add-on will not be calculated. Once the costs are included in the base year cost report, the minimum wage add-on will be excluded from the rate.
7. A minimum wage add-on will be developed by multiplying minimum wage costs pursuant to "4." above by a percentage of Medicaid hours to total hours, divide by total Medicaid hours for each rate.

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 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.

TN #17-0026

Approval Date February 1, 2018

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Effective Date January 1, 2017

**New York**  
**6(a)(4)**

1. 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.
2. 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.)
3. 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.
4. 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 #17-0026

Approval Date February 1, 2018

Supersedes TN New

Effective Date January 1, 2017

New York  
6(a)(7)

Effective April 1, 2018 Medicaid qualified personal care providers in Federally Designated Frontier and Remote (FAR) areas of New York State will be eligible for a rate adjustment to address losses between the amount the provider pays for Level II, Nursing Assessment and Nursing Supervision and the Medicaid reimbursement for these services.

The FAR areas are determined by the US Department of Agriculture Economic Research Service and are based on zip codes and use population and urban-rural data from the 2010 U.S. Census.

**Eligibility**

Eligibility is based on the provider experiencing a combined loss in the Medicaid Personal Care Level II, Nursing Supervision and Nursing Assessment services as identified using the most recent complete calendar year cost reports for providers in the FAR regions.

**Methodology**

- The State identified \$3M to support this rural initiative for both Personal Care services through the State Plan and the NHTD and TBI Waiver services.
- Distribution of the \$3M between the Personal Care services and the NHTD and TBI Waiver services will be based on a demonstration of overall losses between the service areas.
- For Personal Care services, a difference will be calculated between actual cost and current rates paid for the sum of Level II, Nursing Assessment and Nursing Supervisor using the Cost Report data:
  - Each provider's loss is divided by the sum of all eligible losses to establish a percentage of loss for each provide.
  - This percentage of loss is used to allocate up to \$3M to qualifying FAR Personal Care providers.
  - The allocation of funds is divided by the sum of Level II hours, Nursing Supervision visits, and Nursing Assessment visits, by providers in the FAR region using the most recent completed calendar year cost report to establish a rate add-on for the provider. This add-on is added to the current rates of Level II, Nursing Assessment and Nursing Supervision.

TN           #19-0006          

Approval Date 05/29/2019

Supersedes TN   New          

Effective Date 01/01/2019

**New York  
6(a)(i)**

For programs providing services in local social services districts which do not include a city with a population of over one million persons, adjustments to Medicaid rates of payment will be calculated by allocating the total dollars available for the applicable rate period to each individual provider proportionally based on each personal care service provider's total annual hours of personal care service provided to recipients of medical assistance to the total annual hours for all providers in this category. The allocated dollars will be included as a reimbursable cost add-on to the Medicaid rates of payment based on the Medicaid utilization data reported in each provider's annual cost report for the period two years prior to the rate year.

Adjustments to Medicaid rates of payment will, in aggregate, not exceed the following amounts for the following periods.

For programs providing services in local social service districts which include a city with a population of more than one million persons:

For the period April 1, 2002 through December 31, 2002, one hundred ten million dollars.

For the period January 1, 2003 through December 31, 2003, one hundred eighty five million dollars.

For the period January 1, 2004 through December 31, 2004, two hundred sixty million dollars.

For the period January 1, 2005 through December 31, 2006, three hundred forty million dollars annually.

For the period January 1, 2007 through December 31, 2007, three hundred forty million dollars.

For the period January 1, 2008 through December 31, 2008, three hundred forty million dollars.

For the period January 1, 2009 through December 31, 2009, three hundred forty million dollars.

For the period January 1, 2010 through December 31, 2010, three hundred forty million dollars.

For the period January 1, 2011 through March 31, 2011, eighty-five million dollars.

For the period April 1, 2011 through March 31, 2012, three hundred forty million dollars.

For the period April 1, 2012 through March 31, 2013, three hundred forty million dollars.

For the period April 1, 2013 through March 31, 2014, three hundred forty million dollars.

TN #11-14 \_\_\_\_\_

Approval Date July 26, 2011

Supersedes TN #08-27 \_\_\_\_\_

Effective Date April 1, 2011

New York  
6(a)(i)(1)

For programs providing services in local social service districts which do not include a city with a population of over one million persons:

- For the period April 1, 2002 through December 31, 2002, seven million dollars.
- For the period January 1, 2003 through December 31, 2003, fourteen million dollars.
- For the period January 1, 2004 through December 31, 2004, twenty-one million dollars.
- For the period January 1, 2005 through December 31, 2006, twenty-seven million dollars annually; for the period August 17, 2006 through December 31, 2006, an additional aggregate amount of four million dollars.
- For the period January 1, 2007 through June 30, 2007, thirteen million five hundred thousand dollars.
- For the period July 1, 2007 through March 31, 2008, twenty-six million two hundred fifty thousand dollars.
- For the period April 1, 2008 through March 31, 2009, twenty-eight million five hundred thousand dollars.
- For the period April 1, 2009 through March 31, 2010, twenty-eight million five hundred thousand dollars.
- For the period April 1, 2010 through March 31, 2011, twenty-eight million five hundred thousand dollars.
- For the period April 1, 2011 through March 31, 2012, twenty-eight million five hundred thousand dollars.
- For the period April 1, 2012 through March 31, 2013, twenty-eight million five hundred thousand dollars.
- For the period April 1, 2013 through March 31, 2014, twenty-eight million five hundred thousand dollars.

Revisions to rates made for such recruitment and retention costs shall not be subject to subsequent adjustment or reconciliation.

The final rate is payment-in-full for all personal care services provided during the applicable rate year, subject to any revisions made in accordance with rate revision or audit procedures.

For personal care services provided directly by social services district staff, payment is made according to a salary schedule established by the social services district. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2009 and is effective for services provided on or after that date. All rates are published on the New York State Department of Health website at:

[www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/#-cr1](http://www.health.ny.gov/facilities/long_term_care/reimbursement/#-cr1)

The Office of Mental Health (OMH) established the rate of payment to family care providers approved to provide personal care services to family care residents. The agency's fee schedule rate was set as of April 1, 2008 and is published at [www.omh.ny.gov](http://www.omh.ny.gov).

TN #11-14

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Effective Date April 1, 2011

New York  
6(a)(i)(2)

**Personal Care Services (limited)**

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain personal care services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain personal care and nursing services to residents of the adult home or enriched housing program governed by the terms of the limited license. The personal care services for which reimbursement shall be provided are Level II personal care services, including related nursing supervision, as authorized by the Commissioner, provided however, that the services provided are not personal care services that must otherwise be provided to residents of adult homes or enriched housing programs and, provided further, that reimbursement for Level II personal care services shall not include reimbursement for Level I nutritional and environmental support functions. Regional quarter hour rates are established utilizing weighted average Level II personal care rates for the respective regions for direct care and training, capital, and criminal checks, plus no more than fifteen percent of such rates for administrative expenses.

TN #08-27

Approval Date May 11, 2011

Supersedes TN NEW

Effective Date April 1, 2008

**New York  
6(a)(ii)**

**Personal Care Agency – Insurance Costs**

The Commissioner of Health is authorized to provide for increased payments to personal care agencies to support increased employee fringe benefit costs associated with the agencies' provision of enhanced health care coverage for their employees.

The cost of such health care related increased employee fringe benefits is a reimbursable cost for eligible certified personal care agencies. Eligible personal care agencies [as determined by the Commissioner of Health,] are those agencies whose workers are employed in cities within the state which have populations in excess of one million persons [and] or counties within the state which have populations in excess of [one million persons] nine hundred thousand persons if the county is located within the metropolitan commuter transportation district and meet the following conditions: (a) at least fifty percent of the [persons receiving services from] actual total hours of service for the period July 1, 2007 through March 31, 2008 provided by such employers are provided to recipients of medical assistance; and (b) the employer contributes to a group health insurance plan or employer based group health plan on behalf of such employees[; and (c) no benefits are provided under the group health insurance plan or employer based group health plan in excess of the benefits provided to the majority of hospital workers in the community in which the personal care workers are employed].

[Total] Medicaid payments to eligible personal care agencies are based on total funds available for this program, allocated proportionately by Medicaid hours of service provided by each eligible provider. [the documented approved costs of the eligible agency for group health insurance premiums paid for their employed personal care attendants and allocable to the Medicaid hours of service provided by such employees.] Payments may, in the aggregate, and on an annual basis, be no more than \$58,000,000 provided however, that for the period October 2 through December 31, 2003, the amount will increase by \$105,000,000; and for annual periods [on and after] January 1, 2004 through June 30, 2007, the amount of funding shall be no more than \$163,000,000 in the aggregate. For the period July 1, 2007 through March 31, 2008, the amount of funding shall be \$122,300,000 in the aggregate for all eligible certified home health agencies and personal care providers. Rates of payment shall be adjusted for eligible providers and allocated proportionally [to reflect the Medicaid share of the approved costs] based on the [proportional] relationship of the provider's Medicaid annual hours of service [care rendered to Medicaid beneficiaries] to the total Medicaid annual hours of service [care] rendered [to] by all of the providers [patients], based upon each provider's actual Medicaid hours of service for which payment has been made by the State's Medicaid Management Information System for the period July 1, 2007 through March 31, 2008.

TN   #07-32  

Approval Date   April 8, 2008  

Supersedes TN   #05-49  

Effective Date   July 1, 2007



**New York  
6(a)(iii)(A)**

**Accessibility, Quality, and Efficiency of Home Care Services**

The Commissioner of Health shall adjust rates of payment for services provided by personal care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

TN   #07-32  

Approval Date   April 8, 2008  

Supersedes TN   NEW  

Effective Date   July 1, 2007

New York  
6(a)(iv)

- (i) Increased use of technology in the delivery of services, including clinical and administrative management information systems;
- (ii) Specialty training of direct service personnel in dementia care, pediatric care, and/or the care of other conditions or populations with complex needs;
- (iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas;
- (iv) Providing enhanced access to care for high need populations.

The Commissioner shall increase the rates of payment for eligible providers in an [amount up to an] aggregate amount of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, [and] July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as [determined] calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #08-33 Approval Date March 20, 2009  
Supersedes TN #07-13 Effective Date June 1, 2008

**New York  
6(a)(v)**

**Community First Choice Option**

**Methods and Standards for Establishing Payment Rates**

Prior to implementing the CFC program, the State had already been offering CFC like services under various approved state plan and waiver programs authorities. Under CFC, these services have now been consolidated into a single program. For the first year of the CFC program, the State will continue to pay the same fees or use the same methodologies in effect on June 30, 2015 under the former state program to purchase CFC services.

1. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing. The State will use the current fee or methodology identified in the following programs for the providers listed in Attachment 3.1-K Supplement (Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office for People with Developmental Disabilities and the Office of Mental Health are qualified providers of personal care services and supports under CFCO).

TN #13-0035 Approval Date October 23, 2015  
Supersedes TN NEW Effective Date July 1, 2015

New York  
6(a)(vi)

<u>Rate Code</u>	<u>State Program</u>	<u>Current Rate</u>	<u>Methodology</u>
<u>2602, 2622,</u> <u>2623, 2593,</u> <u>2594, 2601,</u> <u>2595, 2596,</u> <u>2681, 2631,</u> <u>2671, 2815,</u> <u>2816, 3855,</u> <u>3856, 3145,</u> <u>9795, 9863</u>	<u>Personal Care</u>	<u>\$20.21/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/">http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/</a> <u>and</u> <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2015-01-01_lthhc_rates.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2015-01-01_lthhc_rates.htm</a>
<u>2422, 2423,</u> <u>2402, 2401,</u> <u>4764, 4769,</u> <u>4770, 4771,</u> <u>4772, 4777</u>	<u>Fiscal Intermediaries</u>	<u>\$17.41/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/">http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/</a>  <u>Or statewide fees based on the level of service provided as set forth in Appendix C of the OPWDD Comprehensive HCBS Waiver (NY 0238).</u>
<u>2611, 2695,</u> <u>2810, 2825,</u> <u>3850, 3865</u>	<u>Home Health Care (aide only)</u>	<u>\$23.18/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates/index.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates/index.htm</a>
<u>9997, 9994,</u> <u>9991</u>	<u>Transportation</u>	<u>Varies depending on mode, region</u>	<u>Fee schedule available at:</u> <a href="https://www.emedny.org/ProviderManuals/Transportation/index.aspx">https://www.emedny.org/ProviderManuals/Transportation/index.aspx</a>

\*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

TN #13-0035Approval Date October 23, 2015Supersedes TN NEWEffective Date July 1, 2015

**New York**  
**6(a)(vii)**

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks. The State will use the current fee or methodology identified in the following programs for the providers listed in Attachment 3.1-K Supplement.

<u>Rate Code</u>	<u>Service</u>	<u>Current Rate</u>	<u>Methodology</u>
4722, 4723, 4724, 4725, 4741, 4742, 4743, 4744, 4755, 4756, 4757, 4758, 4765, 4766, 4767, 4768, 4796, 4797, 4798, 4799	Community Habilitation	N/A	Regional Fee for Provider-Delivered Community Habilitation Region 1: \$ 38.51 (1-to-1); \$ 24.07 (Group) Region 2: \$ 39.91 (1-to-1); \$ 24.95 (Group) Region 3: \$ 39.00 (1-to-1); \$ 24.37 (Group)

3. Back-up systems or mechanisms to ensure continuity of services and supports.

<u>Rate Code</u>	<u>Service</u>	<u>Current Rate</u>	<u>Methodology</u>
2609, 2616, 2809, 2818, 3823, 3831, 3858, 9981	Personal Emergency Response (PERS)	\$23.11/month*	Provider specific fees are established based on provider specific costs reported two years prior to the rate year and are posted at: <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm">http://www.health.ny.gov/facilities/ long_term_care/reimbursement/hhc/2013-01- 01_lthhc_rates.htm</a>

\*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

TN #13-0035

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**New York  
6(a)(viii)**

4. Permissible services/Substitute for human assistance

<u>Rate Code</u>	<u>Service</u>	<u>Current Rate</u>	<u>Methodology</u>
<u>3143, 4482, 4483, 4484, 4485, 9752</u>	<u>Assistive Technology</u>	<u>100% of claim determined reasonable by the state.</u>	<u>AT is purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies using a standard bidding process following the rules established by the Office of the State Comptroller. Under the process, items costing up to \$1000 a year require only one bid, those over \$1000 will require multiple bids.</u> <a href="https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm">https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm</a>
<u>9750</u>	<u>Vehicle Adaptation</u>	<u>100% of billed cost determined reasonable by the state</u>	<u>NHTD current methodology, limit \$15,000; separate from e-Mods limit</u> <a href="https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf">https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf</a>
<u>3144, 4786, 9758, 9867</u>	<u>Community Transitional Services (establishing a household in the community from an institutional setting)</u>	<u>100% of claim/approved cost</u>	<u>One-time payment not to exceed \$5,000. Specific amount will be based on State review and approval of cost projections.</u>
<u>N/A</u>	<u>Durable Medical Equipment</u>		<u>Fee schedule available at:</u> <a href="https://www.emedny.org/ProviderManuals/DME/index.aspx">https://www.emedny.org/ProviderManuals/DME/index.aspx</a>
<u>4476, 4477, 4478, 4479, 9992, 9995, 9998, 9762, 9874</u>	<u>Environmental Modifications</u>	<u>100% of claim determined reasonable by the State</u>	<u>Qualified contractors are selected through a standard bidding process following the rules established by the Office of the State Comptroller. This process is described at:</u> <a href="https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm">https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm</a>

TN #13-0035Approval Date October 23, 2015Supersedes TN NEWEffective Date July 1, 2015

**New York  
6(a)(ix)**

4. Permissible services / Substitute for human assistance (continued):

<u>Rate Code</u>	<u>Service</u>	<u>Current Rate</u>	<u>Methodology</u>
<u>2682, 2685, 2835, 3874, 9781</u>	<u>Home Delivered Meals</u>	<u>\$5.79/Meal*</u>	Provider specific fees are established based on reported costs and are posted on State website at: <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</a>
<u>2638, 2830, 3872</u>	<u>Congregate Meals</u>	<u>\$5.07/Meal*</u>	Provider specific fees are established based on reported costs and are posted on State website at: <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</a>
<u>2636, 2831, 3870, 9787</u>	<u>Moving Assistance (transport of personal belongings)</u>	<u>\$58.79/hr*</u>	Provider specific fees are established based on reported costs and are posted on State website at: <a href="http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</a>

\*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.

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**New York  
6(b)**

**Hospice Services – Adjustment for Minimum Wage Increases**

Effective April 1, 2018, and every January 1, thereafter until the minimum wage reaches the statutorily described per hour wage as shown below, the rates of payment for services provided by Non-Residence Hospice providers include rate add-on to reimbursement in accordance with the wage chart shown below to address increases in labor costs.

**Minimum Wage Chart**

	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>	<u>12/31/2020</u>	<u>12/31/2021</u>
<u>New York City</u>	<u>\$10.50</u>	<u>\$12.00</u>	<u>\$13.50</u>	<u>\$15.00</u>	<u>\$15.00</u>	<u>\$15.00</u>
<u>Nassau, Suffolk, &amp; Westchester counties</u>	<u>\$10.00</u>	<u>\$11.00</u>	<u>\$12.00</u>	<u>\$13.00</u>	<u>\$14.00</u>	<u>\$15.00</u>
<u>Remainder of the State</u>	<u>\$9.70</u>	<u>\$10.40</u>	<u>\$11.10</u>	<u>\$11.80</u>	<u>\$12.50</u>	<u>\$12.50</u>

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

1. Minimum wage costs will mean the additional costs incurred beginning April 1, 2018 and thereafter, as a result of New York State statutory increases to minimum wages.
2. The 2018 provider specific minimum wage add-on will be developed based on collected survey data received and attested to by hospice providers. If a hospice provider fails to submit the attested survey data, a provider will not receive a minimum wage add-on.
  - i. Minimum wage cost development based on survey data collected.
    - a. Survey data will be collected for provider 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 provider has reported total hours paid. To this result, the provider's average fringe benefit percentage is applied and added to the costs.
3. The provider specific cost amount will be adjusted by a factor calculated by dividing the provider'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 same methodology.

TN                   #18-0023                  

Supersedes TN           New          

Approval Date           09/07/2018          

Effective Date           04/01/2018

New York  
6(b)(1)

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.
- i. 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.
  - ii. 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.)
  - iii. 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.
  - iv. 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.
  - v. The agency's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.

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Supersedes TN   New  

Effective Date 04/01/2018

New York  
6(b)(2)

**Hospice Non-Residence:**

The Hospice Non-Residence Provider rate is the Federal minimum rates issued by CMS.

**Hospice Residence:**

On March 31, 2018, a 10% increase in the Hospice residence reimbursement rate of each Wage Equalization Factor (WEF) region will be calculated. The per diem value of this 10% increase will be incorporated into all subsequent fiscal periods, effective April 1, 2018, and every January 1 thereafter.

Effective April 1, 2018, and every January 1 thereafter, Hospice residence reimbursement rates will be equal to 94% of the weighted average Medicaid rate of the nursing facilities located in the WEF region in which the hospice residence is located, plus the per diem value of the 10% increase calculated in the above paragraph.

Hospice rates can be found on the Department of Health website at:

[http://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/hospice/](http://www.health.ny.gov/facilities/long_term_care/reimbursement/hospice/)

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Approval Date 09/12/18

Supersedes TN   New  

Effective Date 04/01/18

New York  
7

RESERVED

TN   #00-05  

Approval Date   January 8, 2001  

Supersedes TN   #99-01  

Effective Date   January 1, 2000

New York  
7(a)

Section 86-2.9, Adult Day Health Care in Residential Health Care Facilities, is hereby amended to read as follows:

Section 86-2.9 Adult Day Health Care in Residential Health care Facilities: (a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of this Title subject to the maximum daily rate provided for in this section.

TN     #00-01     Approval Date     June 6, 2001      
Supersedes TN   #99-37 #97-27   Effective Date     January 1, 2000

New York  
7(a)(i)

- (c) Allowable costs shall include, but not be limited to the following:
  - (1) applicable salary and non-salary operating costs;
  - (2) costs of transportation; and,
  - (3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.
- (d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.
- (e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 through March 31, 1999, July 1, 1999 through March 31, 2003, April 1, 2003 through March 31, 2005, and from April 1, 2005 through March 31, [2007] 2009, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

For adult day health care facilities, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.

For reimbursement of adult day health care services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of adult day health care services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachement.

TN   #08-32   Approval Date   September 9, 2011    
 Supersedes TN   #07-12   Effective Date   April 1, 2008

**New York  
7(a)(ii)**

For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period [shall] will be zero.

For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period [shall] will be no greater than zero. For rates of payment effective for adult day health care services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date September 26, 2019**

**Supersedes TN #17-0034**

**Effective Date April 1, 2019**

**New York**  
**7(b)**

(f) For facilities without a skilled nursing facility rate, computed in accordance with section 86-2.10 or section 86-2.15 of this Subpart, in effect on January 1, 1990, a weighted average rate for each region listed in Appendix 13A of this Title shall be used as the proxy for the facility's January 1, 1990 skilled nursing facility rate in determining the maximum daily rate for such facilities as set forth in subdivisions (d) and (e) of this section. The weighted average rate for each region shall be equal to the statewide weight average 1990 skilled nursing facility rate with the statewide average direct component and indirect component of the rate adjusted respectively by the regional direct and indirect input price adjustment factors described in section 86-2.10. The statewide weighted average rate shall be computed by multiplying each residential health care facility's 1990 skilled nursing facility rate times its 1990 skilled nursing facility patient days, summing the result statewide, and dividing by the statewide total 1990 skilled nursing facility patient days. The 1990 rate used in computing the statewide weighted average rate shall be the latest 1990 rate in effect on July 1, 1992 for the former skilled nursing level of care which is contained in the rate which has been certified by the commissioner pursuant to section 2807(3) of the Public Health Law.

(g) Effective April 1, 1994 and thereafter reimbursement for Adult Day Health Care services provided to registrants with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses and to other high-need populations shall be established as follows. Payment shall be a per visit price with not more than one visit per day per registrant. The rate of payment shall consist of a single price per visit for the operating component, transportation, and the capital cost component and shall be based upon a rate of \$160 per visit per 24 hour period. To be eligible for reimbursement a residential health care facility must be certified by the Department to provide adult day health care services for AIDS/HIV registrants and, effective September 1, 2017, to other high-need registrants. The price shall be full reimbursement for the following: (i) physician services, nursing services, and other related professional expenses directly incurred by the licensed residential health care facility; (ii) administrative, personnel, business office, data processing, recordkeeping, housekeeping, food services, transportation, plant operation and maintenance and other related facility overhead expenses; (iii) all other services required for adult day health care in residential health care facilities appropriate to the level of general medical care required by the patient; (iv) all medical supplies, immunizations, and drugs directly related to the provision of services except for those drugs used to treat AIDS

TN   #17-0006    
Supersedes TN   #94-25  

Approval Date   December 11, 2017    
Effective Date   September 1, 2017

New York  
7(b)(i)

patients for which fee-for-service reimbursement is available as determined by the Department of Health.

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV and other high-need populations by a residential health care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service [and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services.] in accordance with clients' comprehensive care plans. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated unless one or more services are provided in accordance with a client's comprehensive care plan [if these two requirements are not met].

**Core services include:**

- Medical visits
- Nursing visits
- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

**New York**  
**7(b)(ii)**

**Health related (non-core) services include:**

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided to patients diagnosed with HIV/AIDS and other high-risk populations on and after January 1, 2007, medical assistance rates of payment to residential health care facilities shall be increased up to an annual amount of \$2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

For adult day health care services rendered on and after January 1, 2007, through December 31, 2009, and for adult day health care services provided to patients diagnosed with HIV/AIDS and other high-risk populations on and after April 1, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology contained in this Attachment.

Effective April 1, 2011 through June 30, 2011, rates of payment for adult day health care services provided to patients with AIDS or other HIV related illnesses shall be increased by an additional aggregate amount of \$946,350 to be allocated proportionally among such providers based on the Medicaid visits as reported in the most recently available cost report submitted to the State by January 1, 2011.

- (h) For the period April 1, 2007 and thereafter, rates of payment for adult day health care services provided by residential health care facilities, shall be computed in accordance with the following:
- (i) the operating component of the rate for an adult day health care program that has achieved an occupancy percentage of 90% or greater for a calendar year, prior to April 1, 2007, shall be calculated utilizing allowable costs reported in the 2004, 2005, or 2006 calendar year residential health care facility cost report filed by the sponsoring residential health care facility, whichever is the earliest of such calendar year cost reports in which the program has achieved an occupancy percentage of 90% or greater, except that programs receiving rates of payment based on allowable costs for a period prior to April 1, 2007 shall continue to receive rates of payment based on that period;
  - (ii) for programs that achieved an occupancy percentage of 90% or greater prior to calendar year 2004 but did not maintain occupancy of 90% or greater in calendar years 2004, 2005, or 2006, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2004 calendar year cost report divided by visits imputed at 90% occupancy.

TN <u>#17-0006</u>	Approval Date <u>December 11, 2017</u>	
Supersedes TN <u>#11-11</u>	Effective Date <u>September 1, 2017</u>	

**New York**  
**7(b)(ii)(A)**

- (iii) programs that have not achieved an occupancy of 90% or greater for a calendar year prior to April 1, 2007, will have the operating component of the rate of payment calculated utilizing allowable costs reported in the first calendar year after 2006 in which the program achieves an occupancy of 90% or greater effective January first of such calendar year except for calendar year 2007, effective no earlier than April first of such year, provided, however, that effective January 1, 2009 programs that have not achieved an occupancy of 90% or greater for a calendar year prior to January 1, 2009, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2009 cost report filed by the sponsoring residential health care facility divided by actual visits or imputed at 90% occupancy, whichever is greater. This will also apply to programs which achieve an occupancy percentage of 90% or greater prior to calendar year 2004, but in such year had an approved capacity that was not the same as in calendar year 2004.
- (iv) for residential health care facilities approved to commence operation of an adult day health care program on or after April 1, 2007, rates of payment for these programs will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility, and total estimated annual visits by adult day health registrants of not less than 90% of licensed occupancy. Each program shall also be required to submit an individual budget. Multiple programs operated by the same residential health care facility shall each have separate rates of payment;
- (v) Rates developed based upon budgets shall remain in effect for no longer than two calendar years from the earlier of:
- (A) the date the program commences operations; or
  - (B) the date the sponsoring residential health care facility submits a full calendar year residential health care facility cost report in which the program has achieved 90% or greater occupancy. If a sponsoring residential health care facility submits such a cost report within two years of the date the program commences operation, rates shall then be computed utilizing that cost report.

TN   #09-13  Approval Date   September 29, 2010  Supersedes TN   #06-61  Effective Date   April 1, 2009

**New York**  
**7(b)(iii)**

- (vi) If a program fails to achieve 90% or greater occupancy within two calendar years of the date of its commencing operations, rates will be calculated utilizing allowable costs reported in such second calendar year residential health care facility's cost report for the applicable sponsoring residential health care facility divided by visits imputed at 90% occupancy.
- (vii) Effective January 1, 2008, rates of payment will exclude reimbursement for the costs of transportation:
- (viii) All rates of payment established for adult day health programs operated by residential health care facilities [shall] will be subject to the maximum daily rate otherwise provided by law, provided, however, that such maximum daily rate of payment for adult day health programs operated by residential health care facilities that underwent a change of ownership subsequent to 1990 will be determined by utilizing the inpatient rate of payment of the prior operator as in effect on January 1, 1990, and further provided that in the event a residential health care facility operates an off-site adult day health program outside the regional input price adjustment region in which such facility is located, the computation of the maximum daily rate of payment for that program will utilize the weighted average of the inpatient rates of payments for residential health care facilities in the region in which the program is located, as in effect on January 1, 1990, in place of the sponsoring residential health care facility's inpatient rate of payment.

[86-2.10] Computation of basic rate.

[j] Rates for residential health care facility services for [nonoccupants] non-occupants for 1986 and subsequent rate years [shall] will be calculated in accordance with [section] §86-2.9 of this Subpart, with any operating component of the rate trended from the 1983 base year, to the rate year by the applicable roll factor promulgated by the [d]Department.

**Across the Board Increase**

- (1) For dates of service on and after November 1, 2018, the operating component of the rates of reimbursement for Adult Day Health programs operated by residential facilities, as calculated pursuant to this Attachment, will be adjusted to reflect an across the board increase of one and one-half percent (1.5%).
  - a. Sections subjected to the one and one-half percent (1.5%) increase are as follows:
    - i. Adult Day Health Care program
  - b. The capital component of the rates are not subject to the one and one-half percent (1.5%) increase.

TN #18-0063 \_\_\_\_\_

Approval Date August 21, 2019

Supersedes TN #06-0043 \_\_\_\_\_

Effective Date November 01, 2018

New York  
8

RESERVED

<u>[Type of Service</u>	<u>Method of Reimbursement ]</u>
<p>[Outpatient Hospital Mental Health Services</p> <p>Intensive Day Treatment Program (programs certified by OMH pursuant to 14 NYCRR Part 581)]</p>	<p>[In accordance with the State Mental Hygiene Law, the Office of Mental Health establishes Medicaid rates of reimbursement for outpatient programs issued operating certificates by the Office. The Intensive Day Treatment program is an outpatient program. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by Division of the Budget. The methods and standards set forth below do not apply to any other type of outpatient programs licensed by the Office of Mental Health:]</p>

TN   #10-0018   Approval Date   November 1, 2017  

Supersedes TN   #87-0031   Effective Date   July 1, 2010

**New York  
8a**

**RESERVED**

[(1) Operating Costs

Medicaid rates for Intensive Day Treatment programs are established prospectively and are all inclusive, taking into account all allowable costs and all allowable visits.

Because Intensive Day Treatment programs have not yet accumulated sufficient cost information to establish cost related rates, operating costs for all Intensive Day Treatment programs are determined on the basis of cost projections contained in budget documents prepared by Intensive Day Treatment programs selected for operation and submitted for review and approval by the Office of Mental Health.

Allowable operating costs include the costs of services approved by the Commissioner. In determining allowability of costs, the Office of Mental health reviews the categories of costs, described below, with consideration given to the special needs of the patient population to be served by the Intensive Day Treatment program. The categories of costs to be reviewed shall include, but not be limited to, the following:

- (i) Clinical care. This category of cost includes salaries and fringe benefits for clinical and direct care staff of the program.
- (ii) Other than clinical care. This category of cost includes costs associated with administration, maintenance and support expenses.

Allowable operating costs in the category of clinical care are limited to costs approved by the Commissioner in connection with his review of the Intensive Day Treatment programs staffing plan. Allowable operating costs in the category other than clinical care are limited to budgeted costs. The other than clinical costs reported will be reviewed to determine their relative impact within a given program, as well as in comparison to the universe of selected Intensive Day Treatment programs.

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 the Office of Mental Health's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

(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. A return on equity, as determined by the New York State Department of Health, is allowed for proprietary hospitals. To be allowable, capital expenditure subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.]

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New York  
9

RESERVED

<u>[Type of Service</u>	<u>Method of Reimbursement ]</u>
<p>[Ambulatory Services in Facilities Certified Under Article 31 of the State Mental Hygiene Law:</p> <p>OMH Clinic, Day and Continuing Treatment Programs</p> <p>Intensive Day Treatment Program (programs certified by OMH pursuant to 14 NYCRR Part 581) ]</p>	<p>[Flat fee developed by OMH and approved by the Division of the Budget.]</p>

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**New York**  
**10**

**Hospice Services: Routine Home Care, Continuous Home Care, Inpatient Respite Care, And General Inpatient Care**

Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII Annual adjustments shall be made to these rates commencing October 1, 1990, using inflation factors developed by the State.

The Commissioner of Health will increase medical assistance rates of payment by three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

Rates of payment will be additionally adjusted for the purpose of further enhancing the provider's ability to recruit and retain non-supervisory workers or workers with direct patient care responsibility. These additional adjustments to rates of payment will be allocated proportionally based on each hospice provider's non-supervisory workers' or direct patient care workers' total annual hours of service provided to Medicaid patients as reported in each such provider's most recently available cost report as submitted to the Department. The total aggregate available funding for all eligible hospice providers is as follows:

For the period June 1, 2006 through December 31, 2006 - \$730,000.  
 For the period January 1, 2007 through June 30, 2007 - \$730,000.  
 For the period July 1, 2007 through March 31, 2008 - \$1,460,000.  
 For the period April 1, 2008 through March 31, 2009 - \$1,460,000.  
 For the period April 1, 2009 through March 31, 2010 - \$1,460,000.  
 For the period April 1, 2010 through March 31, 2011 - \$1,460,000.  
 For the period April 1, 2011 through March 31, 2012 - \$1,460,000.  
 For the period April 1, 2012 through March 31, 2013 - \$1,460,000.  
 For the period April 1, 2013 through March 31, 2014 - \$1,460,000.  
 For the period June 5, 2014 through March 31, 2015 - \$1,460,000.  
 For the period April 1, 2015 through March 31, 2016 - \$1,460,000.  
 For the period April 1, 2016 through March 31, 2017 - \$1,460,000.  
For the period April 1, 2017 through March 31, 2018 - \$1,460,000.  
For the period April 1, 2018 through March 31, 2019 - \$1,460,000.  
For the period April 1, 2019 through March 31, 2020 - \$1,460,000.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

Hospice services providers that have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility and are prohibited from using such funds for any other purposes. Each hospice provider receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with

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New York  
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direct patient care responsibility. The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup all funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

**Type of Service**

For persons residing in nursing facilities who have elected hospice care, the Medicaid State agency will pay the hospice an amount sufficient to cover room and board as defined in Section 1905 (o) of the Social Security Act.

**Special Needs Patients**

Enhanced Medicaid rates for services to special need hospice patients are established for routine home care, continuous home care and general inpatient care using the following methodology: Use the percentages for each service component as promulgated by the CMS in the routine home care, continuous home care and general inpatient care rates, to determine service component dollar values; use documented cost data which supports specific service component enhancement to calculate amount to be added to rate as an enhancement; apportion each rate into its respective labor and non-labor component using the Medicare prescribed labor to non-labor ratios; adjust labor component of each enhanced rate to account for regional differences in wages using Medicare hospice wage indices; add adjusted labor component to the non-labor component to arrive at the regional enhanced rates.

**[Rehabilitative Services**

The New York State Office of Alcoholism and Substance Abuse Services establishes rates of reimbursement for the provision of rehabilitative services to persons in freestanding chemical dependence residential facilities. Allowable base year costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and relate to patient care. Allowable costs may not include costs for services, which have not been approved by the Commissioner. Total allowable costs are classified as either treatment related costs or room and board related costs. Utilizing only allowable treatment related costs; a provider-specific Medicaid treatment rate shall be established. The treatment rate shall consist of an operating and a capital component.]

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Supersedes TN   #11-0015  

Effective Date   July 1, 2016

**New York  
10(a.1)**

**Rehabilitative Services - Addiction Services**

**Addiction Residential Services**

The New York State Office of Alcoholism and Substance Abuse Services establishes rates of reimbursement for the provision of rehabilitative services to persons in non-hospital freestanding residential addiction facilities under part 818. Allowable base year treatment costs are determined by application of principles developed for determining reasonable cost payments for direct and indirect costs consistent with 2 CFR 200 and 45 CFR 75. Utilizing only allowable treatment related costs; a provider-specific Medicaid treatment rate shall be established. Room and board related costs are not Medicaid reimbursable. All rates are published on the State website at:

<https://www.oasas.ny.gov/mancares/documents/IPRArt32.xlsx>

Reimbursement for all other non-hospital freestanding residential addiction facilities under Part 820 are paid based upon a Medicaid fee schedule established by the State of New York. The State developed fee schedule is the same for both governmental and private individual providers. The agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the State website at:

<https://www.oasas.ny.gov/mancares/ResidentialAddictionServicesPart820.cfm>

The fee development methodology will build residential fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population. as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447 .200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate. where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

A unit of service is defined according to the Healthcare Common Procedure Coding System approved code set per the national correct coding initiative unless otherwise specified.

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**New York  
10(a.2)**

**Rehabilitative Services (42 CFR 440.130(d): OASAS outpatient community-based addiction services**

OASAS will establish regional fee schedules which recognize regional cost differences for outpatient community-based addiction rehabilitative services. All fees are subject to approval by the Division of the Budget. Outpatient community-based addiction providers are certified by OASAS pursuant to New York State Mental Hygiene Law Article 32 and not operated by a hospital.

Definitions

Except for the definitions below, the list of definitions in the APG System: Freestanding Clinics section will apply to the methodology for OASAS outpatient community-based addiction rehabilitative services.

- Peer groups and Regions - There are 6 OASAS Community-based addiction rehabilitative services peer groups. The peer groups are divided into two regions, downstate and upstate. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the rest of the State. The peer groups are as follows: Upstate outpatient addiction agencies; Downstate outpatient addiction agencies; Upstate outpatient rehabilitation agencies; Downstate outpatient rehabilitation agencies; Upstate opioid treatment agencies; Downstate opioid treatment agencies. This information is also on the OASAS website at:

<http://www.oasas.ny.gov/admin/hcf/FFS/RegionAPGBaseRate.cfm>

Providers with sites located in different regions receive reimbursement based on the region where the services are provided.

New providers of OASAS outpatient community-based addiction rehabilitative services will be paid the same as other providers in their peer group.

Units of Service – A unit for outpatient community-based addiction rehabilitative services providers is equal to a service provided to an individual on a single day. An individual may have multiple services in a single day. Providers will not be reimbursed for two of the same services a day (e.g. two individual sessions, two group sessions) or more than two different services provided in a single visit date except for medication administration, medication management, complex care management, collateral visit, and peer support services. Multiple services (where permitted) in each visit will be discounted by 10%. The single unit must include: the discrete visit dates and the multiple CPT or HCPCS codes for services that are delivered on the individual days within the period. Qualified OTPs will receive a 10% add-on for delivery of enhanced services. Qualified outpatient community-based addiction rehabilitative services providers will receive a 50% add-on for services delivered by a certified peer.

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**New York  
10(a.3)**

**Reimbursement Methodology**

Beginning in July 2016, the fee development methodology will be based on the case mix index for similar New York services. The calculation of the case mix index will be used in the periodic determination of the base rates to assure that prospective aggregate disbursements remain within available resources. The initial base rates were based on 2008 Medicaid claims data for OASAS providers. The initial update was based on claims data from 2010 for OASAS providers. Beginning in July 2016, the base rates will be updated at least every two years based on Medicaid claims from the most recent 12-month period, which is complete and accurate billing data. Community-based addiction rehabilitative services will not receive a capital add-on. The total volume of service type multiplied by the service weight and added to the other aggregated volume per service weight will determine initial case mix. Thereafter, case mix will continue to be determined by actual volume of reported services to yield the actual case mix ratio. A link to the base rates in effect can be found at:

[https://www.oasas.ny.gov/manicare/SUDOP\\_OTP.cfm](https://www.oasas.ny.gov/manicare/SUDOP_OTP.cfm)

Payment will be determined by multiplying a dollar base rates (varies by peer group) by the weight for each procedure. The weight is a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. Procedure weights are the same for all outpatient community-based addiction rehabilitative services regardless of peer group. The same weights will be applied to Addiction Rehabilitation Services and OASAS clinics operation under Mental Hygiene Law Article 32 and not operated by a hospital.

Peer Group Base Rates for outpatient community-based addiction rehabilitative services provided by OASAS licensed outpatient community-based addiction rehabilitation agencies and opioid treatment agencies.

<b>Base Rates for Outpatient Addiction Agencies</b>		
<u>Upstate</u>	<u>\$147.59</u>	<u>Effective: 7/1/2016</u>
<u>Downstate</u>	<u>\$172.69</u>	<u>Effective: 7/1/2016</u>
<b>Base Rates for Outpatient Rehabilitation Agencies</b>		
<u>Upstate</u>	<u>\$147.59</u>	<u>Effective: 7/1/2016</u>
<u>Downstate</u>	<u>\$172.69</u>	<u>Effective: 7/1/2016</u>
<b>Base Rates for Opioid Treatment Agencies</b>		
<u>Upstate</u>	<u>\$136.04</u>	<u>Effective: 7/1/2016</u>
<u>Downstate</u>	<u>\$159.17</u>	<u>Effective: 7/1/2016</u>

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New York  
10(a.4)

**Residential Medically Supervised Withdrawal Services**

Medically supervised withdrawal services are for patients at a mild or moderate level of withdrawal, or are at risk for such, as well as patients with sub-acute physical or psychiatric complications related to alcohol and/or substance related dependence, are intoxicated, or have mild withdrawal with a situational crisis, or are unable to abstain yet have no past withdrawal complications. The fee methodology described here will apply only to freestanding (non-hospital) residential medically supervised withdrawal (RMSW) facilities that are certified by the Office of Alcoholism and Substance Abuse Services (OASAS, "the Office") solely under Article 32 of the New York State Mental Hygiene Law. This methodology will not apply to Article 28 facilities.

Medicaid fees will be based on both bed size and the county in which the facility is located. The fees will be inclusive of both operating and capital reimbursement. There will be no capital add-on to these fees or any separate Medicaid reimbursement for capital costs. These fees will be effective on and after January 1, 2019 and will replace those of all prior methodologies for this service.

For new RMSW facilities the "bed size" used for the fee calculation will be based on 80% of the certified capacity rounded to the nearest integer. After the first full year of operation, the fee will be revised based on 90% of certified capacity rounded to the nearest integer. If the certified capacity changes for any RMSW program, including programs that have been in operation for less than one year, the fee will be revised based on 90% of the new certified capacity, effective on the date of the capacity change. Facilities with fewer than 6 "beds" will use the 6 bed fee.

To calculate the fee, the "statewide fee" based on calculated bed size will be taken from the first table below and then adjusted by the applicable regional factor from the second table to arrive at the facility-specific fee.

RMSW providers may request retroactive fee adjustments based on documented low service volume relative to certified capacity (underutilization). These adjustments are approvable solely at the discretion of the Office and will require compelling justification relative to the provider's inability to fill the beds. RMSW beds that were used as "swing beds" for other programs (e.g., Residential Rehabilitation) do not constitute underutilization and will not justify an RMSW fee increase. The adjusted fee will be based on the bed size calculated as follows:

(certified capacity x 365 – approved vacant days) / 365 ; rounded to the nearest integer.

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**New York  
10(a.5)**

Statewide RMSW fees:

<b>Bed Size</b>	<b>RMSW Fees</b>
<u>6</u>	\$ <u>408.97</u>
<u>7</u>	\$ <u>401.53</u>
<u>8</u>	\$ <u>395.20</u>
<u>9</u>	\$ <u>389.70</u>
<u>10</u>	\$ <u>384.85</u>
<u>11</u>	\$ <u>380.51</u>
<u>12</u>	\$ <u>376.59</u>
<u>13</u>	\$ <u>373.01</u>
<u>14</u>	\$ <u>369.74</u>
<u>15</u>	\$ <u>366.72</u>
<u>16</u>	\$ <u>363.91</u>

The geographic regions and regional cost factors applicable to the statewide fees derived from the table above and used to determine the final facility-specific free-standing residential medically supervised withdrawal fees are as follows:

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

TN #19-0017

Supersedes TN #NEW

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**New York  
10(a.6)**

**Chemical Dependence Freestanding Residential Rehabilitation Services**

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) establishes rates of reimbursement for the provision of rehabilitative services to persons in freestanding chemical dependence residential rehabilitation facilities. The fee methodology described here will apply only to freestanding (non-hospital) facilities that are certified solely under Article 32 of the New York State Mental Hygiene Law. This methodology will not apply to Article 28 facilities.

Medicaid fees will be based on both bed size and the county in which the facility is located. The fees will be inclusive of both operating and capital reimbursement. There will be no capital add-on to these fees or any separate Medicaid reimbursement for capital costs. These fees will be effective on and after January 1, 2019 and will replace those of all prior methodologies for this service.

For existing and new freestanding residential rehabilitation facilities, the “bed size” will be based on the OASAS-certified capacity of the program site. The statewide fee will be taken from the following table and then adjusted by the applicable regional factor. If the certified bed size changes, the fee will be revised accordingly and will be effective on the date of the bed size change. Facilities with fewer than 14 certified beds will use the 14 bed fee.

<b><u>Bed Size</u></b>	<b><u>Resid. Rehab Fees</u></b>
<u>14</u>	<u>\$ 327.14</u>
<u>15</u>	<u>\$ 324.07</u>
<u>16</u>	<u>\$ 321.21</u>

The geographic regions and regional cost factors applicable to the statewide fees derived from the table above and used to determine the final facility-specific freestanding CD residential rehabilitation fees are as follows:

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

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New York  
10-1

<u>Type of Service</u>	<u>Method of Reimbursement</u>
Rehabilitative Services	(1) Directly Observed Therapy (DOT) The New York State Department of Health establishes a weekly fee for the provision of Directly Observed Therapy. Fees are established to take into account service site, service complexity, service intensity, any existing relationship between the provider and the recipient, record of compliance and completion of therapy. Access to these fees will be available only to those providers who sign Provider Agreements.
Rehabilitative Services	For Freestanding out-patient providers, the Office <u>for People with</u> [of Mental Retardation and] Developmental Disabilities will utilize established statewide cost related flat clinic fees for off-site services. Fees will be assigned based on provider specific clinic costs or budgets which correspond to the fiscal cycle of the provider. All fees are subject to the approval of the New York State Division of the Budget. Access to these fees will be available only to those providers who enter into Provider Agreements. <u>The above reimbursement methodology sunsets effective December 31, 2015.</u>

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**Rehabilitative Services**

[Reimbursement for approved early intervention providers is associated with resource use patterns to ensure that evaluations and early intervention services are economically and efficiently provided. The method is based on a classification of early intervention services.

Under the reimbursement methodology, individual or combined prices are established prospectively for each service category. For each service category, a price is established to cover labor, administrative overhead; general operating and capital costs. The prices are adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in the Wage Equalization Factor section of this Attachment. All prices are subject to the approval of the New York State Division of the Budget.

Existing rates of reimbursement, for approved early intervention services provided on and after December 1, 2002, shall be increased by three percent. The Commissioner of Health is authorized to require any early intervention provider, with the exception of self-employed early intervention providers, to submit a written certification attesting that such funds were or will be used solely for the purpose of recruitment and retention of early intervention service providers during the 2002-03 state fiscal year.

Effective May 1, 2011, and applicable to services on and after May 1, early intervention program rates for approved services rendered will be reduced by 5%. Prices resulting from this reduction are published on the agency's website at:]

Effective April 1, 2019, and applicable to services on and after April 1, 2019, early intervention rates for EPSDT EI rehabilitation services rendered by licensed speech-language pathologists, licensed occupational therapists and licensed physical therapists, including supplemental evaluation services, will be increased by 5%. Rates effective April 1, 2019 are published on the Department of Health's website below.

[http://www.health.state.ny.us/community/infants\\_children/early\\_intervention/index.htm](http://www.health.state.ny.us/community/infants_children/early_intervention/index.htm)

The rates for Early Intervention services are the same for both governmental and private providers.

[Early Intervention service providers who were authorized to provide early intervention services pursuant to section 236 of the Family Court Act during 1993, shall be reimbursed actual allowable capital costs obligated prior to July 1, 1993. Such reimbursement will continue through June 30, 1996.]

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**New York  
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**[TYPE OF SERVICE**

Rehabilitative Services

**METHOD OF REIMBURSEMENT**

School Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated]

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10-1C**

[Rehabilitative Services  
(continued)]

with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

**Nursing Services**

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

**Psychological Counseling Services**

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.]

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**New York  
10-1D**

[Rehabilitative Services  
(continued)]

Psychological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.]

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**New York**  
**10-1E**

[Rehabilitative Services  
 (continued)]

Preschool Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated]

TN           #16-0020          

Supersedes TN           #92-0042          

Approval Date           November 30, 2016          

Effective Date           July 1, 2016

New York  
10-1F

[Rehabilitative Services  
(continued)]

With the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Nursing Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

Psychological Counseling Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.]

TN           #16-0020          

Supersedes TN           #92-0042          

Approval Date           November 30, 2016          

Effective Date           July 1, 2016

**New York  
10-1G**

[Rehabilitative Services  
(continued)]

Psychological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.]

TN           #16-0020          

Supersedes TN           #92-0042          

Approval Date           November 30, 2016          

Effective Date           July 1, 2016

New York  
10-2

RESERVED

**[TYPE OF SERVICE**

Case Management Services  
Target Group B:

Persons enrolled in Medical Assistance who:

- (1) Have a documented diagnosis of mental retardation or a developmental disability as defined in New York Mental Hygiene Law § 1.03, and
- (2) Are in need of ongoing comprehensive service coordination rather than incidental service coordination, and
- (3) Have chosen to receive the services, and
- (4) Do not reside in intermediate care facilities for the developmentally disabled; State operated developmental centers; small residential unit (SRU); nursing facilities, or hospitals or any other medical assistance institutional settings that provide service coordination, and
- (5) Are not concurrently enrolled in any other comprehensive service coordination service funded under Medical Assistance.

**METHOD OF REIMBURSEMENT**

The method of reimbursement shall be a monthly fee established by OMRDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget.

The method of reimbursement described in the paragraph above will sunset effective March 31, 2013.]

TN <u>  #18-0058  </u>	Approval Date <u>  02/28/2019  </u>
Supersedes TN <u>  #12-0030  </u>	Effective Date <u>  07/01/2018  </u>

**New York  
10-3**

**TYPE OF SERVICE**

Case Management Services  
Target Group D:

Medicaid eligible individuals who are served by the New York State Office of Mental Health's Incentive Case Management Region and who

- (i) are seriously and persistently mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

**METHOD OF REIMBURSEMENT**

For payment to Intensive Case Management providers in New York State a prospective cost based monthly rate shall be established for each provider. Providers may bill for the monthly rate only if the Medicaid eligible adult ICM client has been seen by the case manager a minimum of four times during the month. For Medicaid eligible seriously emotionally disturbed children in the ICM program, providers may bill for the monthly rate only if the case manager achieves a minimum of three face-to-face contacts with the client and the fourth face-to-face contact may be with either the client or a collateral, as defined in 14 NYCRR Part 587, 4(a) (3) .

Rates of payment shall be effective for the annual period ending June 30, for providers in New York City and for the annual period ending December 31, for the remainder of the State. Rates of payment for programs operated by state psychiatric centers shall be effective for the annual period ending March 31.

1. Monthly payments to individual ICM providers is at regional fees approved by the Department of Social Services.
2. The National Institute of Mental Health has approved a grant to the NYS Office of Mental Health to evaluate the effects, if any, of the method of reimbursement on the activities of case managers and the implications, if any, on client interactions and outcomes. The experimental reimbursement methodology provides fee-for-service reimbursement for individual and group face-to-face contacts between Intensive Case Manager and enrolled client as an alternative to the monthly payments paid to other ICM providers. This reimbursement methodology will be in place for the Visiting Nurse Service only for the period January 1, 1992 through December 31, 1992.

TN   #00-07  

Supersedes TN   #91-53  

Approval Date   January 10, 2001  

Effective Date   March 1, 2000

New York  
10-3(a)

**TYPE OF SERVICE**

Case Management Services  
Target Group D1:

Medicaid eligible individuals who are served by the New York State Office of Mental Health's Intensive Case Management Program and who:

- (i) are seriously and persistently mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

**METHOD OF REIMBURSEMENT**

For payments to Flexible Intensive Case Management providers in New York State a monthly fee shall be established for each provider and approved by the Division of the Budget. Providers may bill for the monthly rate only if the Medicaid eligible adult ICM client has been seen by the case manager a minimum of two times during the month. Clients who appear to be ready for disenrollment from the program can be deemed to be in transitional status, and the program can bill during that period if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

The program as a whole must provide in the aggregate four visits times the number of Medicaid recipients per month per case manager. For seriously and emotionally disturbed children's programs/providers, up to 25% of the total required aggregate visits may be made to collaterals as defined in 14NYCRR Part 587.

TN   #02-45    
Supersedes TN   #  

Approval Date   February 27, 2003    
Effective Date   December 1, 2002

New York  
10-3b

**TYPE OF SERVICE**

Case Management Services  
Target Group D2:

Medicaid eligible individuals who:

- (i) are seriously and persistently mentally ill, and
- (ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community, and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system; or are unwilling or unable to adapt to the existing mental health care system; or need support to maintain their treatment connections and/or residential settings.

**METHOD OF REIMBURSEMENT**

Each Flexible and Blended Case Management program will receive a regional rate approved by the Division of the Budget determined by its staffing combination (i.e., the number of Intensive Case Mangers and Supportive Case Mangers on a particular team). No bill can be generated for a particular client unless that client has received at least two face-to-face contacts during the month. [However, in order to bill] The program as a whole is required to [must] provide in the aggregate four visits times the number of Medicaid recipients per month per Intensive Case Management staff and two times the number of Medicaid recipients per month per Supportive Case Manager. For seriously emotionally disturbed children's programs or providers, up to 25% of the total required aggregate Intensive Case Management visits may be made to collaterals as defined in 14 NYCRR Part 587. For those programs which do not achieve the required number of contacts, billings associated with the difference between the required number of contacts and achieved number of contacts shall be withheld pursuant to a schedule furnished to the provider by the Office of Mental Health. Clients who appear [to be] ready for disenrollment from the program can be placed into transitional status. The program can bill for the individual in transitional status during that [period] month if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

TN #04-46 Approval Date March 17, 2005  
 Supersedes TN #02-45 Effective Date October 1, 2004

**New York  
10-4**

**TYPE OF SERVICE**

Case Management Services  
Target Group: F

The targeted group consists of the categorically needy or medically needy who meet one of more of the following criteria.

Certain individuals residing in areas of New York State designated as underserved and economically distressed through the State's Neighborhood Based Alliance (NBA) Initiative. Under Chapter 657 of the Laws of 1990, the NBA is targeting state money, resources and services to designated areas in order to alleviate the pervasive and detrimental effects of poverty, lack of access to services and lack of services. Case management targeted individuals are those residents of the NBA areas who are experiencing chronic or significant individual or family dysfunction's which might be ameliorated through effective case management referral and monitoring of service provision. Such dysfunction's are assessed as chronic or significant by the case manager in accordance with an assessment tool approved by the Office of Children and Families. The assessment will determine chronic or significant dysfunction on the following categories or characteristics:

- (i) school dropout
- (ii) low academic achievement
- (iii) Poor school attendance
- (iv) Foster care placement
- (v) Physical and/or mental abuse or neglect
- (vi) Alcohol and/or substance abuse
- (vii) Unemployment/underemployment
- (viii) Inadequate housing or homelessness
- (ix) family court system involvement
- (x) criminal justice system involvement
- (xi) poor health care
- (xii) family violence or sexual abuse

**METHOD OF REIMBURSEMENT**

Provider-specific rates are replaced with a regional rate structure.

The rate structure is based upon the identification of direct service components and incorporates a percentage allowance for indirect costs, based upon historical data.

The following are the direct service components of the rate:

Personal Services: Case Manager salary.

Fringe benefit: Rates were established at the average fringe rate for New York City, Greater Metropolitan and Upstate New York.

Other cost percentage will constitute a percentage of allowable costs other than case manager salary and fringe benefits such as equipment, rentals, utilities, etc.

The Rate Calculation Formula:

Direct costs/% Direct cost (%)

Billable Hours/4=Quarter Hour Rate.

Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g.

TN   #00-07  

Approval Date   January 10, 2001  

Supersedes TN   #99-03  

Effective Date   March 1, 2000

New York  
10-5

**METHOD OF REIMBURSEMENT**

Intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.

Regionally calculated percentages have been determined for New York City, Greater Metropolitan New York and Upstate New York.

Trend Factor:

The rate will be adjusted by application of a trend factor approved by the Division of the Budget.

TN   #00-07  

Approval Date   January 10, 2001  

Supersedes TN   #95-48  

Effective Date   March 1, 2000

New York  
10-5(a)

Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through the Neighborhood Based Alliance (NBA) — Target Group F on pages 10-4 and 10-5.

TN #11-83 Approval Date August 7, 2012  
Supersedes TN NEW Effective Date December 1, 2011

New York  
10-6

**TYPE OF SERVICE:**

Case Management Services  
Target Group G:

Medicaid eligible clients who are served by the New York State Department of Health's Early Intervention Program and who:

1. are infants and toddlers from birth through two years who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;
2. have been referred to the municipal early intervention agency; and
3. are in need of ongoing and comprehensive rather than incidental case management services.

**METHOD OF REIMBURSEMENT**

Reimbursement for necessary case management services provided to the client and to the family in support of the primary client under the New York State Early Intervention Program shall be at hourly rates established by the New York State Department of Health and approved by the Director of the Budget. Providers will be allowed to bill in quarter hour units.

Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capitol costs. The rates are also adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in 86-2.10(c) (5) of Attachment 4.19-A of the State Plan.

TN <u>  #00-07  </u>	Approval Date <u>  January 10, 2001  </u>
Supersedes TN <u>  #96-47  </u>	Effective Date <u>  March 1, 2000  </u>

New York  
10-7

**Target Group G – Early Intervention**

Existing rates of reimbursement, for approved early intervention services provided on and after December 1, 2002, shall be increased by three percent. The Commissioner of Health is authorized to require any early intervention provider, with the exception of self-employed early intervention providers, to submit a written certification attesting that such funds were or will be used solely for the purpose of recruitment and retention of early intervention service providers during the 2002-03 state fiscal year.

TN #02-45 Approval Date February 27, 2003  
Supersedes TN NEW Effective Date December 1, 2002

New York  
11

**TYPE OF SERVICE**

Case Management Services  
Target Groups: A & E

**METHOD OF REIMBURSEMENT**

- A. Categorically or medically needy  
Persons under age 21, pregnant  
Parenting or at risk of pregnancy

Provider- specific rates are replaced with a regional rate structure.

The rate structure is based upon the identification of direct service components and incorporates a percentage allowance for indirect costs, based upon historical data.

- E. Categorically or medically needy  
women of child-bearing age who are  
pregnant, and infants under one  
year of age.

The following are the direct service components of the rate:

Personal Services: Case manager salary.

Fringe Benefit: Rates were established at the average fringe rate for New York City, Greater Metropolitan and Upstate New York.

Other cost percentage will constitute a percentage of allowable costs other than case manager salary and fringe benefits such as equipment, rentals, utilities, etc.

The Rate Calculation Formula:

Direct costs /%Direct cost (%) /Billable hours/4=Quarter Hour Rate.

TN   #99-03  

Approval Date   August 5, 1999  

Supersedes TN   #97-10  

Effective Date   April 1, 1999

New York  
11-1

**METHOD OF REIMBURSEMENT**

Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g. intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.

Regionally calculated percentages have been determined for New York City, Greater Metropolitan New York and Upstate New York.

Trend Factor:

The rate will be adjusted by application of a trend factor approved by the Division of the Budget.

TN   #99-03  

Supersedes TN   NEW  

Approval Date   August 5, 1999  

Effective Date   April 1, 1999

New York  
11-2

Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through TASA — Target Group A and CONNECT — Target Group E on pages 11 and 11-1.

TN #11-83

Supersedes TN NEW

Approval Date August 7, 2012

Effective Date December 1, 2011

New York  
11-A

**Type of Service**

Case Management Services  
Target Group: C

**Method of Reimbursement**

C. Categorically or medically needy women of child-bearing age, clients of Community Services Programs or Community Based Programs, children and adolescents through 20 years of age who are HIV+ and categorically or medically needy women with children who are negative or unknown serostatus, but who are at risk of HIV infection as a result of their personal activities or the activities of a sexual partner.

The proposed methodology includes the following characteristics:

- o Provider-specific rates are replaced with a regional rate structure
- o Economics of scale associated with larger programs are accounted for;
- o Direct service components are established with a fixed percentage allowance for indirect costs.
- o An annual trend factor approved by the State Division of the Budget is applied in subsequent years;
- o Billable hours continues to be used as the basis for billing. The procedure used to calculate billable hours is modified to recognize non-billable responsibilities and to encourage improved service quality.

**Regional Rate**

Reimbursement amounts will be established for New York City Metropolitan area and for the rest of the state based on the expected costs in those areas of each direct services component. The New York City metropolitan region will consist of the following counties: Nassau, Suffolk, Rockland, Westchester and the five boroughs of New York City.

**Program Size Differential**

The rate structure will reflect the economy of scale produced by larger programs. Reimbursement for larger programs will decrease

TN     #93-58    

Approval Date     September 19, 1994    

Supersedes TN     #90-56    

Effective Date     January 1, 1994

New York  
11-B

based upon the following criteria:

Rate A: For provider with 0 to 6 billable FTE staff.

Rate B: For providers with more than 6 to 12 billable staff.

Rate C: For providers with more than 12 FTE billable staff.

**Direct Service Components**

The rate structure is based upon the identification of direct services components and incorporate a percentage allowance for indirect costs.

The following are the direct service components of the rate.

Personal Services: Case manager salary, case management technician salary, community follow-up worker salary and the program director salary at 50% FTE.

Fringe Benefits: Rates were established at the average fringe rate for the metropolitan and rest of state regions.

Other Direct Costs: Quality Assurance Consultant Service, training cost for CM staff, travel cost for direct staff, conference registration costs for AIDS Institute conference, crisis intervention service costs, escort costs – security.

**Indirect Cost Percentage**

Direct Service will constitute 72% of the total allowable costs with the remaining 28% available for Indirect costs such as equipment, rentals, utilities, etc.

TN   #93-58  

Approval Date   September 19, 1994  

Supersedes TN   #90-56  

Effective Date   January 1, 1994

New York  
11-C

**The rate Calculation Formula:**

Direct costs/% Direct cost (72%) /  
Billable Hours/4 = Quarter Hour Rate

(Billable hours are defined as the total of all case managers time attributable to direct client service in the various components of case management e.g. intake/screening, assessment, reassessment, monitoring, follow-up of crisis intervention.)

**Trend Factor:**

The rate will be adjusted annually by application of a trend factor drawn from the U.S. Department of Labor Statistics Economic Cost Index for civilian workers by industry division, services line; 12 months ending June 1993, and that future year rates be based on this trend factor.

TN #93-58

Approval Date September 19, 1994

Supersedes TN #90-56

Effective Date January 1, 1994

New York  
11-D

**TYPE OF SERVICE**

Case Management Services  
Target Group H:

The target group consists of medical assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program and who:

- (i) are seriously mentally ill; and
- (ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) heavy service users who are known to staff in emergency rooms, acute inpatient units, and psychiatric centers as well as providers of other acute and crisis services, who may have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities; or
- (2) persons with recent hospitalizations in either state psychiatric centers or acute care general hospitals; or,

**METHOD OF REIMBURSEMENT**

Provider Reimbursement for Target Group H

For payment to Supportive Case Management providers in New York State, monthly fees shall be established for each region for SCM Medicaid programs which are not OMH operated and Statewide fees for SCM Medicaid programs operated by OMH. Providers may bill for the monthly fee only if the medicaid eligible recipient has been seen by the case manager a minimum of two times during the month. Clients ready for disenrollment may be placed into "transitional" status for a period not to exceed two months, and during that period the program/provider can bill for a maximum face to face contact of one visit per month. The minimum amount of time required for a client encounter to be credited for the purpose of Medicaid reimbursement is 15 minutes.

The fees for SCM providers will be recommended by OMH, and approved by the State Division of the Budget (DOB). OMH will consult with DOH and DOB regarding any changes to the regulations.

- 1. The regional fees for SCM Medicaid providers which are not OMH operated shall be based upon OMH approved expenditures per SCM in each OMH region and the maximum caseload per SCM approved by OMH for the individual provider. These regional fees shall be developed as follows:

TN #01-02

Approval Date June 19, 2001

Supersedes TN #94-40

Effective Date January 1, 2001

New York  
11-E

(3) mentally ill who are homeless and live on the streets or in shelters; or,

(4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without intervention, be institutionalized, incarcerated or hospitalized; or,

(5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication management and generally improving the individual's quality of life within the community.

**METHOD OF REIMBURSEMENT**, con.

a) Each SCM provider shall be approved for maximum monthly caseloads per SCM employed by the provider of either 20 or 30 enrolled clients.

b) The regional monthly fee for SCM providers approved for 20 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 20 X 12 months X 90%.

c) The regional monthly fee for SMC providers approved for 30 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 30 X 12 months X 90%.

2. The State monthly fees for SCMs employed directly by OMH in either free standing or shared staff arrangements with caseloads of 20 clients or 30 clients shall be the lesser of fees established using the methodology described in 1, above, or fees prescribed by DOB.

TN     #01-02    

Approval Date     June 19, 2001    

Supersedes TN     #94-40    

Effective Date     January 1, 2001

New York  
11-F

**TYPE OF SERVICE:**

Case Management Services

Target Group I:

Reimbursement for services provided to Target Group I, as described in Supplement 1 to Attachment 3.1A, pages I-1 through I-18...

**METHOD OF REIMBURSEMENT**

Reimbursement for case management services provided to children under the New York SSHSP and PSHSP shall be at fees established by the Department of Health and approved by the Director of the Budget.

TN   #96-41  

Approval Date   January 21 1996  

Supersedes TN   NEW  

Effective Date   October 3, 1996

New York  
11(f)(1)

The New York State (NYS) School Supportive Health Services Program (SSHSP) Targeted Case Management (TCM) for Target Group I, which became effective on October 3, 1996, is terminated on July 1, 2010.

TN #10-35

Supersedes TN NEW

Approval Date December 14, 2010

Effective Date July 1, 2010

New York  
11(g)

**Case Management Target Group M Method of Reimbursement:**

**Rate Methodology for Targeted Case Management Services for First-time Mothers/Newborns**

Visit-based rates have been calculated for Targeted Case Management services for the First-Time Mothers/Newborn Program. The rates will allow for costs of nurses, supervisors, fringe benefits and overhead related to providing targeted case management services only. Rates are based on a two and one-half year program cycle. The maximum length of a visit is sixty-six minutes and is billed in fifteen-minute increments with a maximum of two-hundred and sixty increments.

Allowable nursing and nursing supervisor salaries are determined based on a time study and an analysis of registered nurses' salaries in the counties in the state that will be providing targeted case management services. The allowable number of supervisors for reimbursement purposes is based on a time study and is to not exceed one supervisor per seven nurses. The allowable number of nurses for reimbursement purposes is based on a time study and is not to exceed one nurse per 24 clients. Fringe benefits are capped at thirty percent (30%) of salaries of agency nurses and supervisors, and agency overhead is capped at twenty-five (25%) of agency nurse and supervisor salaries and fringe benefits.

The total percentage of fringe costs is calculated by dividing the fringe benefit amount by the total amount of agency nurse and supervisor salaries and is capped at 30% of the salaries of agency nurses and supervisors. The total percentage of agency overhead costs is calculated by adding the totals of all other agency administrative and overhead costs (agency costs exclusive of nurse salaries, supervisor salaries and fringe benefits), and then dividing this amount by the total of agency nurses and supervisors salaries and allowable fringe benefit expenditures and is capped at 25% of the allowable salaries and fringe benefits of agency nurses and supervisors.

Hourly rates are calculated by dividing total allowable agency expenditures by the total number of nurse-hours in one year. This amount is divided by four (4) to determine the 15-minute incremental unit-of-service in which the visit will be billed.

The agency's rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are published in the various program manuals and are also available upon request from the State agencies involved. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.

TN   #09-57   Approval Date   April 6, 2010    
Supersedes TN   NEW   Effective Date   April 1, 2009

## New York 11(h)

### Harm Reduction Services:

**Method of Reimbursement:** The proposed methodology includes the following characteristics:

- A regionally based payment structure of rates billable in quarter-hour and half-hour units of service:
  - To be eligible for payment, a service that is billed in quarter-hour units must be at least 8 minutes in duration; each unit of service provided beyond the initial 15 minutes must be at least 8 minutes in duration. Similarly, services eligible for billing in half-hour units must be at least 15 minutes in duration; each unit of service provided beyond the initial 30 minutes must be at least 15 minutes in duration;
- Direct service cost components are established with a fixed percentage allowance for indirect costs;
- An annual trend factor based on the Medicare Economic Index and approved by the State Division of Budget is applied 12 months following the effective date of the rates and on an annual basis thereafter; and
- The proportion of staff time that is devoted to billable activities is 55%. The procedure used to calculate billable activities recognizes non-billable responsibilities and other activities that encourage improved service quality, such as chart documentation, staff training, phone calls to medical and other providers on behalf of clients.

No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

**Regional Rates:** Regional rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Such rates are posted to the Department of Health's website at:

[http://www.health.ny.gov/diseases/aids/providers/prevention/harm\\_reduction/index.htm](http://www.health.ny.gov/diseases/aids/providers/prevention/harm_reduction/index.htm)

**Direct Service Cost Components:** The rate structure is based on the identification of direct service components and incorporates an allowance for other non-personal services direct costs.

The following are the direct service components of the rate:

**Personal Services:** Salaries for direct service staff such as harm reduction counselors; peers; case managers and service coordinators; and program directors/supervisors, as appropriate for a specific region.

**Fringe Benefits:** Rates were established at the average fringe rates for the New York City region and the rest of the state.

**Other Non-Personal Services Direct Costs:** Space, utilities, phone, equipment, maintenance, supplies, and travel cost for direct service staff, as appropriate.

**Indirect Cost Component:** Indirect costs are included in the rate at 10% of total direct service component costs.

TN           #13-0019          

Approval Date           August 10, 2017          

Supersedes TN           NEW          

Effective Date           April 01, 2014

New York  
11(i)

**The Rate Calculation Formula:**

(Direct costs + Indirect costs) / Adjustment to account for non-billable activities

(Non-billable activities encompass those components of harm reduction attributable to direct client service, such as, crisis intervention, opioid overdose prevention training, and other activities necessary to or in support of providing harm reduction services.)

Effective Date: Rates for harm reduction services will be effective on or after April 1, 2014.

TN #13-0019

Approval Date August 10, 2017

Supersedes TN NEW

Effective Date April 01, 2014

New York  
12

FFY 1995 Medicaid Utilization Data  
for Selected Physician Procedure Codes

PROCEDURE	CLAIMS	AMOUNT PAID	RECIPS	AVG. S/CLAIM
<b>MATERNITY CARE AND DELIVERY</b>				
<b><u>VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE</u></b>				
59400	14, 545	\$12, 857,012	11,446	\$883.96
59409	21, 257	\$13,524,496	19,801	\$636.24
59410	32, 471	\$21,048,830	30,066	\$648.23
59414	170	\$5, 847	167	\$34.39
59430	2, 616	\$109,433	2,319	\$41.83
<b><u>CESAREAN DELIVERY</u></b>				
59510	7,392	\$3,635,548	5,705	\$491.82
59514	7,404	\$3,589,726	8,204	\$484.84
59515	13,812	\$5,803,066	10,818	\$420.15
59525	10	\$1,148	8	\$114.80
<b>PEDIATRIC PRACTICER SERVICES</b>				
<b><u>IMMUNIZATION INJECTIONS</u></b>				
90701	57,486	\$962,025	48,204	\$16.73
90712	124,499	\$2,068,330	97,100	\$16.77
90737	45,753	\$832,702	36,967	\$18.20
<b><u>EVALUATION AND MANAGEMENT</u></b>				
99201	9,734	\$92,546	9,474	\$9.51
99202	72,211	\$835,025	66,971	\$11.56
99204	86,220	\$1,137,787	80,039	\$13.20
99205	116,759	\$2,401,228	108,937	\$20.57
99211	37,125	\$871,248	35,135	\$23.47
99212	123,479	\$963,475	71,694	\$7.96
99213	934,106	\$10,124,967	371,351	\$10.84
99214	979,713	\$11,456,462	373,759	\$11.69
99215	583,111	\$10,761,701	286,706	\$18.46
	83,562	\$1,852,665	53,278	\$22.17
<b><u>PREVENTITIVE MEDICINE SERVICES</u></b>				
99381	2,383	\$73,922	2,342	\$31.02
99382	1,983	\$62,535	1,874	\$31.54
99383	1,738	\$58,288	1,677	\$33.54
99384	1,014	\$32,917	987	\$32.46
99391	8,617	\$267,553	5,246	\$31.05
99392	12,736	\$419,094	10,206	\$32.91
99393	7,633	\$255,916	7,375	\$33.53
99394	3,412	\$108,266	3,333	\$31.14

SOURCE: FFY 1995 PHYSICIAN AND CTHP 8-79 REPORTS.  
QUESTIONS: NANCY HANSEN @ 518-473-8797

TN #97-11

Approval Date April 23, 1997

Supersedes TN NEW

Effective Date April 1, 1997

**New York  
12-1**

New York State Department of Health

Office of Medicaid Management

February 28, 1997

State Plan for April 1, 1997 - March 31, 1998

## OB/GYN

## Family Practitioner

## Pediatricians

Region	Estimated Physicians	Participating Physicians	%	Estimated Physicians	Participating Physicians	%	Estimated Physicians	Participating Physicians	%
I	221	199	90%	279	268	96%	344	402	177%
II	189	173	92%	177	135	76%	326	344	106%
III	227	245	108%	380	370	97%	288	319	111%
IV	188	185	98%	324	321	99%	266	290	109%
V	967	775	80%	602	508	84%	1757	1620	92%
VI (NYC)	1073	770	72%	373	361	97%	1901	1936	102%
Rest of State	1792	1577	88%	1762	1602	91%	2981	2975	100%
Statewide	2865	2347	82%	2135	1963	92%	4882	4911	101%

Source: Participating Physicians: PVR 661 Report run date 12/10/96.

TN   #97-11  

Approval Date   April 23, 1997  

Supersedes TN   #96-11  

Effective Date   April 1, 1997

**New York  
12-2**

**February 1997-New York  
Preferred Physician & Childrens  
Program**

**Upstate****Downstate**

W5000* \$36.00	Well Child – Healthy New Borns & Children Under 18 Years	\$44.00
W5000* \$33.00	Class I Condition	\$39.00
W5000* \$31.00	Medication Administration	\$37.00
W5000* \$42.00	Generally Healthy Children 17-21	\$50.00
W5000* \$37.00	Class II Condition	\$44.00
W5000* \$38.00	Gynecological Exam Females under 21 years	\$45.00
W5000* \$37.00	Reproductive – all patients males or females under 21 w/reproductive	\$44.00
W5000* \$38.00	Class III Condition	\$45.00
W5000* \$69.00	Chemotherapy	\$83.00
W5000* \$44.00	Class IV Condition	\$53.00
W5000* \$36.00	Class V Condition	\$42.00
W5000* \$29.00	Ophthalmology	\$34.00

TN   #97-11  Approval Date   April 23, 1997  Supersedes TN   #96-11  Effective Date   April 1, 1997

**New York  
12-3**

W5000* \$34.00	Default – used when there is some minor information missing from a valid claim	\$29.00
W5004* \$30.00	Emergency Room Visit	\$36.00
W5000 \$67.00	(OB/GYN) 1 <sup>st</sup> Prenatal – females under 21 years with confirmed pregnancy	\$83.00
W5000 \$40.00	Prenatal revisits – females under 21 years with confirmed pregnancy	\$48.00
W5000 \$50.00	Postpartum pregnant females under 21 years (revised 1/94)	\$50.00

TN   #97-11  Approval Date   April 23, 1997  Supersedes TN   #96-11  Effective Date   April 1, 1997

New York  
12-4

**MEDICAID OBSTETRICAL AND MATERNAL SERVICES (MCMS)  
PROCEDURE AND FEE SCHEDULE  
CURRENT as of February 1997**

59400	Global Fee	\$1,440.00
59410	Vaginal Delivery or Cesarean	\$960.00
59420	Antepartum care only initial visit	\$69.00
W0003	Antepartum care only subsequent visit	\$59.00
59430	Postpartum care only	\$59.00

TN   #97-11   Approval Date   April 23, 1997    
Supersedes TN   #96-11   Effective Date   April 1, 1997

**New York  
12-5**

**Child Teen Health Program  
As of February 1997**

**NEW PATIENT**

99384	Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)	\$29.00
99383	late childhood (age 5 through 11 years)	\$29.00
99382	early childhood (age 1 through 4 years)	\$29.00
99381	infant (age under 1 year)	\$29.00
99381	not listed separately procedure code 99831 should be used.	

**ESTABLISHED  
PATIENT**

99394	Interval history and examination related to the healthy individual, including anticipatory guidance; periodic type of examination; adolescent (age 12 through 17 years)	\$29.00
99393	late childhood (age 5 through 11 years)	\$29.00
99392	early childhood (age 1 through 4 years)	\$29.00
99391	infant (age under 1 year)	\$29.00

TN   #97-11  Approval Date   April 23, 1997  Supersedes TN   #96-11  Effective Date   April 1, 1997

New York  
12-6

**Health Maintenance Organization (HMO) Obstetrical and Pediatric Services:**

Section 6306.3 requires that data on HMO obstetrical and pediatric services be given.

Health Maintenance Organizations with Section 1903 (m) Medicaid contracts must offer medical benefit packages that include pediatric and obstetrical services, which at a minimum, must be equal in scope and accessibility as that available to the HMO's are prospectively negotiated, monthly capitation rates which represent payment in full for all the services provided by the HMO's to their Medicaid membership.

The capitation rates are developed by a nationally known expert actuarial firm, and are capped at a percentage of historical Medicaid fee for service costs, which are trended and adjusted to reflect current Medicaid cost experience, including the costs of obstetrical and pediatric services. In many cases the HMO's themselves have chosen to pay their health care practitioners the same rates of payment or use the same payment methodology for service members. Thus the availability of pediatric and obstetrical services to Medicaid recipients enrolled in HMO's is equal to that available to the HMO's general membership.

TN   #97-11   Approval Date   April 23, 1997    
Supersedes TN   #96-11   Effective Date   April 1, 1997

**New York  
12-7**

**New York State Department of Social  
Services Regions**

<b>REGION</b>	<b>DISTRICTS</b>	
I	Allegany Cattaraugus Chautauqua Erie	Genesee Niagara Orleans Wyoming
II	Chemung Livingston Monroe Ontario Schuyler	Seneca Steuben Wayne Yates
III	Broome Cayuga Chenango Cortland Herkimer Jefferson Lewis	Madison Oneida Onondaga Oswego St. Lawrence Tioga Tompkins
IV	Albany Clinton Columbia Delaware Essex Franklin Fulton Greene Hamilton	Montgomery Otsego Rensselaer Saratoga Schenectady Schoharie Warren Washington
V	Dutchess Nassau Orange Putnam Rockland	Suffolk Sullivan Ulster Westchester
VI	New York City	

TN   #97-11  Approval Date   April 23, 1997  Supersedes TN   #96-11  Effective Date   April 1, 1997

New York  
13

TYPE OF SERVICE

Emergency Services for Illegal Aliens

METHOD OF REIMBURSEMENT

Reimbursement for treatment of emergency medical conditions for aliens not lawfully admitted for permanent residency or otherwise permanently residing in the United States under color of law shall be in the same amount (fee or rate dependent on provider type) as for all other Medicaid eligibles.

TN #87-47

Approval Date November 21, 1991

Supersedes TN NEW

Effective Date October 1, 1987

New York  
14

**Clinic Services for Federally Qualified Native American Health Centers not subject to licensure under Article 28 of the State Public Health Law**

Reimbursement for federally qualified health centers located on Native American reservations and operated by Native American tribes or tribal organizations pursuant to applicable Federal Law and for which State licensure is not required will be established consistent with the methodology applicable to freestanding diagnostic and treatment centers, including federally qualified health centers which are licensed under Article 28 of the State Public Health Law. The reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Prospective all inclusive rates of payment will be calculated by the Department of Health, based on the lower of allowable average operating costs per visit or the group ceiling trended to the current year as permitted by law, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2000] 2003. The facilities will be compared with other facilities offering similar types of services. The rates will include a capital component which is not subject to ceiling limitations. Rates are subject to approval of the Division of the Budget. The facilities will be required to forward to the Department of Health on an annual basis any necessary financial and statistical information.

The provisions of this section pertaining to reimbursable base year administrative and general costs of a provider of services shall be deemed to be in full force and effect through March 31, 1999, and from July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003.

The facility specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

TN #00-0001 Approval Date November 21, 1991  
Supersedes TN 99-0043 Effective Date October 1, 1987

New York  
14(a)

**Methods and Standards for Establishing Payment rates for Indian Health Service  
and Tribal 638 Outpatient Facilities**

- Indian Health Service outpatient facilities are paid the outpatient per visit rate published in the Federal Register.
- Tribal 638 outpatient facilities are paid using the outpatient per visit rate published in the Federal Register.
- Indian Health Service outpatient facilities are paid using the same methodologies and standards as non-HIS facilities of the same type.
- Tribal 638 outpatient facilities are paid using the same methodologies and standards as non-Tribal facilities of the same type.
- Indian Health Service outpatient facilities are paid using the methodology described below:
- Tribal 638 outpatient facilities are paid using the methodology decreed below:

Tribal 638 outpatient facilities, operating as diagnostic and treatment centers and designated by the Department as eligible facilities, are paid using the outpatient per visit rate published in the Federal Register, as an all inclusive rate for medical services as otherwise provided by diagnostic and treatment centers licensed under Article 28 of the Public Health Law.

TN #99-39

Approval Date December 9, 1999

Supersedes TN NEW

Effective Date July 1, 1999

New York  
(15)

**Reimbursable Assessment on Ambulatory Care Services**

[Assessments]

Effective January 1, 1997, rates of payment for outpatient services provided by general hospitals including referred ambulatory services and emergency services, and diagnostic and treatment centers providing a comprehensive range of primary health care services or ambulatory surgical services shall be increased by 5.98 percent to reimburse an assessment on net Medicaid patient service revenues. For services provided on and after July 1, 2003, the percentage shall be increased from 5.98% to 6.47%.

Effective October 1, 2000, reimbursement of the [5.98%] assessment on Medicaid net patient service revenue received for referred ambulatory clinical laboratory services of hospitals and diagnostic and treatment centers will be discontinued.

Effective January 1, 2006, an assessment on net patient services revenue for the ambulatory care services identified above that are rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.

TN #06-08  
Supersedes TN #03-31

Approval Date June 20, 2006  
Effective Date January 1, 2006

New York  
16

TYPE OF SERVICE

METHOD OF REIMBURSEMENT

Primary Care Case Management

PCCMs may be reimbursed on a capitated or fee-for-service basis and may be paid case management fees. If capitated, the capitation will cover primary care services routinely provided in a primary care practitioner's office.

TN #00-43

Approval Date March 28, 2001

Supersedes TN NEW

Effective Date October 1, 2000

New York  
16(a)

**Hyperbaric Oxygen Therapy (HBOT)**

The Department of Health will continue to conduct a pilot reimbursement program for a period of three additional years to study and determine the efficacy of funding certain outpatient HBOT services provided by select hospitals in New York State.

- (a) Hospitals will be selected based upon their experience in providing outpatient HBOT services and pending appeals to establish specialty outpatient HBOT rates of reimbursement, which were submitted to the Department no later than January 25, 2000. In order to participate in the program, such hospitals will be required to submit quarterly reports to the Department that include specific measurable outcomes in order to determine the effectiveness of the program.
- (b) Outpatient HBOT services covered by Medicaid in this pilot program include only those listed in Section 35-10A of the Medicare Coverage Issues Manual published by the [Health Care Financing Administration] Centers for Medicare And Medicaid Services.
- (c) The payment rate for outpatient HBOT services provided in accordance with Section 35-10A of the Medicare Coverage Issues Manual shall be the current Medicare APC rate paid through the hospital outpatient prospective payment system.

TN #04-04 Approval Date March 16, 2004  
Supersedes TN #01-05 Effective Date January 1, 2004

New York  
17

Type of Service

Method of Reimbursement

Program of All-Inclusive Care  
for the Elderly (PACE)

The Department uses the following process  
in establishing rates:

The Department will determine a fee-for-  
service equivalent per member per month  
cost for State Plan approved services  
provided to an equivalent non-enrolled  
population group. This information; and/or  
any information received from the PACE  
provider, such as the provider's anticipated  
enrollment, projected utilization of services  
and costs, cost experience, and  
indirect/overhead costs; and/or any other  
relevant information, will be used by the  
Department to determine a per member per  
month capitation rate for the provider that  
is less than the fee-for-service equivalent  
per member per month cost determined by  
the Department.

TN #02-01

Approval Date September 3, 2002

Supersedes TN NEW

Effective Date January 1, 2002

**New York  
17(a)**

**Upper Payment Limit and Rate Methodology**

The methodology used by New York State to determine a Medicaid capitation PMPM rate for a PACE provider follows a two-step process. First, the Department determines a fee for service equivalent per member per month cost for State Plan approved services provided to an equivalent non-enrolled population group. This is called the Upper Payment Limit (UPL). Then, this cost level, and/or any information received from the PACE provider, such as they provider's anticipated enrollment, projected utilization of services and costs, and/or any other relevant information, are used by the Department of Health to determine a per member per month capitation rate. This rate does not exceed the fee for service equivalent per member per month cost (i.e., the UPL in step one) developed by the Department.

In the following two sections, these two steps in the rate determination process are described in more detail.

**Step 1: Development of the Upper Payment Limit (UPL)**

The purpose of the Upper Payment Limit is for the State to ensure that the Medicaid monthly capitation payment amount for a PACE provider is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.

The base period data file used by the Department for the purpose of developing the UPL's was an individual-specific file on recipients, 55 years of age or older, of long term care services in New York State's fee for service program. These long term care services included community based services as well as nursing home care. Only the costs of State Plan approved services from this data file were used for the development of the UPL's. The data file contained expenditures by category of service and eligibility category. Since the file was of recipients of long term care services under the State's Medicaid program, individuals qualifying under the QMB Only, QDWI, SLMB, Q11, and Q12 programs were by definition excluded from this data base. Furthermore, recipients enrolled in capitated Medicaid managed care programs, including PACE participants, and their services were excluded.

TN <u>  #04-02  </u>	Approval Date <u>  April 13, 2004  </u>
Supersedes TN <u>  #02-01  </u>	Effective Date <u>  January 1, 2004  </u>

**New York  
17(b)**

In order to prepare the base period fee for service data file for further analysis, a number of adjustments were made. Claims completion factors were developed based on an examination of the data to determine the claims payment lag by service category. These completion factors were then applied to adjust the base period file expenditures. The pharmacy expenditures in the file were adjusted to net out the impact of rebates for pharmaceutical drugs. For transportation expenditures, an adjustment was made for payments not processed through the MMIS. In order to develop the UPL's for premium groups pertaining to Medicaid Only Eligible individuals, adjustments were also made to the hospital inpatient expenditures in the base period files to exclude graduate medical education (GME) payments, since PACE providers do not make a GME payment to their contracted hospitals.

Once the base period expenditure data were assembled and adjusted as described above, the data base was separated into the Medicare Medicaid Dual Eligible individuals and Medicaid Only Eligible individuals to proceed with UPL development. As a first step, analyses were undertaken to assess the need to smooth the data to improve the variability of rates and improve average predictability. For example, since it was intended that provider capitation rates and hence the UPL's were to be on a county specific level, an analysis was performed to determine whether significant cost variations existed across counties within a given region. A finding of such variation would suggest a smoothing adjustment. However, the analysis of the dual eligible population did not find that variations in costs within regions were significant and hence no smoothing adjustment was applied to the expenditure data for this purpose. No stop less provisions are included in the PACE capitation rates and hence no such feature was reflected in the UPL development.

The analyses of the data base on the fee for service expenditures of individuals eligible for Medicaid Only found that the numbers of long term care recipients by county were extremely small for several counties. Hence, in lieu of UPL's developed on a county specific basis for the Medicaid Only Eligible population, region specific UPL's were developed. The regions used were New York City, Downstate Suburban, Upstate Urban, and Upstate non-Urban counties.

TN <u>  #04-02  </u>	Approval Date <u>  April 13, 2004  </u>
Supersedes TN <u>  #02-01  </u>	Effective Date <u>  January 1, 2004  </u>

**New York  
17(c)**

The data were also examined to determine the appropriate rate category groupings. In lieu of age based or gender based rate groupings, the State chose to differentiate Upper Payment Limits by a "High" and a "Low" risk group based on an analysis of cost variation among fee for service enrollees. The "High" group was defined as representing individuals with a DMS-1 score of 180; the "LOW" group represented individuals with a score of 60 to 179. The DMS-1 is the state designated tool for determining nursing facility level of care. The UPL for each county, and the UPL for each region for the Medicaid Only Eligible population were separated into a "High" and "Low" category using the thresholds:

Using the base year fee for service expenditures as described above, updates of the UPL's for a given rate year were achieved through inflation factors based on State fee for service increases in rates for various categories of expenditures pertaining to the long term care population. This update also included a review for program changes in fee for service long term care for inclusion into the UPL's.

The methodology, as described above, produced Upper Payment Limits for the PACE eligible population, i.e., individuals who are Medicare/Medicaid dual eligible and are 55 years of age or older and certified for nursing home care, on a county specific basis in rate period dollars. Separate UPL's were determined for the "High" and "Low" groups. Regional UPL's, separated into the "High" and "Low" categories were also produced for the PACE eligible population who have only Medicaid coverage and are 55 years of age or older.

**Step 2: Provider Rate Proposal Submission and Rate Determination**

This step constitutes the second step in the process of rate determination, with the UPL development (as described above) being the first. Each PACE provider submits a rate proposal to the State. The State provides the format, guidelines, and instructions for the rate proposal document. In the rate proposal, the provider is instructed to indicate anticipated enrollment, identify the types of services that will be provided to its enrollees, projected levels of utilization of services and the assumptions underlying these projections, and projected prices the provider will have to pay for these services. The rate proposal by a provider shows the monthly capitation rate being requested separately for the "High" and "Low" groups:

TN <u>  #04-02  </u>	Approval Date <u>  April 13, 2004  </u>
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New York  
17(d)

The rate proposal submitted by the provider is reviewed by the State. This review evaluates the reasonableness of utilization projects, appropriateness of unit prices of services, provider arrangements, expected administrative expenditures, historical cost experience and other factors. The result of this review is a capitation rate separately for the "High" and "Low" groups, determined by the State, after discussions with the plan. This capitation rate excludes the enrollee share amount based on the enrollee's applicable spenddown liability and Net Available Monthly Income (NAMI). The State ensures that the capitation rate approved for the provider does not exceed the appropriate upper payment limit (UPL) as developed in step one described above. The rate determined by the Department is subject to the approval of the State Division of the Budget.

TN     #04-02     Approval Date     April 13, 2004      
Supersedes TN     #02-01     Effective Date     January 1, 2004

New York  
17(e)

**Type of Service**

**Early and Periodic screening, diagnostic and treatment services**

Early and Periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Reimbursement Methodologies for Early and Periodic Screening, Diagnostic and Treatment Services provided as the School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) Programs

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are delivered by or through a school district[, a Section 4201 school], a county in the State or the City of New York and include the following Medicaid services as described in Appendix 1 to Attachment 3.1-A and B of the Medicaid State Plan under item 4.b, EPSDT.

- 1. Physical Therapy Services
- 2. Occupational Therapy Services
- 3. Speech Therapy Services
- 4. Psychological Counseling
- 5. Skilled Nursing Services
- 6. Psychological Evaluations
- 7. Medical Evaluations
- 8. Medical Specialist Evaluations
- 9. Audiological Evaluations
- 10. Special Transportation

Effective for dates of service on or after September 1, 2009, payments to a school district[, a Section 4201 school], a county in the State or the City of New York for School Supportive Health Services and Pre-School Supportive Health Services shall be based on fees established by the Department of Health.

TN   #17-0057  

Approval Date   November 28, 2017  

Supersedes TN   #09-0061  

Effective Date   July 1, 2017

**New York  
17(f)**

Fees will be established for each service or procedure and, except for Special Transportation, such fees shall be set at 100[75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], and counties in the state and the City of New York.

**1. Physical Therapy Services**

Fees for physical therapy services and procedures shall be set at 100 [75]% percent of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance for school districts[, Section 4201 schools], counties in the State and the City of New York.

**2. Occupational Therapy**

Fees for occupational therapy services and procedures shall be set at 100 [75]% of the 2017[2010] Medicare fee schedule for the Mid Hudson Region.

Fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

TN #17-0057

Approval Date November 28, 2017

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Effective Date July 1, 2017

New York  
17(g)

**3. Speech Therapy Services**

Fees for speech therapy services and procedures shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

**4. Psychological Counseling**

Fees for psychological counseling services shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

**5. Skilled Nursing Services**

Fees for skilled nursing services shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

TN #17-0057

Approval Date November 28, 2017

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Effective Date July 1, 2017

New York  
17(h)

**6. Psychological Evaluations**

Fees for psychological evaluations shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

**7. Medical Evaluations**

Fees for medical evaluations shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

**8. Medical Specialist Evaluations**

Fees for medical specialist evaluations shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

TN #17-0057

Approval Date November 28, 2017

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Effective Date July 1, 2017

New York  
17(i)

**9. Audiological Evaluations**

Fees for audiological evaluations shall be set at 100 [75]% of the 2017 [2010] Medicare fee schedule for the Mid Hudson Region.

Such fees shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

**10. Special Transportation**

One way rates of payment for special transportation services have been set based on a statistically valid cost study that was conducted in 1999 to establish round trip transportation rates. Such rates have been trended forward based on changes in the Consumer Price Index from 7/99 through 8/09 and converted to one way rates.

Such rates shall be published on the Department of Health's website, on the State Education Department's website, on the eMedNY website and shall be issued in policy and billing guidance distributed to school districts[, Section 4201 schools], counties in the State and the City of New York.

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**School Supportive Health Services Program (SSHSP)**

**A. Reimbursement Methodology for SSHSP**

School-based services, known as School Supportive Health Services (SSHS), are delivered by the school districts and include the Medicaid services as described in Attachments 3.1-A and 3.1-B of the Medicaid State Plan under item 4.b, Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). School districts will be paid only for direct Medicaid-covered services provided pursuant to an Individualized Education Program (IEP). School Supportive Health Services include:

1. Physical Therapy Services
2. Occupational Therapy Services
3. Speech Therapy Services
4. Psychological Counseling
5. Skilled Nursing Services
6. Psychological Evaluations
7. Medical Evaluations
8. Medical Specialist Evaluations
9. Audiological Evaluations
10. Special Transportation

**B. Direct Medical Payment Methodology**

Effective for dates of service on or after October 1, 2011, providers with the exception of those located in a city with a population of over one million will be paid on a cost basis. Providers will be reimbursed interim rates for SSHS direct medical services per unit of service at the statewide interim rate as specified in the EPSDT section of this Attachment. On an annual basis a district-specific cost reconciliation and cost settlement for all over- and under-payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period. SSHSP providers must maintain organized and confidential documentation regarding the services provided, including written orders; session notes; and students' Individualized Education Programs. Such documentation must be maintained for a period of six years from the date the services were furnished or billed, whichever is later.

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**C. Data Capture for the Cost of Providing Health-Related Services**

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data sources:
  - a. SSHS cost reports received from school districts, in the State of New York, inclusive of the Allowable cost categories defined in paragraphs D.1 and D.2 of this section;
  - b. Random Moment Time Study (RMTS) Activity Code 4.b (Direct Medical Services) and Activity Code10 (General Administration):
    - i. Direct medical RMTS percentage; and
  - c. School District specific Individualized Education Program (IEP) Medicaid Eligibility Ratios

A glossary of the key terms used in the cost reporting process described in the SSHSP section can be found as Appendix 2 of the New York State Department of Health Guide to Cost Reporting for the School Supportive Health Service Claiming Program.

**D. Data Sources and Cost Finding Steps**

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. **Allowable Costs:** Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by school districts under Attachments 3.1-A and 3.1-B of the State Plan, excluding transportation personnel costs which are to be reported under *Special Transportation Services Payment Methodology* section as described in paragraph E of this section. These direct costs will be calculated on a Medicaid provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual SSHS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited district level payroll and general ledger data maintained at the district level.

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*a. Direct Medical Services*

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits (employer paid);
- iii. Medically-related purchased services; and
- iv. Medically-related supplies and materials.

*b. Contracted Service Costs*

Contracted service costs represent the costs incurred by the Local Education Agency (LEA) for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs. Contracted service costs are not eligible for the application of the unrestricted indirect cost rate.

*c. Tuition Costs*

Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district (private school, §4201 school) or preschool agency setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services and are not eligible for the application of the unrestricted indirect cost rate. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each out-of-district provider and will be calculated annually based on annual financial reports, the CFR, submitted to the New York State Education Department (SED). The CFRs used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering October 1, 2011 – June 30, 2012, the CFRs from the 2009-2010 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)

and the State Education Department website at:

<http://www.oms.nysed.gov/medicaid/CPEs/home.html>.

The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

**NOTE:** Effective with the cost reporting period beginning on July 1, 2013 a health related portion of tuition payments related to the provision of IEP direct medical services for students in §4201 schools may be included in the cost report for the school district of residence. Effective July 1, 2013 §4201 schools are not eligible to bill for Medicaid services.

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For cost reporting periods prior to July 1, 2013 school districts will not be allowed to include any costs associated with tuition payments made to §4201 schools as these entities were eligible to bill for Medicaid services during these periods.

**NOTE:** When an LEA incurs costs for a student receiving services through a BOCES, the costs for the IEP direct medical services must be discretely identified and included as contracted service costs (as defined in D.1.b). LEAs will not be permitted to report BOCES costs as tuition costs.

d. Intergovernmental Agreement Costs

Intergovernmental agreement costs represent costs for services provided through a contractual or tuition based arrangement in which the LEA purchasing the services and the LEA providing services are both public school districts or counties. Relationships between public schools and private schools, 4201 schools, BOCES, private vendors, or other non-public entities would be reported as described in paragraphs b (Contracted Service Costs) or c (Tuition Costs) of this section.

i. Intergovernmental Agreement Contracted Service Costs

Contracted service costs represent the costs incurred by the LEA for IEP direct medical services rendered by a public school or county through a contractual agreement. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

A revenue offset must be reported by the public school or county providing the IEP direct medical service equal to the expense reported by the school district purchasing the service. The total for all intergovernmental agreement contract costs is expected to equal \$0 in the aggregate, statewide.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the net Medicaid Allowable Cost for the transaction will be \$0.

ii. Intergovernmental Agreement Tuition Costs

Tuition costs represent the costs incurred by the LEA for a student placed in another public school or county for all services (educational and IEP direct medical services). Tuition costs will be reflective of only those costs related to

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the provision of IEP direct medical services. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each public school or county and will be calculated annually based on annual financial reports, the ST-3, submitted to the New York State Education Department. The ST-3s used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering October 1, 2011 – June 30, 2012, the ST-3s from the 2009-2010 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)

and the State Education Department website at:

<http://www.oms.nysed.gov/medicaid/CPEs/home.html>.

The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

A revenue offset must be reported by the public school or county providing the services under the tuition arrangement (receiving the tuition payment) equal to the expense reported by the school district paying the tuition. The total for all intergovernmental agreement tuition costs is expected to equal \$0 in the aggregate, statewide.

2. **Indirect Costs:** Indirect costs are determined by applying the school district specific unrestricted indirect costs rate to the Direct Medical Service Costs, defined in paragraph D.1.a., following the application of the Direct Medical Service Time Study Percentage, defined in paragraph D.3. The unrestricted indirect cost rate will not be applied to Contracted Service Costs (D.1.b), Tuition Costs (D.1.c), Intergovernmental Agreement Costs (D.1.d) and Contracted Transportation Service Costs (E.2.e). New York public schools use predetermined fixed rates for indirect costs. The New York SED, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by public school districts. Pursuant to the authorization in 34 CFR §75.561(b), the New York SED, which is the cognizant agency for school districts, approves unrestricted indirect cost rates in cooperation with the ED. The indirect cost rates are reviewed and updated annually. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

*Indirect Cost Rate*

- a. Apply the New York Public Schools Cognizant Agency Unrestricted Indirect Cost rate applicable for the dates of service in the rate year.
- b. The New York UICR is the unrestricted indirect cost rate calculated by the New York State Education Department.

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3. **Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology will utilize two cost pools: one cost pool for direct therapy staff (includes staff providing Occupational Therapy, Physical Therapy, and Speech Therapy services) and one cost pool for all other direct service staff (includes staff providing Audiological Evaluations, Medical Evaluations, Medical Specialist Evaluations, Psychological Counseling, Psychological Evaluations, and Skilled Nursing services). A minimum number of completed moments will be sampled each quarter in accordance with the Time Study Implementation Plan to ensure time study results will have a confidence level of at least 95 percent with a precision of plus or minus two percent overall. The Direct Medical Service time study percentage for the Direct Medical Service - Therapy cost pool will be applied only to those costs associated with direct medical service therapy. The Direct Medical Service time study percentage for the Direct Medical Service - All other cost pool will be applied only to those costs associated with direct medical service all other.

The RMTS direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. For example, for cost reporting period July 1, 2012 through June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013 and April 2013 to June 2013.

*Direct Medical Service Therapy RMTS Percentage*

- a. Fee-For-Service RMTS Percentage
- i. Direct Medical Service Therapy Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.
- b. General Administrative Percentage Allocation
- i. Direct Medical Service Therapy Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

*Direct Medical Service All Other RMTS Percentage*

- a. Fee-For-Service RMTS Percentage
- i. Direct Medical Service All Other Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

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5. **Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for each school district for Direct Medical Services.

**E. Special Transportation Services Payment Methodology**

Effective for dates of service on or after October 1, 2011, providers will be paid on a cost basis. Providers will be reimbursed interim rates for SSHS Special Transportation services as specified in the *Special Transportation* paragraph of the EPSDT section of this Attachment. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over- and under-payments.

The State requires providers billing the Medicaid program to keep a log of one-way trips. The State conducts audits of SSHSP providers through the Office of the Medicaid Inspector General, including special transportation services. Audit protocols developed include review of documentation of Medicaid services other than transportation delivered to the student on the day s/he received special transportation services.

Special transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

- Special transportation is specifically listed in the IEP as a required service;
- The child required special transportation in a vehicle that has been modified as documented in the IEP;
- A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed; and
- The service billed represents a one-way trip.

1. **Allowable Costs:** Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

- a. Personnel Costs** – Personnel costs include the salary and benefit costs for transportation providers employed by the school district. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers (defined under Paragraph D of this section). The personnel costs may be reported for the following staff:
- i. Bus Drivers;
  - ii. Attendants;
  - iii. Mechanics; and
  - iv. Substitute Drivers.

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- b. Transportation Other Costs** – Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include:
- i. Lease/Rental costs;
  - ii. Insurance costs;
  - iii. Maintenance and Repair costs;
  - iv. Fuel and Oil cost;
  - v. Contracted – Transportation Services and Transportation Equipment cost; and
  - vi. Other transportation non-personnel costs.
- c. Transportation Equipment Depreciation Costs** – Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than \$5,000.

The source of these costs will be audited payroll and general ledger data for each district.

School districts may report all transportation expenditures incurred during the period covered by the annual cost report. School districts will be required to complete the Specialized Transportation Ratio in order to apportion their transportation expenditures between specialized transportation and non-specialized transportation.

**2. Special Transportation Allocation Methodology:** All transportation costs reported on the annual cost report will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One-Way Trip Ratio.

- a. Specialized Transportation Ratio** – The Specialized Transportation Ratio is used to discount the transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible students receiving specialized transportation services in the school district. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services. The data for this ratio will be based on the same point in time as is used for the calculation of the IEP ratio, defined in D.4.

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**b. Medicaid One-Way Trip Ratio-** A district-specific Medicaid One-Way Trip Ratio will be established for each participating school district. When applied, this Medicaid One-Way Trip ratio will discount the transportation costs following the application of the Specialized Transportation Ratio by the percentage of Medicaid IEP one-way trips. This ratio ensures that only Medicaid allowable specialized transportation costs are included in the cost settlement calculation.

The Medicaid One-Way Trip Ratio will be calculated based on the number of one-way trips provided to students requiring specialized transportation services per their IEP and receiving another Medicaid covered service on that same day. The numerator of the ratio will be based on the Medicaid paid one-way trips as identified in the State's Medicaid Management Information System (MMIS) data. The denominator will be based on the school district transportation logs for the number of one-way trips provided to Medicaid eligible students with specialized transportation in the IEP. The denominator should be inclusive of all one way trips provided to students with specialized transportation in their IEP, regardless of whether the trip qualified as Medicaid specialized transportation or not. The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e. all one way trips provided between July 1 and June 30.

**F. Certification of Funds Process**

Each provider certifies on an annual basis, through its cost report, their total actual, incurred allowable costs/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

**G. Annual Cost Report Process**

Each provider will complete an annual cost report for all school health services delivered during the previous fiscal year covering the July 1<sup>st</sup> through June 30<sup>th</sup> period. The cost report is due on or before December 31<sup>st</sup> of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SSHS Cost Reports are subject to a desk review by the DOH or its designee.

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**H. Cost Reconciliation Process**

Once all interim claims (CPT/HCPCS claims) are paid, the State will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual SSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the MMIS and CMS-64 form, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

**I. Cost Settlement Process**

For services delivered for a period covering July 1<sup>st</sup> through June 30<sup>th</sup>, the annual SSHSP Cost Report is due on or before December 31<sup>st</sup> of the same year. The final reconciliation will occur prior to the 24<sup>th</sup> month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance may be subjected to a corrective action plan.

If final reconciled settlement payments exceed the actual, certified costs of the provider for SSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for SSHSP services exceed the interim claiming, the DOH and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider on the CMS-64 form for the quarter corresponding to the date of payment.

**J. Sunset Date**

Effective for dates of service on or after October 1, 2011 through June 30, 2020[2017]; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, 2020[2017].

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**Preschool Supportive Health Services Program (PSSHSP)**

**A. Reimbursement Methodology for PSSHSP**

Preschool-based services, known as Preschool Supportive Health Services (PSSH), are delivered by the counties and include the Medicaid services as described in Attachments 3.1-A and 3.1-B of the Medicaid State Plan under item 4.b, Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). Counties will be paid only for direct Medicaid-covered services provided pursuant to an Individualized Education Program (IEP). Preschool Supportive Health Services include:

1. Physical Therapy Services
2. Occupational Therapy Services
3. Speech Therapy Services
4. Psychological Counseling
5. Skilled Nursing Services
6. Psychological Evaluations
7. Medical Evaluations
8. Medical Specialist Evaluations
9. Audiological Evaluations
10. Special Transportation

**B. Direct Medical Payment Methodology**

Effective for dates of service on or after October 1, 2011, providers with the exception of those located in a city with a population of over one million will be paid on a cost basis. Providers will be reimbursed interim rates for PSSH direct medical services per unit of service at the statewide interim rate as specified the EPSDT section of this Attachment. On an annual basis a county-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period. PSSHSP providers must maintain organized and confidential documentation regarding the services provided, including written orders; session notes; and students' Individualized Education Programs. Such documentation must be maintained for a period of six years from the date the services were furnished or billed, whichever is later.

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**C. Data Capture for the Cost of Providing Health-Related Services**

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data sources:
  - a. PSSHS cost reports received from counties, in the State of New York inclusive of the Allowable cost categories defined in paragraphs D.1 and D.2 of this section:
  - b. Time Study (TS) Activity Code 4.b (Direct Medical Services) and Activity Code10 (General Administration):
    - i. Direct medical TS percentage; and
  - c. School District specific Individualized Education Program (IEP) Medicaid Eligibility Ratios.

A glossary of the key terms used in the cost reporting process described in the PSSHSP section can be found as Appendix 2 of the NY DOH Guide to Cost Reporting for the Pre-School Supportive Health Service Claiming Program.

**D. Data Sources and Cost Finding Steps**

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. **Allowable Costs:** Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by counties under the current Attachments 3.1-A and 3.1-B of the State Plan, excluding transportation personnel costs which are to be reported under *Special Transportation Services Payment Methodology* section as described in paragraph E of this section. These direct costs will be calculated on a Medicaid provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual PSSHS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited county level payroll and general ledger data maintained at the county level.

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*a. Direct Medical Services*

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits (employer paid);
- iii. Medically-related purchased services; and
- iv. Medically-related supplies and materials.

*b. Contracted Service Costs*

Contracted service costs represent the costs incurred by the Local Education Agency (LEA) for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs. Contracted service costs are not eligible for the application of the unrestricted indirect cost rate.

*c. Tuition Costs*

Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district (private school, §4201 school) or preschool agency setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services and are not eligible for the application of the unrestricted indirect cost rate. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each out-of-district provider and will be calculated annually based on annual financial reports, the CFR, submitted to the New York State Education Department (SED). The CFRs used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering October 1, 2011 – June 30, 2012, the CFRs from the 2009-2010 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is available on the Department of Health website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)

and the State Education Department website at:

<http://www.oms.nysed.gov/medicaid/CPEs/home.html>

The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

**NOTE:** Effective with the cost reporting period beginning on July 1, 2013 a portion of tuition payments related to the provision of IEP direct medical services for students in §4201 schools may be included in the cost report for the county or school district of residence. Effective July 1, 2013 §4201 schools are not eligible to bill for Medicaid services.

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17(r)(i)**

For cost reporting periods prior to July 1, 2013 counties or school districts will not be allowed to include any costs associated with tuition payments made to §4201 schools as these entities were eligible to bill for Medicaid services during these periods.

**NOTE:** When a LEA incurs costs for a student receiving services through a BOCES, the costs for the IEP direct medical services must be discretely identified and included as contracted service costs (as defined in D.1.b). LEAs will not be permitted to report BOCES costs as tuition costs.

*d. Intergovernmental Agreement Costs*

Intergovernmental agreement costs represent costs for services provided through a contractual or tuition based arrangement in which the LEA purchasing the services and the LEA providing services are both public school districts or counties. Relationships between counties and private schools, 4201 schools, BOCES, private vendors, or other non-public entities would be reported as described in section b (Contracted Service Costs) or c (Tuition Costs).

i. Intergovernmental Agreement Contracted Service Costs

Contracted service costs represent the costs incurred by the LEA for IEP direct medical services rendered by a public school or county through a contractual agreement. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

A revenue offset must be reported by the public school or county providing the IEP direct medical service equal to the expense reported by the school district purchasing the service. The total for all intergovernmental agreement contract costs is expected to equal \$0 in the aggregate, statewide.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the net Medicaid Allowable Cost for the transaction will be \$0.

ii. Intergovernmental Agreement Tuition Costs

Tuition costs represent the costs incurred by the LEA for a student placed in another public school or county for all services (educational and IEP direct medical services). Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services. The health related portion of the

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tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each public school or county and will be calculated annually based on annual financial reports, the ST-3, submitted to the New York State Education Department. The ST-3s used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering October 1, 2011 – June 30, 2012, the ST-3s from the 2009-2010 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is available on the Department of Health website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)

and the State Education Department website at:

<http://www.oms.nysed.gov/medicaid/CPEs/home.html>.

The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

A revenue offset must be reported by the public school or county providing the services under the tuition arrangement (receiving the tuition payment) equal to the expense reported by the school district paying the tuition. The total for all intergovernmental agreement tuition costs is expected to equal \$0 in the aggregate, statewide.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the net Medicaid Allowable Cost for the transaction will be \$0.

2. **Indirect Costs:** Indirect costs for counties are determined by applying a 10 percent indirect cost rate to the Direct Medical Service Costs, defined in paragraph D.1.a., following the application of the Direct Medical Service Time Study Percentage, defined in paragraph D.3. The unrestricted indirect cost rate will not be applied to Contracted Service Costs (D.1.b), Tuition Costs (D.1.c), Intergovernmental Agreement Costs (D.1.d) and Contracted Transportation Service Costs (E.2.e). The New York SED is not responsible for developing an indirect cost plan for counties and does not approve indirect cost rates for the counties. Per OMB-A-87 Attachment A, Section G, a standard indirect cost allowance of 10 percent shall be applied to adjusted direct costs for counties. This rate will be used on an annual basis and updated to reflect any changes to OMB-A-87. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

*Indirect Cost Rate*

- a. Apply a standard ten percent for indirect cost allowance to adjusted direct costs for New York State counties.

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3. **Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology for counties will include all clinicians that are employees of a county and will utilize a time log approach that accounts for 100 percent of time for each county employed clinician. This methodology will generate a Direct Medical Service time study percentage that will be applied to the appropriate direct costs to determine the Direct Medical Service costs.

The direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. *For example*, for cost reporting period July 1, 2012 through June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013 and April 2013 to June 2013.

*Direct Medical Service TS Percentage*

- a. Fee-For-Service TS Percentage
  - i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.
- b. General Administrative Percentage Allocation
  - i. Direct Medical Service All Other Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

The formula below details the Direct Medical Percentage (Activity Code 4.b) with the applicable portion of General Administration (Activity Code 10) reallocated to it. The same calculation is completed for the Direct Medical Service Therapy and Direct Medical Service All Other cost pools.

A = All Codes

D = IEP Direct Medical Services (Activity Code 4.b)

R = Redistributed Activities (Activity Code 10)

U = Unallowable (Activity Code 11)

$$\text{Direct Medical Service Percentage} = \frac{D + \left( \frac{D}{A - R - U} * R \right)}{A} \#$$

4. **IEP Medicaid Eligibility Ratio:** A county-specific IEP Ratio will be established for each participating county. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The IEP ratio will be based on child count reporting of students with a direct medical service in an IEP during the school year [required for Individuals with Disabilities Education Act (IDEA) on the first Wednesday in October of the Fiscal Year] for which the report is completed. *For example*, for the cost reporting period covering July 1, 2012 through June 30,

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2013, the IEP Ratio will be based on the student [count] of students with an IEP at any time during the July 1, 2013 through June 30, 2013 school year [from October 3, 2012].

[The names and birthdates of students with an IEP with a direct medical service will be identified from the Student Count Report as of the first Wednesday in October and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid.] The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed. [with a direct medical service, as outlined in their IEP.] The denominator will be the total number of students in the LEA with an IEP with a direct medical service as outlined in their IEP at any time during the school year reporting period. Direct medical services are those services billable under the PSSHS program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts, as described above, and MMIS data [as of the first Wednesday of October] for the fiscal year for which the cost report is completed.

5. **Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for each county for Direct Medical Services.

**E. Special Transportation Services Payment Methodology**

Effective for dates of service on or after October 1, 2011, providers will be paid on a cost basis. Providers will be reimbursed interim rates for PSSHS Special Transportation services as specified the *Special Transportation* paragraph of the EPSDT section of this Attachment. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

The State requires providers billing the Medicaid program to keep a log of one-way trips. The State conducts audits of PSSHSP providers through the Office of the Medicaid Inspector General, including special transportation services. Audit protocols developed include review of documentation of Medicaid services other than transportation delivered to the student on the day he or she received special transportation services.

Special transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

- Special transportation is specifically listed in the IEP as a required service;
- The child required special transportation in a vehicle that has been modified as documented in the IEP;
- A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed; and
- The service billed represents a one-way trip.

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- 1. Allowable Costs:** Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:
- a. Personnel Costs** – Personnel costs include the salary and benefit costs for transportation providers employed by the county. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers (defined under paragraph D of this section). The personnel costs may be reported for the following staff:
    - i. Bus Drivers;
    - ii. Attendants;
    - iii. Mechanics; and
    - iv. Substitute Drivers.
  - b. Transportation Other Costs** – Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include:
    - i. Lease/Rental costs;
    - ii. Insurance costs;
    - iii. Maintenance and Repair costs;
    - iv. Fuel and Oil cost;
    - v. Contracted – Transportation Services and Transportation Equipment cost; and
    - vi. Other transportation non-personnel costs.
  - c. Transportation Equipment Depreciation Costs** – Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than \$5,000.

The source of these costs will be audited payroll and general ledger data for each county.

Counties may report all transportation expenditures incurred during the period covered by the annual cost report. Counties will be required to complete the Specialized Transportation Ratio in order to apportion their transportation expenditures between specialized transportation and non-specialized transportation.

- 2. Special Transportation Allocation Methodology:** All transportation costs reported on the annual cost report will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One-Way Trip Ratio.
- a. Specialized Transportation Ratio** – The Specialized Transportation Ratio is used to discount the transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

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The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible students receiving specialized transportation services in the county. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services. The data for this ratio will be based on the same point in time as is used for the calculation of the IEP ratio, defined in D.4.

- b. Medicaid One-Way Trip Ratio-** A county-specific Medicaid One-Way Trip Ratio will be established for each participating county. When applied, this Medicaid One-Way Trip Ratio will discount the transportation costs following the application of the Specialized Transportation Ratio by the percentage of Medicaid IEP one-way trips. This ratio ensures that only Medicaid allowable specialized transportation costs are included in the cost settlement calculation.

The Medicaid One-Way Trip Ratio will be calculated based on the number of one-way trips provided to students requiring specialized transportation services per their IEP and receiving another Medicaid covered service on that same day. The numerator of the ratio will be based on the Medicaid paid one way trips as identified in the State's Medicaid Management Information System (MMIS) data. The denominator will be based on the county transportation logs for the number of one-way trips provided to Medicaid eligible special education students with specialized transportation in the IEP. The denominator should be inclusive of all one way trips provided to students with specialized transportation in their IEP, regardless of whether the trip qualified as Medicaid specialized transportation or not. The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e. all one way trips provided between July 1 and June 30.

**F. Certification of Funds Process**

Each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

**G. Annual Cost Report Process**

Each provider will complete an annual cost report for all school health services delivered during the previous fiscal year covering the July 1<sup>st</sup> through June 30<sup>th</sup>. The cost report is due on or before December 31<sup>st</sup> of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

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The annual PSSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual PSSHS Cost Reports are subject to a desk review by the DOH or its designee.

**H. Cost Reconciliation Process**

Once all interim claims (CPT/HCPCS claims) are paid, the state will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual PSSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the MMIS and CMS-64 form, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

**I. Cost Settlement Process**

For services delivered for a period covering July 1<sup>st</sup> through June 30<sup>th</sup>, the annual PSSHSP Cost Report is due on or before December 31<sup>st</sup> of the same year. The final reconciliation will occur prior to the 24<sup>th</sup> month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance may be subjected to a corrective action plan.

If interim claiming payments exceed the actual, certified costs of the provider for PSSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for PSSHSP services exceed the interim claiming, the Department of Health (DOH) and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider in the CMS-64 form for the quarter corresponding to the date of payment.

**J. Sunset Date**

Effective for dates of service on or after October 1, 2011 through June 30, 2020 [2017]; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, 2020 [2017].

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**C. Data Capture for the Cost of Providing Health-Related Services**

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data sources:
  - a. PSSHS cost reports received from New York City, in the State of New York, inclusive of the Allowable cost categories defined in Section D.1 and D.2;
  - b. Time Study (TS) Activity Code 4.b (Direct Medical Services) and Activity Code10 (General Administration):
    - i. Direct medical TS percentage; and
  - c. School District specific Individualized Education Program (IEP) Medicaid Eligibility Ratios.

A glossary of the key terms used in the cost reporting process described in this SPA can be found as Appendix 2 of the NYS DOH Guide to Cost Reporting for the Pre-School Supportive Health Service Claiming Program.

**D. Data Sources and Cost Finding Steps**

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. **Allowable Costs:** Direct costs for direct medical services listed in paragraph Aa include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel to provide the Medicaid services listed in paragraph Aa. These direct costs will be calculated on a Medicaid provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of Medicaid services listed in paragraph Aa, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual PSSHS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited county level payroll and general ledger data maintained at the district level.

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18(b)**

*a. Direct Medical Services*

Non-federal cost pool for allowable providers consists of:

- ii. Salaries;
- iii. Benefits;
- iv. Medically-related purchased services; and
- v. Medically-related supplies and materials.

*b. Contracted Service Costs*

Contracted service costs represent the costs incurred by the Local Education Agency (LEA) for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct services listed in paragraph Aa.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs. Contracted service costs are not eligible for the application of the unrestricted indirect cost rate.

*c. Tuition Costs*

Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district or preschool agency setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct services listed in paragraph Aa. Tuition costs are not eligible for the application of the unrestricted indirect cost rate. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each out-of-district provider and will be calculated annually based on annual financial reports, the CFR, submitted to the New York State Education Department (SED). The CFRs used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering September 1, 2013 – June 30, 2014, the CFRs from the 2011-2012 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is available on the Department of Health ([https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)) and the State Education Department ([https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)) websites. The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

**NOTE:** Effective with the cost reporting period beginning after July 1, 2018 a portion of tuition payments related to the provision of IEP direct medical services for students in §4201 schools may be included in the cost report for the county or school district of residence.

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18(c)**

NOTE: When an LEA incurs costs for a student receiving services through a BOCES, the costs for the IEP direct medical services must be discretely identified and included as contracted service costs (as defined in D.1.b). LEAs will not be permitted to report BOCES costs as tuition costs.

*d. Intergovernmental Agreement Costs*

Intergovernmental agreement costs represent costs for physical therapy, occupational therapy, and speech therapy services provided through a contractual or tuition based arrangement in which the LEA purchasing the services and the LEA providing services are both public school districts or counties. Relationships between counties and private schools, 4201 schools, BOCES, private vendors, or other non-public entities would be reported as described in section b (Contracted Service Costs) or c (Tuition Costs).

*i. Intergovernmental Agreement Contracted Service Costs*

Contracted service costs represent the costs incurred by the LEA for IEP direct medical services listed in paragraph Aa rendered by a public school or county through a contractual agreement. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

A revenue offset must be reported by the public school or county providing the IEP direct services listed in paragraph Aa equal to the expense reported by the school district purchasing the service. The total for all intergovernmental agreement contract costs is expected to equal \$0 in the aggregate, statewide.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the net Medicaid Allowable Cost for the transaction will be \$0.

*ii. Intergovernmental Agreement Tuition Costs*

Tuition costs represent the costs incurred by the LEA for a student placed in another public school or county for all services (educational and IEP direct medical services). Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each public school or county and will be calculated annually based on annual financial reports, the ST-3, submitted to the New York State Education Department. The ST-3s used in calculating the health related tuition percentage will be those from the most

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current, complete year available. For example, for the cost reports covering September 1, 2013 – June 30, 2014, the ST-3s from the 2011-2012 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health ([https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)) and the State Education Department (<http://www.oms.nysed.gov/medicaid/CPEs/home.html>) websites.

The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

A revenue offset must be reported by the public school or county providing the services under the tuition arrangement (receiving the tuition payment) equal to the expense reported by the county paying the tuition. The total for all intergovernmental agreement tuition costs is expected to equal \$0 in the aggregate, statewide.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the new Medicaid Allowable Cost for the transaction will be \$0.

- 2. Indirect Costs:** Indirect costs for counties are determined by applying a 10% indirect cost rate to the Direct Medical Service Costs, defined in section D.1.a., following the application of the Direct Medical Service Time Study Percentage, defined in D.3. The unrestricted indirect cost rate will not be applied to Contracted Service Costs (D.1.b), Tuition Costs (D.1.c), and Intergovernmental Agreement Costs (D.1.d). The New York State Education Department (SED) is not responsible for developing an indirect cost plan for counties and does not approve indirect cost rates for the counties. Per OMB A-87 Attachment A, Section G, a standard indirect cost allowance of ten percent shall be applied to adjusted direct costs for counties. This rate will be used on an annual basis and updated to reflect any changes to OMB A-87. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

*Indirect Cost Rate*

- a. Apply a standard ten percent for indirect cost allowance to adjusted direct costs for New York State counties.

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**3. Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel providing services listed in paragraph Aa general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology for counties will include all clinicians providing physical therapy services, occupational therapy services, and speech therapy services that are employees of a county and will utilize a time log approach that accounts for 100% of time for each county employed clinician. This methodology will generate a Direct Medical Service time study percentage that will be applied to the appropriate direct costs to determine the Direct Medical Service costs.

The Direct Medical Service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June.

*Direct Medical Service TS Percentage*

a. Fee-For-Service TS Percentage

i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation

i. Direct Medical Service Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

The formula below details the Direct Medical Percentage (code 4.b) with the applicable portion of General Administration (Activity Code 10) reallocated to it. The same calculation is completed for the Direct Medical Service Therapy and Direct Medical Service All Other cost pools.

A = All Codes

D = IEP Direct Medical Services (Activity Code 4.b)

R = Redistributed Activities (Activity Code 10)

U = Unallowable (Activity Code 11)

$$D + \left( \frac{D}{A - R - U} * R \right)$$

Direct Medical Service Percentage =

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- 4. **IEP Medicaid Eligibility Ratio:** A county-specific IEP Ratio will be established for New York City. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The IEP ratio will be based on child count reporting of students with a direct medical service listed in paragraph Aa in an IEP during the school year for which the report is completed.

*For example, for the cost reporting period covering July 1, 2014 through June 30, 2015, the IEP Ratio will be based on the count of students with an IEP at any time during the July 1, 2014 through June 30, 2015 school year.*

The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim involving a service listed in paragraph Aa was processed through the MMIS for the year for which the report is completed. The denominator will be the total number of students in the LEA with an IEP with a direct medical service listed in paragraph A as outlined in their IEP at any time during the school year reporting period. Direct medical services are only those services that are both billable under the SSHS Program and approved for inclusion in the State's certified public expenditure claim for PSSHS (i.e., Medicaid service listed in paragraph Aa).

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts, as described above, and MMIS data.

- 5. **Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for New York City for Direct Medical Services.

**E. Certification of Funds Process**

Each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share for Medicaid services listed in paragraph Aa. Certification is conducted on an annual basis.

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**F. Annual Cost Report Process**

Each provider will complete an annual cost report for all school health services delivered during the previous fiscal year covering July 1<sup>st</sup> through June 30<sup>th</sup>. The cost report is due on or before December 31<sup>st</sup> of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual PSSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual PSSHS Cost Reports are subject to a desk review by the DOH and/or its designee.

**G. Cost Reconciliation Process**

Once all interim claims (CPT/HCPCS claims) are paid, the State will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual PSSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments and tentative settlements for school health services delivered during the reporting period as documented in the MMIS and CMS-64, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

**H. Cost Settlement Process**

For services delivered for a period covering July 1<sup>st</sup> through June 30<sup>th</sup>, the annual PSSHSP Cost Report is due on or before December 31<sup>st</sup> of the same year. The final reconciliation will occur prior to the 24<sup>th</sup> month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as

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outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance may be subjected to a corrective action plan.

If interim claiming and tentative settlement payments exceed the actual, certified costs of the provider for PSSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for PSSHSP services exceed the interim claiming and tentative settlement, the DOH and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider in the CMS-64 quarter corresponding to the date of payment.

**I. Sunset Date**

Effective for dates of service on or after September 1, 2018 through June 30, 2020; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, 2020.

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**School Supportive Health Services Program (SSHSP) – New York City**

**A. Reimbursement Methodology for School Supportive Health Services**

School-based services, known as School Supportive Health Services (SSHS), are delivered by the City of New York school district (New York City Department of Education) and include the Medicaid services as described in Attachments 3.1-A and 3.1-B of the Medicaid State Plan under item 4.b., Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). School districts will be paid only for direct Medicaid-covered services provided pursuant to an Individualized Education Program (IEP). School Supportive Health Services include:

1. Physical Therapy Services
2. Occupational Therapy Services
3. Speech Therapy Services
4. Psychological Counseling
5. Skilled Nursing Services
6. Psychological Evaluations
7. Medical Evaluations
8. Medical Specialist Evaluations
9. Audiological Evaluations
10. Special Transportation

a. Physical, occupational, and speech therapy services which have now undergone satisfactory pre-payment review to verify their accuracy will be included in certified public expenditure claims methodology described in paragraphs (B) – (I).

**B. Direct Medical Payment Methodology**

Effective for dates of service on or after July 1, 2018, the New York City school district (provider located in a city with a population of over one million) will be paid on a cost basis for services identified in section Aa. The provider will be reimbursed interim rates for SSHS direct medical services per unit of service at the statewide interim rate as specified in the EPSDT section of this Attachment. On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period. SSHSP providers must maintain organized and confidential documentation regarding the services provided, including written orders;

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session notes; and students' Individualized Education Programs. Such documentation must be maintained for a period of six years from the date the services were furnished or billed, whichever is later.

**C. Data Capture for the Cost of Providing Health-Related Services**

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data sources:
  - a. SSHS cost reports received from the City of New York school district, in the State of New York, inclusive of the Allowable cost categories defined in Section D.1 and D.2;
  - b. Random Moment Time Study (RMTS) Activity Code 4.b (Direct Medical Services) and Activity Code 10 (General Administration):
    - i. Direct medical RMTS percentage; and
  - c. School District specific Individualized Education Program (IEP) Medicaid Eligibility Ratios.

A glossary of the key terms used in the cost reporting process described in this SPA can be found as Appendix 2 of the NYS Department of Health (DOH) Guide to Cost Reporting for the School Supportive Health Service Claiming Program.

**D. Data Sources and Cost Finding Steps**

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services listed in section Aa include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel to provide the Medicaid services listed in section Aa. These direct costs will be calculated on a Medicaid provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of Medicaid services listed in section Aa, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual SSHS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited district level payroll and general ledger data maintained at the district level.

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*a. Direct Medical Services*

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits;
- iii. Medically-related purchased services; and
- iv. Medically-related supplies and materials.

*b. Contracted Service Costs*

Contracted service costs represent the costs incurred by the Local Education Agency (LEA) for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct services listed in section Aa.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs. Contracted service costs are not eligible for the application of the unrestricted indirect cost rate.

*c. Tuition Costs*

Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district (private school, §4201 school) or preschool agency setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct services listed in section Aa. Tuition costs are not eligible for the application of the unrestricted indirect cost rate. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each out of district provider and will be calculated annually based on annual financial reports, the CFR, submitted to the New York State Education Department (SED). The CFRs used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering September 1, 2013 – June 30, 2014, the CFRs from the 2011-2012 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health ([https://www.health.ny.gov/health\\_care/medicaid/program/psshsp/](https://www.health.ny.gov/health_care/medicaid/program/psshsp/)) and the State Education Department (<http://www.oms.nysed.gov/medicaid/CPEs/home.html>) websites. The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

**NOTE:** Effective with the cost reporting period beginning on July 1, 2018, a health related portion of tuition payments related to the provision of IEP direct

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b. The New York UICR is the unrestricted indirect cost rate calculated by the New York State Education Department.

**3. Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services listed in section Aa, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology will utilize one cost pool for direct therapy staff (includes staff providing Occupational Therapy, Physical Therapy, and Speech Therapy services).

A minimum number of completed moments will be sampled each quarter in accordance with the Time Study Implementation Plan to ensure time study results will have a confidence level of at least 95 percent with a precision of plus or minus two percent overall. The Direct Medical Service time study percentage for the Direct Medical Service - Therapy cost pool will be applied only to those costs associated with direct medical service therapy.

The RMTS direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. For example, for cost reporting period July 1, 2014 through June 30, 2015, the RMTS quarters would be October 2014 to December 2014, January 2015 to March 2015 and April 2015 to June 2015.

Direct Medical Service RMTS Percentage

- a. Fee-For-Service RMTS Percentage
  - i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.
- b. General Administrative Percentage Allocation
  - i. Direct Medical Service Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

The formula below details the Direct Medical Percentage (code 4.b) with the applicable portion of General Administration (Activity Code 10) reallocated to it. The same calculation is completed for the Direct Medical Service Therapy and Direct Medical Service All Other cost pools.

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A = All Codes

D = IEP Direct Medical Services (Activity Code 4.b)

R = Redistributed Activities (Activity Code 10)

U = Unallowable (Activity Code 11)

$$\text{Direct Medical Service Percentage} = \frac{D + \left( \frac{D}{A - R - U} * R \right)}{A}$$

- 4. IEP Medicaid Eligibility Ratio:** A district-specific IEP Ratio will be established for the City of New York school district participating in the SSHSP. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The IEP ratio will be based on child count reporting of students that had a direct medical service in an IEP during the school year.

*For example, for the cost reporting period covering July 1, 2014 through June 30, 2015, the IEP Ratio will be based on the count of students with an IEP at any time during the July 1, 2014 through June 30, 2015 school year.*

The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed. The denominator will be the total number of students in the LEA with an IEP with a direct medical services as outlined in their IEP. Direct medical services are those services billable under the SSSH Program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts, as described above, and MMIS data for the fiscal year for which the cost report is completed.

- 5. Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for the City of New York school district for Direct Medical Services.

**E. Certification of Funds Process**

Each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

**F. Annual Cost Report Process**

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Each provider will complete an annual cost report for all school health services delivered during the previous fiscal year covering July 1<sup>st</sup> through June 30<sup>th</sup>. The cost report is due on or before December 31<sup>st</sup> of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering services listed in section Aa including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures for the delivery of services listed in section Aa. All filed annual SSHS Cost Reports are subject to a desk review by the DOH and/or its designee.

#### **H. Cost Reconciliation Process**

Once all interim claims (CPT/HCPCS claims) are paid, the State will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual SSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments and tentative settlements for school health services delivered during the reporting period as documented in the MMIS and CMS-64, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

#### **I. Cost Settlement Process**

For services delivered for a period covering July 1<sup>st</sup> through June 30<sup>th</sup>, the annual SSHSP Cost Report is due on or before December 31<sup>st</sup> of the same year. The final reconciliation will occur prior to 24<sup>th</sup> month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance may be subjected to a corrective action plan.

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If interim claiming and tentative settlement payments exceed the actual, certified costs of the provider for SSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for SSHSP services exceed the interim claiming and tentative settlement, the DOH and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider in the CMS-64 quarter corresponding to the date of payment.

**J. Sunset Date**

Effective for dates of service on or after July 1, 2018 through June 30, 2020; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, 2020.

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**National Diabetes Prevention Program (NDPP)**

Reimbursement Methodology:

Effective July 1, 2019, the Medicaid rate for NDPP services will be set at 80 percent of the corresponding 2019 Medicare NDPP rate for the same or similar service.

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