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STATE PALN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of the State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3 below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR"
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item A of this attachment, for those groups and payments listed below and designated with the letters "NR"
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item B of this attachment (see 3 above).

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QMBs	Part A <u>MR</u> Deductibles <u>MR</u> Coinsurance
	Part B <u>MR</u> Deductibles <u>[MR]</u> <u>NR</u> Coinsurance
Other Medicaid Recipients	Part A <u>MR</u> Deductibles <u>MR</u> Coinsurance
	Part B <u>MR</u> Deductibles <u>[MR]</u> <u>NR</u> Coinsurance
Dual Eligible (QMB Plus)	Part A <u>MR</u> Deductibles <u>MR</u> Coinsurance
	Part B <u>MR</u> Deductibles <u>[MR]</u> <u>NR</u> Coinsurance

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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Payment of Medicare Part A and Part B Deductible/Coinsurance

Explanation of Medicare Part B Coinsurance Payment for Medicaid Recipients

This Medicare coinsurance policy applies to:

- Qualified Medicare Beneficiaries (QMBs)
- Qualified Medicare Beneficiaries Plus (QMBs+)
- Any other persons who have both full Medicaid and Medicare

For all recipients noted above New York State Medicaid will pay as follows:

1. If the Medicare payment amount is greater than the amount that Medicaid would have paid for that service, then Medicaid will pay \$0.
2. If the Medicare payment is less than the amount that Medicaid would have paid for that service, then Medicaid will pay the lower of the difference between the Medicaid rate and the Medicare payment, or the Medicare coinsurance amount.
3. If a procedure is designated "inactive" on the procedure code file, i.e., procedures that are not covered by Medicaid and have been assigned a \$0 amount, Medicaid will not reimburse any portion of the Medicare Part B coinsurance amount for these procedures.
4. If the service is an outpatient service certified under Articles 16, 31, or 32 of the Mental Hygiene Law, an Independent Practitioner Service for Individuals with Developmental Disabilities (IPSIDD), or is an ambulance or psychologist service, Medicaid will pay the full Medicare coinsurance liability.
5. If the service is an Independent Practitioner Service for Individuals with Developmental Disabilities (IPSIDD), Medicaid will pay up to the regular Medicaid fee, even if that fee is higher than the Medicare approved amount.
6. If the service is an outpatient service certified under Article 28 of the Public Health Law, Medicaid will pay as follows:
 - a. If the Medicare payment is greater than the amount that Medicaid would have paid for that service, then Medicaid will pay \$0.
 - b. If the Medicare payment is less than the amount that Medicaid would have paid for that service, then Medicaid will pay the lower of the difference between the Medicaid rate and the Medicare payment, or the Medicare coinsurance amount.
 - c. If the Medicare payment is equal to the amount that Medicaid would have paid for that service, Medicaid will pay \$0.
7. If the service is a Products of Ambulatory Care Clinic, a clinic primarily serving the developmentally disabled, a Mental Health comprehensive outpatient program services (COPS) program¹, provided by a free standing clinic service certified under Article 28 of the Public Health Law to Traumatic Brain Injury waiver member, or provided by clinic or hospital outpatient department certified under Article 28 of the Public Health Law to an individual with a developmental disability, Medicaid will pay up to the regular Medicaid fee, even if that fee is higher than the Medicare approved amount.

¹Effective 10/1/2010, COPS program means [Freestanding Clinic and Outpatient Hospital] Services licensed pursuant to the Mental Hygiene Law reimbursed pursuant to the APG reimbursement methodology and Partial Hospitalization, Continuing Day Treatment, and Day Treatment for Children [and Intensive Psychiatric Rehabilitation and Treatment] Services.

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Payment of Medicare Part A and Part B Deductible/Coinsurance

[7.]8. Any Medicaid payments made to physicians and durable medical equipment providers for Medicare Part B services during the period April 1, 2005 through June 30, 2005, which are made subject to the 20% of the coinsurance payment provisions cited on Supplement 1 to Attachment 4.19-B page 3, will be the basis of a supplemental payment not to exceed \$5,000,000 pursuant to the following methodology:

For each physician and durable medical equipment provider that received such payments during the period April 1, 2005 through June 30, 2005, the Department of Health will determine the ratio of each physician's and durable medical equipment provider's payments to the total of such payments made during the period, expressed as a percentage.

For each physician, the Department of Health will multiply this percentage by \$4,700,000 and for each durable medical equipment provider the Department of Health will multiply this percentage by \$300,000, respectively. The result of such calculation will represent the "2005 coinsurance enhancement".

[8.]9. Any Medicaid payments made to psychiatrists for Medicare Part B services during the period April 1, 2006 through March 31, 2007, which are made subject to 20 percent of the coinsurance payment provisions cited on Supplement 1 to Attachment 4.19-B page 3, will be the basis of a supplemental payment not to exceed \$2,000,000 pursuant to the following methodology:

For each psychiatrist who received such Medicaid payments during the period April 1, 2006 through March 31, 2007, the Department of Health will determine the ratio of each psychiatrist's Medicaid payments to the total of such Medicaid payments made during the period, expressed as a percentage.

For each psychiatrist, the Department of Health will multiply this percentage by \$2,000,000. The result of such calculation will represent the "2006-2007 coinsurance enhancement".

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Explanation of Payment of Medicare Part C Coinsurance/Copayment for Medicaid Members

The Medicare Part C coinsurance/copayment policy applies to any persons who have both Medicaid and Medicare coverage (dually eligible) and are enrolled in a Medicare Part C health plan (Medicare Advantage or Medicare managed care plan).

If the service is an outpatient service provided to a dually eligible Medicaid member that is enrolled in a Medicare Part C health plan, Medicaid will reimburse eighty-five percent (85%) of the Medicare Part C coinsurance or copayment.

The only exceptions to this policy are:

- If the service is covered under a Medicare Part C health plan and is provided by an ambulance provider or a psychologist, Medicaid will reimburse one hundred percent (100%) of the Medicare Part C coinsurance and/or copayment.

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