STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
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No.  Title of Attachment

* Supplement 5 - Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a - Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 - Standards for Optional State Supplementary Payments
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**Approval Date** July 27, 1995

Supersedes **TN #91-75**  
**Effective Date** July 1, 1991
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014    Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

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

[Citation
45 CFR
Part 201
AT-76-141

As a condition for receipt of Federal funds under
title XIX of the Social Security Act, the

New York State Department of Health
(single state agency)

submits the following State plan for the medical
assistance program, and hereby agrees to administer
the program in accordance with the provisions of
this State plan, the requirements of titles XI and
XIX of the Act, and all applicable Federal
regulations and other official issuances of the
Department.]
New York

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[SECTION 1  SINGLE STATE AGENCY ORGANIZATION

Citation 1.1 Designation and Authority

42 CFR 431.10
AT-79-29

(a) The New York State Department of Health is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to “the Medicaid agency” mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.]

TN  #13-0056 Approval Date October 24, 2014
Supersedes TN  #96-0033 Effective Date January 1, 2014
The State agency that administered or supervised the administration of the plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

[X] Yes. The State Agency so Designated is: Commission for the Blind and Visually Handicapped.

This agency has a separate plan covering that portion of the State Plan under Title XIX for which it is responsible.

[ ] Not applicable. The entire plan under Title XIX is administered or supervised by State agency named in paragraph 1.1(a).]
Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

[X] Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

[ ] Not applicable. Waivers are no longer in effect.

[ ] Not applicable. No waivers have ever been granted.
[Citation
42 CFR 431.10
AT-79-29

[X] The agency named in paragraph 1.1(a)
has responsibility for all determinations of eligibility for
Medicaid under this Plan.

[ ] Determinations of eligibility for Medicaid under this
plan are made by the agency(ies) specified in
Attachment 2.2-A. There is a written agreement between
the agency named in paragraph 1.1(a) and other agency(ies)
making such determinations for specific groups covered
under this plan. The agreement defines the relationships
and respective responsibilities of the agencies.]

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014  Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section
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1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.]
1.2 Organization for Administration

(a) Attachment 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Office of Medicaid Management has been designated as the medical assistance unit. Attachment 1.2-B contains a description of the organization and functions of the medical assistance unit and an organizational chart of the unit.

(c) Attachment 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by the State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

[x] Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014    Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

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<td>The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.</td>
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<tr>
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<td>The plan is State administered.</td>
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<td>The plan is administered by the political subdivisions of the State and is mandatory on them.</td>
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Tribal Consultation Process
For changes to the State’s Medicaid Plan (Plan) that require a State Plan Amendment (SPA), Indian nation leaders and health clinic administrators and Urban Indian Organization leaders and health department administrators will be sent a letter altering that a new tribal consultation has been posted. This notification will be accompanied by summaries of each proposed amendment, an offer of availability of State staff to meet with respective Indian leaders in person upon request made within two weeks of the date of the notification, and also a weblink to the Department of Health website where you may also view the draft plan pages and Federal Public Notice for each proposal. Tribal consultations will be sent at least two weeks prior to submitting a SPA to CMS for approval, allowing for a two-week comment period. [copy of the Federal Public Notice related to a particular SPA, along with a cover letter offering the availability of State staff to meet with respective Indian leaders in person upon requests made within two weeks of the date of notification. A least two weeks’ prior to submitting a SPA to CMS for approval, a draft copy of the proposed amendment will be forwarded to the above Indian representatives, allowing for a two-week comment period.] Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

TN #17-0065 Approval Date 03/12/2018
Supersedes TN #13-0056 Effective Date 12/01/2017
For Medicaid policy changes that do not require a SPA, a draft copy of the Administrative Directive related to the change will be forwarded to Indian representatives, as outlined above, for a two-week comment period. A State contact person will be identified for each draft directive.

Written notification of the State’s intent to submit proposals for demonstration projects or new applications, amendments, extension requests or renewals for waivers that have an impact on Indians, Indian health providers or Urban Indian Organizations will be made to Indian representatives, as identified above, at least 60 days prior to the publication and submission of such. Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

**Tribal Consultation Process Development**

State representatives attended the 2011 Department of Health and Human Services (HHS) Annual Regional Tribal Consultation Session held on March 29, 2011. At that meeting, State staff distributed and discussed the draft Federal Public Notice which contained a summary description of the proposed tribal consultation policy. State staff also distributed a draft SPA and conducted a PowerPoint presentation, both of which elaborated on the proposed tribal consultation policy. Tribal representatives received contact information for various State staff who could answer any questions that may arise. As of May 1, 2011, no questions or comments were received by the State subsequent to the above meeting.

In addition, copies of all handouts were left with HHS IHS representatives to share with those Indian nations and Urban Indian Organizations who did not have representatives in attendance. Further, on April 29, 2011, the State mailed a package to Indian nation and organization leaders and Indian health clinic administrators, which discussed the March 29, 2011 presentation, included the handouts from the presentation, and offered a two-week period of time in which to comment or request a personal meeting with State staff. No responses to our mailing were received as of May 13, 2011.

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>#11-06</td>
<td>August 4, 2011</td>
</tr>
<tr>
<td>Supersedes TN NEW</td>
<td>April 1, 2011</td>
</tr>
</tbody>
</table>
New York
9a

Pediatric Immunization Program

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.
New York
9b

2. The State has not modified or repealed any Immunization law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

   X  State Medicaid Agency
   X  State Public Health Agency

TN  #97-10  Approval Date  July 8, 1997
Supersedes TN  #94-33  Effective Date  October 1, 1996
[SECTION 2 - COVERAGE AND ELIGIBILITY]

[2.1 Application, Determination of Eligibility and Furnishing Medicaid]

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.]
Attachment 1.1

New York

Citation
42 CFR 435.914 1902(a)(34) of the Act

1902(e)(8) and 1905(a) of the Act

1902(a)(47) and 1920 of the Act

2.1(b)(1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

(3) Pregnant women are entitle to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

(c) The Medicaid agency elects to enter into a risk contract with an HMO that is—

X Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in ATTACHMENT 2.1-A.

Not applicable.

TN #93-27 Approval Date September 14, 1993
Supersedes TN #91-76 Effective Date April 1, 1993
The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a) (10) (A) (i) (IV), (a) (10) (A) (i) (VI), (a) (10) (A) (i) (VII), and (a) (10) (A) (ii) (IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.]

TN  #13-54  
Supersedes TN  #91-76  
Approval Date  March 13, 2014  
Effective Date  October 1, 2013
2.1 **Application, Determination of Eligibility and Furnishing Medicaid** (Continued)

1902(e)(13) of the Act

[X] (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after 9/30/2017.

1. The Express Lane option is applied to:

   - [ ] Initial determinations
   - [X] Redeterminations
   - [X] Both

2. A child is defined as younger than age:

   - [X] 19
   - [ ] 20
   - [ ] 21

3. The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

   [The New York State Department of Health (NYSDOH), Office of Health Insurance Program (OHIP), [Division of Coverage and Enrollment (DCE)] Division of Eligibility and Marketplace Integrations (DEMI) administers the Medicaid and Child Health Plus (CHPlus, New York’s separate CHIP program) programs. At CHPlus redetermination, the Medicaid agency elects to rely on findings from the Child Health Plus program to determine initial eligibility for the Medicaid program.

   When applying or renewing for Temporary Assistance the Medicaid agency elects to rely on findings from Temporary Assistance program to automatically enroll and renew eligible children in Medicaid.]
2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

[Child Health Plus annually renews eligibility for children enrolled in CHPlus. Under the screen and enroll process, the first step is to determine if the child is eligible for Medicaid. In order to streamline eligibility for children who screen Medicaid eligible, the Department of Health is implementing a process that will send the eligibility findings made at the renewal by CHPlus to the Local Departments of Social Services (LDSS).

The State will use an income finding from CHPlus and apply this income information to enroll a child in Medicaid if a child is found to be ineligible for CHPlus at renewal. Both Medicaid and Child Health Plus use MAGI (modified adjusted gross income) to determine eligibility. Medicaid will be accepting the income findings determined by CHPlus using MAGI methodology based on Medicaid income rules.

Medicaid and CHPlus both use the same residency rules. Neither Medicaid nor CHPlus require documentation of residency at renewal. Medicaid will accept the CHPlus agency’s finding for residency.

Temporary Assistance requires the same verification of citizenship that Medicaid requires for eligibility. Income budgeting is slightly different, Temporary Assistance uses net income after allowing income disregards. Medicaid determines eligibility using MAGI (modified adjusted gross income) methodology. Since TA income guidelines are lower than the Medicaid levels, this slight discrepancy in budgeting income would not affect eligibility in a majority of the cases.]
2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under Title XXI.

☐ (a) Screening threshold established by the Medicaid agency as:

☐ (i) ___ percentage of the Federal Poverty Level (FPL) which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify _____________________________; or

☐ (ii) ___ percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency; or

[X] (b) Temporary enrollment pending screen and enroll.

☐ (c) State’s regular screen and enroll process for CHIP.

[If Medicaid eligible based on the findings of the Express Lane Agency, the child is given two months of temporary CHPlus coverage, and the case information will be sent to LDSS to open a Medicaid case. In upstate counties, this process will be done manually and in NYC, this will be done electronically.

In both upstate counties and NYC, when a child is determined eligible for Temporary Assistance, the child will automatically be given Medicaid with no action required by the family.]

[X] (6) The State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child’s or family’s affirmative consent to the child’s Medicaid enrollment.

☐ (7) The State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.
2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

[ ] Mandatory categorically needy and other required special groups only.

[ ] Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

[ ] Mandatory categorically needy, other required special groups, and specified optional groups.

[X] Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.
<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Citation] 435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) And P.L. 99-509 (Section 9405)</td>
<td>[2.3 Residence] Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.</td>
</tr>
</tbody>
</table>

**TN #13-57** Approval Date **March 26, 1990**

Supersedes TN **#87-35A** Effective Date **July 1, 1987**
2.4 **Blindness**

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.
2.5 Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.14.b. of ATTACHMENT 2.2-A of this plan.

Citation
42 CFR
435.121,
435.540(b)
435.541
2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.
### Citation

431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)

### 2.7 Medicaid Furnished Out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

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**New York**  
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**TN #86-29-A**  
Approval Date February 23, 1990

Supersedes TN #82-24  
Effective Date October 1, 1986
SECTION 3 - SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

--- Not applicable. Nurse-midwives are not authorized to practice in this State.

*Effective February 3, 1995 nurse-midwife services will be known as midwife services in New York State per Education Law, Article 140.
<table>
<thead>
<tr>
<th>Citation</th>
<th>3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(5) of the Act</td>
<td>(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.</td>
</tr>
<tr>
<td>[X] 1902(a)(10), clause (VII) of the matter following (E) of the Act</td>
<td>(iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.</td>
</tr>
<tr>
<td>1902(a)(10), clause (VII) of the matter following (E) of the Act</td>
<td>(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.</td>
</tr>
</tbody>
</table>

**TN #91-75**

**Approval Date** March 3, 1992

**Supersedes TN #90-27**

**Effective Date** October 1, 1991
## New York

### Citation 3.1(a)(1)  
**Amount, Duration, and Scope of Services: Categorically Needy (Continued)**

<table>
<thead>
<tr>
<th>Citation</th>
<th>3.1(a)(1)</th>
<th>Amount, Duration, and Scope of Services: Categorically Needy (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(vi)</td>
<td></td>
<td>Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.</td>
</tr>
<tr>
<td>1902(e)(7) of the Act</td>
<td>(vii)</td>
<td>Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.</td>
</tr>
<tr>
<td>1902(e)(9) of the Act</td>
<td>(viii)</td>
<td>Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.</td>
</tr>
<tr>
<td>1902(a)(52) and 1925 of the Act</td>
<td>(ix)</td>
<td>Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.</td>
</tr>
<tr>
<td>1905(a)(23) and 1929</td>
<td>(x)</td>
<td>Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.</td>
</tr>
</tbody>
</table>

**ATTACHMENT 3.1-A** identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

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**TN #92-71**  
**Supersedes TN #91-75**  
**Approval Date March 23, 1993**  
**Effective Date October 1, 1992**
New York 19c

[Table]

Citation | Amount, Duration, and Scope of Services: Categorically Needy (Continued)
--- | ---
1905(a)(26) and 1934 | X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.
(Note: Other programs to be offered to Categorically needy beneficiaries would specify all limitations on the amount, duration, and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits - for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN #02-01 Approval Date September 3, 2002
Supersedes TN NEW Effective Date January 1, 2002
New York
20

3.1 Amount, Duration, and Scope of Services (continued)

(a)(2) Medically needy.

[x] This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

[ ] Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

Attachment 1.1
OMB No. 0938-
New York

20a

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

[x] (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

[ ] Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

[x] (vii) Services in an institution for mental diseases for individuals over age 65.

[x] (viii) Services in an intermediate care facility for the mentally retarded.

TN #91-75
Supersedes TN #87-47
Approval Date March 3, 1992
Effective Date October 1, 1991
Attachment 1.1

New York
20b

Citation

3.1(a)(2) **Amount, Duration and Scope of Services: Medically Needy (Continued)**

1902(e)(9) of Act
___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act
___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in [Supplement 2 to Attachment 3.1-A](#) and Appendices A-G to [Supplement 2 to Attachment 3.1-A](#).

**ATTACHMENT 3.1-B** identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN #93-27
Supersedes TN #92-71
Approval Date September 14, 1993
Effective Date April 1, 1993

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___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

---

___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in [Supplement 2 to Attachment 3.1-A](#) and Appendices A-G to [Supplement 2 to Attachment 3.1-A](#).

**ATTACHMENT 3.1-B** identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN #93-27
Supersedes TN #92-71
Approval Date September 14, 1993
Effective Date April 1, 1993
Attachment 1.1

New York
20c

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(26) and 1934  X  Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitations, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.

TN #02-01 Approval Date September 3, 2002
Supersedes TN #NEW Effective Date January 1, 2002
New York

3.1 Amount, Duration, and Scope of Services

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

TN #98-03
Supersedes TN #93-27

Approval Date May 15, 1998
Effective Date Jan 1, 1998
Attachment 1.1

New York
21 (continued)

1902(a)(10) (E)(iv)(II), 1905(p)(3) (A)(iv)(II), 1905(p)(3) the Act

(iv) Other Required Special Groups: Qualifying Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the Families Act

(a)(5) Other Required Special Groups:

Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

TN #98-03 Approval Date May 15, 1998
Supersedes TN NEW Effective Date Jan 1, 1998
Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they—

(A) Are aged, blind, or disabled individuals as defined in section 1614 (a) (1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.
New York
21b

Citation 3.1(a)(6) Amount, Duration, and Scope of Services: Limited
Coverage for Certain Aliens (continued)

1902(a) and 1903(v) of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

1905(a)(9) of the Act

(a)(7) Homeless Individuals.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902(a)(47) and 1920 of the Act

(a)(8) Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55
50 FR 43654
1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act

(a)(9) EPSDT Services.

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN #91-75 Approval Date March 3, 1992
Supersedes TN NEW Effective Date October 1, 1991
The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers’ compliance with their agreements.

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

(iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

A variety of methods are employed, including –

- review of enrollment and utilization data such as periodic reports.
- validation by the New York State Department of Health of the provider’s Quality Assurance Program through review of reports and on-site visits.
- dissemination of informational materials to all individuals.
- review of grievance procedures.
3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

[x] Yes

[ ] Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

[x] Yes, to all

[ ] Yes, to individuals age 21 or over; SNF services are provided

[ ] Yes, to individuals under age 21; SNF services are provided

[ ] No; SNF services are not provided

[ ] Not applicable, the medically needy are not included under this plan
Citation 3.1 Amount, Duration, and Scope of Services (continued)

(c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-C.

(c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).
Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.
3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are not regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.
3.1(f)(1) **Optometric Services**

Optometric services (other than those provided under §435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term “physicians’ services” under this plan and are reimbursed whether furnished by a physician or an optometrist.

[ ] Yes.

[ ] No. The conditions described in the first sentence apply but the term “physicians’ services” does not specifically include services of the type an optometrist is legally authorized to perform.

[x] Not applicable. The conditions in the first sentence do not apply.

(2) **Organ Transplant Procedures**

Organ transplant procedures are provided.

[ ] No.

[x] Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.
New York
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3.1(g) **Participation by Indian Health Service Facilities**

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

(h) **Respiratory Care Services for Ventilator-Dependent Individuals**

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—

[ ] 30 consecutive days;

[ ] __ days (the maximum number of inpatient days allowed under the state plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

[ ] Yes. The requirements of section 1902(e)(9) of the Act are met.

[x] Not applicable. These services are not included in the plan.

TN #87-47
Supersedes TN #79-4

Approval Date November 21, 1991
Effective Date October 1, 1987
3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-In agreement for such payment as indicated below.

Buy-in agreement for:

[x] Part A  [x] Part B

[ ] The Medicaid agency pays premiums for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Attachment 1.1

June 15, 2004

Approval Date  

June 15, 2004

TN #04-09 

Supersedes TN #93-27 

Supersedes TN #93-27 

Effective Date  

April 1, 2004
(ii) **Qualified Disabled and Working Individual (QDWI)**

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

(iii) **Specified Low-Income Medicare Beneficiary (SLMB)**

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

(iv) **Qualifying Individual - 1 (QI-1)**

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

(v) **Qualifying Individual - 2 (QI-2)**

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10) (E)(iv)(II) and subject to 1933 of the Act.
Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

- [x] All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

- [x] Individuals receiving title II or Railroad Retirement benefits.

- [ ] Medically needy individuals (FFP is not available for this group).

Other Health Insurance

[X] The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).
(b) **Deductibles, Coinsurance**

(1) **Medicare Part A and B**

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

(i) **Qualified Medicare Beneficiaries (QMBS)**

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for the QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

(ii) **Other Medicaid Requests**

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

For the entire range of services available under Medicare Part B.

Only for the amount, duration, and scope of services otherwise available under this plan.

(iii) **Dual Eligible - QMB plus**

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).
Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.
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Citation
42 CFR 441.101, 42 CFR 431.620(c) and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

[x] Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

[ ] Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.
3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.
3.5 **Families Receiving Extended Medicaid Benefits**

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are --

[X] Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

[ ] Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

[ ] Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

[ ] Medical or remedial care provided by licensed practitioners.

[ ] Home health services.

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**New York 31a**

**Citation**

1902(a)(52) and 1925 of the Act

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**Attachment 1.1**

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**TN #91-75**

**Supersedes TN #87-47**

**Approval Date** March 3, 1992

**Effective Date** October 1, 1991
Families Receiving Extended Medicaid Benefits
(Continued)

[ ] Private duty nursing services.

[ ] Physical therapy and related services.

[ ] Other diagnostic, screening, preventive, and rehabilitation services.

[ ] Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

[ ] Intermediate care facility services for the mentally retarded.

[ ] Inpatient psychiatric services for individuals under age 21.

[ ] Hospice services.

[ ] Respiratory care services.

[ ] Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.
Families Receiving Extended Medicaid Benefits
(Continued)

(c) [x] The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance --

[x] 1st 6 months [x] 2nd 6 months

[ ] The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

[ ] 1st 6 mos. [ ] 2nd 6 mos.

(d) [ ] (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

[ ] Enrollment in the family option of an employer's health plan.

[ ] Enrollment in the family option of a State employee health plan.

[ ] Enrollment in the State health plan for the uninsured.

[ ] Enrollment in an eligible health Maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).


Citation 3.5  **Families Receiving Extended Medicaid Benefits**
(Continued)

Supplement 2 to Attachment 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency -

   (i) Pays all premiums and enrollments fees imposed on the family for such plan(s)

   [ ] (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s)

3.6  **Unemployed Parent**

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency -

[ ] Uses the standard for measuring unemployment which was in the AFDC State Plan in effect on July 16, 1996

[x] Uses the following more liberal standard to measure unemployment:

   An individual will be considered unemployed if the family’s countable income and resources as determined for the group defined in Section 1931 are below the eligibility standard used for that group (Attachment 2.6-A, Supplement 12 and Supplement 1 to Attachment 2.6-A, Item A-1) or if the family's income and resources, minus deductions allowed for medically needy, including incurred medical expenses, is less than the medically needy income level (Supplement 1 to Attachment 2.6-A, Item D) and Resource level (Supplement 2 to Attachment 2.6-A, Item B).

(Note: This effectively eliminates the old AFDC deprivation requirements from all groups.)
[x] Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.*

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

[ ] (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

[ ] (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

* Only if previously enrolled
SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation 4.1 Methods of Administration

42 CFR 431.15 AT-79-29
The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

42 USC 1396a(13)(A)
The State provides for a public process that conforms to the requirements of section 4711 of the federal Balanced Budget Act of 1997 for determination of rates of payment under this Plan for Attachments 4.19-A Parts 1, 2, 3, 4, 5, 7 and Attachment 4.19-D Parts 1 and 2.
Citation 4.2 **Hearings for Applicants and Recipients**

42 CFR 431.202
AT-79-29
AT-80-31

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
New York
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**Citation**

P.L. 101-508
Section 4724

**Services During Appeal**

The State shall continue to provide medical assistance until a final determination of disability or blindness is made by SSA in those cases where a state determination of disability or blindness, made in accordance with section 1614(a) of the Social Security Act, was reversed by a subsequent SSA decision.

[X] YES
[ ] NO

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**TN #91-30**

**Supersedes TN**

**Effective Date**

**Approval Date**

April 1, 1991

July 22, 1991
4.3 Safeguarding Information on Applicants and Recipients

42 CFR 431.301
AT-79-29 Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967 All other requirements of 42 CFR Part 431, Subpart F are met.
4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

[ ] Yes.

[X] Not applicable. The State has an approved Medicaid Management Information System (MMIS).
4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.
PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

| Citation | | | |
| --- | --- | --- | |
| Section 1902(a)(42)(B)(i) of the Social Security Act | X | The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. | |
| | | The State is seeking an exception to establishing such program for the following reasons: | |
| Section 1902(a)(42)(B)(ii)(I) of the Act | X | The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. | |
| | Place a check mark to provide assurance of the following: | | |
| | X | The State will make payments to the RAC(s) only from amounts recovered. | |
| | X | The State will make payments to the RAC(s) on a contingent basis for collecting overpayments. | |

TN #10-43 Approval Date March 8, 2011
Supersedes TN NEW Effective Date April 1, 2011
### PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

#### 4.5 Medicaid Recovery Audit Contractor Program

<table>
<thead>
<tr>
<th>Section 1902 (a)(42)(B)(ii)(II)(a) of the Act</th>
<th>The following payment methodology shall be used to determine State payments to Medicaid RACs for recovered overpayments (e.g., the percentage of the contingency fee):</th>
</tr>
</thead>
<tbody>
<tr>
<td>X The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</td>
<td></td>
</tr>
<tr>
<td>----- The State attests that if the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.</td>
<td></td>
</tr>
<tr>
<td>----- The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</th>
<th>The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</th>
</tr>
</thead>
<tbody>
<tr>
<td>X The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</td>
<td></td>
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<tr>
<td>Contingency Fee - 5.25%</td>
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**TN #10-43 Approval Date March 8, 2011**  
Supersedes TN **NEW**  
**Effective Date April 1, 2011**
**PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION**

### 4.5 Medicaid Recovery Audit Contractor Program

| Section 1902 (a)(42)(B)(ii)(III) of the Act | X The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RACs. |
| Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act | X The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan. |
| Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act | X The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share. |
| Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act | X Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program. |

**TN #10-43 Approval Date March 8, 2011**

**Supersedes TN NEW Effective Date April 1, 2011**
SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program (Exceptions)

<table>
<thead>
<tr>
<th>Citation</th>
<th>Exception from Medicaid RAC 3-year Look Back Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 455.508(f)</td>
<td>New York State requests an exception to the 3-year look back period for the Medicaid RAC program defined in section 455.508. Subparagraph (f) states, “The entity must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State.”</td>
</tr>
<tr>
<td></td>
<td>New York State regulations (18 NYCRR Section 504.3) require providers “to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health”.</td>
</tr>
<tr>
<td></td>
<td>The State requests the ability to grant a look back period for the Medicaid RAC up to six years, upon State approval of the RAC scenario, for the following reasons:</td>
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<td>• Claim specific detail may be present documenting an overpayment exists for periods beyond the three-years specified in Section 42 CFR 455.508(f);</td>
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<tr>
<td></td>
<td>• A look-back period longer than three years is more consistent with Medicaid provider record retention requirements required by New York State regulatory agencies; and</td>
</tr>
<tr>
<td></td>
<td>• A longer look-back period will allow for additional efficiencies for both the state and provider when a single effort can review and recover an identified overpayment rather than leveraging multiple entities to review and recover different time periods.</td>
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<tr>
<td></td>
<td>This exception will only apply to reviews based on actual claim specific detail. Audits that require sampling and extrapolation will continue to be limited to the 3-year look back period.</td>
</tr>
</tbody>
</table>

TN #12-36 ______________ Approval Date ________________
Supersedes TN NEW Effective Date January 1, 2013

March 19, 2013
Citation
Section 1902(a)(64) of the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation Program
The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN #99-30 Approval Date December 6, 1999
Supersedes TN NEW Effective Date July 1, 1999
4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.
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4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.
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Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency’s rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.
4.9 **Reporting Provider Payments to Internal Revenue Service**

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.
4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual -

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).
4.11 Relations with Standard Setting and Survey agencies

(a) The State Agency utilized by the Secretary to determine qualifications of institutions and supplies of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provides services to Medicaid recipients. This agency is: The New York State Department of Health.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is(are): The New York State Department of Health and The Office of Mental Health.

(c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, are kept on file and made available to the Health Care Financing Administration, on request.
(d) The New York State Department of Health (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.
4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

[x] Yes, as listed below:

1. Public Home infirmaries.
2. Infirmary section of a private home for aged.
3. Institutions for mental diseases including sections for mental diseases of general hospitals.
4. Institutions for Tuberculosis including sections for Tuberculosis in general hospitals.
5. Medical rehabilitation centers.
6. Such other facilities authorized by State law in which care or treatment may be provided.

[ ] Not applicable. Similar services are not provided to other types of medical facilities.
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Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

[ ] Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN #91-75
Supersedes TN 87-47

Approval Date March 3, 1992
Effective Date October 1, 1991
For each provider receiving funds under the plan, all the requirements for advance directive of section 1902(w) are met:

1. Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

   a. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

   b. Provide written information to all adult individuals on their policies concerning implementation of such rights;

   c. Document in the individual’s medical records whether or not the individual has executed an advance directive;

   d. Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

   e. Ensure compliance with requirements of State Law (whether
New York
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statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

Not applicable. No State law or court decision exist regarding advance directives.
4.13 **Utilization/Quality Control**

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

- **Directly**

- **By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO –**

  1. Meets the requirements of §434.6(a);
  2. Includes a monitoring and evaluation plan to ensure satisfactory performance;
  3. Identifies the services and providers subject to PRO review;
  4. Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
  5. Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

- **Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.**

  1. By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

---

**New York**

**46**

**Citation**

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)

---

**TN #92-09** **Approval Date** April 30, 1992

**Supersedes TN 89-43** **Effective Date** January 1, 1992
New York
47

Citation 4.14
42 CFR 456.2
50 FR 15312

(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

[ ] Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

[ ] Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

[ ] All hospitals (other than mental hospitals).

[ ] Those specified in the waiver.

[X] No waivers have been granted.

March 6, 1986

Approval Date

Supersedes TN 76-23

Effective Date October 1, 1985
New York
48

Citation 4.14
42 CFR 456.2
50 FR 15312

(c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

[ ] Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

[ ] Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

[ ] All mental hospitals.

[ ] Those specified in the waiver.

[X] No waivers have been granted.

[ ] Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Attachment 1.1
OMB No. 0938-0193

TN #85-32
Supersedes TN 76-23

Approval Date March 6, 1986
Effective Date October 1, 1985
New York
49

Citation
4.14
42 CFR 456.2
50 FR 15312
(d) The Medicaid agency meets the requirements of
42 CFR Part 456, Subpart E, for the control of
utilization of skilled nursing facility
services.

[ ] Utilization and medical review are
performed by a Utilization and Quality
Control Peer Review Organization designated
under 42 CFR Part 462 that has a contract
with the agency to perform those reviews.

[ ] Utilization review is performed in
accordance with 42 CFR Part 456, Subpart H,
that specifies the conditions of a waiver
of the requirements of Subpart E for:

[ ] All skilled nursing facilities.

[ ] Those specified in the waiver.

[X] No waivers have been granted.

March 6, 1986
TN #85-32 Approval Date
October 1, 1985
Supersedes TN 76-23 Effective Date
4.14

[X] (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

[  ] Facility-based review.

[  ] Direct review by personnel of the medical assistance unit of the State agency.

[  ] Personnel under contract to the medical assistance unit of the State agency.

[  ] Utilization and Quality Control Peer Review Organizations.

[  ] Another method as described in ATTACHMENT 4.14-A.

* [X] Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

[  ] Not applicable. Intermediate care facility services are not provided under this plan.

* See approval letter

New York

Citation
42 CFR 456.2
50 FR 15312

Attachment 1.1
OMB No. 0938-0193

Supersedes TN 76-23
Effective Date October 1, 1985

TN #85-32
Approval Date March 6, 1986
Citation
1902(a)(30)
and 1902(d) of
the Act,
P.L. 99-509
(Section 9431)
P.L. 99-203
(section 4113)

4.14 Utilization/Quality Control (continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

  X  A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

  ___ A private accreditation body.

  ___ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

Attachment 1.1
<table>
<thead>
<tr>
<th>Citation</th>
<th>4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Part</td>
<td>The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:</td>
</tr>
<tr>
<td>456 Subpart I, and 1902(a)(31) and 1903(g) of the Act</td>
<td>___ ICFs/MR;</td>
</tr>
<tr>
<td></td>
<td>___ Inpatient psychiatric facilities for recipients under age 21; and</td>
</tr>
<tr>
<td></td>
<td>___ Mental Hospitals</td>
</tr>
<tr>
<td>42 CFR Part</td>
<td>All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.</td>
</tr>
<tr>
<td>456 Subpart A and 1902(a)(30) of the Act</td>
<td>___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.</td>
</tr>
<tr>
<td></td>
<td>___ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.</td>
</tr>
<tr>
<td></td>
<td>___ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.</td>
</tr>
</tbody>
</table>

**TN #92-23** 
**Approval Date** July 30, 1992 
**Supersedes TN 76-27** 
**Effective Date** April 1, 1992
4.16 **Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees**

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

The Medicaid agency will provide for coordination of the operations under Title XIX with the State's operations under the special supplemental food program for women, infants and children (WIC) under Section 17 of the Child Nutrition Act of 1966 as specified by amendment to Section 1902(a)(11) of the Social Security Act.

**ATTACHMENT 4.16-A** describes the cooperative arrangements with the health and vocational rehabilitation agencies.
4.17 Liens and Adjustments or Recoveries

(a) Liens

_ X_ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid to or be paid on his or her behalf.

_ X_ The State imposes liens on real property on account of benefits incorrectly paid.

_ X_ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

_ X_ The State imposes liens on both real and personal property of an individual after the individual's death.

TN #95-28
Supersedes TN NEW
Approval Date September 27, 1996
Effective Date April 1, 1995
New York
53a

(b) Adjustments or Recoveries

The State complies with the requirement of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual’s estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

[ ] Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) [ ] The State determines “permanent institutional status” of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

[ ] In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Payment for all services are recovered for individuals age 55 and over, except for Medicare cost sharing as specified in section 4.17(b)(3) – continued

TN #10-14 Approval Date September 22, 2010
Supersedes TN #95-28 Effective Date April 1, 2010
New York
53a-1

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB +, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.
(4) **X** The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, supplement 8b.

--- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

**X** The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

--- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

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TN #04-39
Supersedes TN #95-28
Approval Date March 23, 2005
Effective Date December 31, 2004
New York
53c

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

   (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

   (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care of the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.
(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),

- individual's home,

- equity interest in the home,

- residing in the home for at least 1 or 2 years,

- on a continuous basis,

- discharge from the medical institution and return home, and

- lawfully residing.

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TN #95-28
Supersedes TN NEW
Approval Date September 27, 1996
Effective Date April 1, 1995
New York
53e

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.
**New York**

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<table>
<thead>
<tr>
<th>Citation</th>
<th>4.18</th>
<th><strong>Recipient Cost Sharing and Similar Charges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 447.51 through 447.55</td>
<td>(a)</td>
<td>Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54</td>
</tr>
<tr>
<td>1916(a) and of the Act</td>
<td>(b)</td>
<td>Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>No enrollment fee, premium, or similar charge is imposed under the plan.</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:</td>
</tr>
<tr>
<td></td>
<td>(i)</td>
<td>Services to individuals under age 18, or under -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Age 19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Age 20</td>
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<tr>
<td></td>
<td></td>
<td>[X] Age 21</td>
</tr>
<tr>
<td></td>
<td>Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ii)</td>
<td>Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.</td>
</tr>
</tbody>
</table>

| TN #92-28 | Approval Date January 25, 1994 |
| Supersedes TN #91-75 | Effective Date November 1, 1993 |
(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(3) above.

[ ] Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

[ ] 18 or older

[ ] 19 or older

[ ] 20 or older

[X] 21 or older

[ ] Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.
For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

[ ] Not applicable. There is no maximum.
A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.
4.18(c)  [X] Individuals are covered as medically needy under the plan.

(1) [ ] An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

   (i) Services to individuals under age 18, or under –

   [ ] Age 19

   [ ] Age 20

   [X] Age 21

   Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

   

---
Citation 4.18(c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

[ ] Not applicable. No such charges are imposed.
**New York**

**56e**

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.18(c)(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.</td>
</tr>
<tr>
<td></td>
<td>[ ] Not applicable. No such charges are imposed.</td>
</tr>
<tr>
<td></td>
<td>(i) For any service, no more than one type of charge is imposed.</td>
</tr>
<tr>
<td></td>
<td>(ii) Charges apply to services furnished to the following age group:</td>
</tr>
<tr>
<td></td>
<td>[ ] 18 or older</td>
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<td></td>
<td>[ ] 19 or older</td>
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<tr>
<td></td>
<td>[ ] 20 or older</td>
</tr>
<tr>
<td></td>
<td>[X] 21 or older</td>
</tr>
</tbody>
</table>

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

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TN    #92-28
Supersedes TN  #91-75
Approval Date  January 25, 1994
Effective Date  November 1, 1993
(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

[ ] Not applicable. There is no maximum.
Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

[X] Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

[ ] Inappropriate level of care days are not covered.

TN #91-75 Approval Date March 3, 1992
Supersedes TN #87-47 Effective Date October 1, 1991
In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

1. Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

2. Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.
New York
59

Citation
42 CFR 447.40 4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

[X] Yes. The State's policy is described in ATTACHMENT 4.19-C.

[ ] No.

Attachment 1.1

September 29, 1978
Approval Date

Supersedes TN #77-8

Effective Date September 1, 1978
4.19(d) [X] (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

[ ] At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

[ ] At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[X] Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

[ ] At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

[ ] At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[X] Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

(4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.
4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.
New York 62

Citation
42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

4.19(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN #87-47 Approval Date November 21, 1991
Supersedes TN #83-16 Effective Date October 1, 1987
4.19(g) The Medicaid agency assures appropriate audits of records when payment is based on costs of services or on a fee plus cost of materials.
Citation 4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

New York 64

TN #79-24 Approval Date October 16, 1979
Supersedes TN #78-18 Effective Date August 6, 1979
The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.
The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.
<table>
<thead>
<tr>
<th>Citation</th>
<th>4.19(l)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(i)(14) of</td>
<td>The Medicaid agency meets the requirements of section 1903(i)(14) of the Act* with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.</td>
</tr>
<tr>
<td>the Act</td>
<td></td>
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* and Section 6400 of the State Medicaid Manual

<table>
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<tr>
<th>TN</th>
<th>#92-71</th>
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<tr>
<td>Approval Date</td>
<td>March 23, 1993</td>
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<td>Supersedes TN</td>
<td>NEW</td>
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<td>Effective Date</td>
<td>October 1, 1992</td>
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</table>
New York 66(b)

Citation 4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

[X] sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

[___] is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

[___] sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

[___] is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

If indicated, the State will show, via the obstetrical/pediatric State Plan amendment submittal, that the VFC administration fee meets the applicable statutory requirements of the Social Security Act.

TN #94-47 Approval Date January 30, 1995
Supersedes TN NEW Effective Date October 1, 1994
4.20 Direct Payments to Certain Recipients for Physicians’ or Dentists’ Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25

[X] Not applicable. No direct payments are made to recipients.

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.
New York
68

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN #81-33
Supersedes TN #78-79

Approval Date May 7, 1982
Effective Date January 1, 1982
Citation 4.22 Third Party Liability

42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f) (b) ATTACHMENT 4.22-A -
(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3), and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii) (2) Describes the method the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii) (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii) (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

TN #94-12 Approval Date May 9, 1994
Supersedes TN #87-49 Effective Date January 1, 1994
New York
69a

Citation

42 CFR 433.139(b)(3)(ii)(A)  X  (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C)  (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2)  (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)  (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20  (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

TN  #94-12  Approval Date  May 9, 1994
Supersedes TN  #87-49  Effective Date  January 1, 1994
42 CFR 433.151(a)  (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

_X_ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s) --

___ Other appropriate agency(s) of another State --

___ Courts and law enforcement officials.

1902(a)(60) of the Act  (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act  (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

_X_ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.
4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

[ ] Not applicable. The State has no such contracts.

TN #84-3
Supersedes TN #78-26

Approval Date May 24, 1984
Effective Date April 1, 1984
New York
72

Citation 4.24 Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services

With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

--- Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

TN #94-32 Approval Date September 8, 1994
Supersedes TN #80-4 Effective Date April 1, 1994
4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.
**Citation**

1927(g)
42 CFR 456.700

**4.26 Drug Utilization Review Program**

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:
   - Appropriate
   - Medically necessary
   - Are not likely to result in adverse medical results

1927(g)(1)(a)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:
   - Potential and actual adverse drug reactions
   - Therapeutic appropriateness
   - Overutilization and underutilization
   - Appropriate use of generic products
   - Therapeutic duplication
   - Drug disease contraindications
   - Drug-drug interactions
   - Incorrect drug dosage or duration of drug treatment
   - Drug-allergy interactions
   - Clinical abuse/misuse

1927(g)(1)(B)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:
   - American Hospital Formulary Service Drug Information
   - United States Pharmacopeia-Drug Information
   - American Medical Association Drug Evaluations

TN #93-21
Supersedes TN #92-23
Approval Date September 13, 1993
Effective Date April 1, 1993
**Citation**

1927(g)(1)(D) 42 CFR 456.703(b)  
D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

- ___ Prospective DUR  
- **X** Retrospective DUR. *

1927(g)(2)(A) 42 CFR 456.705(b)  
E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7))  
2. Prospective DUR includes screening each prescription filled delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication  
- Drug-disease contraindications  
- Drug-drug interactions  
- Drug-interactions with non-prescription or over-the-counter drugs  
- Incorrect drug dosage or duration of drug treatment  
- Drug allergy interactions  
- Clinical abuse/misuse

1927(g)(2)(A)(ii) 42 CFR 456.705(c) and (d)  
3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B) 42 CFR 456.709(a)  
F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse  
- Gross overuse  
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

* The State’s RetroDUR System will capture and perform retrospective DUR on any drug product not included in a nursing home’s per diem rate.

**TN  #93-21**  
**Approval Date** September 13, 1993  
**Supersedes TN  #92-23**  
**Effective Date** April 1, 1993
The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

The DUR program has established a State DUR Board either:

- Directly, or
- Under contract with a private organization

The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs
- Clinically appropriate dispensing and monitoring of covered outpatient drugs
- Drug use review, evaluation and intervention
- Medical quality assurance.

The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Attachment 1.1

New York
74b

Citation

927(g)(2)(C)
42 CFR 456.709(b)
F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711
3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)
G.1. The DUR program has established a State DUR Board either:

- Directly, or
- Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)
2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs
- Clinically appropriate dispensing and monitoring of covered outpatient drugs
- Drug use review, evaluation and intervention
- Medical quality assurance.

927(g)(3)(C)
42 CFR 456.716(d)
F.1. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN #93-21 Approval Date September 13, 1993
Supersedes TN #92-23 Effective Date April 1, 1993
The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- Intensified monitoring/review of prescribers/dispensers

The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- real time eligibility verification
- claims data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

Prospective DUR is performed using an electronic point of sale drug claims processing system.

Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital’s purchasing cost for such covered outpatient drugs.
New York
75

Citation
42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.
### Citation 4.28 Appeals Process

(a) The Medicaid agency has established appeals procedures for NFs and specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

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**TN #93-14**

**Approval Date** June 28, 1993

**Supersedes TN #89-43**

**Effective Date** January 1, 1993
4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).
### 4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

[X] The agency, under the authority of State law, imposes broader sanctions.
(b) The Medicaid agency meets the requirements of --

(1) Section 1902(p) of the Act by excluding from participation -

(A) At the State’s discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with section 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that -

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
New York 78b

Citation 1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))

(2) Section 1902(a)(39) of the Act by -

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with section 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of -

1902(a)(41) of the Act P.L. 96-272 (sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960).

(b) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.
4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State’s approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.
New York 79c

<table>
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<tr>
<th>Citation</th>
<th>4.35 Remedies for Nursing Facilities that Do Not Meet Requirements of Participation</th>
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<td>1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))</td>
<td>(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for nursing facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.</td>
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<tr>
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<th>(b) The agency uses the following remedy(ies):</th>
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<tr>
<td></td>
<td>1) Denial of payment of new admissions (Direct)</td>
</tr>
<tr>
<td></td>
<td>2) Civil money penalty (Alternative)</td>
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<tr>
<td></td>
<td>3) Appointment of temporary management (Alternative)</td>
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<tr>
<td></td>
<td>4) In emergency cases, closure of the facility and/or transfer of residents (Direct)</td>
</tr>
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| 1919(h)(2)(B)(ii) of the Act | (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use. |

<table>
<thead>
<tr>
<th>1919(h)(2)(F) of the Act</th>
<th>(d) The agency uses one of the following incentive programs to reward nursing facilities that furnish the highest quality care to Medicaid residents:</th>
</tr>
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<tbody>
<tr>
<td>[X] 1) Public recognition.</td>
<td></td>
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<td>[ ] 2) Incentive payments.</td>
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<th>Approval Date</th>
<th>January 26, 1995</th>
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<td>Effective Date</td>
<td>April 1, 1990</td>
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(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

1. nature of noncompliance,
2. which remedy is imposed,
3. effective date of the remedy, and
4. right to appeal the determination leading to the remedy.

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

--- The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Attachment 1.1

New York
79c.1

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR
§488.402(f)

42 CFR
§488.434

42 CFR
§488.402(f)(2)

42 CFR
§488.456(c)(d)

42 CFR
§488.404(b)(1)

TN #95-33

Supersedes TN NEW

Approval Date March 7, 1997

Effective Date July 1, 1995
New York
79c.2

(c) Application of Remedies

42 CFR §488.410
(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF’s provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.
(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)
(v) When immediate jeopardy does not exist, the State terminates an NF’s provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.
(i) The State has established the remedies defined in 42 CFR 488.406(b).

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<tbody>
<tr>
<td>X</td>
<td>(1) Termination</td>
</tr>
<tr>
<td>X</td>
<td>(2) Temporary Management</td>
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<td>X</td>
<td>(3) Denial of Payment for New Admissions</td>
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<td>X</td>
<td>(4) Civil Money Penalties</td>
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<tr>
<td>X</td>
<td>(5) Transfer of Residents; Transfer of Residents with Closure of Facility</td>
</tr>
<tr>
<td>X</td>
<td>(6) State Monitoring</td>
</tr>
<tr>
<td>X</td>
<td>(7) Directed Plan of Correction</td>
</tr>
<tr>
<td>X</td>
<td>(8) Directed Inservice Training</td>
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</table>

Attachments 4.35-B through 4.35-J describe the criteria for applying the above remedies.

TN #95-33
Supersedes TN NEW

Approval Date March 7, 1997
Effective Date July 1, 1995
New York
79c.3

Citation

42 CFR
§ 488.406(b)

(ii) X The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

X (1) Temporary Management
--- (2) Denial of Payment for New Admissions
--- (3) Civil Money Penalties
--- (4) Transfer of Residents; Transfer of Residents with Closure of Facility
--- (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

(e) X State Incentive Programs

X (1) Public Recognition
X (2) Incentive Payments

TN #95-33 Approval Date March 7, 1997
Supersedes TN NEW Effective Date July 1, 1995
<table>
<thead>
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<th>Citation</th>
<th>4.36 Required Coordination Between the Medicaid and WIC Programs</th>
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<tbody>
<tr>
<td>1902(a)(11)(C) and 1902(a)(53) of the Act</td>
<td>The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.</td>
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**New York**

**79d**

<table>
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<th>TN</th>
<th>#91-75</th>
<th>Approval Date</th>
<th>March 3, 1992</th>
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<td>Supersedes TN</td>
<td>NEW</td>
<td>Effective Date</td>
<td>October 1, 1991</td>
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Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 102-508 (Sec. 4801(a)).

4.38 Nurse Aid Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN #92-05 Approval Date April 29, 1992
Supersedes TN NEW Effective Date January 1, 1992
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluations programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) and (3).

(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

TN #92-05
Supersedes TN NEW

Approval Date April 29, 1992
Effective Date January 1, 1992
New York
79q

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State’s nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

(x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

TN #92-05 Approval Date April 29, 1992
Supersedes TN NEW Effective Date January 1, 1992
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.

(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

(bb) The State maintains a nurse aide registry that meets the requirements of 42 CFR 483.156.

(cc) The State includes home health aides on the registry.

(dd) The State contracts the operation of the registry to a non State entity.

(ee) ATTACHMENT 4.38 contains the State’s description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).

(ff) ATTACHMENT 4.38-A contains the State’s description of information included on the registry in addition to the information required by 42 CFR 483.156(c).
New York
79s

Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual
Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a
written agreement with the State mental
health and mental retardation authorities
that meet the requirements of 42 (CFR)
431.621(c).

(b) The State operates a preadmission and
annual resident review program that meets
the requirements of 42 CFR 483.100-138.

(c) The State does not claim as “medical
assistance under the State Plan” the cost
of services to individuals who should
receive preadmission screening or annual
resident review until such individuals are
screened or reviewed.

(d) With the exception of NF services
furnished to certain NF residents defined
in 42 CFR 483.118(c)(1), the State does
not claim as “medical assistance under the
State plan” the cost of NF services to
individuals who are found not to require
NF services.

(e) ATTACHMENT 4.39 specifies the State’s
definition of specialized services.

Attachment 1.1

TN #93-14 Approval Date June 28, 1993
Supersedes TN NEW Effective Date January 1, 1993
New York
79t

4.39 (Continued)

(f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.
## 4.40 Survey & Certification Process

<table>
<thead>
<tr>
<th>Citation</th>
<th>Survey &amp; Certification Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sections</strong> 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))</td>
<td>(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.</td>
</tr>
<tr>
<td>1919(g)(1) (B) of the Act</td>
<td>(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State’s process.</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.</td>
</tr>
</tbody>
</table>

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**TN #92-37**

**Approval Date** January 31, 1995

**Supersedes TN** NEW

**Effective Date** April 1, 1992
1919(g)(2) (A)(i) of the Act

(g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State’s procedures.

1919(g)(2) (A)(ii) of the Act

(h) The State assures that each facility shall have an annual standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident’s assessments, and a review of compliance with resident’s rights not later than 15 months after the date of the previous standard survey.

1919(g)(2) (A)(iii)(I) of the Act

(i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.

1919(g)(2) (A)(iii)(II) of the Act

(j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

1919(g)(2) (B) of the Act

(k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary’s or State’s discretion.

1919(g)(2) (C) of the Act

(l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

TN #92-37

Supersedes TN NEW

Approval Date January 31, 1995

Effective Date April 1, 1992
1919(g)(2) of the Act

(m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.

1919(g)(2) (E)(i) of the Act

(n) The State uses a multidisciplinary team of professionals including a registered professional nurse.

1919(g)(2) (E)(ii) of the Act

(o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.

1919(g)(2) (E)(iii) of the Act

(p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.

1919(g)(4) of the Act

(q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.

1919(g)(5) (A) of the Act

(r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.

1919(g)(5) (B) of the Act

(s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.

1919(g)(5) (C) of the Act

(t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.

1919(g)(5) (D) of the Act

(u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

TN #92-37

Supersedes TN NEW

Approval Date January 31, 1995

Effective Date April 1, 1992
4.41 Resident Assessment for Nursing Facilities

(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity as required in §1919(b)(3)(A) of the Act.

(b) The State is using:

___ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

_X_ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary’s approval criteria) [§1919(e)(5)(B)].
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation 4.43 Cooperation with Medicaid Integrity Program Efforts.

1902(a)(69) of the Act, P.L. 109-171 (section 6034)

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under Section 1936 of the Act.

TN #08-59 Approval Date July 29, 2008
Supersedes TN NEW Effective Date April 1, 2008
4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation: Section 1902(a)(80) of Social Security Act, P.L. 111-148 (Section 6505)

[X] The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN #11-78 Approval Date June 1, 2011
Supersedes TN NEW Effective Date July 6, 2011
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

Citation

1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

PROVIDER SCREENING

X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

ENROLLMENT AND SCREENING OF PROVIDERS

X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

VERIFICATION OF PROVIDER LICENSES

X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

REVALIDATION OF ENROLLMENT

X Assures that providers will be revalidated regardless of provider type at least every 5 years.

TERMINATION OR DENIAL OF ENROLLMENT

X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.
4.46 Provider Screening and Enrollment (Continued)

42 CFR 455.422 APPEAL RIGHTS
X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS
X Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS
X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS
X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agency or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER
X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS
X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
4.46 Provider Screening and Enrollment (Continued)

42 CFR 455.460

**APPLICATION FEE**

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

**TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS**

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

TN #12-07 Approval Date July 16, 2013
Supersedes TN NEW Effective Date April 1, 2013
SECTION 5 PERSONNEL ADMINISTRATION

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

[X] The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.
New York
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5.2 [Reserved]
5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.
SECTION 6  FINANCIAL ADMINISTRATION

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Citation
42 CFR 433.32
AT-79-29

TN #74-2
Supersedes TN None
Approval Date December 31, 1974
Effective Date Prior to January 1, 1974
6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Citation
42 CFR 433.34
47 FR 17490

New York
84

Attachment 1.1

TN #83-3
Supersedes TN #76-15

Approval Date April 8, 1983
Effective Date January 1, 1983
New York
85

6.3 **State Financial Participation**

(a) State funds are used in both assistance and administration.

[ ] State funds are used to pay all of the non-Federal share of total expenditures under the plan.

[X] There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

* For 6.3(b):
  - Approval Date: March 13, 1978
  - Effective Date: October 1, 1977
SECTION 7    GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)  The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN #91-75  Approval Date March 3, 1992
Supersedes TN #74-2  Effective Date October 1, 1991
In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.
7.3 Maintenance of AFDC Efforts

[X] The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

Citation: 1902(c) of the Act

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TN #91-76 Approval Date March 3, 1992
Supersedes TN New Effective Date October 1, 1991
**State Governor's Review**

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

[ ] Not applicable. The Governor --

[ ] Does not wish to review any plan material.

[ ] Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

_____________________________
New York State Department of Health
(Designated Single State Agency)

Date: September 6, 1996

__________________________
/s/ Barbara A. DeBuono, MD
(Signature)

__________________________
Commissioner
(Title)

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TN #96-33
Supersedes TN #91-75
Approval Date November 4, 1996
Effective Date October 1, 1996
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEW YORK

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The New York State Department of Health is the single State agency responsible for:

[ ] administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is:

(STATUTORY CITATION)

[x] supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in:

Sections 363-a and Section 366-a(2)(a) of the Social Services Law and
Section 201 of the Public Health Law

(STATUTORY CITATION)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is:

Section 363-a of the Social Services Law and
Sections 204 and 205 of the Public Health Law

(STATUTORY CITATION)

9/30/14

DATE

Signature: Eric T. Schneiderman

New York State Attorney General
Title

October 24, 2014

TN #13-54 Approval Date January 1, 2014
Supersedes TN #86-33 Effective Date

TN: 13-0056-MM4 Approval Date: 10/24/2014
New York Effective Date: 01/01/2014
A1
As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Department of Health

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

NY Social Services 363-a, PHL 201

The single state agency supervises the administration of the state plan by local political subdivisions.

- Yes
- No

The state statutory citation for the legal authority under which the agency supervises the administration of the plan on a statewide basis is:

NY Social Services 363-a, PHL 201, PHL 206, 366-a, (2) (a)

The state statutory citation under which the single state agency has legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is:

NY Social Services 363-a, PHL 201, PHL 206

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.
The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

- Yes  No

Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

- Yes  No

**Enter the following information for each waiver:**

| Date waiver granted (MM/DD/YY): | 06/11/14
|---------------------------------|

- The type of responsibility delegated is (check all that apply):
  - Determining eligibility
  - Conducting fair hearings
  - Other

- Name of state agency to which responsibility is delegated:
  - NYS Office of Temporary and Disability Assistance (OTDA).

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Consistent with relevant federal and state law with respect thereto and as designated by the Department of Health (DOH), when fair hearings are requested, OTDA: provides such hearings for all non-MAGI Medicaid applicants or beneficiaries with respect to their Medicaid eligibility and any adverse agency action with respect thereto; issues final administrative decisions on behalf of the DOH Commissioner; takes such steps as may be necessary to enforce DOH’s final determinations and decisions.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

DOH communicates Medicaid eligibility and policy directives to OTDA and trains OTDA personnel on such matters. DOH maintains policies and procedures reasonably necessary to monitor and evaluate the effectiveness and efficiency of the activities performed by OTDA with regard to conducting fair hearings. DOH retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by OTDA. OTDA makes and issues the final decision (for non-MAGI cases) on behalf of the Department of Health (DOH) pursuant to DOH statues, regulations and policies. In legal force and effect, the decisions are final DOH decisions. DOH regulations set forth the Commissioner’s authority to review any issued fair hearing decision and correct any error of law or fact and/or any other error occurring in the production of any decision. OTDA conducts all non-MAGI Medicaid fair hearings including service related...
The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☐ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☐ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☐ Medicaid agency

☐ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☐ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

☐ Yes  ☐ No
Medicaid Administration

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Office of Health Insurance Programs (OHIP) and the Office of Health Benefit Exchange are two separate offices, out of a total of twelve offices under the authority of the Commissioner of the Department of Health. OHIP is responsible for administering New York’s Medicaid program by collaborating with stakeholders across the health care industry including other state agencies, local and federal government agencies, providers, members, and community-based organizations to optimize the health of Medicaid members. The Fair hearing process for the MAGI population is within and conducted by the Office of Health Benefit Exchange.

OHIP encompasses eight distinct divisions.

Division of Finance and Rate Setting
This division is responsible for all functions within OHIP related to rate setting, including managed care rates.

Division of Program Development and Management
This division is responsible for all policy and strategic planning including waiver and State Plan Amendments, and policy related to medical, dental, pharmacy (including EPIC), behavioral health and transportation management.

Division of Health Plan Contracting & Oversight
This division is responsible for managed care organization (MCO) contracting, oversight of health plan compliance with applicable federal and state regulations.

Division of Long Term Care
This division is responsible for the managed long term care program which includes oversight of the growth of the program as well as other care coordination models.

Division of OHIP Operations
This division is responsible for fee-for-service (FFS) program management and operations for medical and dental prior approval, pended claim reviews, utilization edit development, rate loading and payment file maintenance, provider enrollment and the electronic health records incentive program.

Division of Health Reform and Health Insurance Exchange Integration
The division is responsible for administering New York’s Medicaid program by collaborating with stakeholders across the health care industry including other state agencies, local and federal government agencies, providers, members, and community-based organizations. The division interprets, develops and implements federal and state legislation. The division also establishes policies, guidelines and instructions by writing directives to local districts for all Medicaid populations including MAGI, Non-MAGI and persons who are aged, blind, or disabled. With division oversight, the local districts process applications and determine eligibility for non-MAGI, Presumptive eligibility for Pregnant Women and Children. Local districts also process renewals for the aforementioned populations, as well as, the MAGI population until the MAGI renewals are transitioned to the SBM. MAGI applications are processed by the Office of Health Benefit Exchange with division guidance.

Division of OHIP Systems
This division is responsible for the oversight of the MMIS (eMedNY system) contract and the technical support of the development of the Health Exchange.

Division of Human Resources and Administration
This division interacts with OHIP management in planning, coordinating, developing and implementing all activities related to OHIP human resources

Upload an organizational chart of the Medicaid agency.

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New York A1
Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Executive Branch of New York State is headed by the Governor. The Executive Branch is the part of the government that has the sole authority and responsibility for the daily administration of the State's business. New York State's governmental activities are carried out by several departments within the Executive Branch. The New York Department of Health is one of these agencies. The Department of Health (DOH) coordinates policy and activities specifically to protect, improve and promote the health, productivity and well being of all New Yorkers. The Department of Health is responsible for the Medicaid program. Separate from DOH and its own distinctive agency the Office of Mental Health determines Medicaid eligibility for seriously emotionally disturbed children up to the age of 21 within the 1915(c) waiver. Separate from DOH and its own distinctive agency the Office of People with Developmental Disabilities determines Medicaid eligibility for developmentally disabled adults and children, within the 1915(c) waiver. OTDA administers public assistance programs, including cash assistance, Supplemental Nutrition Assistance Program (SNAP), and Home Energy Assistance Program (HEAP). The Office of Health Benefit Exchange is a separate and distinct office within the Department of Health.

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

- Yes
- No

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Medicaid Administration

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- Counties
- Parishes
- Other

Are all of the local subdivisions indicated above used to administer the state plan?

- Yes
- No

Indicate the number used to administer the state plan: 58

Description of the staff and functions of the local subdivisions:

Local Department of Social Services employees are civil servants qualified to be appointed to various positions. They receive and process Medicaid applications pursuant to New York State laws and regulations. They determine financial eligibility, categorical classification, continued financial eligibility, and income maintenance review for the Aged, Blind, Disabled, Presumptive eligibility for Pregnant Women, Children and non-MAGI categories, as well as, renewal determinations of MAGI categories until such time as the categories can be transitioned to the Health Benefit Exchange.

State Plan Administration

Assurances

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

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The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
## SUPERSEDING PAGES OF
STATE PLAN MATERIAL

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<td>A2</td>
<td>Notwithstanding any other provisions of the Medicaid State Plan, the agencies designated in A1 and A2 will determine eligibility for coverage to the extent specified in A1 and A2.</td>
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A1
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Refer to Attachment 1.1-A (PDF A1) Section

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

[ State of _____New York____________________________ ]

[ WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED
UNDER THE INTERGOVERNMENTAL COOPERATION ACT OF 1968]

Waiver #1. *
Limited
a. Waiver was granted on May 11, 1969
   (date)

b. The organizational arrangement authorized, the nature
   and extent of responsibility for program administration
   delegated to Department of Mental Hygiene_____, and
   (name of agency)
   the resources and/or services of such agency to be utilized
   in administration of the plan are described below:

   Permits State funds to be appropriated directly to the
   Department of Mental Hygiene for medical assistance under Title
   XIX for patients in State mental hospitals and schools for the
   mentally retarded.

Waiver #2: Granted 7/24/70 Department of Mental Hygiene and
Narcotics Addiction Control Commission

   Limited waiver permits State funds to be appropriated directly
   to the Department of Mental Hygiene and Narcotics Addiction
   Control Commission for Intermediate Care Facilities services under
   Title XVI, (Now Title XIX)

Waiver #3: Granted 7/1/71 Department of Health

   Limited waiver permits State funds to be appropriated directly
   to Department of Health for administering and supervising the
   medical aspects of Title XIX Program.

* 1 / ("...illegible text here..." have been granted is certified in ...."illegible text")

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[c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

Under Title II of the Social Services Law, the Department of Social Services has the responsibility of assuring the accuracy of the claims presented for the Federal reimbursement under Title XIX. As the Single State Agency it is responsible for auditing the Title XIX expenditures of the Departments of Health, Mental Hygiene, and the Narcotics Addiction Control Commission.

Under Section 1, Article V of the New York State Constitution and Section 6, Article 2 of the State Finance Law, the State Comptroller has audit responsibility for examination of expenditures, accounts, revenues, and receipts. He is responsible for all fiscal matters, including the accounting systems in State department and agencies. For this reason, the State Comptroller is responsible for conducting audits of Title XIX expenditures made by the Department of Mental Hygiene, Health and the Narcotics Addiction Control Commission, and for reviewing the methods of accounting used by these departments. Under U.S. Bureau of the Budget Circular A-87 we claim for the indirect costs of the services performed by the Department of Audit and Control on behalf of our Federal programs. These indirect costs include the Comptroller's audit functions on behalf of our Title XIX Medicaid Program.]

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Refer to Attachment 1.1-A (PDF A1) Section

Office of Health Systems Management

Division of Health Facility Planning
- Bureau of Facility and Service Review
- Bureau of Architectural & Engineering Facility Planning
- Bureau of Health Facility Planning
- Bureau of Long Term Care Initiatives

Division of Health Care Standards & Surveillance
- Bureau of Home Health Care Services
- Bureau of Hospital Services
- Bureau of Long Term Care Services
- Office of Professional Medical Conduct
- Bureau of Emergency Medical Services
- Bureau of Funeral Directing
- Bureau of Controlled Substances

Division of Health Care Financing
- Bureau of Health Care Research Information Services
- Bureau of Standards Development
- Bureau of Nursing Home Administrator Licensure
- Elderly Pharmaceutical Coverage Program (EPIC)
- Bureau of Financial Management Support
- Bureau of Health Economics
- Bureau of Long Term Care Reimbursement
- Bureau of Primary & Acute Care Reimbursement

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[Organizational Unit: Division of Health Care Standards and Surveillance]

The responsibilities discharged through the Division of Health Care Standards and Surveillance support the Department’s mandated purposes of protecting, promoting and preserving the health of the residents of New York State. The Division’s activities, include setting the minimum inspection of facilities needed to monitor and enforce those standards to safeguard the health of the State’s entire population, regardless of geographic location or ability to pay. From the newborns in hospitals to the elderly in the nursing homes, the constant surveillance of the full spectrum of medical services provided to the State’s varied population groups serves to reduce morbidity and mortality by ensuring that those services meet Federal and State requirements. This surveillance process includes not only the routine inspection of providers, but also the investigation of all complaints received. Whether they are the frail elderly of the State’s population, or the developmentally disabled children, the surveillance of health care providers helps to ensure that the quality of their lives reaches optimal levels.

The Division discharges its responsibilities through two groups, the Health Care Standards and Analysis Group and the Health Care Surveillance Group.

The Health Care Standards and Analysis Group is comprised of the following bureaus:

1. Bureau of Standards Development

2. Bureau of Health Care Research and Information Services

3. Bureau of Nursing Home Administrator Licensure

The Health Care Surveillance Group is comprised of the following three bureaus:

1. Bureau of Hospital Services

2. Bureau of Long Term Care Services]

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[3. Bureau of Home Health Care Services

The Group’s surveillance function is discharged through area offices located in Albany, Buffalo, Rochester, Syracuse, New York City and New Rochelle. In addition, the New Rochelle area office operates a sub-office on Long Island.

Staff resources are directed toward meeting objectives which will ensure the provision of accessible, efficient, effective and high quality health care services.]
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Refer to Attachment 1.1-A (PDF A1) Section

[Organizational Unit: Bureau of Standards Development]

The Bureau develops health care standards necessary to implement Federal and State legislation applicable to all types of health care providers and services. These standards include facility or agency operating standards and standards governing the quality and availability of services provided under the Medical Assistance Program (Medicaid). In addition to the revision and modification of standards related to established forms of health care services, the Bureau is responsible for the formulation of standards dealing with new and innovative program areas. The Bureau also staffs the Code Committee of the State Hospital Review and Planning Council.

The Bureau, through its Pharmacy Unit, maintains the list of drugs eligible for reimbursement under the NYS Medicaid program, and the list of drugs eligible to the substituted for brand name prescription drugs under the NYS Generic Drug Substitution Program. Pharmaceutical provider plans, to ensure compliance with the Drug Imprinting and Labeling Law, are monitored by the Pharmacy Unit. In addition, support is provided to the EPIC (Elderly Pharmaceutical Insurance Coverage) program to determine the appropriateness of drugs covered under that program.

The Bureau has responsibility for the administration of Medical Assistance Program training funds and assists in the development of specific training initiatives.

The Bureau serves as the primary resource to the OHSM on the qualifications and scope of practice of particular professions. The staff includes administrative as well as professional personnel in various clinical care disciplines including dentistry, medicine, nursing, occupational therapy, pharmacy, and social work.]

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The Bureau of Health Care Research and Information Services (BHCR/IS) staff generate and maintain data registries in support of the Division's standard setting and surveillance activities and coordinate health care research and analysis activities throughout the Division. These services, provided through the use of quantitative analysis, management science and electronic data processing, enhance the Division's ability to meet its objective of assuring that the State's health system provides high quality care, thus reducing morbidity and mortality.

The Bureau has four organizational units:

- **Systems Development:** This unit is responsible for the planning and implementation of mainframe user systems and user portions of production systems that support the regulatory missions of the Division.

- **Policy Analysis:** This unit is responsible for providing quantitative policy analysis and program evaluation services to the regulatory bureaus within the Division and to OHSM executive staff.

- **Personal Computer/Data Communications Support and Application Programming:** This unit is responsible for the completion of all special purpose computer programming tasks requested by executive of program staff, and for the installation and support of PC equipment, terminals and printers throughout the Division.

- **Information Systems and Health Statistics Group (ISHS) Liaison:** An individual has been designated for lead responsibility in coordinating day-to-day contacts between Division staff and ISHS. In addition to facilitating Divisional access to ISHS services, this arrangement provides a quasi-management link to the production programmers assigned to the Division.
The activities of the Bureau of Nursing Home Administrator Licensure help to ensure the provision of appropriate and necessary health care services to the chronically ill and frail elderly population residing in nursing homes in New York State.

The Bureau of Nursing Home Administrator Licensure (BNHAL) services as staff to the New York State Board of Examiners of Nursing Home Administrators. The Board is responsible for establishing standards of education, training, and experience and providing for the examination, licensure, and registration of nursing home administrators in New York State. Currently, there are 3,650 individuals licensed as nursing home administrators in New York State.

The Board is also responsible for initiating disciplinary action against administrators who violate provisions of Article 28-D of the Public Health Law, which defines the practice of nursing home administration. The Board may suspend, revoke, annul or censure the license or registration of an administrator for violations of the Public Health law. In addition, the Board may assess civil penalties against administrators when it deems appropriate.
The Bureau of Home Health Services has six primary areas of program responsibility: 1) regulation and certification of Certified Home Health Agencies (CHHA), 2) licensure and regulation of home care service agencies, 3) development and implementation of the Long Term Home Health Care Program (LTHHCP), 4) certification and regulation of the Hospice program, 5) development, implementation and evaluation of the Chapter 831 Home Health Care Grant program and Home Health Grant Training program, and 6) provision of staff support to the State Council on Health Care Services. The Bureau is responsible for coordinating the activities of program staff in these areas through the six OHSM area offices.

The development of cost effective and high quality noninstitutional alternatives is the common thread which unifies the Bureau’s major responsibilities. Each major program area is developmental in nature when compared to the more traditional forms of health delivery. A major focus of Bureau activity is the creation and implementation of innovative surveillance protocols for assuring quality in the care delivered by such programs. The facilitation and revision of legislation, regulations, and policies to create the proper environment for the development and competitive existence of home based programs is also a major component of such ongoing activities.]
The primary goal of the Bureau of Hospital Services is to promote and assure the quality of inpatient, outpatient and emergency room care provided in the 268 hospitals established under Article 28 of the Public Health Law.

In the assurance of regulatory compliance, the Bureau’s programs include a comprehensive Article 28 survey program, targeted Article 28 surveys, complaint investigation surveys, the incident reporting program, character and competence reviews as part of the certificate of need process, and Title XVIII surveys. In addition, the Bureau initiates enforcement actions against facilities to ensure regulatory compliance.

During the 1988-89 fiscal year, the Department consolidated its Utilization Review (UR) program, and as a result, the Department now has one Medicaid UR agent for upstate New York (Network Design Group) and one for the New York City and Long Island region (Island Peer Review Organization). The actual review activity is being conducted through contractual arrangements with these two medical review groups.

Comprehensive Article 28 Survey Program

The comprehensive Article 28 survey program is designed to focus on patient outcomes through the assessment of quality of patient care and the effectiveness of internal hospital quality assurance systems.
The Bureau of Long Term Care Services is the central program office responsible for the Office of Health Systems Management’s long term care regulatory activities. The Bureau is responsible for directing the area office surveillance program as specified by the Health Care Financing Administration under the 1864 Agreement designating the Department of Health as the state surveillance agent for nursing homes. The program is required to enforce facility operating standards and monitor the quality of care delivered to approximately 103, 714 patients/residents residing in 628 long term care facilities as specified in Titles XVIII/XIX of the Federal Social Security Act and Article 28 of the Public Health Law.

As the central, coordinative point for the survey process, the Bureau must assure that long term care standards are enforced effectively and uniformly throughout the State. The Bureau’s activities are directed at ensuring that the State’s skilled nursing facilities are providing all services and care necessary to enable each resident to achieve his or her highest practicable level of physical, mental and psychosocial well-being as required by federal regulation.

The activities of the Bureau of Long Term Care Services are carried out by three separate units within the Bureau: (1) Quality Assurance, Complaint Investigation, and Enforcement; (2) Surveillance Program Operations and Development; and (3) Facility Operations and Control.}
The Division of Health Facility Planning, funded within the Health Care Standards and Surveillance program is responsible for the administration of the State's Certificate of Need (CON) activities. The State mandated CON program provides a planning mechanism to ensure that health care resources are developed and made available to the public in a comprehensive, coordinated manner which is responsive to the public's health care needs. Each proposal is evaluated based on community need for beds and services, financial feasibility and cost efficiency of the project, and the competence and character of the sponsors. The review of CON applications and determination of need provide a vital step in achieving the Department's goal of quality care for all that is affordable and accessible.

In addition to its responsibility for administering the State's CON program, the Division is involved in activities designed to improve the efficiency of the existing health care network. Through examination of specific facilities and services, the Division makes recommendations regarding the merger or consolidation of facilities and changes in services to more appropriately reflect factors such as utilization and facility financial status.

The Division is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two bureaus:

1. Bureau of Health Facility Planning
2. Bureau of Architectural and Engineering Facility Planning

The Certificate of Need Review Group is composed of two bureaus and one unit:

1. Bureau of Facility and Service Review
2. Bureau of Financial Analysis and Review
3. Project Management Unit]
Division of Health Care Financing

Office of Deputy Director

Bureau of Financial Mgmt.
Information Support

Data Systems Management
Reg/State Plan Administration
Fin Performance Analysis
Cap Project Fin Review
& PACB Support
HDCC and Provider Assessment
Pool Administration
Nursing Home Patient Assessment
Instrument Data Collection

Bureau of Health Economics

Reimburse Methodology Dev.
Trend Factor Administration
Litigation Review
Health Care Labor Analysis
Health Care Res & Prog Eval
Regulations/State Plan Dev.
Child Health Insurance Program
Regional Insurance Pilot

Bureau of Long Term Care Reimbursement

CHHA/LTHHCP Ratesetting
RHCF Ratesetting

Bureau of Primary & Acute Care Reimbursement

Hospital Ratesetting
D&TC Ratesetting
Fin Distressed Hospital Monitoring

Bureau of Health Economics (EPIC)

Fiscal Intermediary Management
System Development Pharmacy Audits
Utilization Review Manufacturers’ Rebate
Therapeutic Drug Monitoring
Outreach & Publicity

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The Division of Health Care Financing is organizationally responsible for ensuring that health care resources are most appropriately allocated. Financial management of New York State’s health care system is accomplished through a variety of activities. They include developing reimbursement methodologies, setting third party reimbursement rates, administering State revenue collection programs generated through various assessments charged to health care providers, and reviewing the financing mechanisms of proposed health facility construction and expansion projects. Alternative health care financing mechanisms that offer potential cost control incentives and savings are also examined, tested and evaluated.

The following units are responsible for carrying out the duties of the Division:

1. Bureau of Health Economics
2. Bureau of Primary and Acute Care Reimbursement
4. Bureau of Long Term Care Reimbursement

THE MAJOR RESPONSIBILITIES OF THE DIVISION INCLUDE:

- Calculating and/or promulgating and approving rates of payment for hospitals, residential health care facilities, diagnostic and treatment centers, home health agencies, and other Article 28, 36, 40, 43, and 44 certified facilities.

- Adjudicating appeals to rates of payment consistent with regulations and statute.

- Developing and evaluating new and alternative financing methods for health care providers and insurers. These financing methods include improving methods of pricing health care services, refining patient provider encounters, and examining capital financing methods and utilizing insurance vehicles for providing health care services for the uninsured and underinsured.

- Administering several grant programs for global budgeting, health networks and health care demonstrations.

- Developing and implementing sponsored health care financing research activities.

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TN #13-0056
Supersedes TN #97-0010
Approval Date October 24, 2014
Effective Date January 1, 2014
Establishing and administering the financing reforms detailed in the Health Care Reform Act of 1996. Developing policies, procedures and protocols that will for the first time, allow New York to move to negotiated rates for hospital care and will continue support of public policy priorities including uncompensated care, graduate medical education and numerous health care initiatives.

Administering approximately $2.0 billion in pooled funds financed through health care provider and insurer assessments and surcharges for medically indigent subsidies, various health care project initiatives, graduate medical education and physician excess malpractice coverage.

Administering collection of statutory assessments on health care providers pertaining to the Health Facility Cash Receipts Assessment Program, and the HMO Differential.

Maintaining the Patient Review Instrument (PRI) processing system, including collection of data via electronic mail, correction of data, auditing of data, assignment of Resource Utilization Group (RUG), and updating of Residential Health Care Facility (RHCF) rates to reflect changes in case mix index (CMI).

Collecting cost report data via electronic mail for five provider groups; hospitals, RHCFs, Diagnostic & Treatment Centers (D&TCs), Certified Home Health Agencies (CHHAs), and Long Term Home Health Care Programs (LTHHCPs).

Providing financial analysis services to State mortgage loan programs which provide construction financing to non-profit nursing homes and hospitals.

Designing and evaluating payment methodologies for hospitals, nursing homes and ambulatory care programs which includes conducting research studies to support Departmental policy recommendations concerning payment for and delivery of health care services; preparing Title XIX (Medicaid) State Plans for health care services which are submitted to the federal government to procure Medicaid federal financial participation; drafting regulations to implement reimbursement methodologies; preparing responses to litigation brought against the Department by providers pertaining to reimbursement methodologies; responding to inquiries from industry, other State agencies, legislative staff and the general public regarding the Medicaid financing systems; and, developing grant applications to procure outside funding for research on financing issues and economic analyses of health care systems.]

Attachment 1.2-A

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Approved Date: 10/24/2014  Effective Date: 01/01/2014
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TN  #13-0056  Approval Date  October 24, 2014
Supersedes TN  #97-0010  Effective Date  January 1, 2014
Coordinating the development of all new Medicaid Program finance regulations and providing administrative services to the State Hospital Review and Planning Council, Fiscal Policy Committee and Medical Advisory Committee.

Ensuring compliance with Federal statutory requirements relating to the State’s provider tax programs. This includes preparation of any necessary waiver applications, and corresponding statistical testing and analysis, pursuant to Federal Law.

Ensuring compliance with Federal Disproportionate Share payment limitations. This includes projecting hospital distributions, Medicaid and uninsured net revenue/losses and implementing such limits into the pool distribution process.

Monitoring the Receivership Program and its related Receivership Fund, calculating capital costs, monitoring the Article 28-A Mortgage Program and controlling its related Operating Escrow Account activities.

Monitoring and evaluating the uniform physician billing form and electronic claims submission legislative requirements, including coordination of the activities of the Physician Claim Task Force.

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

TN #13-0056 Approval Date October 1, 2014
Supersedes TN #97-0010 Effective Date January 1, 2014
New York
16

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[Organizational Unit: Elderly Pharmaceutical Insurance Coverage Program (EPIC)]

The Elderly Pharmaceutical Insurance Coverage (EPIC) program provides assistance to low and moderate income elderly through subsidizing the costs of their prescription medications. As of March 1990, over 76,000 seniors were enrolled in EPIC. Since the program began in October 1987, EPIC has saved these older New Yorkers over $52 million on the costs of their medications.

The program performs outreach and promotion to inform seniors about the program, enrolls eligible persons, supervises a large contractual operation which processes payments to pharmacies and participants, and performs audits of both the contractor and the providers to assure the fiscal integrity of program operations. In addition, a utilization review function assists in the detection of potential fraud or abuse, research is completed on various aspects of program participation and utilization, and a process for reconsideration and fair hearing is maintained to address participant and provider disputes.]
Office of the Director

The Office of the Director leads and supports the work of the Office of Medicaid Management (OMM). The Director’s Office performs the following functions:

- Provide ambassadorship to the outside world
- Works with Department of Health (DOH) executives on high-level DOH management and strategy
- Leads the overall internal functioning of OMM
- Serves as a resource to OMM managers to clarify director’s views on emerging issues
- Establishes and holds division heads accountable for performance agreements
Bureau of Administration & Resource Support

The Bureau of Administration and Resource Support provides the other OMM units with the necessary resources to produce OMM’s expected results. The Bureau performs the following functions:

- Forecasts and plans resources
- Allocates resources to the divisions and bureaus
- Manages and tracks financial State Purposes expenditures
- Coordinates the preparation of budget initiatives
- Acquires human resources necessary to support program needs
- Secures materials and equipment needed by OMM units
- Space planning
- Day-to-day operational needs
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014  Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

Division of Consumer and Local District Relations

The Division of Consumer and Local District Relations will help serve both OMM consumers and local governments. The Division will perform the following functions:

- Create eligibility guidelines
- Determine consumer eligibility (including Third Party Liability and disability reviews)
- Provide local district support (technical assistance, training, transportation)
- Resolving consumer complaints
- Assessing performance of local districts
- Educating consumers
- Connecting consumers to the correct services
[Division of Information and System Support]

The Division of Information and System Support will manage and support the information and system needs of the entire OMM organization. The Division will perform the following functions:

- Developing systems (planning, coordination and testing)
- Procuring and monitoring system contracts
- Monitoring and correcting the work of systems contractors
- Responding to data requests
- Developing and supporting OMM’s internal PC/LAN system (strategic planning, maintenance, Internet access, help desk)
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014    Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[Bureau of Enforcement Activities]

The Bureau of Enforcement Activities will combat actions of those groups and individuals who fail to comply with Medicaid and OMM rules and regulations. The Bureau will perform the following functions:

- Confirm occurrences of Medicaid fraud (investigation processing)
- Penalizing (sanctioning) providers guilty of Medicaid fraud
- Penalizing (sanctioning) recipients guilty of Medicaid fraud
- Actualizing due process
- Supporting prosecution with/by other law enforcement authorities
- Establishing and maintaining internal controls for OMM]
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014   Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

[State of New York]

[Staffing Summary of Personnel
Used in the Administration of the Plan]

[New York State Department of Health]

Division of Health Care Financing
Division of Health Standards and Surveillance
Office of Medicaid Management
Office of Managed Care
Division of Administration
Division of Legal Affairs
Information Systems & Health Statistics Group

TN   #13-0056   Approval Date October 24, 2014
Supersedes TN   #97-0015   Effective Date January 1, 2014
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[Executive Office]

Policy and oversight for:

- Nursing Homes
- Adult Care Facilities
- Home Health Care Services
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care manage Care
- Partnership for Long Term Care Insurance
- Personal Care
- Waiver Programs
- Aide Training Programs]
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014   Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

Division of Program Development and Initiatives

The Division is responsible for:

- Program Development
- Regulatory Reform
- Strategic Planning
- Intergovernmental Relations
- Cash and Counseling
- Managed Long Term Care Demonstrations
- Continuing Care Retirement Communities

TN #13-0056 Approval Date October 24, 2014
Supersedes TN #98-0047 Effective Date January 1, 2014
**Division of Quality and Licensure**

The Division is responsible for:

Licensure, Surveillance and Quality Initiatives for:
- Adult Homes
- Home Health Care Services Agencies
- Nursing Homes
- Enriched Housing Programs
- Assisted Living Programs
- Residences for Adults

Credentialing of:
- Nursing Home Administrators
- Certified Nursing Aides
- Home Health Aides
- Personal Care Aides

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**TN #13-0056 Approval Date October 24, 2014**

**Supersedes TN #98-0047 Effective Date January 1, 2014**
NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

Division of Finance and Insurance

The Division is responsible for:

- Long Term Care Capitated Rates
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care Partnership Plan
- Traumatic Brain Injury Program
- Personal Care
- Long Term Home Health Care Program
- Community Home Health Agency Services and Waivers

TN #13-0056 Approval Date October 24, 2014
Supersedes TN #98-0047 Effective Date January 1, 2014
[Information Services]

The Bureau is responsible for:

- Network Administration
- Computer Support
- Database Administration
- Research and Evaluation Systems Activities

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014  Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

TN  #13-0056
Supersedes TN  #98-0047
Approval Date  October 24, 2014
Effective Date  January 1, 2014
New York

NOTE: Page deleted under approved SPA 13-0056-MM4
Approved Date: 10/24/2014 Effective Date: 01/01/2014
Refer to Attachment 1.1-A (PDF A1) Section

[Administration Services]

The Bureau is responsible for:

- Budget
- Personnel
- Regulation Processing
- Correspondence Control]
A “health maintenance organization” (HMO) is defined in section 4401 of the Public Health Law, Chapter 45 of the Consolidated Laws of the State of New York, to mean “any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan.”

A “comprehensive health services plan” is defined in Section 4401 to mean “a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance of periodic charge.”

“Comprehensive health services” are defined in Section 4401 to mean “all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services.”

Section 4402 of the Public Health Law provides that “no person or groups of persons may operate a health maintenance organization or issue a contract to an enrollee for membership in a comprehensive health services plan without first obtaining a certificate of authority from the commissioner (of health).”

The Commissioner of Health may issue a certificate of authority pursuant to Section 4403 or 4403-a of the Public Health Law only if the applicant demonstrates that it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan, is financially responsible for the cost of providing comprehensive health services to enrollees and satisfies other conditions assuring quality of care, resolution or enrollee complaints, etc.

The HMO must make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO.

The HMO must make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO’s debts if it does become insolvent.
The following groups are covered under this plan.

### A. Mandatory Coverage – Categorically Needy and Other Required Special Groups

#### 1. Recipients of AFDC

The approved State AFDC plan includes:

- [X] Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months
- [X] Pregnant women with no other eligible children.
- [X] AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

#### 2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

* Agency that determines eligibility for coverage.]

TN #13-0053

Supersedes TN #91-0076

Approval Date  June 26, 2014

Effective Date  January 1, 2014
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

b. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support [and meets the requirements of section 406(h) of the Act].

c. Title IV-E Subsidized Adoption, Foster Care, or Kinship Guardianship Assistance for Children. Individuals who meet the requirements of section 473(b) of the Act for whom an adoption assistance agreement is in effect or foster care maintenance or kinship guardianship assistance payments are made under title IV-E of the Act.

* Agency that determines eligibility for coverage.
### New York

#### 2a

**Agency**

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>[407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act]</th>
<th>3. Qualified Family Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.</td>
<td></td>
</tr>
<tr>
<td>[X] Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.</td>
<td></td>
</tr>
<tr>
<td>1902(a)(52) and 1925 of the Act</td>
<td>3. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage

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**TN #13-0053**

**Approval Date** **June 26, 2014**

**Supersedes TN #91-0076**

**Effective Date** **January 1, 2014**
### New York

#### [Agency * Citation(s)] Groups Covered

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<thead>
<tr>
<th>Agency *</th>
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<th>Groups Covered</th>
</tr>
</thead>
</table>
|          | 42 CFR 435.113 | 5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:
|          |             | a. Families denied AFDC solely because of income and resources deemed to be available from – –
|          |             | (1) Stepparents who are not legally liable for support of stepchildren under a state law of general applicability;
|          |             | (2) Grandparents;
|          |             | (3) Legal guardians; and
|          |             | (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);
|          |             | b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.
|          |             | c. Families denied AFDC because the family transferred a resource without receiving adequate compensation. |

* Agency that determines eligibility for coverage.*

**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #91-0076**

**Effective Date** January 1, 2014
### Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.114</td>
<td>6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
</tr>
<tr>
<td>[X]</td>
<td>Includes persons who would have been eligible cash assistance but had not applied in August 1972 (this group was included in this State’s August 1972 plan).</td>
</tr>
<tr>
<td>[X]</td>
<td>Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State’s August 1972 plan).</td>
</tr>
<tr>
<td>[ ]</td>
<td>Not applicable with respect to intermediate care facilities; State did or does not cover this service.</td>
</tr>
<tr>
<td></td>
<td>a. A pregnant woman whose pregnancy has been medically verified who --</td>
</tr>
<tr>
<td></td>
<td>(1) Would be eligible for an AFDC cash payment (or who would be eligible if the State had an AFDC-unemployed parents program) if the child had been born and was living with her;</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.*

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**New York
3a**

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**Attachment 2.2-A**

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**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #91-0076**

**Effective Date** January 1, 2014
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

COVERAGE AND CONDITIONS OF ELIGIBILITY

---

Citation(s) | Groups Covered
---|---

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.

1902(a)(10)(A) (i)(III) and 1905(n) of the Act

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.

___ Children born after
(specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.]

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TN #13-0053 | Approval Date | June 26, 2014
Supersedes TN #92-0027 | Effective Date | January 1, 2014
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citations(s) | Groups Covered
--- | ---
A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

8. Pregnant women and infants under 1 year of age with family income up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children

8. Children born after _12/31/79_____ (specify optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for those groups are specified in Supplement 1 to ATTACHMENT 2.6A.]

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #99-0002 Effective Date January 1, 2014
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**COVERAGE AND CONDITIONS OF ELIGIBILITY**

<table>
<thead>
<tr>
<th>Citations(s)</th>
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</tr>
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<tbody>
<tr>
<td><strong>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</strong></td>
<td></td>
</tr>
<tr>
<td>[1902(a)(10) (A)(ii)(V) and 1905(m) of the Act]</td>
<td>[10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.]</td>
</tr>
<tr>
<td>1902(3)(5) of the Act</td>
<td>11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>1902(e)(6) of the Act</td>
<td>b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.</td>
</tr>
</tbody>
</table>

**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #9-0027**

**Effective Date** January 1, 2014
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citations(s)                    Groups Covered

A.  Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(e)(4) of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child’s birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

_ X_ a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

_ X_ Aged
_ X_ Blind
_ X_ Disabled

TN #92-27 Approval Date January 20, 1993
Supersedes TN #91-76 Effective Date April 1, 1992
A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

435.121  

13. [ ] b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act, and who met the State’s more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(a)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

___ Aged  
___ Blind  
___ Disabled

The more restrictive categorical eligibility criteria are described below:

* Agency that determines eligibility for coverage.

<table>
<thead>
<tr>
<th>Approval Date</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>March 3, 1992</td>
<td>October 1, 1991</td>
</tr>
</tbody>
</table>

(Financial criteria are described in ATTACHMENT 2.6-A)
### New York 6b

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1902(a)</td>
<td>14. Qualified severely impaired blind and disabled individuals under age 65, who --</td>
</tr>
<tr>
<td></td>
<td>(10)(A)</td>
<td>a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or</td>
</tr>
<tr>
<td></td>
<td>(i)(II)</td>
<td>b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must --</td>
</tr>
<tr>
<td></td>
<td>and 1905 (q) of the Act</td>
<td>(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Have unearned income amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

**Approval Date** March 3, 1992  
**Effective Date** October 1, 1991
### Agency * Citation(s) Groups Covered

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</table>

#### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

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* Agency that determine eligibility for coverage.

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Supersedes TN</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#91-76</td>
<td>March 3, 1992</td>
<td>#87-35A</td>
<td>October 1, 1991</td>
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### Agency * Citation(s) Groups Covered

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A. <strong>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</strong></td>
</tr>
<tr>
<td></td>
<td>1619(b)(3)</td>
<td>[ ] The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.</td>
</tr>
</tbody>
</table>

** Agency that determines eligibility for coverage.

| TN #91-76 | Approval Date March 3, 1992 |
| Supersedes TN NEW | Effective Date October 1, 1991 |
### Agency * Citation(s) Groups Covered

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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
<td></td>
</tr>
<tr>
<td>1634(c) of the Act</td>
<td>15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who – –</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Are at least 18 years of age;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Lose SSI eligibility because they become entitled to OASDI child’s benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. The State applies more restrictive eligibility requirements than those under SSI, and part of all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.122</td>
<td>16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.</td>
<td></td>
</tr>
<tr>
<td>45 CFR 435.130</td>
<td>17. Individuals receiving mandatory State supplements.</td>
<td></td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

**TN #91-76** 
**Approval Date** March 3, 1992

**Supersedes TN NEW** 
**Effective Date** October 1, 1991
### Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

[X] In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

- [X] Aged
- [X] Blind
- [X] Disabled

[ ] Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

---

* Agency that determines eligibility for coverage.

**TN #91-76**

**Supersedes TN NEW**

**Approval Date** March 3, 1992

**Effective Date** October 1, 1991
### Agency * Citation(s) Groups Covered

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong></td>
<td>42 CFR 435.132</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
<tr>
<td></td>
<td>19.</td>
<td>Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they - -</td>
</tr>
<tr>
<td></td>
<td>a.</td>
<td>Continue to meet the December 1973 Medicaid State plan eligibility requirements; and</td>
</tr>
<tr>
<td></td>
<td>b.</td>
<td>Remain institutionalized; and</td>
</tr>
<tr>
<td></td>
<td>c.</td>
<td>Continue to need institutional care.</td>
</tr>
<tr>
<td></td>
<td>42 CFR 435.133</td>
<td>20. Blind and disabled individuals who - -</td>
</tr>
<tr>
<td></td>
<td>a.</td>
<td>Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and</td>
</tr>
<tr>
<td></td>
<td>b.</td>
<td>Were eligible for Medicaid in December 1973 as blind or disabled; and</td>
</tr>
<tr>
<td></td>
<td>c.</td>
<td>For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

**TN #91-76**

**Approval Date** March 3, 1992

**Supersedes TN NEW**

**Effective Date** October 1, 1991
### New York

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
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<tbody>
<tr>
<td></td>
<td>42 CFR 435.134</td>
<td></td>
</tr>
</tbody>
</table>

**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

[X] Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State’s August 1972 plan).

[X] Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State’s August 1972 plan).

[ ] Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

* Agency that determines eligibility for coverage.

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**TN #91-76**

**Approval Date** March 3, 1992

**Supersedes TN #87-35A**

**Effective Date** October 1, 1991
### New York

#### Agency * Citation(s) Groups Covered

<table>
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<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.135</td>
<td>22. Individuals who --</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Not applicable because the State applies more restrictive eligibility requirements than those under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

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**TN #91-76**

**Supersedes TN #87-35A**

**Approval Date** March 3, 1992

**Effective Date** October 1, 1991
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups</td>
<td></td>
</tr>
<tr>
<td>1634 of the Act</td>
<td>23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for the purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.</td>
<td></td>
</tr>
</tbody>
</table>

[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

[ ] The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have the income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

* Agency that determines eligibility for coverage.

**TN #91-76**

**Approval Date** March 3, 1992

**Effective Date** October 1, 1991
<table>
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<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
</table>
|          | 1634(d) of the Act | A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups**  

24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for the purposes of title XIX, to be SSI beneficiaries under section 1634(d) of the Act.  

[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.  

[ ] Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases.  

[ ] The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of the countable income for categorically needy eligibility.  

* Agency that determines eligibility for coverage.

**TN #91-76**

Approval Date **March 3, 1992**

Supersedes TN **#91-72**

Effective Date **October 1, 1991**
### New York 9b

**Agencies**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td></td>
<td>1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D)</td>
<td><strong>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups</strong></td>
</tr>
</tbody>
</table>

#### 25. Qualified Medicare Beneficiaries --

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal Poverty Level; and
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical Assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

#### 26. Qualified disabled and working individuals

- a. Who are entitled to hospital insurance benefits under Section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level.
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<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<td>c.</td>
<td>Whose resources do not exceed twice the maximum standard under SSI.</td>
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<td></td>
<td>d.</td>
<td>Who are not otherwise eligible for medical assistance under Title XIX of the Act.</td>
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<tr>
<td></td>
<td></td>
<td>(Medical assistance for this group is limited to Medicare part A premiums under section 1818A of the Act.)</td>
</tr>
<tr>
<td></td>
<td>a.</td>
<td>Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under 1818A of the Act);</td>
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<td></td>
<td>b.</td>
<td>Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</td>
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<td></td>
<td>c.</td>
<td>Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</td>
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<tr>
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<td></td>
<td>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</td>
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<tr>
<td></td>
<td>a.</td>
<td>Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under 1818A of the Act);</td>
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<td></td>
<td>b.</td>
<td>Whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</td>
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<td></td>
<td>c.</td>
<td>Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</td>
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</tbody>
</table>

**TN #10-15**

**Approval Date** September 15, 2010

**Supersedes TN #93-27**

**Effective Date** April 1, 2010
A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups** (Continued)

1634(e) of the Act  

28. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.

* Agency that determines eligibility for coverage.

<table>
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<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tr>
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<td>1634(e) of</td>
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<td>the Act</td>
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<td>or (v) of</td>
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<td>Section 1611</td>
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<td>(e)(3)(A)</td>
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<td>month.</td>
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TN #95-15

Approval Date April 26, 1995

Supersedes TN NEW

Effective Date February 10, 1995
### New York 9c

**B. Optional Groups Other Than the Medically Needy**

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.210 1902(a) (10)(A)(ii) and 1905(a) of the Act</td>
<td>[X] 1.</td>
<td>Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. [X] The plan covers all individuals as described above. [ ] The plan covers only the following group or groups of individuals:</td>
</tr>
<tr>
<td>___ Aged</td>
<td>___ Blind</td>
<td>___ Disabled</td>
</tr>
<tr>
<td>___ Caretaker relatives</td>
<td>___ Pregnant women</td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.211</td>
<td>[X] 2.</td>
<td>Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.</td>
</tr>
</tbody>
</table>
B. **Optional Groups - Other Than Medically Needy**

(Continued)

42 CFR 435.212

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in a Medicaid managed care organization as defined in section 1903(m)(1)(A), with a primary care case manager as defined in section 1905(1), or with an eligible organization under section 1876 of the Act, and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (not more than six months beginning on the effective date of enrollment), the State Plan may provide, notwithstanding any other provision of this title that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum enrollment period, but, except for benefits furnished under section 1905(a)(4)(c), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

---

The State elects not to guarantee eligibility

**X** The State elects to guarantee eligibility. The minimum enrollment period is 6 months (not to exceed six).

The State measures the minimum enrollment period from:

---

The date beginning the period of enrollment in the MCO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

**X** The date beginning the period of enrollment in the MCO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

---

The date beginning the last period of enrollment in the MCO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or of periods of enrollment as a private paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.

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**TN #99-18**

**Approval Date** February 10, 2000

**Supersedes TN #92-09**

**Effective Date** April 1, 1999
### B. Optional Groups - Other Than Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>1932 of the Act</td>
<td>The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of a managed care entity as defined in section 1932 of the Act. The requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.</td>
</tr>
<tr>
<td>P.L. 98-369 (section 2364), P.L. 99-272 (section 9517),</td>
<td><em>X</em> Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).</td>
</tr>
<tr>
<td>P.L. 101-508 (section 4732), P.L. 105-33 (section 4701)</td>
<td>During the first ninety (90) days of the first twelve month restricted period and after the first twelve months the recipient may disenroll without cause. The State will provide notification at least sixty (60) days before the end of each enrollment period, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</td>
</tr>
<tr>
<td>1903(m)(2)(H), 1902(a)(52) of the Act</td>
<td><em>X</em> The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible into the same entity in which they enrolled at the time eligibility was lost.</td>
</tr>
<tr>
<td>P.L. 101-508 (section 4732), P.L. 105-33 (section 4702(b)(1)(A))</td>
<td><em>X</em> The agency elects not to reenroll the above individuals into the same entity in which they were previously enrolled.</td>
</tr>
</tbody>
</table>

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**TN #99-18**  
**Supersedes TN #92-09**  
**Approval Date February 10, 2000**  
**Effective Date April 1, 1999**
B. Optional Groups Other Than the Medically Needy (continued)

Citation 42 CFR 435.217

_X_ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver.* The group or groups covered are listed in waiver request. This option is effective on the effective date of the State’s section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*This group of individuals includes PACE enrollees, and will be effective on the effective date of the amendment electing PACE as a State service.
B. **Optional Groups - Other Than Medically Needy**  
*(Continued)*

1902(a)(10)  
(A)(ii)(VII)  
of the Act

[ ] 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

[ ] The State covers all individuals as described above.

[ ] The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of --
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

---

**TN #91-77**  
**Approval Date** March 11, 1992  
**Supersedes TN** NEW  
**Effective Date** October 1, 1991
### Optional Groups - Other Than Medically Needy

(Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>42 CFR 435.220</td>
<td>6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii) and 1905(a) of the Act</td>
<td>[ ] The State covers only the following group or groups of individuals:</td>
</tr>
<tr>
<td></td>
<td>___ Individuals under the age of - -</td>
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<tr>
<td></td>
<td>___ 21</td>
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<td>___ 20</td>
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<td>___ 19</td>
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<td>___ 18</td>
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<tr>
<td></td>
<td>___ Caretaker relatives</td>
</tr>
<tr>
<td></td>
<td>___ Pregnant women</td>
</tr>
<tr>
<td>42 CFR 435.2</td>
<td>7. [X] a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are 21 years of age or younger as indicated below.</td>
</tr>
<tr>
<td>1902(a)(10) (A)(ii) and 1905(a)(i) of the Act</td>
<td>___ 20</td>
</tr>
<tr>
<td></td>
<td>___ 19</td>
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<tr>
<td></td>
<td>___ 18]</td>
</tr>
</tbody>
</table>
B. Optional Groups – Other Than Medically Needy (Continued)

42 CFR 435.222 [X] b. Reasonable classifications of individuals described in (a) above, as follows:

_X_ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of 21).

___ (b) In private institutions (and are under the age of 21).

___ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

_X_ (d) Children under the age of 21 for whom guardianship assistance payments are made and individuals in the care and custody of the local social services district commissioner or who are in the care and custody of the Office of Children and Family Services for the purpose of receiving foster care (and are under the age of 21).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).

___ (3) Individuals in NFs (who are under the age of ___.) NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ___).]
B. Optional Groups - Other Than Medically Needy (Continued)

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of Attachment 2.2-A.]
B. Optional Groups - Other Than Medically Needy (Continued)

1902(a)(10) (A)(ii)(VIII) of the Act

[X] 8. A child for whom there is in effect a state adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement --

   a. Was eligible for Medicaid under the State's approved Medicaid plan; or

   b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of --

  _X_ 21
  ___ 20
  ___ 19
  ___ 18}
### B. Optional Groups - Other Than Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>42 CFR 435.223</td>
<td>[ ] 9.</td>
<td>Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:</td>
</tr>
<tr>
<td>1902(a)(10) (A)(ii) and 1905(a) of the Act</td>
<td>___</td>
<td>Individuals under the age of --</td>
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<td>___ 21</td>
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<td>___ Caretaker relatives</td>
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<td></td>
<td>___ Pregnant women]</td>
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</tbody>
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**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #91-0077**

**Effective Date** January 1, 2014
### New York

15

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.230</td>
<td>[X] (10) <strong>States using SSI criteria with agreements under sections 1616 and 1634 of the Act.</strong></td>
</tr>
</tbody>
</table>

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is --

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual’s countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

- [X] (1) All aged individuals.

- [X] (2) All blind individuals.

- [X] (3) All disabled individuals.

---

**TN #91-77**          **Approval Date** March 11, 1992

**Supersedes TN #86-29A**          **Effective Date** October 01, 1991
<table>
<thead>
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<tbody>
<tr>
<td>___</td>
<td>42 CFR 435.230</td>
<td>(Continued)</td>
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</tbody>
</table>

B. **Optional Groups - Other Than Medically Needy**

|   |   |   |
|___|___|___|

|   |   |   |
|___|___|___|

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230

___ (9) Individuals in additional classifications approved by the Secretary as follows:

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**TN **#91-77 ** Approval Date  March 11, 1992

**Supersedes TN **#86-29A ** Effective Date  October 01, 1991

---
### Optional Groups - Other Than Medically Needy

(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- [X] Yes.
- [ ] No.

The standards for optional State supplementary payments are listed in [Supplement 6 of ATTACHMENT 2.6-A](#).

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**Agency** * Citation(s)  **Groups Covered**

<table>
<thead>
<tr>
<th>Agency *</th>
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<tbody>
<tr>
<td>TN #91-77</td>
<td></td>
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</tr>
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**Supersedes TN ** NEW **

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**Approval Date** | **March 11, 1992**

**Effective Date** | **October 01, 1991**
### New York

#### 17

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<tr>
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<td>42 CFR 435.120</td>
<td></td>
</tr>
<tr>
<td></td>
<td>435.121</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1902(a)(10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(A)(ii)(XI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of the Act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] 11. <strong>Section 1902 (f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.</strong></td>
<td></td>
</tr>
</tbody>
</table>

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is --

- a. Based on need and paid in cash on a regular basis.

- b. Equal to the difference between the individual’s countable income and the income standard used to determine eligibility for the supplement.

- c. Available to all individuals in each classification and available on a Statewide basis.

- d. Paid to one or more of the classifications of individuals listed below:

  - ___ (1) All aged individuals.
  - ___ (2) All blind individuals.
  - ___ (3) All disabled individuals.
New York
17a

[Agency * Citation(s) Groups Covered

<table>
<thead>
<tr>
<th>[Agency * Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
</table>
| 1902(a)(10)(A)(ii)(IX) and 1902(1) of the Act, P.L. 99-509 (Sections 9401(a) and (b)) | ___ 13. The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount up to 100 percent of the Federal nonfarm poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and infant or child and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A.

(a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987);

___ (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987);

___ (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988);

___ (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989);

___ (e) Children who have attained four years of age but not attained five years of age (effective October 1, 1990).]

Infants and children covered under items 13(a) through (e) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.

* Agency that determines eligibility for coverage.

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #87-0035A Effective Date January 1, 2014
## New York

### 17b

<table>
<thead>
<tr>
<th>Agency</th>
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<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>[The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.][1]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[X]</td>
<td>Not applicable. The State does not provide coverage of this optional categorically needy group.</td>
</tr>
</tbody>
</table>

1902(a) ___ 14. In addition to individuals covered under item B.13, individuals --

(a) Who are 65 years of age or older or are disabled --

(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

(c) Whose resources do not exceed the maximum amount allowed --

* Agency that determines eligibility for coverage.

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**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #87-0035A**

**Effective Date** January 1, 2014
### Agency * Citation(s) Groups Covered

<table>
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<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 4101(a)</td>
<td>PL100-203 Sec 1902L (1)(A)(B) of the Act</td>
<td>The following individuals who are described in Section 1902L(1)(A)(B) of the Act whose income level (established at an amount up to 185% of the Federal nonfarm poverty line) specified in Supplement 1 page 2a to Attachment 2.6A for a family of the same size including the woman or infant under one who meet the resource standards specified in Supplement 2 to Attachment 2.6A.</td>
</tr>
</tbody>
</table>

(a) Woman during pregnancy (and during the 60 day period beginning on the last day of pregnancy) and infants under one year of age (effective July 1, 1988).

(b) The resource standard & methodology applied to the pregnant woman.

- **X** The State does not apply a resource standard.
- ___ The State applies a resource standard not more restrictive than SSI.

(c) The resources standard & methodology applied to the child under one year.

- **X** The State does not apply a resource standard.
- ___ The State applies a resource standard not more restrictive than AFDC.

(d) Where the gross income of the pregnant woman or child (less child care expenses) exceeds 150% of the FPL for a family of relevant size a premium not to exceed 10% of the excess may be applied.

- **X** The State does not apply a premium.
- ___ The State applies a ___ percent premium.

---

**Attachment 2.2-A**

**New York 17b-1**

**Supersedes TN #90-0003**

**Approval Date** June 26, 2014

**Effective Date** January 01, 2014
New York
17c

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<table>
<thead>
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<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>[1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)]</td>
<td>[ <em>X</em> 15. Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under Attachment 2.6A who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.]</td>
<td></td>
</tr>
</tbody>
</table>

C. Optional Coverage of the Medically Needy

Title XIX 435.301 This plan includes the medically needy.

___ No

_X_ Yes. This plan covers:

1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

* Agency that determines eligibility for coverage.

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #90-0003 Effective Date January 01, 2014
## B. Optional Groups Other Than the Medically Needy
(Continued)

<table>
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<tr>
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<th>Groups Covered</th>
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<tbody>
<tr>
<td>___ (4)</td>
<td></td>
<td>Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>___ (5)</td>
<td></td>
<td>Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>___ (6)</td>
<td></td>
<td>Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>___ (7)</td>
<td></td>
<td>Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td>___ (8)</td>
<td></td>
<td>Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td>___ (9)</td>
<td></td>
<td>Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>

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**Attachment 2.2-A**

**New York**

**18**

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**Agency * Citation(s) Groups Covered**

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**B. Optional Groups Other Than the Medically Needy**
(Continued)

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**March 11, 1992**

**Approval Date**

**October 01, 1991**

**Effective Date**

---

**Supersedes TN #86-29A**

---

**TN #91-77**

---

**Approval Date March 11, 1992**

---

**Effective Date October 01, 1991**

---
B. Optional Groups Other Than the Medically Needy
   (Continued)

   The supplement varies in income standard by political subdivisions according to cost-of-living differences.

   ___ Yes
   ___ No

   The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A
### New York

#### 19

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tr>
<td></td>
<td>42 CFR 435.231</td>
<td></td>
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<tr>
<td></td>
<td>1902(a)(10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(A)(ii)(V)</td>
<td></td>
</tr>
<tr>
<td>of the Act</td>
<td>[ ] 12.</td>
<td>Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>[ ] The State covers all individuals as described above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] The State covers only the following group or groups of individuals:</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10)(A)</td>
<td>[ ] Aged</td>
<td></td>
</tr>
<tr>
<td>(ii) and 1905(a)</td>
<td>[ ] Blind</td>
<td></td>
</tr>
<tr>
<td>of the Act</td>
<td>[ ] Disabled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Individuals under the age of --</td>
<td></td>
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<tr>
<td></td>
<td>[ ] 21</td>
<td></td>
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<tr>
<td></td>
<td>[ ] 20</td>
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<td></td>
<td>[ ] 18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Caretaker relatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Pregnant women</td>
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**TN #91-77**

**Approval Date** March 11, 1992

**Supersedes TN #90-3**

**Effective Date** October 01, 1991
Attachment 2.2-A

New York
20

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<tbody>
<tr>
<td>B.</td>
<td></td>
<td>Optional Groups Other Than the Medically Needy (Continued)</td>
</tr>
</tbody>
</table>

1902(e)(3) of the Act 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(a)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10) (A)(ii)(IX) and 1902(1) of the Act 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and

b. Infants under one year of age.]
New York  
21

<table>
<thead>
<tr>
<th>Agency *</th>
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<th>Groups Covered</th>
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</thead>
</table>

**B. Optional Groups Other Than the Medically Needy (Continued)**

1902(a) (10)(A) (ii)(IX) and 1902(1)(1) (D) of the Act

[X] 15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained --

[ ] 7 years of age; or

[X] 8 years of age.

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Supersedes TN #91-0077

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New York
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Agency *  Citation(s)  Groups Covered

---

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a) (ii)(X)
and 1902(m) (1) and (3)
of the Act

[X] 16. Individuals --

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State’s more restrictive financial criteria; or under the State’s medically needy program as specified in ATTACHMENT 2.6-A.

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TN #91-77
Supersedes TN NEW

Approval Date  March 11, 1992
Effective Date  October 01, 1991
Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(47) and 1920 of the Act

X  17. Pregnant women who are determined by a “qualified provider” (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.]
### Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
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<th>Citation(s)</th>
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</thead>
<tbody>
<tr>
<td>1906 of the Act</td>
<td>18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of ___ months.</td>
</tr>
<tr>
<td>1902(a)(10)(F) and 1902(u)(1) of the Act</td>
<td>19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See <a href="#">Supplement 11 to Attachment 2.6-A</a>.</td>
</tr>
</tbody>
</table>
### Groups Covered

<table>
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<tr>
<th>Citation(s)</th>
<th>B. Optional Groups Other Than the Medically Needy (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBRA 1993</td>
<td>Coverage is extended to individuals who are described in subsection (z)(1) relating to certain TB infected individuals whose income and resources are as follows:</td>
</tr>
<tr>
<td>Sec. 1902(a)(10)(A)(ii – XII)</td>
<td>Income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income of a disabled individual described in subsection (a)(10)(A)(i).</td>
</tr>
<tr>
<td><em>X</em></td>
<td>More liberal income disregards in accordance with section 1902(r)(2) as described in Supplement 8a to Attachment 2.6A page 4 are applied.</td>
</tr>
<tr>
<td>___</td>
<td>Resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in section (a)(10)(A)(ii) may have.</td>
</tr>
<tr>
<td><em>X</em></td>
<td>More liberal resource disregards in accordance with section 1902(r)(2) as described in Supplement 8b to Attachment 2.6A page 4 are applied.</td>
</tr>
</tbody>
</table>

**TN #13-0053**

**Approval Date** June 26, 2014

**Supersedes TN #94-0014**

**Effective Date** January 1, 2014
New York
23c

B. Optional Groups Other Than Medically Needy (Continued)

1902(a)(10)(A) (ii)(xiv) of the act

_ X_ 20. Optional Targeted Low Income Children who:

a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);

b. would not be eligible for Medicaid under the policies in the State’s Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(1)(2)(D));

c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no federal funds for the program;

d. have family income at or below:

200 percent of the federal poverty level for the size family involved, as revised annually in the federal Register; or

A percentage of the federal poverty level, which is in excess of the “Medicaid applicable income level” (as defined in §2110(b)(4) of the Act) but no more than 50 percentage points.

The State covers:

_ X_ All children described above who are under age 19 (18, 19) with family income at or below 100 percent of the federal poverty level.]
[B. Optional Groups Other Than Medically Needy (Continued)]

___ The following reasonable classifications of children described above who are under age ___ (18,19) with family income at or below the percent of the federal poverty level specified for the classifications:

(Add Narrative Descriptions(s) Of The Reasonable Classification(s) And The Percent Of The Federal Poverty Level Used To Establish Eligibility For Each Classification.)

1920A(b)(3)(A) _X_ 21. Continuous Eligibility For Children

A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

[1902A(b)(3)(A) [ _X_ 22. Presumptive Eligibility For Children

Children under age 19 who are determined by a “qualified entity” (as determined in §1920(A)(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child’s behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If the application is not filed on the child’s behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the last day.

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #07-0040 Effective Date January 1, 2014
B. Optional Groups Other Than Medically Needy
(Continued)

1902(a)(10)(A)_(ii)(XVIII) of the Act

23. Women who:

a. have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

1920B of the Act

24. Women who are determined by a “qualified entity” (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.
### Citation

<table>
<thead>
<tr>
<th>Citation</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td><strong>Optional Groups Other Than the Medically Needy (Continued)</strong></td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>BBA Work Incentives Eligibility Group</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act</td>
<td>TWWIIA Medical Improvement Group</td>
</tr>
</tbody>
</table>

#### BBA Work Incentives Eligibility Group -

Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.

#### TWWIIA Basic Coverage Group -

Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.

#### TWWIIA Medical Improvement Group -

Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.

NOTE: If the State elects to cover this group, it MUST also cover the basic coverage Group Described in No. 26 above.

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**TN #03-11**

**Approval Date** June 26, 2003

**Supersedes TN NEW**

**Effective Date** July 01, 2003
New York
23g

B. Optional Groups Other Than the Medically Needy (Continued)

Sections 477, 1902(a)(10)(A)(ii)(XVII), and 1905(w) of the Act

28. Independent Foster Care Adolescents.

An individual who is younger than age 21, who on the individual’s 18th birthday was in foster care under the responsibility of a State, who meets the targeting criteria in a.) below, and whose income and resources do not exceed the level(s), if any, established in b.) below.

a. Individuals who meet the following criteria:

1) Are under the age of:  
   _X_ 21  
   ___ 20  
   ___ 19

2) Are:  
   _X_ All such individuals.  
   ___ Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individuals turned 18 years old.  
   ___ Other reasonable classifications:

b. Financial requirements

1) Income test:  
   _X_ There is no income test.  
   ___ The income test is:

2) Resource test:  
   _X_ There is no resource test.  
   ___ The resource test is:

Note: If there is an income or resource test, the standards and methodologies may not be more restrictive than those for the State’s section 1931 population, as specified in Supplement 12 of Attachment 2.6-A.]
[B. Optional Groups Other Than the Medically Needy (Continued)]

Citation: 1902(a)(10)(A)(ii)(XXI) and 1902(ii)

[X] Individuals who are *not* pregnant and whose income does not exceed the State established income standard of 200% of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 200% of the Federal Poverty Level.

[ ] In determining eligibility for this group, the State considers only the income of the applicant or recipient.

[X] In determining eligibility for this group, the State will apply the income disregards listed in Supplement 8A to Attachment 2.6-A of the State Plan.

Note: Services are limited to family planning services and family planning-related services as described in section 4.c.ii of Attachment 3.1-A of the State Plan.

Citation: 1920C - Presumptive Eligibility for Family Planning:

[X] The State provides a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option.

The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.

[X] In addition to family planning services, the State covers family planning-related services to such individuals during the period of presumptive eligibility.]

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #12-0012 Effective Date January 1, 2014
### Optional Coverage of the Medically Needy

**42 CFR 35.301**

This plan includes the medically needy.

- [X] Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

- 1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

- 1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.
New York
25

C. Optional Coverage of Medically Needy (Continued)

[1902(e)(4) of the Act]

42 CFR 435.308

5. [X] a. Financially eligible individuals who are not described in section C.3. above and who are under the age of --

   ___ 21
   ___ 20
   ___ 19
   ___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

[ ] b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

   ___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

   ___ (a) In foster homes (and are under the age of ___).
   ___ (b) In private institutions (and are under the age of ___).
### C. Optional Coverage of Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).</td>
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<td></td>
<td>(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).</td>
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<td>(3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.</td>
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<td>(4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ___).</td>
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<td></td>
<td>(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.</td>
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<td></td>
<td>(6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.</td>
<td></td>
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**March 11, 1992**

**TN #91-78**

**Approval Date** March 11, 1992

**Supersedes TN**

**Effective Date** October 1, 1991
<table>
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<tr>
<td><strong>C. Optional Coverage of Medically Needy (Continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.326</td>
<td>[X] 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.</td>
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<tr>
<td>435.340</td>
<td>11. Blind and disabled individuals who:</td>
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<td></td>
<td>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;</td>
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<td></td>
<td>b. Were eligible as medically needy in December 1973 as blind or disabled; and</td>
<td></td>
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<tr>
<td></td>
<td>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</td>
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</table>
### Optional Coverage of Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency *</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
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<tbody>
<tr>
<td>1906 of the Act</td>
<td>12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ____ months.</td>
<td></td>
</tr>
</tbody>
</table>

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**TN #91-78**

**Approval Date** March 11, 1992

**Supersedes TN NEW**

**Effective Date** October 1, 1991
I. Excluded Populations

In addition to the Medicaid eligibles previously identified, the following Medicaid population groups will not be eligible for enrollment under this SPA.

1. Children in State-operated psychiatric facilities and residential treatment facilities for children and youth.

2. Children who are residents of residential health care facilities at the time of enrollment and children who enter a residential health care facility subsequent to enrollment, except for short-term rehabilitative stays anticipated to be no greater than 30 days.


4. Infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for the SSI related category (shall not be enrolled or shall be disenrolled retroactive to date of birth).

5. Children with access to comprehensive private health care coverage that is available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premium or cost-sharing amounts would be cost-effective, as determined by the local social services district.

6. Children expected to be eligible for Medicaid for less than six months.

7. Homeless children residing in a NYC DHS and not enrolled in a plan at the time they enter the shelter.

8. Children in receipt (at the time of enrollment) of institutional long-term care (except ICF services for the Developmentally Disabled), Long Term Home Health Care programs, Child Care Facilities, or Hospice.

9. Children receiving mental health family care services.

10. Children enrolled in the Restricted Recipient Program.

II. Voluntary (Exempt) Populations

There are a number of population groups that will be eligible for an exemption from mandatory enrollment. (Information on the exemption criteria and process will be
included in the enrollment materials sent to all potential eligibles. A separate pamphlet will discuss the implications and conditions of any exemptions from enrollment which are allowed. Children who fall into one of the following categories will be enrolled only on a voluntary basis:

1. **Children who are HIV+.** Once SNPs are established and certified through the milestone process, children with HIV disease must enroll in a managed care arrangement (either mainstream MCOs or SNPs). As soon as HIV SNPs are established through the milestone process in a given service area, those HIV positive children in that area who have voluntarily enrolled in mainstream MCOs will be given the option of enrolling in a SNP.

2. **Children who are diagnosed seriously emotionally disturbed (SED).** Children who have utilized 10 or more mental health visits (mental health clinic services or mental health specialty services, or a combination of these services) in the previous calendar year will be SED. Once SNPs are established and certified through the milestone process, enrollment in SNPs will remain voluntary for the SNP-eligible population, with the exception of SED children who have not selected a mental health option and are auto-assigned to a mental health SNP. These children will be mandatorily enrolled in a certified SNP for receipt of mental health services. However, a FFS option for mental health services will only be offered in counties where there is only one mental health SNP which is operated by the county.

   If SNPs are not eventually established in certain areas of the State, children who would otherwise be eligible for enrollment in mental health SNPs may: (a) receive both mental health and physical benefits on a FFS basis; (b) voluntarily enroll in certified mainstream MCOs and receive the same physical and mental health services available to other Partnership Plan enrollees residing in the same service area; or (c) voluntarily enroll in certified mainstream MCOs for the provision of physical health-only services and receive mental health benefits on a FFS basis.

3. **Children for whom a managed care provider is not geographically accessible** so as to reasonably provide services. To qualify for this exemption, a person must demonstrate that no participating MCO has a provider located within thirty minutes travel time from the children’s home who is accepting new patients, and that there is a fee-for-service Medicaid provider available within the thirty minutes travel time.

4. **Pregnant women who are already receiving prenatal care from a prenatal primary care provider** not participating in any managed care plan (note: this status will last through a woman’s pregnancy and sixty (60) days postpartum; after that time, she will be enrolled mandatorily into an MCO if she belongs to one of the mandatory aid categories).

5. **Children with a chronic medical condition** who, for at least six months, have been under active treatment with a non-participating subspecialist physician who is not a network provider for any MCO participating in the Medicaid managed care program service area.

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**TN #99-40**  
**Supersedes TN NEW**  
**Approval Date** February 20, 2002  
**Effective Date** April 01, 2002
6. *Children with end state renal disease (ESRD).*

7. *Children who are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).*

8. *Children with characteristics and needs similar to those who are residents of ICF/MRs based on criteria cooperatively established by the State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the NYS Department of Health (DOH).*

9. *Children already scheduled for a major surgical procedure* (within 30 days of scheduled enrollment) *with a provider who is not a participant in the network of an MCO under contract for The Partnership Plan.*

10. *Children with a developmental or physical disability who receive services through a Medicaid Home-and-Community-Based Services waiver or Medicaid Model Waiver (care-at-home) through a Section 1915c waiver, or children having characteristics and needs similar to such children (including children on the waiting list), based on criteria cooperatively established by OMRDD and DOH.*

11. *Children who are residents of Alcohol and Substance Abuse Long Term Residential Treatment Programs.*

12. *New York City beneficiaries who are homeless and do not reside in a DHS shelter are exempt.* Homeless children residing in a NYC DHS shelter and already enrolled in a plan at the time they enter the shelter may choose to remain enrolled. In areas outside of NYC, exemption of homeless children residing in the shelter system is at the discretion of the local district.

13. *Children who cannot be served by a managed care provider due to a language barrier which exists when the child is not capable of effectively communicating his or her medical needs in English or a secondary language for which PCPs are available in the managed care program.* Children with a language barrier still have a choice of three (3) PCPs, at least one of which is able to communicate in the primary language of the child or has a person on her/his staff capable of translating medical terminology, and the other two (2) PCPs have access to the AT&T Language Line as an alternative to communicating directly with the child in his/her language. Children will be eligible for an exemption when:

   - The child has established a relationship with a primary care provider who has the language capability to serve the child and who does not participate in any of the managed care plans available within a thirty minute/thirty mile radius of the child’s residence.
   - Neither fee-for-service nor the above described three (3) participating PCPs are available within the thirty minute/thirty mile radius, and a fee-for-service provider with the language capability to serve the child is available outside the thirty minute/thirty mile radius and the above-described three (3) participating PCPs are not available within that radius.

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**TN #99-40**

**Approval Date**

**February 20, 2002**

**Effective Date**

**April 01, 2002**
14. **Children with a County of Fiscal/Responsibility code of 98 (OMRDD in MMIS) will be exempt until the state establishes appropriate program features.** Recipients with a code of 97 (OMH in MMIS) will be mandatorily enrolled when the state establishes appropriate program features. However, many of these children will qualify for other exemptions (SED) or exclusions.

15. **Children temporarily residing out of district**, (e.g., college students) will be exempt until such time as the purpose of the absence is accomplished. The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p). These children will have difficulty accessing services within travel time and distance standards.

Note: Any exemption granted to children with chronic medical conditions being treated by a non-participating sub-specialist physician or those scheduled for major surgical procedures prior to enrollment with a provider outside the MCO network will apply only until such time as the child’s course of treatment is completed. Such exemptions must be renewed annually. The treating physician will determine when a child’s course of treatment is completed. However, if the child’s treating physician subsequently becomes a network provider for one of the participating MCOs the exemption will no longer apply.

Determination of a child’s eligibility for exemption will be conducted by local districts upon the request of the individual or his/her designee. Local districts (or the broker) will follow state guidelines in determining eligibility for exemption. When exemption status is unclear, the district may request assistance from the SDOH Office of Managed Care.

Children may request an exemption to enrollment in an MCO. Children eligible for an exemption who choose to enroll in managed care will be treated as voluntary enrollees for purposes of disenrollment provisions. Accordingly, these children may disenroll from an MCO with thirty days notice and return to the fee-for-service program.

Children who become eligible for exemption due to a change in eligibility status after they have enrolled in managed care may apply for an exemption and be disenrolled within 30-60 days. All managed care enrollees will have received information on the exemption criteria and process in the enrollment kits.

### III. Other Children with Unusually Severe Chronic Care or Complex Referral Needs

The SDOH Medical Director for Managed Care will, upon the request of an enrollee or his/her guardian, review for a possible exemption from mandatory enrollment in managed care cases of children with unusually severe chronic care needs if such children are not otherwise eligible for an exemption (i.e., meet one of the criteria listed in the previous section). The Medical Director may also authorize disenrollment for such children.

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**TN #99-40**

**Supersedes TN NEW**

**Approval Date** February 20, 2002

**Effective Date** April 01, 2002
IDENTIFICATION OF CHILDREN TO BE EXCLUDED OR EXEMPT WHO HAVE SERIOUS AND/OR COMPLEX MEDICAL AND EMOTIONAL NEEDS

The local social services districts (LDSS) in New York State will assume primary responsibility for the enrollment process under this State Plan Amendment. Under the existing Medicaid program, each LDSS is responsible for the determination of Medicaid eligibility. LDSS operations, including policies and staffing, will be enhanced to accommodate the new program established under this SPA. LDSS responsibilities (with assistance from SDOH) will include identification of excluded and exempt populations, including the handling of exemption requests.

Children may be either excluded or exempted from mandatory participation. Excluded populations will not participate; exempt populations are not required to participate. However, children designated as exempt may elect to voluntarily enroll.

In some cases, the State and LDSS can identify exempt populations through existing claims and eligibility data. Some excluded populations can be identified through the eligibility system. The State and/or LDSS will append the eligibility records with an identifier that will enable the Enrollment and Benefits Counselor or the Local District to determine whether a child is exempt from mandatory participation. In cases where the State can determine in advance a child's exempt status the system will flag this child's eligibility files to prevent an auto-assignment from taking place. However, in the case of children who may be exempt, but cannot be identified in advance and certain children actually eligible for an exemption in other categories), the algorithm will assign these children to an MCO unless they actually apply for and receive an exemption from the LDSS.

Children who are identified as exempt through analysis of existing aid category or through claims data will not receive a notice indicating that the State has found them to be exempt from mandatory participation. Exempt children will be informed of their option to enroll in an MCO or be waived from mandatory participation. These children will be receiving the same enrollment package as others being recertified or applying for assistance. This package includes information on exemptions and who is eligible. However, the recipients case will be electronically flagged as exempt which will prevent auto-assignment. Exempt children so flagged will not receive a reminder notice regarding the requirement to enroll in a MCO. If the recipient chooses to enroll in an MCO, the worker inputting the enrollment information will get a computer message that alerts him/her that an exemption code is on file, and if the client chooses to disenroll at a later date, will not be auto-assigned as long as that exemption code remains.

In certain cases, the State and LDSS may lack the information necessary to determine in advance whether the child is exempt from participation. Accordingly, the State has developed an exemption application to enable such children to apply for exemption from participation. The LDSS will collect and process applications for exemption from mandatory participation. The exemption application forms and criteria for approving or

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<td>#99-40</td>
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<td>Supersedes TN NEW</td>
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</table>
denying requests shall be provided by the State to the LDSS. Exemption forms, including the look-alike screening form, are available to beneficiaries through the LDSS.

Eligible enrollees may apply for an exemption at any time. However, if the child is enrolled already in an MCO, s/he may be required to access services through the MCO until the LDSS and State have had the opportunity to process the application and disenroll the child from an MCO.
### SPA County Participation

<table>
<thead>
<tr>
<th>Counties with 2 MCOs*</th>
<th>Counties with 1 MCO in Rural Areas*</th>
<th>Counties with no MCOs or 1 MCO in Urban Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>Cortland</td>
<td>Allegany</td>
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<td>New York City</td>
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* These counties will be participating as mandatory Medicaid managed care counties under this SPA.

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**TN #99-40 — Approval Date February 20, 2002**

**Supersedes TN ___NEW__ — Effective Date April 01, 2002**
Rural Area Residents

For recipients who reside in a rural area with a single MCO, the State will limit enrollment to such MCO, provided however, such recipient may:

1. Choose from at least two physicians or case managers; and

2. Obtain services from any other provider under the following circumstances:
   
   (a) The service or type of provider is not available within the MCO network.
   
   (b) The provider is not part of the MCO network, but has an existing relationship with the recipient.
   
   (c) The only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.
   
   (d) The State determines that other circumstances warrant out-of-network treatment.
Methodology and Process For Capacity/ Network Analysis

A managed care organization (MCO) provider network consists of physicians, groups(s) of physicians, specialists and the service centers, i.e., hospitals, pharmacy, clinics, etc. that are contracted to the MCO to provide all of the health care services that may be required by enrollees. The MCO, through its provider network, must plan, direct, coordinate, and provide for the health care services of every enrollee.

The New York State Department of Health (SDOH), in conjunction with the Local Departments of Social Services (LDSS) and the New York City Office of Medicaid Managed Care (OMMC) will evaluate the provider networks of every MCO to determine that it has an adequate network that will be accessible to all enrollees for their health care needs. This review ensures that the MCO has the adequate capacity in its provider network to meet the needs of the target population and there is an adequate network structure.

To serve the Medicaid population in New York State, an MCO must successfully complete the Certification of Authority (COA) process. Review and evaluation of the provider network are essential components of the Certification process since the inception of Article 44 of the Public Health Law.

MCO network evaluation is a multi-step process. To qualify, a MCO network has to achieve a successful quantitative score assigned by SDOH using a Statistical Analysis Software (SAS) program. Then the network has to pass the scrutiny of the LDSS, which evaluates the network for compliance with time and distance standards. The third and final step is verification of the network during the Readiness Review conducted by SDOH Area Office staff just prior to an MCO becoming operational. During the Readiness Review site visits contracts are pulled to verify the network information submitted by the MCO.

The following discussion provides the necessary information to understand how SDOH calculates and monitors Medicaid MCO capacity on an on-going basis.

A. Network Adequacy Definition

Pursuant to Section 98.5(b)(9) of Title 10, NYCRR, each fully capitated MCO is required to provide:

“Identification of the type of HMO that is proposed and a description of the service delivery system of the proposed HMO, including the numbers and locations of primary care providers and providers of other services such as ambulatory, ancillary and hospital services;...”
In addition, pursuant to Section 98.16(a) of Title 10, NYCRR, MCOs must submit an annual listing of providers and facilities by location. Section 364-j(8)(f) & (g) of the Social Services Law requires:

“(f) Every managed care provider shall ensure that the provider maintains a network of health care providers adequate to meet the comprehensive health needs of its participants and to provide an appropriate choice of providers sufficient to provide the services to its participants by determining that:

(i) there are a sufficient number of geographically accessible participating providers;
(ii) there are opportunities to select from at least three primary care providers; and
(iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrolled population.

(g) The commissioner of health shall establish standards to ensure that managed care providers have sufficient capacity to meet the needs of their enrollees, which shall include patient to provider ratios, travel and distance standards and appropriate waiting times for appointments.”

1. Providers and Service Centers

The MCO provider network must include providers for services included in a core benefit package (listed below) which is required for certification. If the MCO does not directly provide such services, contractual relationships with appropriately qualified providers must exist prior to certification. In addition to the core providers, the network must contain any other providers necessary to provide all the health care services included in the benefit package. If, for example, the MCO covers podiatry services, the network must contain a podiatrist in each service area. The following lists the core group of providers and services required for certification.

### Medicaid Core Benefit Package

<table>
<thead>
<tr>
<th>Provider File:</th>
<th>Provider File:</th>
<th>Service/Ancillary File:</th>
<th>Service/Ancillary File or Provider File:</th>
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<td>Specialty Care</td>
<td>Ancillary/Tertiary Care</td>
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<tr>
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<td>Allergy/Immunology</td>
<td>Ambulance</td>
<td>Anesthesiology</td>
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<tr>
<td>General Practice</td>
<td>Cardiology</td>
<td>Durable Medical Equipment</td>
<td>Audiology</td>
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<td>Internal Medicine</td>
<td>Dermatology</td>
<td>Home Health Care</td>
<td>Infectious Disease</td>
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<td>Gastroenterology</td>
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<td>Radiology</td>
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<tr>
<td>OB/GYN as PCP</td>
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<table>
<thead>
<tr>
<th>Certified Nurse Midwife</th>
<th>Geriatrics</th>
<th>Pharmacies</th>
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<td>Social Work</td>
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<td>Therapy: Speech/Language</td>
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<td>Oncology/Hematology</td>
<td>Therapy: Occupational</td>
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<td>Psychiatry</td>
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<td>Pulmonary Medicine</td>
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<td>Urology</td>
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<td></td>
<td>Dentistry**</td>
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</tbody>
</table>

**=Optional benefit, not a mandatory benefit

2. Network Adequacy Determination

The Bureau of Certification and Surveillance within SDOH is responsible for assessing the adequacy of the network. While obstetricians, gynecologists and certified nurse mid-wives are not generally considered primary care providers, these specialties may be included with the Primary Care Physician (PCP) grouping because they may act as a PCP if they have met SDOH qualifications. Part of the adequacy determination is evaluating whether the MCO has a sufficient number of PCPs to allow the member to have choice.

B. Network Capacity Definition

TN #99-40 Approval Date February 20, 2002
Supersedes TN NEW Effective Date April 01, 2002
Most often, the capacity of a provider may depend on the efficiency of the doctor and her associated staff. Capacity may be defined as either a member-to-provider ratio or a maximum number of enrollees a primary care provider can properly handle on a full time basis (i.e., 40 hrs/week). The SDOH is using a combination of these two definitions. SDOH is using the following definition of capacity.

“MCOs must adhere to the member-to-PCP ratios shown below. These ratios are for Medicaid members only, are MCO-specific, and assume that the practitioner is an FTE (practices 40 hours per week for the MCO):

- No more than 1,500 Medicaid members for each physician, or 2,400 for a physician practicing in combination with a physician assistant. (i.e., a physician extender adds 900 to physician capacity)
- No more than 1,000 Medicaid members for each nurse practitioner. (RFP, p.34)"

The above ratios are used as an initial starting point for the analysis of capacity.

Additionally, SDOH uses the following additional criteria for Article 28 comprehensive community-based primary care provider centers and Outpatient Departments of Hospitals (OPDs).

- Individual providers practicing in Article 28 Comprehensive Community based Primary Care centers may have 3,000 enrollees: 1 PCP and practicing with a Physician Extender they may have 4,000 enrollees: 1 PCP with a physician extender
- Individual providers with practices based primarily in OPDs may have 2,500 enrollees: 1 PCP and practicing with a Year 2 or 3 resident they may have 4,000 enrollees: 1 PCP and FTE Resident.

C. Capacity Calculation and Process

It is important to recognize that there are technically two types of capacity reviewed by the SDOH for each MCO: potential capacity and financial capacity. Potential capacity refers to the number of enrollees that can be managed by the existing provider network. Financial capacity is defined as the capacity that is financial feasible for the MCO to pay for based on their available capital and escrow deposit reserve requirement.

The following discussion details how the potential capacity is calculated; thus, the term capacity in the following section refers to the potential or calculated network capacity. Throughout the process of examining capacity it is also important to note that the value placed on capacity of the number of enrollees that a PCP may serve greatly controls the outcome of the capacity algorithm.

1. Potential Provider Capacity

The first step in calculating capacity for a MCO is the collection of data. SDOH collects network data electronically on an intranet system referred to as the Health Provider.
Network (HPN). This system was established in winter, 1996 for SDOH to collect information electronically from the MCOs. The MCOs are connected to the SDOH by a modem on their personal computer; they submit the data electronically in a specified format, the data is then edited immediately and a report is sent back to the MCOs with the number of records accepted along with an explanation of the records with errors. The steps below outline the methodology created for the entire provider network calculation of capacity.

- **Health Provider Network**
  - a. Elimination of incomplete or incorrect data
  - b. Electronic edit program

- **Capacity Program**
  - a. Matching to Physician License Master File
  - b. PCP Calculated Capacity based on FTE
  - c. PCP Calculated Capacity within and across MCOs
  - d. Capacity for each county

### a. Health Provider Network (HPN) Process

As described above, all of the MCOs are required to submit provider network information on the SDOHs intranet system called the Health Provider Network (HPN). The details for submitting the provider network information are outlined in the *Data Dictionary for Managed Care Provider Network*. There are two files that are sent electronically to the SDOH, a provider file on people or physicians and other providers that are contacted to provide services to the members and a service file on places that are contacted with the MCO. Only the provider file is the used for the capacity calculation.

#### I. Elimination of Incomplete Data

Each submitted provider network record must contain certain data elements which, if omitted, will result in the deletion of a provider record. The required data elements are listed below:

- Last Name
- First Name
- License Number
- County Code
- Address (Street, Town/City)
- Board Status
- Primary Specialty
- Provider Type
- Primary Designation
- Residency Status
- Physician Status
- Panel Status

**Data Elements for Primary Care Providers (PCPs) Only- all office hours**

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>#99-40</td>
<td>February 20, 2002</td>
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<tr>
<th>Supersedes TN</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>NEW</td>
<td>April 01, 2002</td>
</tr>
</tbody>
</table>
If any of these data elements are missing or incorrectly coded by the MCO, it will receive an error message for the record(s) containing the missing element.

II. Electronic Edit Program

The edit program on the HPS currently checks for 46 different errors on the provider file; 20 of these are classified as critical or "hard" errors; the remaining errors are referred to as soft errors. MCOs are required to pass all critical errors for the data submission to be acceptable for use in any analysis. If they have not passed critical errors on the day after the submission is due (it is due 15 business days after the end of the calendar quarter) then the MCO is sent a letter requesting that their submission be corrected.

2. Capacity Program

The capacity program was developed using the SAS programming language. The quarterly provider file from the HPN and the physician master file from the NYS Department of Education are the two data sets used in the program. A Primary Care Provider or PCP subset of the Provider File data file is created for New York State providers indicated to be a Medicaid Primary Care Provider.

(Primary Care Providers are identified by editing the primary designation (PRIMDESG) and primary specialty (PRIMSPEC) fields; i.e., PRIMDESG values must equal 1=PCP and/or 3=PCP and Specialist AND PRIMSPEC values must equal 050' (Family Practice), 060' (Internal Medicine), 182' or 776' (General Practice), 150' (General Pediatrics) OR 089', 159', 169', (OB/GYN providers) (OBG/GYN are subject to DOH qualifications). The STATE data field must equal NY.

a.) Matching to the Physician License Master File

The first step involves a match of the physician/provider license number on the HPN provider file to the NYS Education file. This is to verify that the physicians on the HPN are currently licensed and registered to practice. During this step a variable is created on each data file to define each individual provider; this variable is created by the concatenation of the last three digits in the provider's last name and their license number. The records that match on both the HPN provider file and the education file are then stored in a data set, called PCPCAP, to be used for the remainder of the capacity program.

b.) PCP Capacity for Each Individual Provider

The next steps involve the calculation of capacity for each individual PCP using the member-to-provider ratios previously described. Several new variables are created within the PCPCAP data set for use in the capacity program. There are:

| TOTOFFHR (Total Office Hours). This represents the sum of all available office hours. The maximum office hours attributed to an individual provider is 40. If the provider's total office hours across MCOs and sites exceeds 40, the hours |

 TN    #99-40       Approval Date    February 20, 2002
 Supersedes TN    NEW       Effective Date    April 01, 2002
at each site and MCO are reduced and allocated to each site on a prorated basis.

UNIQSITE (each provider's location for each MCO). This variable accounts for the unique MCO and location for each provider and is constructed by concatenating the MCO identifier, provider license number and location address (site name, street number, room number, and street name). Many IPA and network model MCOs have overlapping provider networks, thus many of the providers are not unique to a particular MCO. (Usually, providers belonging to a staff or group model MCOs are unique to one program). To determine the effect of this on the capacity for each MCO, this field was created to capture the unique capacity that each MCO is offering.

TOTMPANL (Total Medicaid Panel Size). This is the sum of the total Medicaid panel or the total of the capitated enrollees that are recorded for a particular provider in each MCO. This will sum the panel size for all Medicaid MCOs.

FTE (Full Time Equivalent). TOTOFFHR are used to create a Full time equivalent of FTE based upon 40 hours per week. This is done by examining the multiple sites that a provider may have within an MCO and the multiple number of MCOs that a provider may belong to, i.e., a provider may be contracted in more than one MCO.

Only PCPs with TOTOFFHR (total office hours) equaling 16 hours of more per location are selected; this criteria is modified for residents; second year resident physicians must practice at least (8) continuity of care hours per week at a primary site; third and fourth year residents must practice at least twelve (12) continuity of care hours per week at a primary site. If a provider’s total office hours at a particular site is below program minimum standards, his/her record is deleted.

The remaining steps calculate the PCP capacity for each provider. Specifically, the remaining steps are:

- For non-medical resident physicians practicing alone, capacity will be set equal to the lesser of: actual capacity reported or 1,500 * FTE

  Under this formula, a physician practicing full time would have a maximum capacity of 1,500 * 40/40 = 1,500.

- For PGY2 medical residents physicians, as denoted by 2” in the Resident Status filed, capacity will be set equal to the lesser of: actual capacity reported or 750 * FTE

- For PGY3 medical residents physicians, as denoted by 3” in the Resident Status filed, capacity will be set equal to the lesser of: actual capacity reported or 1,125 * FTE

- For PGY4 medical residents physicians, as denoted by 4” in the Resident Status filed, capacity will be set equal to the
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lesser of: actual capacity reported or 1,500 * FTE

- For nurse practitioners and certified midwives, capacity will be set equal to the lesser of: actual capacity reported or 1,500 * FTE

- The sum of the Medicaid panel size for every MCO that a provider identified is then subtracted from the potential capacity for only those physicians having an open panel.

- Physicians that have a closed panel for any MCO are assigned the Medicaid panel size for their capacity.

c.) Capacity Calculation Within And Across MCOs

After the above calculations are made, the program can identify providers if they practiced in multiple MCOs. For those providers, the total reported office hours across sites are summed and compared against a maximum of 40 hours. If the total exceeded 40 hours, the hours at each site and MCO were prorated down and the capacity at each MCO also is prorated accordingly. For example, if a provider reported working 40 hours at MCO A and 40 hours at MCO B (80 hours in total), and reported a capacity of 1,500 at each site, the provider’s capacity was reset to equal 750 at each site. She would be counted as a .5 FTE for each MCO.

The next step in the capacity program summarizes the adjusted provider-specific capacity for each MCO. The summation of all the capacity values for each of the individual PCPs determines the MCO’s total capacity.

d.) Capacity for Each County

The final step in the capacity program produces the capacity for all MCO and county combinations; the county service area is based on the geographic border of the location of the physicians within the county borders.

C. Financial Capacity

In addition to the worksheets on provider network information, MCOs are also asked to provide Revenue and Expense and enrollment projections. These are statements detailing the capacity that could be supported by their financial reserves and capital.
D. Borough/County Network Analysis

New York City and the individual counties also will evaluate provider networks. The City and counties are sent a Network Composition proposal for each of the MCOs proposing for contract. They then were responsible for assembling local review teams to examine the proposals and complete a County Network Evaluation Form. (Training has been provided to City and county evaluators to ensure that proposals were reviewed in a consistent manner across the State.)

The Borough/County Network form was designed to supplement the information captured through the State Network Evaluation, by asking New York City and the other LDSS to:

- verify that the distribution of providers re: travel time/distance standards for PCPs, hospitals, and pharmacies;
- verify that networks include all providers with whom the county is mandating MCOs to contract (i.e., public hospitals), and
- document any gaps in service area coverage that the must be filled pursuant to awarding a contract.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

REASONABLE CLASSIFICATION OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19 AND 18

Citation: 42 CFR 435.222

Pregnant Minors, who are under age 21, are eligible without regard to household income.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home

TN #91-80 Approval Date February 3, 1992
Supersedes TN NEW Effective Date October 1, 1991
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. General Conditions of Eligibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each individual covered under the plan:</td>
</tr>
<tr>
<td>42 CFR Part 435, Subpart G</td>
<td>1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.</td>
</tr>
<tr>
<td></td>
<td>a. For the categorically needy:</td>
</tr>
<tr>
<td></td>
<td>[(i) Except as specified under items A.2.a.(i) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.]</td>
</tr>
<tr>
<td></td>
<td>(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
</tr>
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TN #13-0053 Approval Date June 26, 2014
Supersedes TN #92-0027 Effective Date January 1, 2014
NOTE: The deleted information on this page has been replaced by PDF Form 589 effective January 1, 2014.

<table>
<thead>
<tr>
<th>Citation</th>
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<tbody>
<tr>
<td>b. 1905(p) of the Act</td>
<td>For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>c. 1905(s) of the Act</td>
<td>For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>d.</td>
<td>For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).</td>
</tr>
<tr>
<td>[42 CFR 435.402]</td>
<td>[3. Is residing in the United States and —</td>
</tr>
<tr>
<td>a. [Sec. 245A of the Immigration and]</td>
<td>Is a citizen;</td>
</tr>
<tr>
<td>b. [1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration &amp; Nationality Act]</td>
<td>Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;</td>
</tr>
<tr>
<td>c.</td>
<td>Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;]</td>
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NOTE: The deleted information on this page has been replaced by PDF Form S88 effective January 1, 2014.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>[42 CFR 435.403 1902(b) of the Act]</td>
<td>[4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.</td>
</tr>
<tr>
<td>[X] State has interstate residency agreement with the following States:</td>
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<tr>
<td></td>
<td>Georgia</td>
</tr>
<tr>
<td>[ ] State has open agreement(s).</td>
<td></td>
</tr>
<tr>
<td>[ ] Not applicable; no residency requirement.]</td>
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State: New York

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<tr>
<th>Approval Date</th>
<th>Effective Date</th>
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<td>June 17, 2014</td>
<td>January 1, 2014</td>
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<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
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<tr>
<td>42 CFR 435.1008</td>
<td>5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.</td>
</tr>
<tr>
<td>42 CFR 435.1008 1905(a) of the Act</td>
<td>b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.</td>
</tr>
<tr>
<td>42 CFR 433.145 1912 of the Act</td>
<td>6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>

**TN #91-78**

**Approval Date** March 11, 1992

**Supersedes TN** NEW

**Effective Date** October 1, 1991
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

42 CFR 435.910 7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).
<table>
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<th>Citation</th>
<th>Condition or Requirement</th>
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</thead>
<tbody>
<tr>
<td>1902(c)(2)</td>
<td>8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.</td>
</tr>
<tr>
<td>1902(e)(10)(A) and (B) of the Act</td>
<td>9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State’s AFDC plan, the agency determines if they are otherwise eligible under the State’s Medicaid plan.)</td>
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<td>Citation(s)</td>
<td>Condition or Requirement</td>
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<tr>
<td>1906 of the Act</td>
<td>10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility to expect for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child’s eligibility).</td>
</tr>
<tr>
<td>U.S. Supreme Court Case, New York State Department of Social Services v. Dublino</td>
<td>11. Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.</td>
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<tr>
<td>TN #05-56</td>
<td></td>
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<tr>
<td>Supersedes TN #91-78</td>
<td></td>
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<tr>
<td>Approval Date: December 06, 2005</td>
<td></td>
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<tr>
<td>Effective Date: January 1, 2006</td>
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</tbody>
</table>
### Citation | Condition or Requirement

| B. Posteligibility Treatment of Institutionalized Individuals’ Incomes |
| --- | --- |
| 1. The following items are not considered in the posteligibility process: |
| 1902(o) of the Act | a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF. |
| Bondi v Sullivan (SSD) | b. Austrian Reparation Payments (pension (reparation) payments made under §500-506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments. |
| 1902(r)(1) of the Act | c. German Reparations Payments (reparation payments made by the Federal Republic of Germany). |
| 1. (a) of P.L. 103-286 | e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II). |
| 10405 of P.L. 101-239 | f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) |
| 6(h)(2) of P.L. 101-426 | g. Radiation Exposure Compensation. |
| 12005 of P.L. 103-66 | h. VA pensions limited to $90 per month under 38 U.S.C. 5503. |
New York
4a

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924 of the Act</td>
<td>2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:</td>
</tr>
<tr>
<td>435.725</td>
<td>Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons.</td>
</tr>
<tr>
<td>435.733</td>
<td>a. Aged, blind, disabled:</td>
</tr>
<tr>
<td>435.832</td>
<td>Individuals $501</td>
</tr>
<tr>
<td></td>
<td>Couples $1002</td>
</tr>
<tr>
<td></td>
<td>For the following persons with greater need:</td>
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<tr>
<td></td>
<td>Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</td>
</tr>
<tr>
<td>501</td>
<td>b. AFDC related:</td>
</tr>
<tr>
<td>1002</td>
<td>Children $501</td>
</tr>
<tr>
<td></td>
<td>Adults $1002</td>
</tr>
<tr>
<td></td>
<td>For the following persons with greater need:</td>
</tr>
<tr>
<td></td>
<td>Supplement 12A to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</td>
</tr>
<tr>
<td></td>
<td>c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2-A.</td>
</tr>
<tr>
<td></td>
<td>$501</td>
</tr>
</tbody>
</table>

1. $35 if person is not in an Article 28 Facility. |
2. $70 if person is not in an Article 28 Facility. 

TN #98-05
Supersedes TN NEW
Approval Date May 15, 1998
Effective Date January 1, 1998
For the following persons with greater need:

Supplement 12-A to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amounts when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1924 of the Act</td>
<td>3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:</td>
</tr>
<tr>
<td>a.</td>
<td>The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse’s income. The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</td>
</tr>
<tr>
<td>___</td>
<td>The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</td>
</tr>
<tr>
<td>___</td>
<td>The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ______ %, of the official poverty level (still subject to maximum maintenance needs standard).</td>
</tr>
<tr>
<td>X</td>
<td>The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).</td>
</tr>
<tr>
<td>Except that, when applicable, the State will set the community spouse’s monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse’s income, or at the amount of any court-ordered support.</td>
<td></td>
</tr>
</tbody>
</table>

TN #98-05 Approval Date May 15, 1998
Supersedes TN NEW Effective Date January 1, 1998
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In determining any excess shelter allowance, utility expenses are calculated using:</td>
</tr>
<tr>
<td>___</td>
<td>the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or</td>
</tr>
<tr>
<td>___</td>
<td>the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.</td>
</tr>
<tr>
<td>b.</td>
<td>The monthly income allowance for other dependent family members living with the community spouse is:</td>
</tr>
<tr>
<td>X</td>
<td>one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income.</td>
</tr>
<tr>
<td>___</td>
<td>a greater amounted calculated as follows:</td>
</tr>
<tr>
<td></td>
<td>The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1):</td>
</tr>
<tr>
<td>c.</td>
<td>Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:</td>
</tr>
<tr>
<td>(i)</td>
<td>Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</td>
</tr>
<tr>
<td>(ii)</td>
<td>Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)</td>
</tr>
</tbody>
</table>

TN #98-05
Supersedes TN ___ NEW
Approval Date May 15, 1998
Effective Date January 1, 1998
New York
5

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.725</td>
<td>4. In addition to any amounts deductible under the items above the following monthly amounts are deducted from the remaining the remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.733</td>
<td>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</td>
</tr>
<tr>
<td>435.832</td>
<td>• AFDC level; or</td>
</tr>
<tr>
<td></td>
<td>• Medically needy level;</td>
</tr>
<tr>
<td></td>
<td>(Check One)</td>
</tr>
<tr>
<td></td>
<td>___ AFDC levels in Supplement 1</td>
</tr>
<tr>
<td></td>
<td><em>X</em> Medically needy level in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>___ Other: $ ________________________</td>
</tr>
<tr>
<td></td>
<td>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</td>
</tr>
<tr>
<td></td>
<td>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</td>
</tr>
<tr>
<td></td>
<td>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)</td>
</tr>
<tr>
<td>435.725</td>
<td>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.733</td>
<td>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</td>
</tr>
<tr>
<td>435.832</td>
<td>___ No.</td>
</tr>
<tr>
<td></td>
<td><em>X</em> Yes (the applicable amount is shown on page 5a.)</td>
</tr>
</tbody>
</table>

* The State uses the higher of the standard for Low Income Families (AFDC), or medically needy income level.

TN #98-05 Approval Date May 15, 1998
Supersedes TN #93-3 Effective Date January 1, 1998
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount for maintenance of home is:</td>
</tr>
<tr>
<td></td>
<td>$ medically needy level for one in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is the actual maintenance costs not to exceed $________.</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals’ home and the community spouse’s home are different.</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.</td>
</tr>
</tbody>
</table>

New York 5a

Attachment 2.6-A
OMB NO. : 0938-0673

May 15, 1998

Supersedes TN  NEW

Approval Date  May 15, 1998
Effective Date  January 1, 1998
### Citation(s) | Condition or Requirement
--- | ---
42 CFR 435.711, 435.721, 435.831 | **C. Financial Eligibility**

For individuals who are [AFDC or] SSI recipients, the income and resource levels and methods for determining countable income and resources of the [AFDC and] SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not [AFDC or] SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.


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**TN #13-0053**

**Supersedes TN #92-0027**

**Approval Date** June 1, 2014

**Effective Date** January 1, 2014
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>[X]</td>
<td>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.</td>
</tr>
<tr>
<td>[ ]</td>
<td>Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.</td>
</tr>
<tr>
<td>[ ]</td>
<td>Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td>[ ]</td>
<td>Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td>[X]</td>
<td>Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs permitted under section 1902(r)(2) of the Act.</td>
</tr>
<tr>
<td>[X]</td>
<td>Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</td>
</tr>
</tbody>
</table>

TN  #91-78  Approval Date  March 11, 1992
Supersedes TN  NEW  Effective Date  October 1, 1991
New York 6 M-2

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.721</td>
<td>a. Except as specified under item C.1.e. below, in determining countable income for AFDC related individuals, the disregards and exemptions in the State’s approved AFDC plan are applied.</td>
</tr>
<tr>
<td>435.831</td>
<td>b. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:</td>
</tr>
<tr>
<td>1902(m)(1)(B) and (m)(4) of the Act, P.L. 99-509 (Secs. 9402(a) and (b))</td>
<td><em>X</em> The disregards of the SSI program.*</td>
</tr>
<tr>
<td></td>
<td>___ The disregards of the State supplementary payment program, as follows:</td>
</tr>
<tr>
<td></td>
<td>___ The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:</td>
</tr>
</tbody>
</table>

* Except for the less restrictive disregards as specified in Supplement 11 to Attachment 2.6A of the State Plan Amendment 85-25.

TN #87-35  
Superseded TN #85-25  
Approval Date December 5, 1991  
Effective Date July 1, 1987
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(r)(2)</td>
<td>1. Methods of Determining Income</td>
</tr>
<tr>
<td>of the Act</td>
<td>a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</td>
</tr>
<tr>
<td></td>
<td>[(1) In determining countable income for AFDC-related individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>___ (a) The methods under the State's approved AFDC plan only; or</td>
</tr>
<tr>
<td></td>
<td><em>X</em> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.]</td>
</tr>
<tr>
<td>1902(e)(6)</td>
<td>(3) Agency continues to treat women eligible under provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>

**TN #13-0053**

**Approval Date** June 1, 2014

**Supersedes TN #92-0027**

**Effective Date** January 1, 2014
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act</td>
<td>b. <strong>Aged Individuals.</strong> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>___ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

---

**TN #92-27**

**Approval Date** January 20, 1993

**Effective Date** April 1, 1992
c. In determining countable income for blind individuals, the following disregards are applied:

  _X_ The disregards of the SSI program.*

  ___ The disregards of the State supplementary payment programs, as follows:

  ___ The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act.

435.721  435.831
and 1902(m)(1)(B)
and (m)(4) of
the Act,
P.L. 99-509
(Secs. 9402(a)
and (b))

d. In determining countable income for disabled individuals, including disabled individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act the following disregards are applied:

  _X_ The disregards of the SSI program.*

* Except for less restrictive disregards as specified in Supplement 11 to Attachment 2.6A of the State Plan Amendment 85-25.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>[ ] For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
<td></td>
</tr>
<tr>
<td>[ ] For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A</td>
<td></td>
</tr>
<tr>
<td>[ ] For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements --</td>
<td></td>
</tr>
<tr>
<td>___ SSI methods only.</td>
<td></td>
</tr>
<tr>
<td>___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A</td>
<td></td>
</tr>
<tr>
<td>___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

**March 11, 1992**

**TN #91-78**

**Approval Date**

**Supersedes TN #87-35A**

**Effective Date**

**October 1, 1991**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(1)(3)(E) of the Act, P.L. 99-509 (Sec. 9401(b)) | e. For pregnant women and infants or children covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act --  
(1) In determining countable income, the following disregards and exemptions are those in the State’s approved AFDC plan; or those in the State’s approved title IV-E plan, as appropriate. |
<p>| 1902(e)(6) of the Act, P.L. 99-509 (Sec. 9401(d)) | X (2) The agency continues to treat women eligible under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act as eligible, without regard to any changes in income of the family of which she is a member, until the end of the 60-day period beginning on the last day of her pregnancy. |</p>
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act</td>
<td>c. <strong>Blind individuals.</strong> In determining countable income for blind individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>___ The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in <a href="#">Supplement 8a to ATTACHMENT 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <a href="#">Supplement 4 to ATTACHMENT 2.6-A</a>, and any more liberal methods described in <a href="#">Supplement 8a to ATTACHMENT 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td></td>
<td>___ For optional State supplemental recipients under §435.230, income methods more liberal than SSI, as specified in <a href="#">Supplement 4 to ATTACHMENT 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>___ For optional State supplement recipients in Section 1902(f) States and SSI criteria States without section 1615 or 1634 agreements --</td>
</tr>
<tr>
<td></td>
<td>___ SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>___ SSI methods and/or any more liberal methods than SSI described in <a href="#">Supplement 8a to ATTACHMENT 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <a href="#">Supplement 4 to ATTACHMENT 2.6-A</a> and more liberal methods are described in <a href="#">Supplement 8a to ATTACHMENT 2.6-A</a>.</td>
</tr>
</tbody>
</table>

**TN #91-78**

**Approval Date** March 11, 1992

**Supersedes TN #87-35A**

**Effective Date** October 1, 1991
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, and 435.831, 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act</td>
<td>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>d. <strong>Disabled individuals.</strong></td>
<td><strong>In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</strong></td>
</tr>
<tr>
<td>___</td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td>X</td>
<td>SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>For institutional couples: the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td>___</td>
<td>For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

**TN #91-78**

Approved Date **March 11, 1992**

Supersedes TN #88-1

Effective Date **October 1, 1991**
## New York 11

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements --</td>
</tr>
<tr>
<td>___</td>
<td>SSI methods only.</td>
</tr>
<tr>
<td>___</td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

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**Attachment 2.6-A**

<table>
<thead>
<tr>
<th>TN</th>
<th>#91-78</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes TN</td>
<td>#87-35A</td>
</tr>
<tr>
<td>Approval Date</td>
<td>March 11, 1992</td>
</tr>
<tr>
<td>Effective Date</td>
<td>October 1, 1991</td>
</tr>
</tbody>
</table>
### Citation(s)

1902(1)(3)(E) and 1902(r)(2) of the Act

### Condition or Requirement

#### e. Poverty level pregnant women, infants, and children.

For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act --

1. The following methods are used in determining countable income:

   - The methods of the State’s approved AFDC plan.
   - The methods of the approved title IV-E plan.
   - The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
   - The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.]</td>
</tr>
<tr>
<td>1902(e)(6) of the Act</td>
<td>(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>f. <strong>Qualified Medicare beneficiaries.</strong> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><em>X</em></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td>___</td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
</tbody>
</table>

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #92-0027 Effective Date January 1, 2014
Citation | Condition or Requirement
---|---

If an individual receives a title II benefit, and amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a “transition period” beginning with January, when the title II benefit for December is received, and ending with the last day of the month including the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(s) of the Act  

g. (1) **Qualified disabled and working individuals.**

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act  

(2) **Specified low-income Medicare beneficiaries.**

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(ii) of the Act, the same method as in f. is used.
### Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>COBRA Continuation Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td></td>
</tr>
</tbody>
</table>

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

- The disregards of the SSI program;
- The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

**NOTE:** For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td><strong>Working Individuals with Disabilities - BBA</strong></td>
</tr>
</tbody>
</table>

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

___ The methodologies of the SSI program.

___ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in [Supplement 4](#) (income) and/or [Supplement 5](#) (resources) to Attachment 2.6-A.

___ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in [Supplement 8a to Attachment 2.6-A](#). More liberal resource methodologies are described in [Supplement 8b to Attachment 2.6-A](#).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(a)(10)(A) (ii)(XV) of the Act | (ii) **Working Individuals with Disabilities - Basic Coverage Group - TWWI1A**

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

___ The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

_ X_ The agency applies the following income and/or resource standard(s):

Net available monthly income, using SSI methodology for a one-person or a two-person household, may not exceed 250 percent of the applicable Federal Poverty Level. Countable resources may not exceed [the Medically Needy resource level] $20,000 for a one-person or $30,000 for a two-person household.

---

*TN #11-44*  
*Approval Date* December 07, 2011

*Supersedes TN #08-10*  
*Effective Date* October 01, 2011
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act (cont.)</td>
<td><strong>Income Methodologies</strong></td>
</tr>
</tbody>
</table>

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- **X** The income methodologies of the SSI program.

- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in [Supplement 4 to Attachment 2.6-A](#).

- The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in [Supplement 8a to Attachment 2.6-A](#).

---

**TN #03-11**

**Supersedes TN ** NEW **

**Approval Date** June 26, 2003

**Effective Date** July 01, 2003
### Citation | Condition or Requirement
---|---
1902(a)(10)(A) (ii)(XV) of the Act (cont.) | **Resource Methodologies**

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in [Supplement 8b to Attachment 2.6-A](#).

--- The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

--- The agency disregards funds in retirement accounts in a manner other than those described above. The agency’s disregards are specified in [Supplement 8b to Attachment 2.6-A](#).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)</td>
<td>The agency does not disregard funds in retirement accounts.</td>
</tr>
<tr>
<td>(ii)(XV) of the Act (cont.)</td>
<td>The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in <a href="#">Supplement 8b to Attachment 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the resource methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in <a href="#">Supplement 5 to Attachment 2.6-A</a>.</td>
</tr>
</tbody>
</table>

**TN #11-44**

**Approval Date** December 07, 2011

**Supersedes TN** #03-11

**Effective Date** October 01, 2011
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act</td>
<td>(iii) <strong>Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA</strong></td>
</tr>
</tbody>
</table>

In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:

---

The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

---

**X** The agency applies the following income and/or resource standards(s):

Net available monthly income, using SSI methodology for a one-person or two-person household, may not exceed 250% of the applicable Federal Poverty Level. Countable resources may not exceed [the Medically Needy resource level] $20,000 for a one-person or $30,000 for a two-person household.

---

**TN #11-44**

Supersedes TN **#08-10**

Approval Date **December 07, 2011**

Effective Date **October 01, 2011**
### Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- **X** The income methodologies of the SSI program.

- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

- The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.
### New York 12j

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)</td>
<td><strong>Resource Methodologies</strong>&lt;br&gt; In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</td>
</tr>
<tr>
<td>(ii)(XVI) of the Act (cont.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in <a href="#">Supplement 8b to Attachment 2.6-A</a>.</td>
</tr>
<tr>
<td></td>
<td>--- The agency disregards funds held employer-sponsored retirement plans, but not private retirement plans.</td>
</tr>
<tr>
<td></td>
<td>--- The agency disregards funds in retirement accounts in a manner other than those listed above. The agency’s disregards are specified in <a href="#">supplement 8b to Attachment 2.6-A</a>.</td>
</tr>
</tbody>
</table>

**TN #03-11**<br>**Approval Date** June 26, 2003<br>**Supersedes TN **<br>**Effective Date** July 01, 2003
### Citation | Condition or Requirement
--- | ---
1902(a)(10)(A) (ii)(XVI) of the Act (cont.) | ___ The agency does not disregard funds in retirement accounts.

|X| The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in [Supplement 8b to Attachment 2.6-A](attachment2.6-a).

___ The agency uses the resource methodologies of the SSI program.

___ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in [Supplement 5 to Attachment 2.6-A](attachment2.6-a).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act</td>
<td><strong>Definition of Employed - Employed Medically Improved Individuals - TWWIIA</strong></td>
</tr>
<tr>
<td><strong>X</strong> The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage, and working at least 40 hours per month.</td>
<td></td>
</tr>
<tr>
<td><strong>___</strong> The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria are described below:</td>
<td></td>
</tr>
</tbody>
</table>

**TN #03-11**

Supersedes TN **NEW**

**Approval Date** **June 26, 2003**

**Effective Date** **July 01, 2003**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act</td>
<td><strong>Payment of Premiums or Other Cost Sharing Charges</strong></td>
</tr>
</tbody>
</table>

For individuals eligible under the BBA eligibility group described in No. 25 on page 23f of Attachment 2.2-A:

The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

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**TN #03-11**

*Supersedes TN ___ NEW___*

**Approval Date** June 26, 2003

**Effective Date** July 01, 2003
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)</td>
<td>For individuals eligible under the Basic Coverage Group described in No. 26 on page 23f of Attachment 2.2-A, and the Medical Improvement Group described in No. 27 on page 23f of Attachment 2.2-A:</td>
</tr>
</tbody>
</table>

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums.

**X** The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on page 120.
### Citation

Sections 1902(a)(10)(A) (ii)(XV), (XVI), and 1916(g) of the Act (cont.)

### Condition or Requirement

**Premiums and Other Cost-Sharing Charges**

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

A person whose net available income is at least 150 percent of the applicable Federal Poverty Level must pay a premium equal to the sum of 3 percent of the person's net earned income and 7.5 percent of the person's net unearned income. No premium shall be required from a person whose net available income is less than 150 percent of the applicable Federal income official Poverty Level.

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**TN #03-11**  
**Approval Date** June 26, 2003  
**Supersedes TN** NEW  
**Effective Date** July 01, 2003
(4) Other deductions from income applied under the Medicaid plan.

(5) Required incurred medical and remedial services.

5. **Resource Exemptions - Categorically and Medically Needy**

a. Except as specified in item C.5.e below, in determining countable resources for AFDC related individuals, the disregards and exemptions in the State’s approved AFDC plan are applied.

b. In determining countable resources for aged individuals, including aged individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:

   _X_ The disregards of the SSI program. *

   ___ The disregards of the SSI program, except for the following restrictions, applied under the provisions of section 1902(f) of the Act:

   c. In determining countable resources for blind individuals, the following disregards are applied:

   _X_ The disregards of the SSI program. *

   ___ The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act:

* Except for less restrictive disregards as specified in Supplement 12 to Attachment 2.6A of the State Plan 85-25.
## Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.

## Medically needy income levels (MNILs)

Medically needy income levels (MNILs) are based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
### New York 13 M-2

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(a)(10) and 1902(m)(1)(C) of the Act, P.L. 97-248 (Section 137) and P.L. 99-509 (Section 9402) | d. In determining countable resources for disabled individuals, including disabled individuals with incomes up to the Federal nonfarm poverty line described in section 1902(m)(1) of the Act, the following disregards are applied:  
  - X  The disregards of the SSI program. *  
  - The disregards of the SSI program, except for the following restrictions applied under the provision of section 1902(f) of the Act:  
  - Not applicable. No resource standard is applied. |
| 1902(1)(3)(B) of the Act, P.L. 99-509 (Section 9401(b)) | e. In determining countable resources of women during pregnancy and during the 60-day period beginning on the last day of pregnancy covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act, the following disregards are applied:  
  - Not applicable. No resource standard is applied.  
  - The disregards of the SSI program.  
  - The following disregards which are different but not more restrictive than the disregards of the SSI program: |

* Except for less restrictive disregards as specified in Supplement 11 and 12 to Attachment 2.6A of the State Plan 85-25.

<table>
<thead>
<tr>
<th>TN #87-35</th>
<th>Approval Date December 5, 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes TN #86-29</td>
<td>Effective Date July 01, 1987</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
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</tr>
<tr>
<td>1902(1)(3)(B) of the Act, P.L. 99-509 (Section 9401(b))</td>
<td>e. In determining countable resources of women during pregnancy and during the 60-day period beginning on the last day of pregnancy covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act, the following disregards are applied:</td>
</tr>
<tr>
<td></td>
<td><em>X</em> Not applicable. No resource standard is applied.</td>
</tr>
<tr>
<td></td>
<td>___ The disregards of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>___ The following disregards which are different but not more restrictive than the disregards of the SSI program:</td>
</tr>
</tbody>
</table>

TN #90-3  
Supersedes TN **NEW**  
Approval Date **May 10, 1990**  
Effective Date **January 01, 1990**
4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 1 or 6 month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

   (a) Health insurance premiums, deductibles and coinsurance charges.

   (b) Expenses for necessary medical and remedial care not included in the plan.

   (c) Expenses for necessary medical and remedial care included in the plan.

Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.
### Citation  
1903(f)(2) of the Act 

### Condition or Requirement

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. <strong>Medically Needy (continued)</strong></td>
<td></td>
</tr>
<tr>
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</tbody>
</table>

_X_ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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**TN #91-78**  
**Supersedes TN NEW**  
**Approval Date** March 11, 1992  
**Effective Date** October 01, 1991
### Medically Needy (continued)

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(17)</td>
<td>States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application</td>
</tr>
<tr>
<td>435.831(g)(2)</td>
<td>Yes, the State elects to exclude such expenses.</td>
</tr>
<tr>
<td>436.831(g)(2)</td>
<td>No, the State does not elect to exclude such expenses.</td>
</tr>
</tbody>
</table>

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**TN #96-20**

**Supersedes TN NEW**

**Approval Date** August 5, 1996

**Effective Date** April 01, 1996
### Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 42 CFR 435.732 | **b. Categorically Needy - Section 1902(f) States**

The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

1. Any SSI benefit received.
2. Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.
3. Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.
4. Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.
5. Incurred expenses for necessary medical and remedial services recognized under State law.

| 1902(a)(17) of the Act, P.L. 100-203 | Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government. |

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**TN #91-78**  
**Supersedes TN #87-35A**  
**Approval Date** March 11, 1992  
**Effective Date** October 01, 1991
<table>
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<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.b. Categorically Needy - Section 1902(f) States Continued</td>
<td>1903(f)(2) of the Act (6) Spenddown payments made to the State by the individual.</td>
</tr>
<tr>
<td></td>
<td>NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.</td>
</tr>
</tbody>
</table>
5. **Methods for Determining Resources**

a. **AFDC-related individuals (except for poverty level related pregnant women, infants, and children).**

   (1) In determining countable resources for AFDC-related individuals, the following methods are used:

   (a) The methods under the State's approved AFDC plan; and

   [X] (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

   (2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act</td>
<td></td>
</tr>
</tbody>
</table>

5. **Methods for Determining Resources**

b. **Aged individuals.** For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

- The methods of the SSI program.
- SS1 methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

**c. Blind individuals.** For blind individuals, the agency uses the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and resources of parents as available to children living with parents until the children become 21.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act</td>
<td>d. <strong>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</strong> The agency uses the following methods for the treatment of resources:</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>___</td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td>___</td>
<td>SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
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</table>

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

[1902(1)(3) and 1902(r)(2) of the Act]

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<thead>
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<tbody>
<tr>
<td>e. <strong>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</strong></td>
<td></td>
</tr>
</tbody>
</table>

The agency uses the following methods in the treatment of resources.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>___</td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td>___</td>
<td>The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

**TN #13-0053**

Supersedes TN #91-0078

**Approval Date**

**June 26, 2014**

**Effective Date**

**January 1, 2014**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Treatment of Income and Resources - Categorically and Medically Needy and Qualified Medicare Beneficiaries</td>
<td></td>
</tr>
<tr>
<td>a. AFDC related individuals (other than under items 9.e. and f. below)</td>
<td></td>
</tr>
<tr>
<td>The agency uses the same methodologies for treatment of income and resources as used in the State’s approved AFDC State plan.</td>
<td></td>
</tr>
<tr>
<td>b. Aged individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act</td>
<td></td>
</tr>
<tr>
<td>The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). *</td>
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</tr>
<tr>
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</tr>
<tr>
<td>The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>c. Blind individuals</td>
<td></td>
</tr>
<tr>
<td>The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). *</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act.</td>
<td></td>
</tr>
</tbody>
</table>

* Except for less restrictive disregards as specified in Supplement 11 and 12 to Attachment 2.6A of the State Plan 85-25.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>X</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
<tr>
<td>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents available to children living with parents until the children become 21.</td>
<td></td>
</tr>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>f. Poverty level infants covered under section 1902(a)(10)(A)(iv) of the Act.</td>
</tr>
<tr>
<td>___</td>
<td>The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td>___</td>
<td>The methods of the State’s approved AFDC plan.</td>
</tr>
<tr>
<td>___</td>
<td>Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>X</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
</tbody>
</table>

TN  #13-0053
Supersedes TN  #91-0078
Approval Date  June 26, 2014
Effective Date  January 1, 2014
### Eligibility Conditions and Requirements

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>The methods of the State’s approved AFDC plan.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with the parents until the children become 21.

---

**TN #13-0053**

**Approval Date**

**Supersedes TN #91-0027**

**Effective Date**
### New York

#### 19b

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

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>g. <strong>Poverty level children under section 1902(a)(10)(A)(i)(VII)</strong></td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>___ Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>___ Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___ Not applicable. The agency does not consider resources in determining eligibility.</td>
<td></td>
</tr>
</tbody>
</table>

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.]

---

*TN #13-0053*  
**Supersedes TN #92-0027**  
**Approval Date** June 26, 2014  
**Effective Date** January 1, 2014
### Citation | Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), and 1902(m)(1)(B) and (C) of the Act, P.L. 99-509 (Section 9402(a))</td>
<td>The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
| 1902(1)(3) of the Act, P.L. 99-509 (Section 9401(b)) | d. **Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act**  
*The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). *  
___ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to ATTACHMENT 2.6-A. |
|  | e. **Individuals who are pregnant women covered under section 1902(a)(10)(A)(ii)(X)(A) of the Act.**  
*(1) **Treatment of Income**  
The agency uses the same methodologies for treatment of income as used under --  
___ The State’s approved AFDC plan.  
___ The approved title IV-E plan.  

(2) **Treatment of Resources**  
___ The agency uses the same methodologies for treatment of resources as used in the SSI program. *  

* Except for less restrictive disregards as specified in Supplement 11 and 12 to Attachment 2.6A of the State Plan 85-25.

**TN #87-35** | **Approval Date** December 5, 1991  
Supersedes TN **NEW** | **Effective Date** July 01, 1987
### Citation | Condition or Requirement
--- | ---
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act | **5. h.** For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:

___ The methods of the SSI program only.

**X** The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.

1905(s) of the Act | i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.

1902(u) of the Act | j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:

**X** The methods of the SSI program only.

___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

---

**TN #91-78** | **Approval Date** March 11, 1992
Supersedes TN #91-51 | **Effective Date** October 01, 1991
k. **Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act**

   The agency uses the same method as in 5.h. ofAttachment 2.6-A.

6. **Resource Standard – Categorically Needy**

   a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

   ___ Same as SSI resource standards.

   ___ More restrictive.

   The resource standards for other individuals are the same as those in the related cash assistance program.

   b. Non-1902(f) States (except as specified under items 6.c. and d. below)

   The resource standards are the same as those in the related cash assistance program.

   Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
### New York

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

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(A), (B) and (C) of the Act</td>
<td>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td> </td>
<td> </td>
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<tr>
<td> </td>
<td> </td>
</tr>
<tr>
<td>1902(1)(3)(A) and (C) of the Act</td>
<td>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency supplies a resource standard.</td>
</tr>
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</tr>
</tbody>
</table>

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**TN _#13-0053_**

**Approval Date** _June 26, 2014_

**Supersedes TN _#92-0027_**

**Effective Date** _January 1, 2014_
### Citation | Condition or Requirement
--- | ---
[1902(m)(1)(C) and (m)(2)(B) of the Act] | [e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:

--- Same as SSI resource standards.

--- Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.]
### 7. Resource Standard - Medically Needy

<table>
<thead>
<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>b. A single standard is employed in determining resource resource eligibility for all groups.</td>
</tr>
<tr>
<td>___ Aged ___ Blind ___ Disabled</td>
<td>c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for --</td>
</tr>
</tbody>
</table>

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.

### 8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(ii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act</td>
<td>9. Resource Standard - Qualified Disabled and Working Individuals. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.</td>
</tr>
<tr>
<td>1902(u) of the Act</td>
<td>10. For COBRA continuation beneficiaries, the resource standard is:</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>1902(u) of the Act</td>
<td><strong>11. Excess Resources</strong> *</td>
</tr>
<tr>
<td></td>
<td>a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals</td>
</tr>
<tr>
<td></td>
<td>b. Categorically Needy Only</td>
</tr>
<tr>
<td></td>
<td><em>X</em> This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.</td>
</tr>
<tr>
<td></td>
<td>c. Medically Needy</td>
</tr>
<tr>
<td></td>
<td>Any excess resources make the individual ineligible.</td>
</tr>
</tbody>
</table>

- In accordance with Westmiller v. Sullivan, individuals are allowed to use incurred medical bills to offset excess resources and become eligible for Medicaid. See Supplement 8b to Attachment 2.6-A.
ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<tbody>
<tr>
<td>___ d.</td>
<td>As specified in Supplement 4 to Attachment 2.6A, the agency disregards the value of resources in addition to items 5a-c.</td>
</tr>
</tbody>
</table>

6. Excess Resources - Categorically Needy and Medically Needy

The method(s) checked below are used in handling resources in excess of those specified above:

a. Categorically Needy
   
   _X_ Any excess resources make the individual ineligible.
   
   _X_ This State has a section 1634 agreement with SSI. Conditional eligibility is provided for individuals who are receiving SSI while disposing of excess resources.

b. Medically Needy

The method(s) checked below is used in handling resources in excess of those specified above:

___ Excess non-income producing property (except the home) must be disposed of

___ Any excess resources render the individual ineligible

_X_ Other, described as follows:

Excess liquid assets are applied to cost of care

* See Supplement 12, page 2 to Attachment 2.6A

**TN #88-35**

**Supersedes TN NEW**

**Approval Date** September 17, 1990

**Effective Date** October 1, 1982
ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
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<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Treatment of Income and Resources - Medically Needy

*X* a. Individuals under 21.

_X_ The agency uses the same methodologies for treatment of income and resources as used in the AFDC State plan.

* Except for the disregards as contained in NY 82-9 approved on 4/26/84 effective 1/1/82 and as protected under the moratorium provision of the DRA.

<table>
<thead>
<tr>
<th>TN</th>
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<th>Supersedes TN</th>
<th>Effective Date</th>
</tr>
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<tbody>
<tr>
<td>#88-35</td>
<td>September 17, 1990</td>
<td>NEW</td>
<td>October 1, 1982</td>
</tr>
</tbody>
</table>
### 11. Effective Date of Eligibility

**a. Groups Other Than Qualified Medicare Beneficiaries**

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

- [ ] Aged, blind, disabled.
- [ ] AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- [ ] Aged, blind, disabled.
- [ ] AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

- [ ] Aged, blind, disabled.
- [ ] AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied:

- [ ] Aged, blind, disabled.
- [ ] AFDC-related.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
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<tr>
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<tbody>
<tr>
<td>[1920(b)(1) of the Act]</td>
<td>[ <em>X</em> (3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day of a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.]</td>
</tr>
<tr>
<td>1902(e)(8) and 1905(a) of the Act</td>
<td><em>X</em> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for --</td>
</tr>
<tr>
<td></td>
<td><em>X</em> 12 months</td>
</tr>
<tr>
<td></td>
<td>___ 6 months</td>
</tr>
<tr>
<td></td>
<td>___ ___ months (no less than 6 months and no more than 12 months)</td>
</tr>
</tbody>
</table>

TN _#13-0053_ Approval Date **June 1, 2014**
Supersedes TN _#92-0027_ Effective Date **January 1, 2014**
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</thead>
<tbody>
<tr>
<td>1902(a)(18) and 1902(f) of the Act</td>
<td><strong>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</strong>&lt;br&gt;The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.&lt;br&gt;Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.</td>
</tr>
<tr>
<td>1917(c)</td>
<td><strong>13. Transfer of Assets - All eligibility groups</strong>&lt;br&gt;The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.&lt;br&gt;Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.</td>
</tr>
<tr>
<td>1917(d)</td>
<td><strong>14. Treatment of Trusts - All eligibility groups</strong>&lt;br&gt;The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.&lt;br&gt;--- The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;&lt;br&gt;--- The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.&lt;br&gt;The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

**TN #95-12**  
**Approval Date August 18, 1995**  
**Supersedes TN #91-78**  
**Effective Date January 1, 1995**
<table>
<thead>
<tr>
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<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924 of the Act</td>
<td>13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.</td>
</tr>
<tr>
<td></td>
<td>When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:</td>
</tr>
<tr>
<td></td>
<td>___ the maximum standard permitted by law;</td>
</tr>
<tr>
<td></td>
<td>___ the minimum standard permitted by law; or</td>
</tr>
<tr>
<td>$74,820</td>
<td>a standard that is an amount between the minimum and the maximum.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

2.1 Application, Determination of Eligibility and Furnishing Medicaid
(continued)

✓ (f) Using the Income Determination from another Means-Tested Public
Benefit Program to Support Medicaid Determinations

(1) The state elects the option to use income determined by the
following means-tested public benefits program(s) to support
Medicaid eligibility determinations:

__ SNAP
✓ TANF
__ Other Means-Tested Program: ________________________

In electing this option, the state assures that it:

(a) Verifies citizenship and non-citizen status consistent with Medicaid
statutory and regulatory requirements in Section 1137 of the Social

(b) Complies with Medicaid reporting requirements with respect to
participants enrolled through this strategy.

(c) Provides applicants with program information required under 42 CFR
435.905, such as information about available services and the rights and
responsibilities of applicants and beneficiaries.

(d) Has procedures to ensure that eligible individuals are enrolled in the
appropriate Medicaid eligibility group. Description:

Medicaid workers in the local department of social services code Medicaid
consumers based on their Medicaid eligibility group. There is a small
population who may look like the Adult group, but have income over the
MAGI level because they reside in temporary housing, such as motels,
domestic violence shelters or AIDS housing, and receive an unlimited shelter
allowance. The State will data mine for these consumers using codes
available in their budgets and code them to claim the appropriate Federal
share of 50 percent if they have income above 138 percent FPL. These
consumers will still be eligible under the State’s 1115 Waiver, which gives
the authority to use the Temporary Assistance determination to authorize
Medicaid coverage.

TN # 17-0014 Approval Date December 22, 2016
Supersedes TN NEW Effective Date December 01, 2016
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2 - COVERAGE AND ELIGIBILITY

(e) Has procedures to ensure that eligible American Indians or Alaska Natives enrolled through this strategy are exempt from cost sharing and or premiums, consistent with section 1916A(b)(3) of the Social Security Act. Description:

Medicaid does not have premiums. A majority of American Indian and Alaska Native consumers enrolled through this strategy will be below 100 percent of the FPL because Temporary Assistance first compares gross income to 100 percent FPL in order to be found eligible. Medicaid consumers with income under 100 percent FPL do not have cost sharing. A small number of consumers who reside in temporary housing, such as motels, domestic violence shelters or AIDS housing receive an unlimited shelter allowance and therefore may have income about 100 percent FPL. The State intends to data mine for individuals with unlimited shelter allowances to see if they are MAGI eligible. The State will also determine if there are eligible American/Indian or Alaska Natives who should not be charged a copayment and manually exempt them.

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(f) Has post-enrollment procedures to ensure assignment of rights to third party benefits and to secure cooperation in establishing medical support as appropriate, per 42 CFR 435.610.

(2) SNAP-Specific Criteria

   (i) The state will use gross income determined by SNAP to support Medicaid eligibility determinations for all MAGI-based Medicaid eligibility groups at:

   Initial application
   Renewal of Medicaid eligibility

   In applying this option, all of the following conditions are met:

   (a) All members of the SNAP household are eligible for SNAP, other than for SNAP transitional benefits.

   (b) No one in the SNAP household has any type of income that is excluded in determining gross income for purposes of eligibility for SNAP, but would be included in MAGI-based income.

   (c) No one in the SNAP household is part of a tax household that includes an individual who lives outside the home.

____________________________________________________________________________

TN # 17-0014 Approval Date December 22, 2016
Supersedes TN NEW Effective Date December 01, 2016
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

(d) The SNAP household consists of individuals who live alone, parents living with their children, or married couples (with or without children), with the result that they will also be considered a household under Medicaid rules and either:

- There are no other members present who would not be considered to be part of the household used for purposes of determining MAGI-based Medicaid eligibility; or

- Other members are present in the household, but the total household income is below the applicable Medicaid standard for a household of one.

(e) Households with self-employment income are excluded from this option if the state uses a state-specific methodology for treating self-employment income in SNAP.

Does the state use a methodology for treating self-employment income that differs from the standard SNAP methodology?

- Yes
- No

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(f) None of the household’s income is excluded from gross income as payment of child support for children living outside of the household.

Does the state exclude payment of child support for children from gross income when determining eligibility for SNAP?

- Yes, the state adds the amount of child support excluded to the household’s SNAP gross income.
- Yes, these families will be excluded from the method.
- No

(g) The state obtains all information necessary for a Medicaid eligibility determination that is not contained in the case record for SNAP. If available, electronic data sources are consulted before paper documentation is requested.

(ii) Collection of Information to Determine Eligibility

(a) The state collects information to ensure that no one in the SNAP household is part of a tax household that includes an individual who lives outside the home through the following:

- Information is available through electronic data sources.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

☐ Information is collected on the application or renewal form for the means-tested program.
☐ The state agency provides a form to the individual to complete and return.
☐ For renewals only, the state agency provides a renewal notice requesting that the beneficiary notify the agency if household information has changed.
☐ Other. Description:

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(b) The state identifies individuals who have income which is counted in determining household income using MAGI-based methodologies but is not included in SNAP gross income. This includes, but may not be limited to income received through an AmeriCorps Education Award not used for educational expenses, or income from a minor dependent child above the applicable tax filing threshold. The status uses the following processes:

☐ Information is available through electronic data sources.
☐ Information is collected on the application or renewal form for the means-tested program.
☐ The state agency provides a form to the individual to complete and return.
☐ For renewals only, the state agency provides a renewal notice requesting that the beneficiary notify the agency if anyone in the household has a new type of income.
☐ Other. Description:

(c) The state obtains a signature authorizing a determination of Medicaid eligibility as required under 42 CFR 435.907(f).

☐ The household applies for Medicaid by requesting a Medicaid determination through the application for SNAP.
☐ The household applies for Medicaid at its SNAP recertification by requesting a Medicaid determination on the SNAP recertification form.
☐ Individuals are sent a separate form for signature and return. The state allows the form to be completed:
2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(3) **TANF-Specific Criteria**

- √ (i) The state will use gross income determined by TANF to support Medicaid eligibility determinations for all MAGI-based Medicaid eligibility groups at:
  - √ Initial application
  - √ Renewal of Medicaid eligibility

In applying this option, all of the following conditions are met:

(a) The state has completed or obtained a study indicating that the state’s gross income determination under TANF rules is equal to a MAGI-based determination under the circumstances set forth in the SPA.

(b) All members of the TANF assistance unit are eligible for TANF.

(c) No one in the TANF assistance unit has any type of income that is excluded in determining income for purposes of TANF, but would be included in MAGI-based income.

(d) No one in the TANF assistance unit is part of a tax household that includes an individual who lives outside the home.

(e) The TANF assistance unit consists of individuals who live alone, parents living with their children, or married couples (with or without children), with the result that they will also be considered a household under Medicaid rules and either:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

- There are no other members present who would not be considered to be part of the household used for purposes of determining MAGI-based Medicaid eligibility; or

- Other members are present in the household, but the total household income is below the applicable Medicaid standard for a household of one.

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(f) Households with income from stepparents are excluded from this option if the state uses state-specific methodology to exclude any income from stepparents living in TANF assistance unit.

Does the state exclude any portion of stepparents’ income from the household income?

[ ] Yes
[ ] No

(g) The criteria described under this strategy are applied statewide in states with TANF eligibility requirements that vary by region.

Does the state have TANF eligibility requirements that vary by region?

[ ] Yes. Description:

The standard of need varies by county in New York State. However, Temporary Assistance, statewide, first compares income to 100 percent of the FPL before comparing income to the county specific standard of need.

[ ] No

(h) The state obtains all information necessary for a Medicaid eligibility determination that is not contained in the case record for TANF. If available, electronic data sources are consulted before paper documentation is requested.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(ii) Collection of Information to Determine Eligibility

The state obtains all information necessary for a Medicaid eligibility determination that is not contained in the case record for TANF. If available, electronic data sources are consulted before paper documentation is requested.

(a) Describe how the state collects information to ensure that no one in the TANF household is part of a tax household that includes an individual who lives outside the home:

- Information is available through electronic data sources.
- ✓ Information is collected on the application or renewal form for TANF.
- ☐ The state agency provides a form to the individual to complete and return.
- ☐ The state agency provides a renewal notice requesting that the beneficiary notify the agency if household information has changed.
- ☐ Other. Description:

(b) Describe how the state identifies individuals who have income which is counted in determining household income using MAGI-based methodologies but is not included in TANF income:

- ☐ Information is available through electronic data sources.
- ☐ Information is collected on the application or renewal form for the means-tested program.
- ☐ The state agency provides a form to the individual to complete and return.
- ☐ For renewals only, the state agency provides a renewal notice requesting that the beneficiary notify the agency if anyone in the household has a new type of income.
- ✓ Other. Description:

Prior to performing a net income budget, the TANF budget first compares a consumer’s gross income to 100 percent of the federal poverty level. All income included in a MAGI-based budget would be included in this poverty level test.
2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(c) Describe how the state obtains a signature authorizing a determination of Medicaid eligibility as required under 42 CFR 435.907(f).

√ The household applies for Medicaid by requesting a Medicaid determination through the application for TANF.

☐ The household applies for Medicaid at its TANF recertification by requesting a Medicaid determination on the TANF recertification form.

☐ Individuals are sent a separate form for signature and return. The state allows the form to be completed:
  ☐ On paper
  ☐ By telephone
  ☐ Online
  ☐ Through other means. Description: ________________

☐ Not applicable. State has only elected option to use strategy at Medicaid renewal.

☐ Other. Description: ________________

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(4) Criteria for Other Public Means-Tested Benefit Program

__ (i) The state will use gross income determined by _____________________ to support Medicaid eligibility determinations for all MAGI-based Medicaid eligibility groups at:

__ Initial application
__ Renewal of Medicaid eligibility

In applying this option, the following conditions are met:

(a) The state has completed or obtained a study indicating that the state’s gross income determination for the means-tested benefit program described above is equal to a MAGI-based determination under the circumstances set forth in the SPA.

(b) All members of the household for the [means-tested benefit program name] __________ are eligible for that program.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

(c) No one in the household for the [means tested benefit program] has any type of income that is excluded in determining gross income for purposes of the program, but would be included in MAGI-based income.

(d) No one in the household for the [means tested benefit program] is part of a tax household that includes an individual who lives outside the home.

(e) The household for the means-tested benefit program consists of individuals who live alone, parents living with their children, or married couples (with or without children), with the result that they will also be considered a household under Medicaid rules and either:

   o There are no other members present who would not be considered to be part of the household used for purposes of determining MAGI-based Medicaid eligibility; or

   o Other members are present in the household, but the total household income is below the applicable Medicaid standard for a household of one.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(f) The household for the means-tested benefit program consists of individuals who live alone, parents living with their children, or married couples (with or without children), with the result that they will also be considered a household under Medicaid rules and either:

- There are no other members present who would not be considered to be part of the household used for purposes of determining MAGI-based Medicaid eligibility; or

- Other members are present in the household, but the total household income is below the applicable Medicaid standard for a household of one.

(g) The criteria described under this strategy are applied statewide in states with eligibility requirements for the means-tested program described above that vary by region.

Do the eligibility requirements for the means-tested program vary by region?

__ Yes. Description:

__ No

(h) The state obtains all information necessary for a Medicaid eligibility determination that is not contained in the case record for the means-tested program. If available, electronic data sources are consulted before paper documentation is requested.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF New York

SECTION 2- COVERAGE AND ELIGIBILITY

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(iii) Collection of Information to Determine Eligibility

(a) Describe how the state collects information to ensure that no one in the [means-tested benefit program] household is part of a tax household that includes an individual who lives outside the home:

☐ Information is available through electronic data sources.
☐ Information is collected on the application or renewal form for the means-tested program.
☐ The state agency provides a form to the individual to complete and return.
☐ The state agency provides a renewal notice requesting that the beneficiary notify the agency if household information has changed.
☐ Other. Description:

(b) Describe how the state identifies individuals who have income which is counted in determining household income using MAGI-based methodologies but is not included in total income for the means-tested benefit program:

☐ Information is available through electronic data sources.
☐ Information is collected on the application or renewal form for the means-tested program.
☐ The state agency provides a form to the individual to complete and return.
☐ For renewals only, the state agency provides a renewal notice requesting that the beneficiary notify the agency if anyone in the household has a new type of income.
☐ Other. Description:

TN #       17-0014__________________ Approval Date _December 22, 2016________________
Supersedes TN NEW ___________________________ Effective Date _December 01, 2016________________
2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

(c) Describe how the state obtains a signature authorizing a determination of Medicaid eligibility as required under 42 CFR 435.907(f).

☐ The household applies for Medicaid by requesting a Medicaid determination through the application for the means-tested benefit program.

☐ The household applies for Medicaid at recertification for the means-tested benefit program by requesting a Medicaid determination on the recertification form for the means tested benefit program.

☐ Individuals are sent a separate form for signature and return. The state allows the form to be completed:

☐ On paper
☐ By telephone
☐ Online
☐ Through other means. Description:

Not applicable. State has only elected option to use strategy at Medicaid renewal.

☐ Other. Description:
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

INCOME ELIGIBILITY LEVELS

A. Mandatory Categorically Needy

1. AFDC-Related Groups other than Poverty Level Pregnant Women and Infants:
   Eligibility for these groups is based on the monthly standard of need (SON) as
   reflected in the Title IV-A State Plan approved as of July 16, 1996. The monthly SON
   equals the payment standard. The following illustrated how the SON is derived:

   For a household of three living in Suffolk County, and paying for Public Service
   Commission (PSC) electric heat, the family is allowed: a basic allowance of $238,
   which is intended to be used for food, clothes, personal incidentals, etc.; a Home
   Energy Allowance of $30; a Supplemental Home Energy Allowance of $23; a Shelter
   Allowance of $387; and a Fuel Allowance for PSC electric heat of $90. The total
   monthly SON for a family of 3 living in Suffolk County is $768.

   Additional items of need as described on page 1 of Attachment E, “Standard of
   Need” for the July 16, 1996 Title IV-A State Plan, in Section 352.1, paragraph (c) are
   also provided as circumstances warrant. The SON/payment standard would then
   increase accordingly.

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(A)(IV) of the Act:
   Effective April 1, 1990, based on the following percent of the official Federal income
   poverty level --

   ___133 Percent ______185 Percent (No more than 185 percent)
   (as revised annually in the
   Federal Register for the size family involved.)

Note: A State Plan amendment was approved under Section 1902(r)(2) to allow for a disregard
on income between 185% and 200% of the poverty level for pregnant women and infants.]
Section 352.1  Standard of need for determining eligibility.

The eligibility for public assistance of all persons who constitute or are members of a family household must be determined by a social services district by applying the following statewide standard of monthly need which must consist of:

(a) regular recurring monthly needs, exclusive of shelter, fuel for heating, home energy payments and supplemental home energy payments, in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Number of persons in household</th>
<th>Each additional Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>$112</td>
</tr>
<tr>
<td>Two</td>
<td>$179</td>
</tr>
<tr>
<td>Three</td>
<td>$238</td>
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<tr>
<td>Four</td>
<td>$307</td>
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<tr>
<td>Five</td>
<td>$379</td>
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<tr>
<td>Six</td>
<td>$438</td>
</tr>
<tr>
<td>$60</td>
<td></td>
</tr>
</tbody>
</table>

(b) plus the amount of money for shelter, fuel for heating, home energy payments and supplemental home energy payments, required monthly for such persons in accordance with provisions of law and department regulations; and

(c) for any of such persons who may because of their case circumstances require any of the following items in accordance with applicable provisions of law and department regulations, the standard of need must include the cost of the required item or items in accordance with such provisions: furniture and furnishings for the establishment of a home, essential repair of heating equipment, cooking stoves and refrigerators, additional cost of meals for persons unable to prepare meals at home, replacement of clothing or furniture which has been lost in fire, flood or other like catastrophe, cost of services and supplies already received, miscellaneous shelter costs, day care, camp fees and payment of life insurance premiums.

352.2  Allowances and grants for persons who constitute or are members of a family household.

(a) Each social services district must utilize the applicable schedules of monthly grants and allowances as found in subdivision (d) of this section to provide for all items of need, exclusive of:

(1) shelter;
(2) fuel for heating;]

TN  #13-0053 Approval Date  June 26, 2014
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[(3) additional cost of meals for persons who are unable to prepare meals at home;
(4) purchase of necessary and essential furniture required for the establishment of a
home;
(5) replacement of necessary furniture and clothing for persons in need of public
assistance who have suffered the loss of such items as the result of fire, flood, or
other like catastrophe;
(6) essential repair of heating equipment, cooking stoves and refrigerators;
(7) allowances for occupational training; and
(8) other items for which specific provision is otherwise made in this Part.

(b) For the purposes of such monthly grants and allowances under Family Assistance or
Emergency Assistance to Needy Families with Children, children or adults residing with an
SSI beneficiary must be considered as a separate household from the SSI beneficiary.

(c) Supplemental allowances and grants may not be made other than as authorized under the
regulations nor in excess of established schedules in no event, except as provided in Part
397 of this Title, must a special allowance and grant be required to be made because the
cash has been lost, stolen or mismanaged. Any duplicate allowance and grant made for
such purpose is not reimbursable by the State unless made as a result of an order made
after May 1, 1977 by a court of competent jurisdiction or a payment made after May 1,
1977 pursuant to an order by a court of competent jurisdiction.

(d) The monthly grants and allowances much be as follows:

SCHEDULE SA-2a
STATEWIDE MONTHLY GRANTS AND ALLOWANCES,
EXCLUSIVE OF HOME ENERGY PAYMENTS AND
SUPPLEMENTAL HOME ENERGY PAYMENTS
FOR SNA-VA-FA

<table>
<thead>
<tr>
<th>Number of persons in household</th>
<th>Each additional person</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>$112</td>
</tr>
<tr>
<td>Two</td>
<td>$179</td>
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<tr>
<td>Three</td>
<td>$238</td>
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<td>Six</td>
<td>$438</td>
</tr>
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</table>

TN #13-0053 Approval Date June 1, 2014
Supersedes TN #04-0001 Effective Date January 1, 2014
STATEWIDE MONTHLY HOME ENERGY PAYMENTS FOR SNA-VA-FA

Number of persons in household

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<th></th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Five</th>
<th>Six</th>
</tr>
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<tr>
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STATEWIDE MONTHLY SUPPLEMENTAL HOME ENERGY PAYMENTS FOR SNA-VA-FA

Number of persons in household

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<td>Each</td>
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<td>$17</td>
<td>$23</td>
<td>$30</td>
<td>$37</td>
<td>$42</td>
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<tr>
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<td>$5</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
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</table>

(e) Provision of home energy assistance payments set forth in subdivision (d) of this section must be effective for grants made on or after July 1, 1981.

(f) Provision of supplemental home energy assistance payments set forth in subdivision (d) of this section must be effective for grants made on or after January 1, 1986.

352.3 Rent allowances.

(a) Each social services district must provide a monthly allowance for rent in the amount actually paid, but not in excess of the appropriate maximum of such district for each family size, in accordance with the following schedules:

LOCAL AGENCY MAXIMUM MONTHLY SHELTER ALLOWANCES WITHOUT HEAT

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Supersedes TN #04-0001 Effective Date January 1, 2014
### New York

#### 1a-4

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**TN #13-0053**

Supersedes TN #04-0001

Approval Date **June 1, 2014**

Effective Date **January 1, 2014**
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**TN #13-0053**

**Approval Date** June 1, 2014

**Supersedes TN #04-0001**

**Effective Date** January 1, 2014
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</tr>
<tr>
<td>Yates</td>
<td>181</td>
<td>210</td>
<td>241</td>
<td>263</td>
<td>284</td>
<td>294</td>
<td>306</td>
<td>335</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TN #13-0053**

**Supersedes TN #04-0001**

**Approval Date** June 26, 2014

**Effective Date** January 1, 2014
When the recipient is obligated to pay for water as a separate charge to a vendor, an allowance must be made for the additional amount required to be paid. When the recipient is obligated to pay for sewer, water (except when paid as a separate charge) and/or garbage disposal, an allowance must be made therefore to the extent that the total of the rent allowances plus such charge or charges does not exceed the appropriate maximum amount in the schedule in subdivision (a) of this section. For the purpose of this subdivision, the term “separate charge” refers to a billing made directly to a recipient in his or her name, which is limited to charges for his or her utility service.

An allowance for household expenses must be made for a period not in excess of 180 days, when essential to retain a housing accommodation and to maintain the home to which a recipient temporarily receiving care in a medical facility is reasonably expected to return upon discharge from such facility. Payments under this subdivision must not continue for more than 45 days unless, within 45 days following placement in the medical facility, the social services official has reviewed the recipient’s status and determined that the recipient is expected to remain in the facility for not more than 180 days and is likely to return to the home following discharge. The basis for these conclusions must be documented in the case record.

Public Housing.

An allowance for rent must be made for recipients who are tenants of city, State or federally aided public housing up to the amount actually paid or the following schedule, whichever is less, except when a modified schedule or allowances is approved by this department for a specific housing authority or when the housing authority calculates the rent based on a percentage of household income:

<table>
<thead>
<tr>
<th>Apartment size</th>
<th>Monthly rent</th>
</tr>
</thead>
<tbody>
<tr>
<td>“0” Bedrooms</td>
<td>$ 65</td>
</tr>
<tr>
<td>1 Bedroom</td>
<td>77</td>
</tr>
<tr>
<td>2 Bedrooms</td>
<td>90</td>
</tr>
<tr>
<td>3 Bedrooms</td>
<td>101</td>
</tr>
<tr>
<td>4 Bedrooms</td>
<td>107</td>
</tr>
<tr>
<td>5 Bedrooms</td>
<td>110</td>
</tr>
</tbody>
</table>

Modified schedule approved.

When a modified schedule is approved by this department for a specific housing authority, the allowance for rent must be the amount actually paid up to the approved schedule amount.
[(ii) Rent calculated based on a percentage of income.]

For any household for which the amount of rent is determined by a public housing authority as a percentage of either gross or adjusted gross income, the applicable shelter allowance is the amount so calculated up to the maximum allowance for the given household size found in subdivision (a) of this section.

(2) (i) **Section 236 Rental Assistance Program, Section 8 Housing Vouchers, Section 8 Housing Program (non-certificate).**

The rent allowance for tenants of housing subsidized under the Section 236 Rental Assistance Program or the Section 8 Housing Assistance Payments Program, except as provided in clause (ii) of this paragraph, is the amount of rent actually paid (exclusive of the subsidy) but not more than the amount in the applicable schedule in subdivisions (a) and (b) of this section.

(ii) **Section 8 Existing Housing Program (certificate).**

The rent and fuel for heating allowance for recipients whose housing payments of rent are subsidized under the Section 8 Existing Housing Program who hold a certificate of family participation (not including a recipient participating in the program of special allowances for owners of manufactured homes) is the amount in the applicable schedule in clause (iii) or clause (iv) of this paragraph. Such amount will not be adjusted in accordance with the actual cost of shelter and utilities. Subdivisions (a) and (b) of this section and subdivision (a) of section 352.5 do not apply; provided, however, that allowances hereunder may not exceed the applicable amount under subdivision (a) of this section. Shelter and fuel allowances pursuant to this subdivision are not subject to proration under section 352.32(e)(2)(ii) of this Part unless the members of each assistance unit in the household reside together as a single economic unit subject to proration of the basic monthly allowance, the home energy allowance and the supplemental home energy allowance under section 352(e)(2)(i) of this Part. Any amounts by which the rental obligation of the tenant is reduced below the amounts in the applicable schedule in clause (iii) or clause (iv) of this paragraph as an allowance for payment of utilities and any amounts remitted to the tenant or to a vendor for payment of utilities as a result of participation in the section 8 program are deemed to be an actual payment for housing by the tenant for the purposes of this clause. No such utility allowance or reimbursement constitutes income for purposes of determining eligibility for or the amount of public assistance.]
((iii) Local agency maximum monthly section 8 rent allowances

By Family Size
(No recipient having earned income which is or may be exempt under Section 352.19 of this Part)

<table>
<thead>
<tr>
<th>Number of Persons Receiving Assistance in Household</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children under 18</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>1</td>
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<td></td>
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<td></td>
<td>7</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Each additional person</th>
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<tr>
<td></td>
</tr>
<tr>
<td>$59</td>
</tr>
<tr>
<td>$94</td>
</tr>
<tr>
<td>$125</td>
</tr>
<tr>
<td>$161</td>
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<tr>
<td>$198</td>
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<tr>
<td>$229</td>
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<tr>
<td>$260</td>
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<tr>
<td>$291</td>
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<td></td>
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<tr>
<td>$42</td>
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<tr>
<td>$77</td>
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<tr>
<td>$108</td>
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<tr>
<td>$144</td>
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<tr>
<td>$181</td>
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<tr>
<td>$212</td>
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<tr>
<td>$243</td>
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<tr>
<td>$274</td>
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<td></td>
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<tr>
<td>$60</td>
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<tr>
<td>$91</td>
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<tr>
<td>$127</td>
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<tr>
<td>$164</td>
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<td>$195</td>
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<tr>
<td>$226</td>
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<td>$257</td>
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<tr>
<td>$74</td>
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<tr>
<td>$110</td>
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<tr>
<td>$147</td>
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<tr>
<td>$178</td>
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<tr>
<td>$209</td>
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<tr>
<td>$240</td>
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<tr>
<td>$93</td>
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<td>$130</td>
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<td>$161</td>
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<tr>
<td>$192</td>
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<tr>
<td>$223</td>
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<td></td>
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<tr>
<td>$113</td>
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<tr>
<td>$144</td>
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<tr>
<td>$175</td>
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<tr>
<td>$206</td>
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<td></td>
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<tr>
<td>$127</td>
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<tr>
<td>$158</td>
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<tr>
<td>$189</td>
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<td></td>
</tr>
<tr>
<td>$141</td>
</tr>
<tr>
<td>$172</td>
</tr>
<tr>
<td>$155</td>
</tr>
</tbody>
</table>

For each additional dependent child in the household under the age of 18 years, subtract $17.]
(iv) Local agency maximum monthly section 8 rent allowances

By Family Size
(At least one recipient having earned income subject to disregard as a work expense)

Number of Persons Receiving Assistance in Household

<table>
<thead>
<tr>
<th>Number of children under 18</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Each additional person</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$98</td>
<td>$133</td>
<td>$164</td>
<td>$200</td>
<td>$237</td>
<td>$268</td>
<td>$299</td>
<td>$330</td>
<td>$31</td>
</tr>
<tr>
<td>1</td>
<td>$81</td>
<td>$116</td>
<td>$147</td>
<td>$183</td>
<td>$220</td>
<td>$251</td>
<td>$282</td>
<td>$313</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$99</td>
<td>$130</td>
<td>$166</td>
<td>$203</td>
<td>$234</td>
<td>$265</td>
<td>$296</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$113</td>
<td>$149</td>
<td>$186</td>
<td>$217</td>
<td>$248</td>
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<tr>
<td>4</td>
<td>$132</td>
<td>$169</td>
<td>$200</td>
<td>$231</td>
<td>$262</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$152</td>
<td>$183</td>
<td>$214</td>
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<tr>
<td>6</td>
<td>$166</td>
<td>$197</td>
<td>$228</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>$180</td>
<td>$211</td>
<td>$245</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$194</td>
</tr>
</tbody>
</table>

For each additional dependent child in the household under the age of 18 years, subtract $17.

(e) Rent allowances for hotel/motel facilities. An allowance for shelter must be made for recipients temporarily housed in hotel/motel facilities under the following circumstances:

(1) No other suitable housing either public or private is available to house the recipient.

(2) Hotel/motel accommodations without cooking facilities must be utilized only when accommodations with such facilities are not available. An allowance for the actual cost of the rental of a refrigerator, not to exceed $10 per week per room, must be made when a homeless family is temporarily placed in a hotel/motel which does not have cooking facilities and which provides a refrigerator on a rental basis.

(3) The continued need for hotel/motel accommodations must be reviewed, evaluated and authorized monthly by the social services district.]
[4) A detailed report of that review, evaluation and authorization must be submitted to
the department’s division of income maintenance on the form prescribed by the
department, on or before the 10th working day of the fourth month of temporary
residence, and at monthly intervals thereafter.

(f) Reimbursement for shelter costs and restaurant allowances and rental fees for
refrigerators as provided for in paragraph (e)(2) of this section is available to social
services districts for expenditures made by such districts on behalf of recipients
temporarily living in hotels or motels for so long as the recipients are actively seeking
permanent housing, but in no event for a period in excess of six months unless the local
commissioner of social services determines on an annual basis that housing other than
hotels or motels or facilities regulated under Part 900 of this Title is not readily available in
the social services district and the commissioner submits such determination to the
department on an annual basis. Upon such a determination and submission, the social
services district will continue to be reimbursed for shelter costs, restaurant allowances as
appropriate and rental fees for refrigerators provided to public assistance recipients
beyond such six month period. A recipient’s continued need for hotel/motel
accommodations must be reviewed and evaluated monthly. The maximum reimbursable
amount for shelter costs after August 1, 1984 is $16 per day for the first person in each
hotel room, and $11 per day for the remaining occupants in each room. Restaurant
allowances, if necessary, must be provided in accordance with department regulations.

(g) Standards.

No family must be referred to a hotel/motel, nor must any reimbursement be made for
costs incurred from such referral unless all of the requirements set forth below are met:

(1) Primary consideration must be given to the needs of children. Specific factors
considered must include but must not be limited to educational needs, security, the
nature of the facility in which the children would be placed, and factors which will
insure the minimum disruption of community ties.

(2) The hotel/motel must have appropriate contractual or other arrangements for
maintenance, repair and sanitation in the hotel/motel. The hotel/motel must have
available for review by the local social services district information verifying the
above-mentioned arrangements or record of such. Such information would include,
for example, contracts with private carters, bills, receipts, or other evidence of
performance. Such arrangements must include but not be limited to agreements for
provision of the following services:

   (i) removal of garbage;]
[(ii) maintenance of floor coverings, draperies and furniture;
(iii) repainting of the facility at least once every five years;
(iv) maintenance and inspection of the electrical system;
(v) maintenance of plumbing and plumbing fixtures;
(vi) maintenance and inspection of heating, ventilation and air conditioning systems;
(vii) a regular vermin control program; and
(viii) provision to insure that entrances, exits, steps and walkways are kept clear of garbage, ice, snow and other hazards]

(3) Rooms must be cleaned at least every other day by hotel/motel staff.

(4) Furniture necessary for daily living, including but not limited to tables, bureaus, chairs, beds and cribs must be in each room.

(5) No more than two adults must be placed in the same room.

(6) When children are placed in the same room as adults, there must be sufficient beds so children must not have to share single beds.

(7) All mattresses and bedding material must be clean. Each bed must have at least two clean sheets, adequate clean blankets, clean pillows and pillowcases. A complete change of linens must be made by hotel/motel staff at least once a week and more often where individual circumstances warrant or when a new family occupies the unit. Each unit must be supplied with towels, soap and toilet tissues. A clean towel must be provided daily to easy resident.

(8) Each unit must have operational door and window locks. All windows at and above the second floor must have window guards in place unless windows are sealed and the air conditioning works.

(9) A heating system must be permanently installed and operated in accordance with applicable local law. Where local law or code does not govern the provision of heat, the system will provide heat to maintain a temperature of 69°F (20°C) in all occupied parts of the building, including corridors. Where windows do not open, proper ventilation, including but not limited to air condition, must be operational.]
(10) Each family must have a private bathroom. At a minimum, this must include a toilet, a sink and a shower or bathtub, all of which must be properly maintained with hot and cold running water. Couples without children may be placed in rooms with common bathroom facilities.

(h) Inspection.

Local social services districts which make hotel/motel referral must inspect at least once every six months the hotels/motels in which families are placed. In addition to verifying that the hotel/motel meets the requirements set forth in subdivision (g) of this section, the local district must make appropriate inquiries to determine whether the hotel/motel is in compliance with all applicable state and local laws, regulations, codes and ordinances. Any violation found during the on-site inspection must be reported to appropriate authorities. Further, each inspection must at least review arrangements for hygiene, vermin control, security, furnishings, cleanliness and maintenance and must include a review of any applicable documents pertaining to compliance with any local laws or codes. A written report must be made of each such inspection and must be maintained at the office of the local district together with such other information as the district may maintain concerning the families placed in the hotel/motel.

(i) (1) To the extent that units of housing are available and subject to the department approval based upon the housing conditions in the region, social services districts may provide an allowance to secure housing to any homeless family:

(i) residing in a municipality having a rental vacancy rate for low-income housing less than three percent;

(ii) for whom no housing can be located at a rent within the shelter maximum under this section; and

(iii) in which at least one member of the family has resided in a hotel or motel and/or a shelter (including, but not limited to, facilities operated under Part 900 of this Title) at public expense for a period exceeding 12 weeks. Social services districts may consider decreasing this length of stay requirement if a long term temporary placement in a hotel or motel or shelter would be detrimental to the health and welfare of families, including families with immediate medical needs.

(2) In determining priority for placement in housing units for which an allowance is paid under this subdivision, the district must consider factors affecting need such as:
(i) the length of stay in a hotel or motel and/or a shelter (including, but not limited to, facilities operated under Part 900 of this Title) at public expense;

(ii) the size of the family; and

(iii) the location of schools in relation to the temporary housing where the family is residing.

(3) Social services districts must submit to the department for approval annual plans for the operation of programs to make allowances available under this subdivision. Plans must be submitted within 45 days after funds have been authorized in the State budget for allowances for this program.

(i) indicate the number of units of housing for which the allowance will be made available pursuant to this subdivision, identifying the number that would be privately owned units and the number that would be publicly owned units, and the amount of funds being requested,

(ii) describe the housing to be utilized,

(iii) indicate the number of months that the allowance will be available (not to exceed eight months in the case of privately owned units or four months in the case of publicly owned units),

(iv) set forth the procedures for assuring local housing code compliance,

(v) set forth the procedures to identify those families likely to be long-term residents of hotels and motels and/or shelters (including, but not limited to, facilities operated under Part 900 of this Title)

(vi) indicate the criteria to be used in determining priorities for placement,

(vii) indicate the services available in the social services district to assist persons to remain in housing after placement under this program;

(viii) indicate the number of homeless facilities in the social services district that requested emergency housing each month during the most recent twelve month period and the number of families that resided in hotels and motels and/or shelters during the most recent twelve month period; and}
(ix) indicate the number of months that the social services district will require participating landlords to make specified apartments available to selected families.

(4) The allowance consists of a rent supplement in an amount to be determined by the social services district, with the prior approval of the department, but cannot exceed the difference between the maximum shelter allowance and the hotel/motel rate for the family. Social services districts must submit claims for State reimbursement for such allowances on forms and in the manner prescribed by the department.

(5) No allowance will be paid under this subdivision for housing developed for the homeless financed partially or wholly with public funds.

(6) No allowance under this subdivision will be paid unless the social services district documents that such allowance will not be used to replace funds previously used, or designated for use, to secure housing for homeless families.

(7) No allowance provided under this subdivision will be paid for housing which does not comply with or which is not brought into substantial compliance with the local housing code or which has been occupied by a family receiving Family Assistance (FA) or Safety Net Assistance (SNA) within one year prior to the payment of an allowance hereunder; provided, however, that such allowance may be held in escrow by the district pending correction of existing code violations. Moreover, no allowance will be paid unless the participating landlord agrees to make a specified apartment available to the selected family for a period of up to 32 months as approved by the department, except as provided herein. The landlord must agree that, in the event that a selected family does not remain for any reason in the specified apartment for the period for which it is to be available, the landlord will return a pro rata portion of the allowance reflecting the balance of the period. In such event, the district may provide an allowance with respect to a subsequently selected family for the balance of the period, provided further that such family meets the eligibility criteria set forth in this subdivision.

(8) Allowances provided under this subdivision must be paid for a maximum period specified by the district and approved by the department.

(9) Social services districts providing allowances under this subdivision must submit information on a monthly basis in a manner prescribed by the department including but not limited to:

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TN #13-0053  
Supersedes TN #04-0001  
Approval Date June 26, 2014  
Effective Date January 1, 2014  

(i) the number of units rented that were privately owned and the number of units rented that were publicly owned and the addresses of such units;

(ii) the individual allowances issued; and

(iii) the number of families leaving apartments funded with allowances under this subdivision.

(j) If rent has not been paid for the month in which the case is accepted, a non-prorated shelter allowance, not to exceed the appropriate local agency maximum monthly shelter allowance, must be provided to retain the living accommodation.

(k) Emergency shelter allowances:

(1) An emergency shelter allowance must be provided, upon request, to a household composed of an applicant for or recipient of public assistance, who has been medically diagnosed as having AIDS or HIV-related illness as defined from time-to-time by the AIDS Institute of the State Department of Health, and any family members residing with such person. Such household must be homeless or faced with homelessness and have no viable and less costly alternative housing available. The social and medical needs of the household members must be considered in making a determination concerning the availability of alternative housing.

(2) An emergency shelter allowance must not exceed $480 for the first person in the household and $330 for each additional person in the household, and in no event be greater than the actual monthly rent due. A person with AIDS or HIV-related illness is considered to be the first person in the household. Except for cases specified in paragraph (3) of this subdivision, the emergency shelter allowance is considered to be the household’s public assistance shelter allowance for public assistance budgeting purposes.

(3) When a household comprising both FA and SSI eligible persons requests an emergency shelter allowance, the social services district must compute the amount of the allowance as follows:

(i) determine the public assistance grant of the FA eligible persons using the appropriate rent schedule amount in section 352.3(a) of this Part:
[(ii) calculate the net amount of actual household shelter costs by subtracting the appropriate rent schedule amount, as determined by referring to section 352.3(a) of this Part, from the total actual household shelter costs;

(iii) calculate the maximum amount of emergency shelter allowance available to the household by subtracting the appropriate rent schedule amount, as determined by referring to section 352.3(a) of this Part, from the maximum allowance authorized by paragraph (2) of this subdivision for the total number of persons in the household; and

(iv) subtract the SSI benefits and other income of the SSI eligible persons from the sum of the amount calculated in accordance with the provisions of subparagraph (ii) or subparagraph (iii) of this paragraph, whichever is less, and the incremental non-shelter public assistance standard of need of the SSI eligible persons. The resulting amount, if greater than zero, is the household’s emergency shelter allowance. This allowance is added to the public assistance grant determined in accordance with subparagraph (i) of this paragraph.

(4) When necessary, social services districts must:

(i) address the social services needs of a person in receipt of an emergency shelter allowance through the direct provision of services or through the provision of appropriate information and referral services; efforts should be made to ensure that an applicant for or a recipient of such an allowance has established appropriate social and medical support networks;

(ii) assist an applicant for or a recipient of an emergency shelter allowance to secure the required documentation so that eligibility for such allowance can be determined; and

(iii) arrange for required face-to-face interviews to be conducted during home visits or at other appropriate sites. In accordance with department regulations, designation representatives may file and sign application and recertification documents on behalf of an applicant for or a recipient of an emergency shelter allowance.]
[352.4 Shelter costs for applicant/recipient-owned property.]

(a) Purchase of interest in low cost housing development.

(1) A social services official may approve a grant, not to exceed $2,500 toward the purchase of an interest in a cooperative unit in a low cost housing development.

(2) The social services official must require assignment of applicant's/recipient's equity in such cooperative housing.

(b) Carrying charges.

On applicant/recipient-owned property used as a home, carrying charges must be met in the amount actually paid by the applicant/recipient, but not in excess of the appropriate maximum of the rent schedule, for the items of taxes; interest on mortgage; fire insurance; and garbage disposal, sewer and water assessments.

(c) Amortization.

The amounts required to amortize a mortgage on the applicant's/recipient's property must be included in the carrying charges when property is income-producing and the resulting carrying charges do not exceed the property income by an amount in excess of the maximum of the established rent schedule or when property is not income-producing but it is essential to retain the home of the applicant/recipient and the resulting carrying charges do not exceed the appropriate maximum of the established rent schedule.

(d) Property repairs.

The cost of property repairs must be met when:

(1) the property is income-producing and the repairs are essential to retain that status; or

(2) the repairs are essential to the health or safety of the applicant/recipient.

(e) Shelter costs of property deeded to social services official.

(1) Property on which a social services official has taken a deed under the provisions of section 106 of the Social Services Law may be used to shelter a public assistance recipient whether it be the recipient who conveyed such property or other recipient.]

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Supersedes TN #04-0001 Effective Date January 1, 2014
[(2) Except in cases when property is used to shelter a surviving spouse of a former recipient who conveyed such property, it must be used to shelter other recipients only for a period of one year subsequent to the date of the death of the recipient who conveyed such property. After the expiration of a six-month period from such date of death but on or before the expiration of such one year, appropriate action must be taken to initiate a sale of such property in accordance with the provisions of section 106 of the Social Services Law.

(3) In cases in which property conveyed to a social services official is used to shelter a recipient other than the recipient who conveyed such property or his surviving spouse, a reasonable rental for such shelter must be determined. Such reasonable rental must be included in the grant of assistance of the recipient sheltered in such property and the net amount of such rent, in excess of all carrying charges paid for by the social services district, must be credited to the amount required to redeem the property as provided in section 106 of the Social Services Law.

352.5 Energy assistance.

(a) Tenant and customer of record requirements.

Prior to granting energy assistance under subdivisions (b) through (g) of this section, it must be documented that the applicant/recipient/grantee is the tenant and customer of record. A tenant of record is a person who has primary responsibility for payment of the monthly rent or mortgage for the dwelling unit. Individuals who contribute a portion of the monthly rent/mortgage to a person responsible for payment of the monthly rent/mortgage for the dwelling unit will not be considered a tenant of record. A customer of record is a person who has an account in his or her name with a home energy vendor. An individual who is not the tenant and customer of record considered to meet the tenant and customer of record requirement(s) when such individual is the spouse of the tenant and customer of record who is living in the same household or who is the surviving spouse of a deceased spouse who was the tenant and customer of record. The term home energy vendor means an individual or entity engaged in the business of selling electricity, natural gas, oil, propane, kerosene, coal, wood, or any other fuel used for residential heating and/or domestic (lights, cooking, hot water) energy.]

TN #13-0053
Supersedes TN #04-0001
Approval Date June 26, 2014
Effective Date January 1, 2014
[(b) Fuel for heating allowances.]

Each social services district must grant an allowance for fuel for heating to a public assistance applicant/recipient or self-maintaining grantee in receipt of public assistance for a dependent child or children when it is documented that the applicant/recipient/grantee is the tenant of record, as defined in subdivision (a) of this section, with primary responsibility for payment of the residential heating costs. A fuel for heating allowance must also be granted to a public assistance applicant/recipient/grantee whose utility heating bill may include costs for service for the applicant/recipient/grantee’s own residential unit and for space outside that unit or whose non-utility heating bill includes costs for the applicant/recipient/grantee’s own residential unit and for other residential units when it is documented that the applicant/recipient/grantee is the tenant and customer of record as defined in subdivision (a) of this section. When a fuel for heating allowance is granted to an applicant/recipient/grantee who is the customer of record for a utility bill which may include costs for service for the applicant/recipient/grantee’s own residential unit and for space outside that unit, the social services district must determine whether a referral for a shared meter investigation, in accordance with the provisions of section 52 of the Public Service Law, is appropriate. A fuel for heating allowance is not granted to an applicant/recipient/grantee budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) of this Part. To have primary responsibility for the payment of residential heating costs, the applicant/recipient/grantee must be the customer of record, as defined in subdivision (a) of this section, for the residential heating bill with a home energy vendor. Fueled for heating allowances must be provided on a 12-month heating season (October 1st to September 30th) in accordance with the following schedules and must be based upon the applicant/recipient/grantee’s primary residential heating source:

**SCHEDULE SA-6a**

**MONTHLY ALLOWANCES FOR FUEL FOR HEATING**

**BEGINNING OCTOBER 1, 1987:**

*Oil, Kerosene, Propane*

| Counties of: Nassau, New York City, Suffolk, Westchester |
| Number of persons | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8+ |
| 12 month | $70 | 70 | 70 | 73 | 77 | 82 | 88 | 93 |

| Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster |
| Number of persons | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8+ |
| 12 month | $68 | 68 | 68 | 71 | 74 | 80 | 85 | 91 |
### counties of: Columbia, Erie, Genesee, Livingston, Monroe, Niagara, Onondaga, Ontario, Orleans, Oswego, Wayne

<table>
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<td>$75</td>
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### counties of: Albany, Cayuga, Chemung, Greene, Schenectady, Schuyler, Seneca, Tompkins, Yates

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### counties of: Clinton, Lewis, Oneida, St. Lawrence

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### counties of: Essex, Franklin, Hamilton, Herkimer

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### Schedule SA-6b

**Monthly Allowances for Fuel for Heating**

**Beginning October 1, 1987**

**Natural Gas, Coal, Wood, Municipal Electric Utilities**

*not Regulated by the Public Service Commission*

*Any Other Fuel not Covered by SA-6a and SA-6c*

### Counties of: Nassau, New York City, Suffolk, Westchester

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### Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster

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### New York 1a-22

#### Counties of: Columbia, Erie, Genesee, Livingston, Monroe, Niagara, Onondaga, Ontario, Orleans, Oswego, Wayne

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#### Counties of: Albany, Cayuga, Chemung, Greene, Schenectady, Schuyler, Seneca, Tompkins, Yates

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**SCHEDULE SA-6c**

**MONTHLY ALLOWANCES FOR FUEL FOR HEATING**

**BEGINNING OCTOBER 1, 1987**

**Public Service Commission-Regulated Electric Utilities, Village of Greenport Electric**

#### Counties of: Nassau, New York City, Suffolk, Westchester

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#### Counties of: Chautauqua, Dutchess, Orange, Putnam, Rockland, Ulster

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**TN #13-0053**

**Supersedes TN #04-0001**

**Approval Date** June 26, 2014

**Effective Date** January 1, 2014
(c) Payment essential to obtain non-utility heating fuel for an applicant for family assistance (FA), safety net assistance (SNA), veteran assistance or emergency public assistance. The district must authorize a nonrecoupable payment to an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance for non-utility (other than natural gas or electricity) heating fuel, including an applicant whose non-utility heating bill includes costs for the applicant’s own residential unit and for other residential units, provided such payment is necessary to obtain non-utility heating fuel essential for the applicant’s residential heating purposes. Such payment may only be made when it is documented that the applicant is the tenant of record and the customer of record, as defined in subdivision (a) of this section, and alternative payment or housing accommodations cannot be arranged and the applicant is without liquid resources to pay for such non-utility heating fuel. Such payment must not exceed the cost of non-utility heating fuel required to meet the applicant’s immediate need. However, once an initial payment has been authorized for an applicant whose non-utility heating bill includes costs for the applicant’s own residential unit and for other residential units, subsequent emergency payments to obtain non-utility heating fuel for that applicant may only be authorized for deliveries made on an alternate basis with the other unit(s) sharing the fuel source. Prior to issuing payment for each subsequent delivery, it must be documented that heating fuel in amounts reasonably comparable to the most recent delivery paid for by the social services district has been provided by or on behalf of the other unit(s) sharing the fuel source. When the alternate delivery requirement has not been met or cannot be
[documented, the social services district must address the applicant’s hearing emergency with alternative methods. These methods include, but are not limited to, the following: referrals to services and/or other agencies; exploration of alternative housing; exploration of other funding sources (including HEAP); or the lending of safe supplemental heating devices. Documentation of need for the social services district payment must be fully recorded in the applicant’s case file.

(d) Payment essential to obtain non-utility heating fuel. This subdivision applies to recipients of family assistance, safety net assistance, veteran assistance or self-maintaining grantees in receipt of family assistance or safety net assistance on behalf of dependent children and in receipt of fuel for heating allowances as outlined in subdivision (b) of this section. An advance allowance subject to recoupment, in accordance with section 352.11 of this Part, must be authorized for such recipient or grantee when it is documented that the recipient/grantee is the tenant and customer of record for the residential heating bill, as defined in subdivision (a) of this section, and when the recipient/grantee has made a request in writing for such an allowance and also has requested in writing that the monthly grant be reduced to recover the advance allowance. This provision is applicable in those cases where the recipient/grantee’s non-utility heating bill includes costs for the recipient/grantee's own residential unit and for other residential units. Once an initial payment has been authorized for a recipient/grantee whose non-utility heating bill includes costs for the recipient/grantee’s own residential unit and for other residential units, subsequent payments to obtain non-utility heating fuel for that recipient/grantee may only be authorized for deliveries made on an alternate basis with the other unit(s) sharing the fuel source. Prior to issuing payment for each subsequent delivery, it must be documented that heating fuel in amounts reasonably comparable to the most recent delivery paid for by the social services district has been provided by or on behalf of the other unit(s) sharing the fuel source. When the alternate delivery requirement has not been met or cannot be documented, the social services district must address the recipient/grantee’s heating emergency with alternative methods. These methods include, but are not limited to, the following: referrals to services and/or other agencies; exploration of alternative housing; exploration of other funding sources (including HEAP); or lending of safe supplemental heating devices.

(e) Payment essential to continue or restore utility service for an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance. A payment must be made for utilities previously provided to an applicant for family assistance, safety net assistance, veteran assistance or emergency public assistance if such payment is essential to continue or restore utility service. Payment essential to continue or restore utility service may be provided to an applicant whose utility bill includes costs for service for the applicant's own residential unit and for space outside that unit. Payment may only be made when it is documented that the applicant is the tenant of record and the customer of record as defined in subdivision (a) of this section, and]
[alternative payment or housing accommodations cannot be made and the applicant is without liquid resources to continue or restore utility service. Payment must not exceed the cost of utilities provided to the applicant during the four most recently completed monthly billing periods or two most recently completed bi-monthly billing periods for which a bill has been issued immediately preceding the date of application for such assistance. Payment is limited to the applicant's proportionate share of the cost of service for the most recently completed four monthly or two most recently completed bi-monthly billing periods for which a bill has been issued immediately preceding the date of application for such assistance when the applicant's utility bill includes costs for service for the applicant's own residential unit and for space outside that unit. Payment must not exceed the balance due on the account. In a shared meter situation subject to the provisions of section 52 of the Public Service Law, the proportionate share is to be determined by the utility company's apportionment of retroactive charges upon completion of a shared meter investigation and determination. As a condition of receiving such assistance, an applicant not in receipt of recurring public assistance or supplemental security income whose gross monthly household income on the date of application exceeds the public assistance standard of need for the same size household must sign an agreement to repay the assistance within one year of the date of the payment. A household consists of all persons who occupy a housing unit. A house, an apartment or other group of rooms, or a single room is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters. A household includes related family members and all unrelated persons, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone, or a group of unrelated persons sharing a housing unit as partners, also constitutes a household. The public assistance standard of need is determined by applying the following statewide standards of need in accordance with office regulations: the pre-add allowance as set forth in Schedule SA-2a of section 352.3 of this Part; the shelter allowance as paid, but not to exceed the maximum allowance set forth in section 352.3 of this Part; the fuel allowance set forth in Schedule SA-6a, SA-6b or SA-6c of section 352.5 of this Part, if the applicant is the tenant of record and customer of the record for residential heating bill; the home energy and supplemental home energy payments (HEA and SHEA) as set forth in schedule SA-2b or SA-2c of section 352.1 of this Part; and, if applicable, the additional cost of meals for persons unable to prepare meals at home as set forth in schedule SA-5 of section 352.7 of this Part. The repayment agreement must set forth a schedule of payments that will assure repayment within one year of the date of payment. Subsequent assistance to continue or restore utility service must not be provided unless any prior utility arrearage payments have been repaid or are being repaid in accordance with the schedule of payments contained in each prior repayment agreement as of the date of application for such subsequent assistance. Repayment agreements under this subdivision may be enforced in any manner available to a creditor, in addition to any other remedy the district may have pursuant to the Social Services Law.]
[(f) Payment essential to continue or restore utility service for a recipient of family assistance, safety net assistance, veteran assistance, or self-maintaining grantee in receipt of public assistance for dependent children and in receipt of a home energy allowance and supplemental home energy allowance (HEA and SHEA) and/or a fuel for heating allowance, as defined in subdivision (b) of this section. For purposes of this subdivision, the term recipient is defined as: a recipient of family assistance, safety net assistance, veteran assistance, or a self-maintaining grantee in receipt of public assistance on behalf of dependent children and in receipt of a HEA and SHEA and/or a fuel for heating allowance, as defined in subdivision (b) of this section.

(1) A payment must be made for utilities previously provided to a recipient of family assistance, safety net assistance, veteran assistance or grantee in receipt of public assistance for dependent children and in receipt of an HEA and SHEA and/or a fuel for heating allowance, as defined in subdivision (b) of this section if such payment is essential to continue or restore utility service. Payment essential to continue or restore utility service may be provided to a recipient whose utility bill includes costs for service for the recipient's own residential unit and for space outside that unit. Payment may only be granted when it is documented that the recipient/grantee is the tenant and customer of record, as defined in subdivision (a) of this section and when alternative payment or housing accommodations cannot be made and the recipient is without liquid resources to continue to restore utility service. Payment must not exceed the cost of utilities provided to the recipient for the four most recently completed monthly billing periods or two most recently completed bi-monthly billing periods in which service was rendered within the 10 monthly or five bi-monthly most recently completed billing periods immediately preceding the date of request for such assistance. When the recipient's utility bill includes costs for service for the recipient's own residential unit and for space outside that unit, payment is limited to the recipient's proportionate share of the cost of service for the time frames outlined above. In a shared meter situation subject to the provisions of section 52 of the Public Service Law, the proportionate share is to be determined by the utility company's apportionment of retroactive charges upon completion of a shared meter investigation and determination. Payment must not exceed the balance due on the account and must be provided in accordance with the provisions of paragraphs (2), (3) and (4), (5), (6), and (7) of this subdivision.

(2) Payment must be provided as a nonrecoupable grant when it is documented that during the period specified in paragraph (1) of this subdivision the recipient has fully applied the public assistance grant to purposes intended to be included in such grant. Such documentation for recipients not budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) of this Part must include proof of payment of: an amount at least equal to the combined]
[Home Energy Allowance and supplemental Home Energy Assistance (HEA and SHEA) budgeted in the public assistance grant to domestic (lights, cooking, hot water) energy costs; the monthly fuel for heating allowance budgeted in the public assistance grant to incurred heating costs; and the monthly shelter allowance budgeted in the public assistance grant to shelter costs. In addition, there must be no other evidence of mismanagement. Documentation for recipients budgeted in accordance with the provisions outlined in section 352.3(d)(2)(ii) of this Part must include proof of payment of: an amount at least equal to the combined Home Energy Allowance and Supplemental Home Energy Allowance (HEA and SHEA) budgeted in the public assistance grant to domestic energy costs (lights, cooking, hot water); an amount at least equal to the shelter allowance budgeted in the public assistance grant towards shelter, heating, water, and other shelter-related items covered by the federal Department of Housing and Urban Development utility allowance. In addition, there must be no other evidence of mismanagement.

(3) If such recipient is not eligible for a nonrecoupable grant pursuant to paragraph (2) of this subdivision, or for other available non-recoupable grants including Home Energy Assistance Program benefits, payment must be provided as an advance allowance subject to recoupment in accordance with section 352.11 of this Part.

(4) Whenever a social services district makes an arrearage payment to continue or restore the utility service of a public assistance recipient, the district must also, prospectively for a period of six months or until the case is closed, whichever occurs first, act as a guarantor of the recipient's future utility bills or place the recipient on voucher payment. When the recipient is the customer of record for a utility bill which includes costs for service for the recipient's own residential unit and for space outside that unit, only the recipient's proportionate share of the bill is the prospective responsibility of the social services district.

(5) If the agency uses a voucher payment to meet the prospective responsibility for an FA recipient the agency must be able to document recipient mismanagement. For the purposes of this subdivision, mismanagement is determined in accordance with the provisions outlined in paragraph (2) of this subdivision. In such cases, amounts not to exceed the following are restricted from the recipient's grant:

(i) if the recipient's utility bill represents "heat only," and the recipient does not reside in or is not budgeted in accordance with the Section 8 certificate housing provisions outlined in section 352.3(d)(2)(ii) for this Part, the recipient's monthly fuel for heating allowance is removed from the recipient's monthly grant. If the recipient's utility bill represents "heat only"

TN #13-0053 Supersedes TN #04-0001 Approval Date June 26, 2014 Effective Date January 1, 2014
[and the recipient does reside in Section 8 certificate housing or is budgeted in accordance with section 352.3(d)(2)(ii) of this Part, the balance of the shelter allowance minus the actual rent obligation, up to an amount equal to the appropriate fuel allowance schedule set forth in subdivision (b) of this section for the appropriate heating type and public assistance household size, is removed from the grant. Heating costs paid by the district which exceed the amount removed from the recipient’s grant are considered to be overpayments subject to recoupment in accordance with section 352.31 (d) of this Part;

(ii) if the recipient’s utility bill represents domestic costs only (lights, cooking, hot water), the recipient’s Home Energy Allowance and Supplemental Home Energy Allowance (HEA and SHEA) or the average monthly cost of the recipient’s domestic utility service, whichever is less, is removed from the recipient’s grant. Domestic energy costs paid by the district which exceed the amount removed from the grant must be considered to be overpayments subject to recoupment in accordance with section 352.31(d) of this Part.

(iii) if the recipient’s utility bill represents heat and domestic costs, a combination of the amounts outlined in subparagraphs (i) and (ii) of this paragraph is removed from the grant. If the recipient’s combined heat and domestic costs exceed the amounts removed from the recipient’s grant, the balance must be considered an overpayment subject to recoupment in accordance with section 352.31(d) of this Part.

(6) If the agency uses a vendor payment to meet the prospective responsibility for an SNA recipient, the agency may do so in accordance with section 381.3(c)(2) of this Title.

(7) When a recipient has been placed on vendor payment, whereby the social services district pays the energy vendor directly, as a result of mismanagement by the recipient or for administrative ease, the district must at least annually, at case closing, and upon termination of the vendor payment arrangement, determine if there has been an under/overpayment. Identified underpayments/overpayments are to be reconciled in accordance with section 352.31 (d), (e), and/or (f) of this Part.

(g) For recipients with heating costs in excess of their annual allowance provided pursuant to the schedules set forth in this section, the district should explore the possibility of alternative housing (renters only) and/or weatherization/conservation services.]
(2) Recipients who retain responsibility for the payment of their own heating bills should be made aware of and encouraged to use budget billing programs offered by their heating vendors.

(3) When the heating and/or domestic energy bill of a public assistance recipient/grantee has been placed on vendor payment as a result of a mismanagement determination, voluntary request, or administrative easy provision, the district must determine if there has been an under/overpayment. This reconciliation must be conducted at least annually, at case closing, and upon termination of the vendor payment arrangement. Identified under/overpayments are to be reconciled in accordance with section 352.31(d), (e), and/or (f) of this Part.

(h) The social services official must designate a staff member to function as a liaison to energy vendors, other agencies, and to individuals seeking energy-related information and/or assistance.

(i) The social services official must ensure that 24 hour/seven day a week referral capability exists for receipt of referrals from energy vendors, outside agencies, and individuals with energy related emergencies. The official may either designate social services district staff to be available on a 24 hour, seven days a week basis or may choose to designate an agency/organization in the community which agrees to accept calls after normal business hours and on weekends and to assist a referred household in the temporary alleviation of a life threatening energy emergency until the household can make application for financial assistance on the next normal business day.

352.6 Miscellaneous shelter allowances and grants.

(a) (1) A social services official must provide funds for household moving expenses utilizing the least costly practical method of transportation, a rent security deposit, and/or a brokers’ or finders’ fee only when, in his judgment, one of the following conditions exists:

(i) the move is to a less expensive rental property and the amount paid for a security deposit and moving expenses is less than the amount of a two-year difference in the rentals; or

(ii) the move is necessitated by one of the following criteria:

(a) the need to move results from a disaster/catastrophe and/or a vacate order placed against the premises by a health agency or code enforcement agency;]
[(b) the move is necessitated by a serious medical or physical handicap condition. Such need must be verified by specific medical diagnosis;

(c) the individual or family is rendered homeless as a result of having been put out by another occupant with whom they were sharing accommodations;

(d) the move is from temporary to permanent housing;

(e) the move is from permanent housing to temporary housing whenever necessary due to the unavailability of permanent housing;

(f) the move is from one temporary accommodation to another temporary accommodation whenever necessary due to the unavailability of permanent housing;

(g) the move is from an approved relocation site or to an approved cooperative apartment; or

(h) there is a living situation which adversely affects the mental or physical health of the individual or family, and the need for alternative housing is urgent, and not issuing a security deposit, moving expenses and/or brokers’ or finders’ fees would prove detrimental to the health, safety and well-being of the individual or family.

(2) A security deposit and/or brokers’ or finders’ fees must be provided only when an applicant or recipient is unable to obtain a suitable vacancy without payment of such allowances.

(3) Documentation of the need for a security deposit, moving expenses and/or brokers’ or finders’ fees must be fully recorded in the case record.

(b) Avoidance of abuses in connection with rent security deposits.

(1) Whenever a landlord requires that he be secured against nonpayment of rent or for damages as a condition to renting a housing accommodation to a recipient of public assistance, a local social services official may secure the landlord by either of the following means:

   (i) by means of an appropriate agreement between the landlord and the social services official; or]
[ii] by depositing money in an escrow account, not under the control of the landlord or landlord's agent, subject to the terms and conditions of an agreement between the landlord and the social services official in such form as the department may require or approve; provided, however, that the provisions of this subparagraph do not apply where a public assistance recipient resides in public housing.

(2) A social services official may not pay money to a landlord to be held as a security deposit against the payment of rent or for damages by a public assistance recipient, or issue a grant to a recipient of public assistance therefor, except as provided in paragraph (3) of this subdivision.

(3) When, in the judgment of a social services official, housing accommodations available in a particular area are insufficient to accommodate properly recipients of public assistance in need of housing, and in order to secure such housing, it is essential that the official pay money to landlords to be held as security deposits against the non-payment of rent or for damages by public assistance recipients or to issue grants to recipients of public assistance therefor, such social services official may pay or furnish funds for such security deposits until sufficient housing accommodations are available in the particular area to accommodate properly recipients of public assistance in need of housing. Social services officials must not pay or furnish such funds where recipients of public assistance reside in public housing. In no case will temporary residence in a shelter, including those defined in Parts 900 or 1000 of this Title, a hotel/motel or any other such emergency or transitional residential facility be considered sufficient housing accommodations for purposes of this paragraph. Landlords receiving such security deposits must comply with the provisions of article seven of the General Obligations Law. The recipient is required to assign to the social services official any right the recipient may have to the return of the security deposit and interest accrued thereon. Any social services official paying or furnishing funds for a security deposit in accordance with this paragraph must make diligent efforts to recover such payments or funds from the landlord as allowed by law. Such efforts must not delay recoupment or recovery from a recipient if recoupment or recovery from the recipient is required by this section.]
**[(c) Recovery of rent security payments.](#)**

(1) If as a result of non-payment of the shelter allowance, the security deposit or security agreement for non-payment of rent is required to be paid to the landlord, such payment must be considered to be an overpayment made to the recipient and as such, must be recovered according to the provisions of section 352.31(d) of this Part. If rent has not been paid due to a legitimate landlord/tenant dispute, a rent strike or as a result of the application of Section 143-b of the Social Services Law, such payment is not an overpayment and cannot be recouped or recovered.

(2) When a security deposit or monies under a security agreement are paid to a landlord for damages caused by a recipient, such payment must be considered an overpayment and must be recovered from a recipient pursuant to the provisions of section 352.31(d) of this Part provided that a social services official has conducted (or arranged for) a pre-tenancy and post-tenancy inspection or survey of the premises, or verified by some other means that the damages were caused by the recipient. The condition of the premises when the recipient moves and when the recipient moves out must be documented and agreed to by signature of the landlord and the recipient. If the verification does not confirm that there are damages caused by the recipient, then cash much not be issued under a security agreement or, if a cash security deposit had been issued and the landlord retains it for alleged damages, the social services official must attempt to recover the deposit from the landlord. When the verification confirms that the recipient caused the damages, the district must recover the deposit amount from the recipient.

(d) When non-payment of the shelter allowance or client-caused damages, as confirmed by a pre-tenancy inspection and post-tenancy inspection or survey conducted by the social services district or by some other means of verifying that the damages were caused by the recipient pursuant to paragraph (2) of subdivision (c) of this section necessitates the authorization of finders’ or brokers’ fees, or household moving expenses, such payments must be considered to be overpayments made to the recipient and as such, must be recovered according to the provisions of section 352.31(d) of this Part. If rent has not been paid due to a legitimate landlord/tenant dispute, a rent strike or as a result of the application of Section 143-b of the Social Services Law, such payments are not overpayments and cannot be recouped or recovered.

(e) Unless prohibited by State or federal law or regulation, an allowance for expenses, not otherwise authorized under this title, for the repair, maintenance or retention of housing occupied by, but not owned by, a recipient of public assistance must be paid when necessary for the health and safety of the recipient and his or her family, when other appropriate housing is not available and when the payment is necessary to permit the recipient and his or her family to remain in the housing. An allowance for expenses for]
[repair and maintenance must be paid only when the owner of the housing is not obligated to provide the repair or maintenance. An allowance under this subdivision does not include payments for utility deposits for gas and electricity, payments covered under subdivision (b) of this section, payments for rent, property taxes or mortgage arrears and payments for litigation costs of any kind, including attorney’s fees.

(f) An allowance for storage of furniture and personal belongings must be made when it is essential, for circumstances such as relocation, eviction or temporary shelter, so long as eligibility for public assistance continues and so long as the circumstances necessitating the storage continue to exist.

352.7 Allowances and grants for other items of need.

(a) Furnishings.

(1) If provision therefore cannot otherwise be made, each social services district must provide for the purchase of necessary and essential furniture, furnishings, equipment and supplies required for the establishment of a home for persons in need of public assistance. For purposes of this subdivision, such an allowance must be provided only when, in the judgment of the social services official, one of the following conditions exists:

(i) An individual or family temporarily housed in a hotel, motel, homeless shelter, residential program for victims of domestic violence or other temporary accommodation to which the individual or family has been referred by the social services district is being permanently rehoused in unfurnished housing accommodations, and suitable furnished accommodations are not available.

(ii) An unattached individual, whose needs cannot otherwise be met under Part 397 of this Title is discharged from an institution, is determined to be capable of maintaining an apartment in the community and suitable furnished accommodations are not available.

(iii) An adult whose needs cannot otherwise be met under Part 397 of this Title, is discharged from an institution and wishes to rejoin his family, which is in need of additional furniture to provide adequate shelter for him.

(iv) A child is returned to his parents, who are in need of additional furniture to provide adequate shelter for him.]
[(v) An individual’s or family’s living situation adversely affects the physical and mental health of that individual or family, and it is essential that the individual or family be rehoused in unfurnished housing accommodations in order to safeguard his or their health, safety and well-being.

(2) An allowance provided under paragraph (1) of this subdivision may not exceed the amounts authorized for the appropriate rooms and items in the following schedule:

**SCHEDULE SA-4a**

**INITIAL OR REPLACEMENT COST OF ESSENTIAL HOUSEHOLD FURNITURE, FURNISHINGS, EQUIPMENT AND SUPPLIES**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Room</td>
<td>$182</td>
</tr>
<tr>
<td>Bedroom</td>
<td></td>
</tr>
<tr>
<td>with a single bed</td>
<td>$145</td>
</tr>
<tr>
<td>with two single beds</td>
<td>$205</td>
</tr>
<tr>
<td>with double bed</td>
<td>$184</td>
</tr>
<tr>
<td>Kitchen</td>
<td></td>
</tr>
<tr>
<td>(excluding appliances)</td>
<td>$142 (plus $12 for each additional person)</td>
</tr>
<tr>
<td>Range</td>
<td>$182</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>$182 (or $258 for four or more persons)</td>
</tr>
<tr>
<td>Bathroom</td>
<td>$6 (plus $4 for each additional person)</td>
</tr>
<tr>
<td>Other equipment</td>
<td></td>
</tr>
<tr>
<td>Cabinet for linens</td>
<td>$22</td>
</tr>
<tr>
<td>Stove for heating</td>
<td>$72 (or $82 for five or more persons)</td>
</tr>
</tbody>
</table>

(3) Documentation of the need for such furniture must be fully recorded in each case record.

(b) **Equipment repairs.**

Each social services district must provide for the essential repair of heating equipment, cooking stoves and refrigerators used by persons in need of public assistance in their homes, provided provision therefor cannot otherwise be made except that replacement may be authorized when less expensive than repair. Such allowances for cooking stoves and refrigerators cannot exceed the amount authorized under schedule SA-4a.

(c) **Additional cost of meals.**

Each social services district must provide for the additional costs of meals for persons unable to prepare meals at home or who do not otherwise receive meals in their residences in accordance with the following schedule:]

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #04-0001 Effective Date January 1, 2014
RESTAURANT ALLOWANCE

Monthly allowances to be added to appropriate monthly grants and allowances for combinations of restaurant meals and meals prepared at home or meals otherwise provided in the residence, including sales tax.

Dinner in a restaurant $29.00
Lunch and dinner in a restaurant $47.00
All meals in a restaurant $64.00

Additional special restaurant allowance as described below.

Effective November 1, 1986, a special monthly restaurant allowance of an additional $36 must be granted to any pregnant woman or person under 18 years of age, or any person under 19 years of age who is a full-time student regularly attending a secondary school or in the equivalent level of vocational or technical training if, before such person attains age 19, such person may reasonably be expected to complete the program of such secondary school or training.

HOME DELIVERED MEALS

Monthly allowances to be added to appropriate monthly grants and allowances.

Extra allowance $36.00

(d) Replacement of clothing or furniture. Each social services district must provide for partial or total replacement of clothing or furniture which has been lost in a fire, flood or other like catastrophe, provided such needs cannot otherwise be met through assistance from relatives or friends or from other agencies or other resources. Such allowances must not exceed the amounts authorized under schedules SA-4a and SA-4b.

SCHEDULE SA-4b
REPLACEMENT COST OF CLOTHING

Birth through 5 years $48.00
6 through 11 years $73.00
12 through adult $89.00

(e) Reserved.]

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #04-0001 Effective Date January 1, 2014
Payment for services and supplies already received. Assistance grants must be made to meet only current needs. Under the following specified circumstances payment for services or supplies already received is deemed a current need:

(1) **Replacement of lost or stolen checks.**

(i) If an applicant or recipient reports to a local social services official that a check has been lost or stolen, an affidavit of loss much be required of the recipient, and payment of the check must be stopped: If the recipient has not already done so, he must be required by the local social services official to report the loss or theft to the police, to obtain from them the blotter entry number, or classification number, or file number or other available evidence of the reporting, and to furnish such evidence to the local social services official. When satisfied that such police report has been made, the local social services official must issue a replacement check to the recipient, on which there must appear above the place for the recipient’s signature, the following: “By endorsing or cashing this check I acknowledge that this is a replacement for a check, number dated drawn to my order on which was lost/stolen, that I have not received the proceeds of said check directly or indirectly; and that I have been informed it is illegal for me to cash said check, and if I do so, I am liable to prosecution.”

(ii) If payment is not stopped on the original check and it and the replacement check are both cashed, only one must be subject to State reimbursement, and the social services district must limit its claim for State reimbursement to one of the two checks.

(iii) If it is established that a recipient endorsed and cashed an allegedly lost or stolen check which has been replaced, the amount of such check must be recovered from the recipient as provided for by the provisions of the regulations of this department.

(2) **Replacement of electronic benefits.**

When a recipient claims that he or she has not received electronic cash public assistance benefits which the Department’s computer issuance record indicated were issued, the social services district must verify the validity of the computer issuance record in accordance with procedures established by the Department. If it is verified that a valid issuance transaction occurred, the benefits cannot be replaced. If it is determined that a valid issuance transaction did not occur, the benefits must be restored in accordance with section 352.31(f) of this Part.]
A grant may be made to pay for rent, property taxes or mortgage arrears for the time prior to the month in which the public assistance case was opened or for applicants for emergency assistance under Parts 370 and 372 of this Title only when:

(i) such payment is essential to forestall eviction or foreclosure and no other shelter accommodations are available; or

(ii) the health and safety of the applicant is severely threatened by failure to make such payment; and

(iii) the authorization for the payment receives special written approval by the social services official or such other administrative officer as he or she may designate, provided such person is higher in authority than the supervisor who regularly approves authorization.

(iv) the applicant reasonably demonstrates an ability to pay shelter expenses, including any amounts in excess of the appropriate local agency maximum monthly shelter allowance, in the future. However, when in the judgment of the local social services official, the individual or family has sufficient income or resources to secure and maintain alternate permanent housing, shelter arrears need not be paid to maintain a specific housing accommodation;

(v) such payment does not exceed the local agency maximum monthly shelter allowance. A district may, consistent with subparagraph (iv) of this paragraph, issue a grant for arrears in excess of the maximum monthly shelter allowance. However, any amount above the local agency maximum monthly shelter allowance paid towards the monthly arrears is an overpayment subject to recovery and recoupment in accordance with section 352.31 of this Part;

(vi) the applicant, if accepted for on-going public assistance, agrees to future restriction of shelter payments in accordance with Part 381 of this Title; and

(vii) in the case of an applicant who is not eligible for Safety Net Assistance, Family Assistance, Emergency Assistance to Families or Emergency Assistance to Adults, such applicant is without income or resources immediately available to meet an emergency need, such applicant’s gross household income at the time of application does not
[exceed 125 percent of the federal income official poverty line as defined and annually revised by the Federal Office of Management and Budget, and such applicant signs an agreement to repay the assistance in a period not to exceed 12 months from receipt of such assistance. The repayment agreement must set forth a schedule of payments that will assure repayment within the 12 month period, and must specify the frequency of the payments, the due date of the first payment, the address where payments must be made and the consequences of failing to repay the assistance as agreed. Subsequent assistance to pay arrears may not be granted unless there are not past-due amounts owed under any such repayment agreement. The social services district, in addition to any rights it has pursuant to the Social Services Law, may enforce the repayment agreement in any manner available to a creditor.

(4) A recipient of family assistance or safety net assistance who is threatened with eviction or foreclosure or who is being evicted or whose property is being foreclosed upon for non-payment of rent, mortgage or taxes incurred during a period for which a grant had been previously issued to the recipient may be provided with an advance allowance for rent, mortgage principal and interest payments or taxes in accordance with section 352.11 of this Part. Advance investigation of the need for restricted payments must be conducted in accordance with Part 381 of this Title. An allowance for rent, mortgage principal and interest payments or taxes which exceeds the appropriate local agency maximum monthly shelter allowance can be made only if all of the following conditions are met:

(i) notwithstanding section 352.23(b) of this Part, the recipient agrees to use all available liquid resources for the payment of shelter expenses necessary to prevent eviction or foreclosure;

(ii) the recipient demonstrates an ability to pay shelter expenses in the future, including any amounts in excess of the appropriate local agency maximum monthly shelter allowance;

(iii) the recipient agrees to future restriction of rent or mortgage payments; and

(iv) the recipient has not previously received an allowance pursuant to this paragraph and, subsequent to receiving such allowance, requested discontinuation of restriction of the shelter payments to which he or she agreed pursuant to this paragraph.]
[(h) Chattel mortgages or conditional sales contracts.

If the furniture or household equipment of an applicant, who has not been a recipient of public assistance within the previous six months preceding his application, is essential to making his living accommodations habitable but are presently encumbered by a chattel mortgage or a conditional sales contract, every effort must be made to defer, cancel or reduce payments on such chattel mortgage or conditional sales contract. If all such efforts fail, an allowance may be made for a compromise settlement of such payments or, if a compromise cannot be reached, for other essential payments; provided, however, that the compromise settlement or allowances must not exceed the cost of replacement.

(i) Camp fees.

When funds cannot be obtained from other sources, camp fees may be paid for children receiving FA not in excess of total cost of $400 per child per annum, in amounts not to exceed $200 per week.

(j) Reserved.

(k) Additional needs because of pregnancy.

A monthly allowance of $50 must be added to the appropriate monthly grant and allowance of a needy pregnant woman beginning with the fourth month of pregnancy or the month in which medical verification of pregnancy is presented to the district, whichever is later.

(l) Reserved.

(m) Supplemental payments.

The social services official must provide a monthly allowance to supplement the income of an FA, SNA or VA household when the household experiences a net loss of cash income due to the acceptance of employment by a JOBS participant who is a member of the household, when such acceptance is required by the social services district. A net loss of cash income occurs when the monthly gross income of the household, subtracting necessary actually work-related expenses, is less than the cash assistance the household received in the month in which the offer of employment was made. The supplement must equal the monthly net loss of cash income that would occur if the supplement were not paid to the household.

(1) Gross income includes, but is not limited to, earnings, unearned income and cash assistance.

(2) Cash assistance means the budget deficit as defined in section 352.29 of this part.

(3) Necessary actually work-related expenses are the actual, verifiable and unreimbursed expenses directly related to maintaining employment.]
(i) Such expenses include, but are not limited to:
   
   (a) mandatory payroll deductions such as federal, State and local taxes, social security taxes, disability insurance and union dues;

   (b) tools, materials, uniforms and other special clothing required for the job;

   (c) mandatory fees for licenses or permits fixed by law;

   (d) deductions for medical insurance coverage;

   (e) child care up to the local market rate; and

   (f) transportation, including the cost of transporting children to and from day care, except that the amount for use of a motor vehicle must be computed on a mileage basis at the same rate paid to employees to the social services district and must only be allowed when public transportation is not available.

(ii) Such expenses do not include:

   (a) meals;

   (b) business-related depreciation;

   (c) personal business and entertainment expenses;

   (d) personal (not work related) transportation;

   (e) purchase of capital equipment; and

   (f) payments of the principal of loans.

(n) Burials.

Allowances must be made for burial of applicants for and recipients of public assistance in accordance with section 141 of the Social Services Law.

(o) Removals.

Allowances must be made to applicants for or recipients of public assistance who are removed to another state or country in accordance with section 310.1(h) of this Title. Such allowances can only be made for the reasonable and necessary expenses of such removals, as authorized by section 310.1(h)(2) of this Title.

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #04-0001 Effective Date January 1, 2014
A. Mandatory Categorically Needy (Continued)

3. Children under Section 1902(a)(10)(i)(VI) of the Act who have attained age 1 but have not attained age 6:

   Effective April 1, 1990 based on 133 percent of the official Federal income poverty level (as revised annually in the Federal Register for the size family involved).*

*New York State implemented these provisions effective October 1, 1990.]
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

A. MANDATORY CATEGORICALLY NEEDY (continued)


Based on 100 percent of the official Federal Income Poverty level (as revised annually in the Federal Register for the size family involved.) *

* A State Plan amendment was approved under section 1902(r)(2) to allow for a disregard of income between 100% and 133% of the poverty level for children ages 6 to 18.]

TN #13-0053
Supersedes TN #11-0075
Approval Date June 26, 2014
Effective Date January 1, 2014
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on ______ percent of the official Federal income poverty line.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>$__________</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>$__________</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>$__________</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>$__________</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>$__________</td>
</tr>
</tbody>
</table>

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a “transition period” beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

TN #92-27
Supersedes TN #91-79B

Approval Date January 20, 1993
Effective Date April 1, 1992
C. Qualified Medicare Beneficiaries with Income Related to Federal Poverty Level

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. Non-Section 1902(f) States

   a. Based on the following percent of the Official Federal Income Poverty Level:

      Eff. Jan. 1, 1989: ______ 85 percent 100 percent (no more than 100)
      (as revised annually in the Federal Register for the size family involved.)

      Eff. Jan. 1, 1990: ______ 90 percent ______ percent (no more than 100)

      Eff. Jan. 1, 1991: 100 percent

      Eff. Jan. 1, 1992: 100 percent

   [b. Levels:

      [Family Size     Income Level]

      [_____1_____]      $ 9,310]

      [_____2_____]      $ 12,490]
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: New York

Income Levels (Continued)

D. Medically Needy

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for</th>
<th>Amount by which column (2) exceeds limits specified in 42 CFR 435.1007</th>
<th>Net income for persons living in rural areas for</th>
<th>Amount by which column (4) exceeds limits specified in 42 CFR 435.1007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$[9,900]</td>
<td>10,100</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$[14,500]</td>
<td>14,800</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$[16,675]</td>
<td>17,020</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$[18,850]</td>
<td>19,240</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

☐ Urban Only

☐ Urban & Rural

TN#: #18-0006 Approval Date: 5/08/18

Supersedes TN#: #15-0006 Effective Date: 1/01/18
## D. Medically Needy

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for months.</th>
<th>Amount by which column (2) exceeds limits specified in 42 CFR 435.1007</th>
<th>Net income for persons living in rural areas for months.</th>
<th>Amount by which column (4) exceeds limits specified in 42 CFR 435.1007</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$[21,025] 21,460</td>
<td>$</td>
<td>$</td>
<td>.</td>
</tr>
<tr>
<td>7</td>
<td>$[25,375] 25,900</td>
<td>$</td>
<td>$</td>
<td>.</td>
</tr>
<tr>
<td>8</td>
<td>$[27,550] 28,120</td>
<td>$</td>
<td>$</td>
<td>.</td>
</tr>
<tr>
<td>10</td>
<td>$[31,900] 32,560</td>
<td>$</td>
<td>$</td>
<td>.</td>
</tr>
</tbody>
</table>

For each additional person add $[2,175] 2,220 $ $ $.

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**TN#: #18-0006**

**Approval Date: 5/08/18**

**Supersedes TN#: #15-0006**

**Effective Date: 1/01/18**
New York

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

   a. Mandatory Groups

      [ ] Same as SSI resources levels.
      [X] Less restrictive than SSI resource levels and is as follows:

      | Family Size | Resource Level |
      |-------------|---------------|
      | 1           | No resource test |
      | 2           | No resource test |

   b. Optional Groups

      [ ] Same as SSI resources levels.
      [X] Less restrictive than SSI resource levels and is as follows:

      | Family Size | Resource Level |
      |-------------|---------------|
      | 1           | No resource test |
      | 2           | No resource test |
2. Infants

a. Mandatory Group of Infants

[ ] Same as resource levels in the State’s approved AFDC plan.

[X] Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No resource test</td>
</tr>
<tr>
<td>2</td>
<td>No resource test</td>
</tr>
<tr>
<td>3</td>
<td>No resource test</td>
</tr>
<tr>
<td>4</td>
<td>No resource test</td>
</tr>
<tr>
<td>5</td>
<td>No resource test</td>
</tr>
<tr>
<td>6</td>
<td>No resource test</td>
</tr>
<tr>
<td>7</td>
<td>No resource test</td>
</tr>
<tr>
<td>8</td>
<td>No resource test</td>
</tr>
<tr>
<td>9</td>
<td>No resource test</td>
</tr>
<tr>
<td>10</td>
<td>No resource test</td>
</tr>
</tbody>
</table>

TN #13-0053 Approval Date June 26, 2014
Supersedes TN #91-0078B Effective Date January 1, 2014
b. Optional Group of Infants

[X] Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No resource test</td>
</tr>
<tr>
<td>2</td>
<td>No resource test</td>
</tr>
<tr>
<td>3</td>
<td>No resource test</td>
</tr>
<tr>
<td>4</td>
<td>No resource test</td>
</tr>
<tr>
<td>5</td>
<td>No resource test</td>
</tr>
<tr>
<td>6</td>
<td>No resource test</td>
</tr>
<tr>
<td>7</td>
<td>No resource test</td>
</tr>
<tr>
<td>8</td>
<td>No resource test</td>
</tr>
<tr>
<td>9</td>
<td>No resource test</td>
</tr>
<tr>
<td>10</td>
<td>No resource test</td>
</tr>
</tbody>
</table>
3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

[ ] Same as resource levels in the State’s approved AFDC plan.

[X] Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No resource test</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

[ ] Same as resource levels in the State’s approved AFDC plan.

[X] Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No resource test</td>
</tr>
<tr>
<td>2</td>
<td>No resource test</td>
</tr>
<tr>
<td>3</td>
<td>No resource test</td>
</tr>
<tr>
<td>4</td>
<td>No resource test</td>
</tr>
<tr>
<td>5</td>
<td>No resource test</td>
</tr>
<tr>
<td>6</td>
<td>No resource test</td>
</tr>
<tr>
<td>7</td>
<td>No resource test</td>
</tr>
<tr>
<td>8</td>
<td>No resource test</td>
</tr>
<tr>
<td>9</td>
<td>No resource test</td>
</tr>
<tr>
<td>10</td>
<td>No resource test</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIIX OF THE SOCIAL SECURITY ACT

4. **Aged and Disabled Individuals**

[ ] Same as SSI resource levels.

[ ] More restrictive than SSI levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

[X] Same as medically needy resource levels (applicable only if State has a medically needy program)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Resource Levels (Continued)

B. Medically Needy

[Applicable to all groups-

Except those specified below under the provision of section 1902(f) of the Act.]

The annual Medically Needy resource standard is equal to 150% of the annual Medically Needy income standard, by family size.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

New York State allows all medical expenses in accordance with 1902(r)(1)(A)(ii) of the Social Security Act.

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

TN #06-34
Supersedes TN #85-25

Approval Date August 10, 2006
Effective Date April 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)
New York
1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

TN #91-79B Approval Date June 26, 1992
Supersedes TN #85-25 Effective Date October 1, 1991
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

TN  #91-79B  Approval Date  June 26, 1992
Supersedes TN  #87-35A  Effective Date  October 1, 1991
## Standards for Optional State Supplementary Payments

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>Administered by</th>
<th>Gross</th>
<th>Net</th>
<th>Income Level</th>
<th>Income Disregard Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasonable Classification</td>
<td>Federal State</td>
<td>1 person</td>
<td>Couple</td>
<td>1 person</td>
<td>Couple</td>
</tr>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>Living Alone</td>
<td>X</td>
<td>300% of SSI FBR</td>
<td>300% of SSI FBR</td>
<td>[724]</td>
<td>[1,060] As per CFR 416. Part K</td>
</tr>
<tr>
<td>Living w/ others</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[660]</td>
<td>[1,002] 300%</td>
</tr>
<tr>
<td>Level I Family Care NYC, Nassau, Rockland, Suffolk, Westchester Counties</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[903.48]</td>
<td>[1,806.96]</td>
</tr>
<tr>
<td>Rest of State</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[865.48]</td>
<td>[1,730.96]</td>
</tr>
<tr>
<td>Level II Residential Care NYC, Nassau, Rockland, Suffolk, Westchester Counties</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[1,072]</td>
<td>[2,144]</td>
</tr>
<tr>
<td>Rest of State</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[1,042]</td>
<td>[2,084]</td>
</tr>
<tr>
<td>Level III Enhanced Residential Care NYC, Nassau, Rockland, Suffolk, Westchester Counties and Rest of State</td>
<td>X</td>
<td>300%</td>
<td>300%</td>
<td>[1,293]</td>
<td>[2,586]</td>
</tr>
</tbody>
</table>

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**TN #09-38**

Supersedes TN #08-07

**Approval Date** June 26, 2012

**Effective Date** January 1, 2009
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME LEVELS FOR 1902(f) STATES - CATEGORYCALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

June 26, 1992

TN #91-79B Approval Date June 26, 1992
Supersedes TN #85-25 Effective Date October 1, 1991
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN #91-79B
Supersedes TN #85-25
Approval Date June 26, 1992
Effective Date October 1, 1991
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT**

<table>
<thead>
<tr>
<th>Disregard</th>
<th>How More Liberal</th>
<th>Groups Covered</th>
<th>Approved/Protected by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income - In determining eligibility for NYSSPLTC policyholders* who have satisfied the minimum duration requirements of their policy, disregard an amount of income equal to the Minimum Monthly Maintenance Needs Allowance for a married policyholder, and one-half of that amount for a single individual. This disregard will not be applied during the post eligibility treatment of income process.</td>
<td>Disregards income otherwise countable under 42 CFR 435.831.</td>
<td>All MN</td>
<td></td>
</tr>
</tbody>
</table>

* These are Partnership qualified long-term case policies meeting New York State's guidelines and are available from selected insurance carriers. Policies must guarantee certain standards and requirements and will carry the project logo to identify them as meeting the necessary standards and requirements for participation in this public/private partnership. If purchasers utilize the minimum required benefits under the private insurance policy, they will be enrolled in a special State Medicaid program. Under this program, the Medicaid applicant either will not be subject to a resource test as usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan, or will be subject to a more limited resource test different than usually required under 42 CFR 435.840 and 42 CFR 435.841, and as otherwise specified in New York State's Title XIX State Plan that is based on the disregard of an amount of resources equal to the amount of private insurance benefits paid by a selected insurance carrier on behalf of the applicant.

TN #09-59 Approval Date December 21, 2009

Supersedes TN #91-79B Effective Date July 1, 2009
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT]

[X] Non-Section 1902(f) State


2. In determining eligibility for pregnant women and infants under age 1, as referenced under Section 1902(a)(10)(A)(ii)(IX), disregard the difference between 185% and 200% of the Federal Poverty Level by family size as revised annually in the Federal Register.

3. In determining eligibility for children under age 21 for whom kinship guardianship assistance payments are made on behalf of or who are receiving foster care and are in the care and custody of the local social services district commissioner or in the care and custody of the Commissioner of the Office of Children and Family Services, as authorized by Sections 1902(a)(10)(A)(i)(I) and 1905(a)(i) of the Act and by 42 CFR Section 435.222(b)(1) and as described in Attachment 2.2-A, page 13, paragraph B.(b)(1)(d), disregard all income.]

TN #13-0053
Supersedes TN #11-0002

Approval Date June 26, 2014
Effective Date January 1, 2014
4. All wages paid by the Census Bureau for temporary employment related to Census activities are excluded for the following eligibility groups:

- 1902(a)(10)(A)(i)(III) - Qualified children, qualified pregnant women as defined in 1905(n);
- 1902(a)(10)(A)(i)(IV) - Poverty level pregnant women and infants under age one as defined in 1902(l)(1)(A) and (B);
- 1902(a)(10)(A)(i)(VI) - Poverty level children age 1 up to age 6 as defined by 1902(l)(1)(C);
- 1902(a)(10)(A)(i)(VII) - Poverty level related children aged 6 up to 19 as defined by 1902(l)(1)(D);
- 1902(a)(10)(A)(ii)(I), (II), and (IV) the populations defined by 1905(a)(i) children, (ii) parents and other caretaker relatives, and (viii) pregnant women;
- 1902(a)(10)(A)(ii)(IX) - Poverty-related pregnant women and infants;
- 1902(a)(10)(A)(ii)(XV) - Working individuals with disabilities Basic Coverage Group TWWIIA;
- 1902(a)(10)(A)(ii)(XVI) - Working Individuals with disabilities - Employed Medically Improved Individuals TWWIIA;
- 1902(a)(10)(C)(Medically Needy) - [435.301(b)(1) AFDC related medically needy,] 435.308 medically needy under age 21, 435.310 specified relatives, 435.320 aged, 435.322 blind, 435.324 disabled; and
- 1905(p) - QMBs, SLMBs, QIs.

[5. In determining eligibility for children who have attained 6 years of age but have not attained 19 years of age, as referenced under 1902(a)(10)(A)(i)(VII), disregard the difference between 100% and 133% of the Federal Poverty Level by family size as revised annually in the Federal Register.

6. For children under the age of 21 covered under 1902(a)(10)(A)(ii)(XXI) and 1902(ii) of the Act, parental income is disregarded.]
New York
3b

Disregard all household income for pregnant minors under age 21 covered under 42 CFR 435.222 as specified under the Reasonable Classification of Individuals under the Age of 21, 20, 19 and 18 section in Supplement 1 to Attachment 2.2-A.

TN #13-64
Supersedes TN NEW

Approval Date February 5, 2014
Effective Date December 31, 2013
STATE PLAN UNDER TITLE XIX OF THESOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State  [X] Non-Section 1902(f) State

The income above the maximum income level of a disabled individual eligible under Section 1902(a)(10)(A)(ii)(xii) and below the State’s Medically Needy Income Level is disregarded when determining the eligibility of TB infected individuals for TB related services.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

_X_ For all eligibility groups not subject to the limitations on payment explained in section 1903(f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

* Less restrictive methods may not result in exceeding gross income limitations under section 1903(f).]

TN #08-45  Approval Date September 13, 2011
Supersedes TN #00-09  Effective Date April 1, 2008
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(R)(2) OF THE ACT

[ ] Section 1902(f) State  [X] Non-Section 1902(f) State

<table>
<thead>
<tr>
<th>Disregard</th>
<th>How More Liberal</th>
<th>Groups Covered</th>
<th>Approved/Protected by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings of infants under age 21 of less than $500</td>
<td>Additional resource is not considered in the determination of eligibility</td>
<td>All MN</td>
<td>Existing State Policy since October 1, 1982 &amp; 18 NYCRR 360-4.6(b)(5)</td>
</tr>
<tr>
<td>Trust funds of an infant under age 21 of less than $1000</td>
<td>Additional resource is not considered in the determination of eligibility</td>
<td>All MN</td>
<td>Existing State policy since October 1, 1982.</td>
</tr>
<tr>
<td>A car - no cap</td>
<td>No limit</td>
<td>All MN *TWWIIA-BC TWWIIA-MI</td>
<td>18 NYCRR 360-4.7(a)(2)(iv)</td>
</tr>
<tr>
<td>Essential personal property - no cap</td>
<td>No limit</td>
<td>All MN TWWIIA-BC TWWIIA-MI</td>
<td>18NYCRR 360-4.7(a)(2)</td>
</tr>
<tr>
<td>Equity value of income producing property from $6,000 to $12,000</td>
<td>Equity value can exceed $6,000 up to $12,000</td>
<td>All MN</td>
<td>18 NYCRR 360-4.4(d)</td>
</tr>
<tr>
<td>Resource eligibility achieved effected with the first day of the month (including retroactive period) in which resources are reduced to the allowable level.</td>
<td>Federal policy prohibits eligibility for entire month if applicant has excess resources on 12.01 am of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive month(s) if excess resources existed in that month.</td>
<td>All MN TWWIIA-BC TWWIIA-MI</td>
<td>Exiting State Policy since October 1, 1982.</td>
</tr>
</tbody>
</table>

TWWIIA=Ticket to Work and Work Incentives Improvement Act
TWWIIA BC=Basic Coverage Group
TWWIIA MI=Medical Improvement Group

TN    #03-11                                          Approval Date       June 26, 2003
Supersedes TN #91-79B                                   Effective Date      July 1, 2003
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### MORE LIBERAL METHODS OF TREATING RESOURCES

**UNDER SECTION 1902(R)(2) OF THE ACT**

<table>
<thead>
<tr>
<th>Disregard</th>
<th>How More Liberal</th>
<th>Groups Coverage</th>
<th>Approved/Protected by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity value of income-producing property up to $12,000</td>
<td>Equity value of up to $12,000 not considered in the determination of eligibility</td>
<td>ADC-related MN TWWIIA BC TWWIIA - MI</td>
<td>18 NYCRR 360-4.4</td>
</tr>
<tr>
<td>Equity value of nonbusiness income-producing property from $6,000 to $12,000</td>
<td>Equity value can exceed $6,000 up to $12,000</td>
<td>SSI-related MN TWWIIA BC TWWIIA - MI</td>
<td>18 NYCRR 360-4.4</td>
</tr>
</tbody>
</table>

---

**TN #03-11**

Supersedes TN #91-79B

Approval Date **June 26, 2003**

Effective Date **July 1, 2003**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r) (2) OF THE ACT

[ ] Section 1902(f) State  [X] Non-Section 1902(f) State

[Deemed resources of parents of pregnant women described under 1902(a)(10)(A)(i)(IV) and 1902(1) of the Act are disregarded when determining eligibility for pregnant women.]

Deemed resources of parents of medically needy pregnant women are disregarded when determining eligibility for pregnant women.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

<table>
<thead>
<tr>
<th>Disregard</th>
<th>How More Liberal</th>
<th>Groups Covered</th>
<th>Approved/ Protected by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All resources, for a person who exhausts the minimum required benefits under a &quot;total asset protection&quot; long-term care insurance policy approved under the NYS Partnership for Long Term Care.*</td>
<td>Disregards resources otherwise countable under 42 CFR 435.845.</td>
<td>All MN</td>
<td></td>
</tr>
<tr>
<td>2. An amount of resources equivalent to the value of benefits received under a “dollar for dollar” long-term care insurance policy approved under the NYS Partnership for Long Term Care, or under a Partnership Policy approved by another state participating with New York in reciprocity, for a person who exhausts the minimum required benefits under such a policy. [*]</td>
<td>Disregards resources otherwise countable under 42 CFR 435.845.</td>
<td>All MN</td>
<td></td>
</tr>
</tbody>
</table>

* Long-term care insurance policies bearing the logo of the NYS Partnership for Long Term Care have been approved by the NYS Department of Insurance as meeting minimum benefit standards. A "total asset protection" policy provides a minimum benefit of at least [three] two years of nursing facility care. A "dollar for dollar" policy provides a minimum benefit of one and a half, but less than three, years of nursing facility care.

TN    #11-79                   Approval Date    February 17, 2012
Supersedes TN    #04-39                   Effective Date    October 1, 2011
New York

4

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

**MORE LIBERAL METHODS OF TREATING RESOURCES**

**UNDER SECTION 1902(r)(2) OF THE ACT**

| [ ] | Section 1902(f) State | [X] | Non-Section 1902(f) State |

The Resource amount above the maximum resource level of a disabled individual eligible under Section 1902(a)(10)(A)(ii)(XII) and below the State's Medically Needy Resource Level is disregarded when determining the MA eligibility of TB infected individuals for TB related services.

<table>
<thead>
<tr>
<th>TN #94-14</th>
<th>Approval Date July 1, 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes TN NEW</td>
<td>Effective Date January 1, 1994</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING - RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State  [X] Non-Section 1902(f) State

When determining the MA eligibility of Qualified Individuals under Section 1902(a)(10)(E)(iv) of the Act, the resource amounts are to be disregarded.

When determining the eligibility of Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries under the Section 1902(a)(10)(E) of the Act, the resource amounts are to be disregarded.

TN #08-05
Supersedes TN #02-15
Approval Date August 21, 2000
Effective Date April 1, 2000
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING - RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[ ] Section 1902(f) State              [X] Non-Section 1902(f) State

[1.] In determining eligibility for children under age 21 for whom kinship guardianship assistance payments are made on behalf of or who are receiving foster care and are in the care and custody of the local social services district commissioner or in the care and custody of the Commissioner of the Office of Children and Family Services, as authorized by Sections 1902(a)(10)(A)(ii)(I) and 1905(a)(i) of the Act and by 42 CFR 435.222(b)(1) and as described in Attachment 2.2-A, page 13, paragraph B.(b)(1)(d), disregard all resources.

[2.] In determining the Medicaid eligibility of persons under Section 1902(a)(10)(C) of the Social Security Act, for for AFDC-Related Medically Needy persons, the resource amounts are to be disregarded.

TN #13-0053                        Approval Date       June 26, 2014
Supersedes TN #11-0002             Effective Date     January 1, 2014
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING - RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

[   ] Section 1902(f) State
[X] Non-Section 1902(f) State

In determining the Medicaid eligibility for persons under 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Social Security Act, disregard all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans.

TN #11-44 Approval Date December 7, 2011
Supersedes TN NEW Effective Date October 1, 2011
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF RESOURCES *

1902(f) and 1917 of the Act  The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

   a. [X] The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

   Where the UCV is more than $12,000, the time limit for consideration of the UCV amount toward resources shall be extended for one month for each additional $2,000 in excess of the $12,000.

   The amount of the UCV may be diminished by an amount equal to the amount of medical expenses incurred in this period.

* The State is in compliance with the transfer of assets provision of the MCCA as amended by the Family Support

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TN __#91-79B______________ Approval Date June 26, 1992
Supersedes TN __#85-25______________ Effective Date October 1, 1991
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

b. [X] The period of ineligibility is less than 24 months, as specified below:

Where the UCV is $12,000 or less the UCV amount must be counted towards the resource limit for a period of 24 months from the date of the transfer, or until the amount of medical expenses equals the UCV.

c. [ ] The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

2. Transfer of the home of an individual who is an inpatient in a medical institution.

[X] A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

b. [ ] Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

No individual is ineligible by reason of item A.2 if --

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual’s spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) The agency determines that denial of eligibility would work an undue hardship.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. **1902(f) States**

[ ] Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:
1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. **Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.**

The agency withholds payment to institutionalized individuals for the following services:

- Payments based on a level of care in a nursing facility;
- Payments based on a nursing facility level or care in a medical institution;
- Home and community-based services under a 1915 waiver.

2. **Non-institutionalized individuals:**

[ ] The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled and elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

[ ] The following other long-term care services for which medical assistance is otherwise under the agency plan:
3. **Penalty Date --**

The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

- [ ] the first day of the month in which the asset was transferred;
- [X] the first day of the month following the month of transfer.

4. **Penalty Period – Institutionalized Individuals --**

In determining the penalty for an institutionalized individual, the agency uses:

- [ ] the average monthly cost to a private patient of nursing facility services in the agency;
- [X] the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. **Penalty Period – Non-institutionalized Individuals --**

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

- [ ] imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:
6. **Penalty period for amounts of transfer less than cost of nursing facility care** --

   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency;
      
      [ ] does not impose a penalty;
      
      [X] imposes a penalty for less than a full month, based on the proportion of the agency’s private nursing facility rate that was transferred.

   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
      
      [ ] does not impose a penalty;
      
      [X] imposes a series of penalties, each for less than a full month.

7. **Transfers made so that penalty periods would overlap** --

   The agency:
      
      [X] totals the value of all assets transferred to produce a single penalty period;
      
      [ ] calculates the individual penalty periods and imposes them sequentially.

8. **Transfers made so that penalty periods would not overlap** --

   The agency:
      
      [X] assigns each transfer its own penalty period;
      
      [ ] uses the method outlined below:
TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual --

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

In the case of a transfer by a spouse of an individual which results in a period of ineligibility for the individual, if the spouse becomes eligible for MA before such period of ineligibility ends, the remaining portion of the period of ineligibility will be divided equally between the individual and the spouse so long as both remain eligible for MA.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset --

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

[X] The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

[X] For transfers of individual income payments, the agency will impose partial month penalty periods.

[X] For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

[ ] The agency uses an alternate method to calculate penalty periods, as described below:
TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship --

The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an under hardship. The agency will use the following procedures in making undue hardship determinations:

- The form, “Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility”, is made available to all individuals who request such information and must be given to all MA-only applicants at the time of the initial application. The form must also be sent when an A/R is denied/discontinued due to a prohibited transfer. This form notifies A/R’s that an undue hardship provision exists.

- At any time during or after the application process, an A/R or his/her representative may request that a determination based on undue hardships be made. The local district must base its decision on the criteria set forth below. Local districts must determine whether an undue hardship waiver will be granted within 30 days of such a request by an A/R or his/her representative. A longer time period may be allowed in situations where additional time is needed due to difficulties or delays in obtaining evidence.

- The mandated client notice that informs the A/R of his/her denial/discontinuation for MA due to transfer of assets, provides detailed information on the process under which an adverse action determination can be appealed via fair hearing process.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship cannot be claimed; if the client failed to fully cooperate, to the best of his/her ability, as determined by the social services district, in having all of the transferred assets returned or the trust declared void (where possible). Cooperation may include but is not limited to, assisting in providing all legal records pertaining to the transfer creation of the trust, assisting the district, wherever possible, in providing information regarding the transfer amount, to whom it was transferred, any documents to support the transfer or any other information related to the circumstances of the transfer; or

Additionally, undue hardship cannot be claimed when after payment of medical expenses, the individual’s or couple’s income and/or resources is above the allowable MA exemption standard for a household or the same size; or

When the only result is the individual’s or the individual’s spouse claim that the assets are needed to maintain a pre-existing life style; or

when application of the transfer of assets provision merely causes
New York
5(a)

TRANSFER OF ASSETS

11. **Imposition of a penalty would work an undue hardship** --

   The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

   (continued from previous page)

   Fair hearings are provided pursuant to federal regulations (Goldberg v. Kelly)

   **The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:**

   (continued from previous page)

   the individual inconvenience; or

   when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;
   Nursing facility level of care provided in a medical institution;
   Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

   The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF ASSETS

than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date --

The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

• the first day of a month during or after which assets have been transferred for less than fair market value;

___ The State uses the first day of the

Supersedes TN NEW

TN #06-71 Approval Date December 12, 2006

Effective Date August 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF ASSETS

month in which the assets were transferred

X  The State uses the first day of the month after the month in which the assets were transferred

or

•  the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals --

In determining the penalty for an institutionalized individual, the agency uses:

   --- the average monthly cost to a private patient of nursing facility services in the State at the time of application;

   X  the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals --

TN  #06-71

Supersedes TN  NEW

Approval Date  December 12, 2006

Effective Date  August 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF ASSETS

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. **Penalty period for amounts of transfer less than cost of nursing facility care --**

   _X_ Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

   _X_ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. **Penalty periods – transfer by a spouse that results in a penalty period for the individual --**

   (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

   (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served the remaining spouse.

8. **Treatment of a transfer of income --**

   When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF ASSETS

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship --

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty

Approval Date: December 12, 2006
Effective Date: August 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TRANSFER OF ASSETS

that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

___ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed _____ days (may not be greater than 30).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The agency does not apply the trust provisions in any case in which the agency determines that such applications would work as undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardships.

The same criteria will be used as applies to transfer of assets.

Under the agency’s undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $______*______.

*There is no maximum value.
COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guideline used in determining cost-effectiveness by selecting one of the following methods:

___ The methodology as described in SMM section 3598.

X Another cost-effective methodology as described below. *

*See Supplement 11 to Attachment 2.6(A), pages 2 and 3

TN #91-79B Approval Date June 26, 1992
Supersedes TN #91-10 Effective Date October 1, 1991
COST EFFECTIVENESS DETERMINATION FOR PREMIUM PAYMENTS UNDER THE COBRA CONTINUATION COVERAGE PROGRAM

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district staff obtain insurance policy and the individual applying for the premium payment.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgment of local district staff.

The following points should be considered in making a determination whether or not to pay insurance premiums within the framework of the COBRA Continuation Coverage Program.

1. Assess the types of medical services covered by the health insurance policies.

2. Has there been a high utilization of medical services by the applicant/recipient (A/R)?

   Request the applicant/recipient to bring to the interview all medical bills (paid and unpaid), statements of insurance benefit payments and premium notices for the past year. Determine the total amount paid by all parties for the medical services.

3. Can the past utilization of medical expenses be expected to continue or increase?

   During the interview inquire if any acute or chronic medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization?
Due to the client's age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected.

5. For policies in force, what are the maximum benefit levels of the policy?
   a) Have the maximum benefit levels been met, rendering the A/R?
   b) If so, is the maximum benefit recurring? Will it be reinstituted on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?
   c) If there will be benefits or recurring benefits that will pertain to the A/R’s potential medical expenses, how do these benefits compare to the cost of the premium?

6. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.

7. Compare the cost of the COBRA premium to the cost of all medical services received by the applicant/recipient in the previous year (see #2). Using this comparison and the other factors related to anticipated future utilization (3 through 6) decide whether or not it is cost beneficial to pay the premium. That is, does the cost of the COBRA premium payment appear likely to be less than the Medicaid expenditures for an equivalent set of services.

NOTE: For those districts that use the “Health Insurance Automated Decision Tree” (HIADT), make sure that the premium payment used in the calculation is the total premium. Under COBRA continuation coverage, the individual (or Medicaid) is generally responsible for both the employer's and employee's share of the insurance premium not to exceed 102% of the applicable premium (or 150% of the premium for disabled individuals beginning in the nineteenth month of coverage). In addition, only use the Medicaid payments for the equivalent set of services that would otherwise be paid for by the insurance policy.
### Resource Policies Permitted Under Section 1902(r)(2) of the Social Security Act

<table>
<thead>
<tr>
<th>Disregard</th>
<th>How More Liberal</th>
<th>Groups Covered</th>
<th>Approved/Protected by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings of infants under age 21 of less than $500</td>
<td>Additional resource is not considered in the determination of eligibility</td>
<td>All MN</td>
<td>Existing State policy since October 1, 1982 &amp; 18 NYCRR 360-4.6(b)(5)</td>
</tr>
<tr>
<td>Trust funds of an infant under age 21 of less than $1000</td>
<td>Additional resource is not considered in the determination of eligibility</td>
<td>All MN</td>
<td>Existing State policy since October 1, 1982</td>
</tr>
<tr>
<td>A car - no cap</td>
<td>No limit</td>
<td>All MN</td>
<td>18 NYCRR 360-4.7(a)(2) (iv)</td>
</tr>
<tr>
<td>Essential personal property - no cap</td>
<td>No limit</td>
<td>All MN</td>
<td>18 NYCRR 360-4.7(a)(2)</td>
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<tr>
<td>Equity value of income producing property from $6,000 to $12,000</td>
<td>Equity value can exceed $6,000 up to $12,000</td>
<td>All MN</td>
<td>18 NYCRR 360-4.4(d)</td>
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<tr>
<td>Resource eligibility achieved effective with the first day of the month (including retroactive period) in which resources are reduced to the allowable level.</td>
<td>Federal policy prohibits eligibility for entire month if applicant has excess resources on 12.01 am of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive month(s) if excess resources existed in that month.</td>
<td>All MN</td>
<td>Existing State Policy since October 1, 1982</td>
</tr>
</tbody>
</table>

**TN #91-50**  
Supersedes TN #91-10  
Approval Date November 19, 1991  
Effective Date July 1, 1991
**New York 1A**

**Resource Policies Permitted Under Section 1902(r)(2) of the Social Security Act**

<table>
<thead>
<tr>
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<th>How More Liberal</th>
<th>Groups Covered</th>
<th>Approved/Protected by</th>
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<tbody>
<tr>
<td>Equity value of income-producing property up to $12,000</td>
<td>Equity value of up to $12,000 not considered in the determination of eligibility</td>
<td>ADC-related MN</td>
<td>18 NYCRR 360-4.4</td>
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<tr>
<td>Equity value of nonbusiness income-producing property from $6,000 to $12,000</td>
<td>Equity value can exceed $6,000 up to $12,000</td>
<td>SSI-related MN</td>
<td>18 NYCRR 360-4.4</td>
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**TN #91-50 Supersedes TN NEW**

**Approval Date** November 19, 1991  
**Effective Date** July 1, 1991
New York

This provision supersedes the resource spend-down provision on Supplement 12, page 1 and all other resource spend-down prohibitions, which were voided by the United States District Court for the Western District of New York in its final order entered on February 6, 1990 and retroactive to January 1, 1982.

Case: Westmiller v. Sullivan

<table>
<thead>
<tr>
<th>DISREGARD</th>
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<th>GROUPS COVERED</th>
<th>AS APPROVED AND PROTECTED BY</th>
</tr>
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<tbody>
<tr>
<td>Resource eligibility achieved effective with the first day of the month (including retroactive period) in which resources are reduced to the allowable level.</td>
<td>Federal policy prohibits eligibility for entire month if applicant has excess resources on 12:01 A.M. of the first day of the month. Federal policy also prohibits gaining resource eligibility for retroactive month(s) if excess resources existed in that month.</td>
<td>All MN</td>
<td>US District Court Order of 2/6/90 retroactive to 1/1/82</td>
</tr>
</tbody>
</table>

- incurred expenses subject to payment by third parties will not be deducted from resources to the same extent that such cannot be deducted in an income spend-down.

- the same incurred medical and remedial care expenses will not be used to meet both income and resources spend-down; and

- the Medicaid program will not pay for any of the incurred expenses used to meet the spend-down of resources provision.

Supersedes TN NEW

Approval Date September 17, 1990
Effective Date October 1, 1982
**New York**  
2a

### RESOURCE POLICIES PERMITTED UNDER SECTION 1902(r)(2) OF THE SOCIAL SECURITY ACT

<table>
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<tr>
<th>DISREGARD</th>
<th>HOW MORE LIBERAL</th>
<th>GROUPS COVERED</th>
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<tr>
<td>Parental resources of pregnant minors (under 21) living with their</td>
<td>Parental resources are disregarded</td>
<td>MN Pregnant Women</td>
<td>Woe v. Perales</td>
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<td>parents are disregarded in determining the pregnant minor’s eligibility</td>
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**TN NY #90-58**  
**Supersedes TN NEW**  
**Approval Date** July 27, 1992  
**Effective Date** October 1, 1990
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act. The following groups were included in the AFDC State plan effective July 16, 1996:

- **X** Pregnant woman with no other eligible children.
- **X** AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

- The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

- The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

The income standard by household size is based on 130% of the Suffolk County Standard of Need in 1996, adjusted each year effective January 1st by the annual increase in the October CPI-U. (see Page 4a)]
[Section 1931 Income Levels]

<table>
<thead>
<tr>
<th>[Household Size]</th>
<th>[Baseline (1996 Monthly Income Level; same level used 1997 through 2007)]</th>
<th>[130% of Baseline (2008 Monthly Income Level)]</th>
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<tr>
<td>[1]</td>
<td>[517.10]</td>
<td>[672]</td>
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<tr>
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<td>[768.00]</td>
<td>[999]</td>
</tr>
<tr>
<td>[4]</td>
<td>[891.70]</td>
<td>[1,160]</td>
</tr>
<tr>
<td>[5]</td>
<td>[1,019.70]</td>
<td>[1,326]</td>
</tr>
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<td>[6]</td>
<td>[1,113.20]</td>
<td>[1,448]</td>
</tr>
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<td>[7]</td>
<td>[1,211.70]</td>
<td>[1,576]</td>
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<td>[8]</td>
<td>[1,338.20]</td>
<td>[1,740]</td>
</tr>
<tr>
<td>[9]</td>
<td>[1,410.70]</td>
<td>[1,834]</td>
</tr>
<tr>
<td>[10]</td>
<td>[1,483.20]</td>
<td>[1,929]</td>
</tr>
<tr>
<td>[Each Additional]</td>
<td>[73]</td>
<td>[95]</td>
</tr>
</tbody>
</table>
The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

1. Individual development accounts*

2. Household gross income is first compared to 185% of the 1931 income level for the appropriate household size. If gross income is equal to or below this level and the combined earned and unearned gross income does not exceed 100% of the federal poverty level (FPL) for a household of the appropriate size, a percentage (as defined below) of earned income is disregarded. This percentage disregard is calculated as follows: from 100% FPL amount for a household of three, subtract $90 work disregard and the 1931 income level for a household of three. The amount remaining is divided by the difference between 100% FPL for a household of three and $90. This result, rounded up, is the percent of earned income to be disregarded. This percentage is adjusted June 1st yearly, based on the Federal Poverty Level amounts published for that year in the Federal Register. However, if it is more advantageous, $30 and 1/3 of the remaining income is disregarded if the employed person was on PA one of the four proceeding months instead of disregarding income based on the percentage above. At the conclusion of the four months, only the $30 portion of the $30 and 1/3 disregard is applied for an additional eight months.

3. All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

4. All resources are to be disregarded.

*Individual development accounts (IDA) are excluded from resources; interest earned on IDA accounts is excluded from income.]

TN  #13-0053
Supersedes TN  #10-0002

Approval Date  June 26, 2014
Effective Date  January 1, 2014
[The income and/or resources methodologies in effect as of July 16, 1996 that the less restrictive methodologies replace are as follows:

1. Individual development accounts (IDA) are an available resource; interest from IDA is income.

2. The income standard is equal to the PA Standard of need, which is based on household size and county of residence, and consists of the Public Assistance (PA) basic allowance, home energy allowance, supplemental home energy allowance, shelter allowance, and fuel for heating allowance. The $30 and 1/3 of remaining income is disregarded if the employed person was on PA one of the four preceding months. At the conclusion of the four months, only the $30 portion of the $30 and 1/3 disregard is applied for an additional eight months.

3. $1500 equity value of an automobile is excluded from the total value; the remaining value is counted as an available resource.

4. Census Bureau wages are counted as earned income.

5. Countable resources cannot exceed $1000.

___ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

___ The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.]
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY UNDER SECTION 1925 OF THE ACT
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative’s employment, or due to the loss of a time-limited earned income disregard while there is a dependent child in the household. (42 CFR 435.112, 1902(a)(52), 1902(e)(1)(B), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

_X_ During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

_X_ For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

For at least 1 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931.

The State extends Medicaid eligibility under TMA for an initial period of:

___ 6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

_X_ 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.
New York
ADDENDUM

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

_X_ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

___ The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

---

TN #13-0053
Supersedes TN #00-0009
Approval Date June 26, 2014
Effective Date January 1, 2014
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

TN #98-05
Supersedes TN ____NEW____

Approval Date May 15, 1998
Effective Date January 1, 1998
NOTE: The deleted information on this page has been replaced by PDF Form S89 effective January 1, 2014.

[STATE PLAN UNDER TITLE XIIX OF THE SOCIAL SECURITY ACT
State: New York

ELIGIBILITY CONDITIONS AND REQUIREMENTS]

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>[42 CFR 435.406]</td>
<td>[3. Is residing in the United States (U.S.), and --</td>
</tr>
<tr>
<td>a.</td>
<td>Is a citizen or national of the United States;</td>
</tr>
<tr>
<td>b.</td>
<td>Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA’s eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;</td>
</tr>
<tr>
<td>c.</td>
<td>Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</td>
</tr>
<tr>
<td>d.</td>
<td>Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</td>
</tr>
<tr>
<td>e.</td>
<td>Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.</td>
</tr>
<tr>
<td>[X]</td>
<td>State covers all authorized QAs.</td>
</tr>
<tr>
<td>[ ]</td>
<td>State does not cover authorized QAs.</td>
</tr>
<tr>
<td>f.</td>
<td>State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:</td>
</tr>
</tbody>
</table>
NOTE: The deleted information on this page has been replaced by PDF Form S89 effective January 1, 2014.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS]

[(1) A “Qualified alien” otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

(a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

(b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;

(c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;

(d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:

• A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;
• A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;
• A religious worker under section 101(a)(15)(R);
• An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;]
### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and</td>
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<tr>
<td></td>
<td>• An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.</td>
</tr>
<tr>
<td>[X]</td>
<td>Elected for pregnant women.</td>
</tr>
<tr>
<td>[X]</td>
<td>Elected for children under age 21</td>
</tr>
<tr>
<td>g. [X]</td>
<td>The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual’s initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements:

A. The request and response system must be electronic:

   (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).

   (2) The system cannot be based on mailing paper based requests.

   (3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department’s National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency’s AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant’s home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual’s eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

TN #09-40
Supersedes TN NEW

Approval Date May 27, 2009
Effective Date September 30, 2009
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

_X_ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

___ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.
3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

[New York State’s Financial Institution Recipient Match (FIRM) is a State developed financial institution computer match that provides Local Departments of Social Services (LDSS) with resource information for use in assessing Medicaid and Temporary Assistance eligibility of applicant/recipients (A/Rs). FIRM is part of the resource file integration (RFI) system. The RFI system compares A/Rs against individuals on the resource files of various State and Federal agencies and financial institutions in order to verify the information provided by A/Rs on the Medicaid application and renewal forms and to provide additional information to the Medicaid eligibility worker.

When an applicant/recipient is being reviewed for eligibility or having their eligibility redetermined, they are subject to the RFI process. As part of this process, FIRM is accomplished by electronically matching the demographic information of the A/Rs to the financial institution database maintained by the Office of Temporary and Disability Assistance (OTDA). The A/R is matched against all financial institutions on the database. If multiple matches are made, all information will be provided electronically to the eligibility worker at the LDSS office to review.

OTDA maintains a database of financial information from approximately 800 financial institutions. These financial institutions are comprised of New York State only financial institutions as well as national and international financial institutions. Financial institutions submit their account information through a secure file transmission to OTDA. Some institutions update their information weekly while some update the information quarterly. The information collected reflects current and closed accounts as well as demographic changes to the account since the last submission by the financial institution.]

New York State executed a contract with Public Consulting Group on August 15, 2014 for an automated asset and real property verification service. PCG and the Department defined portal requirements and began testing at the end of July 2015. The program will be phased in starting with three upstate counties in March 2016. The remaining upstate counties will begin in June 2016. The AVS portal will be used for both applications and renewals as part of the eligibility (re)determination.

Due to unique data requirements, NYC will begin using AVS in June 2016 for nursing home applications and conversion cases (community Medicaid cases that transition to nursing home coverage). NYC will expand to community applications and renewals in the last quarter of 2016.

A nightly batch file of Medicaid applicants/recipients (aged, blind and disabled) is pulled from our eligibility system (Welfare Management System) and sent to PCG to access AVS information. A manual web service allows a Medicaid eligibility worker to access AVS information for a non-applying spouse. New forms were created to obtain authorization to use AVS from a non-applying spouse. Information from AVS is returned on a web-based, secure portal.

The Department has established rules to set flags for potential transfer of assets.

Numerous user roles were created in order for Medicaid eligibility workers to manage tasks related to AVS responses.

TN #16-0014 Approval Date May 9, 2016
Supersedes TN #09-0040 Effective Date January 1, 2016
New York

State Plan under Title XIX of the Social Security Act

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 - Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the State will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on January 28, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.
Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Relevant Population Group Income Standard</th>
<th>Resource Proxy</th>
<th>Enrollment Cap</th>
<th>Special Circumstances</th>
<th>Other Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/Caretaker Relatives</td>
<td>For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter “Not covered”.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disabled Persons, non-institutionalized</td>
<td>Attachment A Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disabled Persons, institutionalized</td>
<td>Attachment A Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Children Age 19 or 20 (Living with Parents)</td>
<td>Attachment A Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Children Age 19 or 20 (Living Alone)</td>
<td>Attachment A Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>Attachment A Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Enter “Y” (Yes), “N” (No), or “NA” in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.

TN #13-14 Approval Date July 2, 2014
Supersedes TN NEW Effective Date January 1, 2014
Part 2 - Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. New York applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ✔ New York does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which New York applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   New York:

   ___ Applies existing state data from periods before January 1, 2014.

   ___ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology:

   Attachment B describes the sampling approach or other methodology used for calculating the adjustment.
New York

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. _ _ _ An enrollment cap adjustment is applied (complete items 2 through 4).
   ✓ An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that New York covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. New York applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
   _ _ _ Yes. The combined enrollment cap adjustment is described in Attachment C.
   ✓ No.

4. Enrollment Cap Methodology:

   Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. _ _ _ New York applies special circumstances adjustment(s).
   ✓ New York does not apply a special circumstances adjustment.

2. _ _ _ New York applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
   ✓ New York does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

TN #13-14
Supersedes TN NEW
Approval Date July 2, 2014
Effective Date January 1, 2014
New York  
5  
Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

✓  Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

Individuals previously eligible for Medicaid coverage through the state’s 1115 demonstration program, specifically the Temporary Assistance for Needy Families (TANF) recipients, enrolled in the state’s section 1115 Demonstration Population 11, will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E.

___  New York does not have any relevant populations requiring such transitions.

Part 4 – Applicability of Special FMAP Rates

A. Expansion State Designation

New York:

___  Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 4).

✓  Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated June 18, 2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

New York:

✓  Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

___  Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____________ (insert date). New York will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).
Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual’s eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- Attachment A – Conversion Plan Standards Referenced in Table 1 (for medically needy levels, refer to the note on Table 1)
- Attachment B – Resource Criteria Proxy Methodology
- Attachment C – Enrollment Cap Methodology
- Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E – Transition Methodologies

TN #13-14 Approval Date July 2, 2014
Supersedes TN NEW Effective Date January 1, 2014
### Conversions for FMAP Claiming Purposes

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Net standard as of 12/1/09</th>
<th>Converted standard for FMAP claiming</th>
<th>Same as converted eligibility standard? (yes, no, or n/a)</th>
<th>Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)</th>
<th>Data source for Conversion (SIPP or state data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/Caretaker Relatives</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>FPL %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>150%</td>
<td>150%</td>
<td>yes</td>
<td>Part 1 of approved state MAGI conversion plan</td>
<td>SIPP</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Noninstitutionalized Disabled Persons</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dollar standards by family size</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>$767</td>
<td>$767</td>
<td>n/a</td>
<td>New SIPP conversion</td>
<td>SIPP</td>
</tr>
<tr>
<td></td>
<td>$1,117</td>
<td>$1,150</td>
<td></td>
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<tr>
<td>Institutionalized Disabled Persons</td>
<td></td>
<td></td>
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<tr>
<td>Dollar standards by family size</td>
<td></td>
<td></td>
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<tr>
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The numbers in this summary chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

n/a: Not applicable.
Attachment D
Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

Individuals in the new adult population, determined eligible under the Modified Adjusted Gross Income (MAGI) methodology, will receive continued benefits during any period within a twelve month eligibility period when these individuals would have been found ineligible if subject to redetermination. To reflect that only the regular matching rate is available for these demonstration expenditures, pursuant to the State’s Special Terms and Conditions of the 1115 Waiver, the State will make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate, and will instead claim those expenditures at the regular matching rate.
December 4, 2013

Eliot Fishman, Director
Children and Adult Health Program Group
Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 23244-1850

Re: Request for authority under section 1902(e)(14)(A) to waiver certain requirements

Dear Mr. Fishman:

In response to CMS' guidance regarding targeted enrollment strategies that are available to states to help support a streamlined enrollment process in implementing the Affordable Care Act (ACA), and to establish income and eligibility determination systems that protect beneficiaries, New York requests a waiver under section 1902(e)(14)(A) of the Social Security Act in three areas: 1) compliance with grandfathering protections, 2) delayed application of full MAGI-based methods to current beneficiaries and 3) transition of 1115 demonstration beneficiaries into the adult group.

Waiver of Compliance with Grandfathering Protections

New York seeks to waive full compliance with the grandfathering protections afforded under section 435.603 (a)(3) of the regulations. With respect to Medicaid individuals eligible as of December 31, 2013 who are renewed based on 2013 standards and methodologies prior to April 1, 2014, the State is requesting waiver authority to not apply an income test using MAGI-based methodologies until the next renewal in 2015. If on or after April 1, 2014, there is a reported change in income or a family member is added to or removed from a case, methodologies and standards that approximate the MAGI-based rules (MAGI-like) would apply to the re-determination of eligibility. This will enable the State to operate only one set of rules on the legacy system for months leading up to February 2014 (months when renewals are completed for new authorization periods starting January, February and March 2014). This will ensure continuity of care and protect beneficiaries.

The State seeks the same waiver authority for the Children’s Health Insurance Program.
New York

1

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided:  [ ] No limitations  [X] With limitations *

2.a. Outpatient hospital services.

Provided:  [ ] No limitations  [X] With limitations *

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not Provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub, 45-4).

[X] Provided:  [ ] No limitations  [X] With limitations *

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

[X] Provided:  [ ] No limitations  [X] With limitations *

j. Other laboratory and x-ray services.

Provided:  [ ] No limitations  [X] With limitations *

* Description provided on attachment.

TN  #91-75 Approval Date March 3, 1992
Supersedes TN #91-52 Effective Date October 1, 1991
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
   - Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (Limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.)

4.c.i. Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachments 2.2-A and 2.2-B, if this eligibility option is elected by the State.
   - Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

4.c.ii. Family planning-related services provided under the above State Eligibility Option.
   - Provided: ☒ No limitations ☐ With limitations*

4.c.iii. Fertility services for women ages 21 through 44
   - Provided: ☒ No limitations ☐ With limitations*
   *Limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.

4.d.1. Face-to-Face Counseling Services provided:
   - (i) By or under supervision of a physician;
   - (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
   - (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (none are designated at this time)

4.d.2. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women
   - Provided: ☒ No limitations ☐ With limitations*
   *Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.
   All Medicaid recipients, including pregnant women, receiving tobacco cessation counseling services can receive these services without any limitation as stated above.

   Please describe any limitations: ☐

* Description provided on attachment.
New York
2.1

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5.a. Physicians’ services whether furnished in the office, the patient’s home, a hospital, a nursing facility or elsewhere.

☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

i. Lactation counseling services.

☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists’ services.

☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

*Description provided on attachment.
List of Available Organ Transplants - categorically needy

- heart - bone - heart/lung
- kidney - skin - bone marrow
- liver - cornea

Attachment 3.1-A
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists’ services.

[X] Provided:  [ ] No limitations  [X] With limitations *

c. Chiropractors’ services. (EPSDT only.)

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not Provided.

d. Other practitioners’ services.

[X] Provided:  Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

(i). Other Licensed Practitioner services. (EPSDT only.)

[X] Provided:  Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided:  [ ] No limitations  [X] With limitations *

b. Home health aide services provided by a home health agency.

Provided:  [ ] No limitations  [X] With limitations *

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided:  [ ] No limitations  [X] With limitations *

* Description provided on attachment.
d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation therapy.

[X] Provided: [X] No limitations [ ] With limitations *

[ ] Not provided

8. Private duty nursing services.

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not provided

* Description provided on attachment.

TN #91-75 Approval Date March 3, 1992
Supersedes TN NEW Effective Date October 1, 1991
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not provided.

10. Dental services.

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not provided.

11. Physical therapy and related services.

a. Physical Therapy

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not provided.

b. Occupational Therapy

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not provided.

* Description provided on attachment.
12. Prescribed drugs, dentures, and prosthetic devices: and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

   a. Prescribed drugs.

      [X] Provided: [ ] No limitations [X] With limitations *
      [ ] Not provided.

   b. Dentures.

      [X] Provided: [ ] No limitations [X] With limitations *
      [ ] Not provided.

   c. Prosthetic devices.

      [X] Provided: [ ] No limitations [X] With limitations *
      [ ] Not provided.

   d. Eyeglasses.

      [X] Provided: [ ] No limitations [X] With limitations *
      [ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

   a. Diagnostic services.

      [X] Provided: [ ] No limitations [X] With limitations *
      [ ] Not provided.

* Description provided on attachment.
New York

6

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not provided.

c. Preventive services.

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not provided.

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not provided.

14. Services for individuals under 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

[X] Provided: [x] No limitations [ ] With limitations *

[ ] Not provided.

b. Skilled nursing facility services.

[ ] Provided: [ ] No limitations [ ] With limitations *

[X] Not provided.

c. Intermediate care facility services.

[ ] Provided: [ ] No limitations [ ] With limitations *

[X] Not provided.

* Description provided on attachment.

TN #93-49 Approval Date March 8, 1995
Supersedes TN #92-10 Effective Date September 1, 1993
New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

i. Lactation counseling services.

☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided

* Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services.
   a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

      [X] Provided: [X] With limitations
      [ ] Not provided.
   b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

      [X] Provided: [X] With limitations
      [ ] Not provided.

20. Extended services for pregnant women.
   a. Pregnancy-related and postpartum services for 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

      [X] Additional coverage ++

   b. Services for any other medical condition that may complicate pregnancy.

      [X] Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment

---

TN #94-39
Supersedes TN #94-14
November 23, 1994
January 1, 1994
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☑ No limitations □ With limitations* □ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through 1902(e)(9)(C) of the Act.*

☐ Provided: ☐ No limitations □ With limitations* ☒ Not provided

23. Pediatric or family nurse practitioners’ services.

☐ Provided: ☒ No limitations □ With limitations* □ Not provided

a. Lactation counseling services.

☒ Provided: ☒ No limitations □ With limitations* □ Not provided

* State statute does not recognize service, but it is available to EPSDT population through the clinic and home health benefit.

* Description provided on attachment.
New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

   a. Transportation.

      [X] Provided: [ ] No limitations [X] With limitations *

      [ ] Not provided

   *b. Services provided in Religious Nonmedical Health Care Institutions.

      [ ] Provided: [ ] No limitations [ ] With limitations *

      [X] Not provided

   c. Reserved

   d. Nursing facility services for patients under 21 years of age.

      [X] Provided: [ ] No limitations [X] With limitations *

      [ ] Not provided

   *e. Emergency hospital services.

      [X] Provided: [ ] No limitations [X] With limitations *

      [ ] Not provided

   f. Personal care services in recipient’s home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

      [X] Provided: [X] No limitations [ ] With limitations *

      [ ] Not provided

   * Description provided on attachment

*24e. For emergency outpatient services threshold limits for clinic services apply.

*24b. This service is not provided to the EPSDT population as they are not considered part of the healing arts and therefore not recognized by State law.

TN #01-40 Approval Date February 8, 2002
Supersedes TN #91-75 Effective Date January 1, 2002
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided  
_X_ Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded on institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) furnished in a home.

_X_ Provided  ___ State Approved (Not Physician) Service Plan Allowed

_X_ Services Outside the Home Also Allowed  
_X_ Limitations Described on Attachment

___ Not provided

27. Primary Care Case Management

_X_ Provided  ___ Not provided

---

New York 10

TN #00-43 Approval Date March 28, 2001
Supersedes TN #94-49 Effective Date October 1, 2000
### Covered Services for Pregnant Women

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#### Included Services
- Physician Care
- Midwife Care
- Outpatient Clinic/ Ambulatory Surgery
- Pharmacy/Supplies
- Dental
- Laboratory/"X-ray"
- Eye Care
- Transportation
- Home Health Care
- Personal Care
- Nursing Services
- Clinical Psychology
- Outpatient/Mental Health
- Outpatient/Alcoholism
- Health Education
- Nutritional Counseling
- Family Planning
- Lactation Counseling
- Included Services
  - Physician Care
  - Midwife Care
  - Outpatient Clinic
  - Pharmacy
  - Dental
  - Laboratory
  - Transportation
  - Home Health Care
  - Personal Care
  - Nursing Services
  - Physical Therapy
  - Occupational Therapy
  - Speech Pathology
  - Durable Med. Equip.
  - Abortion
  - Clinical Psychology
  - Outpatient/Mental Health
  - Outpatient/Alcoholism
  - Health Education
  - Nutritional Counseling
  - Family Planning
  - Hospice
  - Inpatient Care
  - Alternate Level Care
  - Institutional LTC
  - Lactation Counseling

#### Excluded Services
- Inpatient Care
- Alternate Level Care
- Institutional LTC
- LT Home Health Care
- None
- None
- Alternate Level Care
- Institutional LTC
- Lactation Counseling

*Pregnant women enrolled in a managed care plan, regardless of income level, will receive the full managed care service package without exclusions. A full listing of services is available from each managed care plan.

TN#: #12-16 Approval Date: December 28, 2012 Supersedes TN#: #90-3 Effective Date: September 1, 2012
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

[X] Election of PACE: By virtue of this submittal, the State elects PACE as an option State Plan service.

[ ] No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☒ No limitations  ☐ With limitations  ☐ None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☒ No limitations  ☐ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.). *

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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TN #13-27 Approval Date February 4, 2015
Supersedes TN NEW Effective Date October 1, 2013
New York 12

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. **Physician’s assistants.**
   - Provided: ☑️ No limitations ☐ With limitations* ☐ Not provided
   a. **Lactation counseling services.**
      - Provided: ☑️ No limitations ☐ With limitations* ☐ Not provided

30. **Registered Nurses.**
   - Provided: ☑️ No limitations ☐ With limitations* ☐ Not provided
   a. **Lactation counseling services.**
      - Provided: ☑️ No limitations ☐ With limitations* ☐ Not provided

* Description provided on attachment.

TN #12-16 Approval Date December 28, 2012
Supersedes TN NEW Effective Date September 1, 2012
New York

TITLE XIX STATE PLAN

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY.

NOTE: By prior approval, when indicated below, is meant that prior approval/authorization of the local professional director and/or the local social services commissioner is required for that service.

1. Inpatient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those inpatient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of section 365a of the Social Services Law, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, inpatient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate.

Inpatient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an outpatient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an inpatient basis.

1. Limits other than medical necessity are not applicable to EPSDT recipients in accord with 1903(r)3.

2. We have received the State Plan and reviewed it and determined that we are in compliance with EPSDT requirements.

Approval Date February 18, 1992
Supersedes TN #85-30
Effective Date July 1, 1991
2a. **Outpatient Hospital Services**

Outpatient Hospital Services provided by hospitals licensed pursuant to Article 31 of the Mental Hygiene Law and Article 28 of the Public Health Law are in accordance with 42 CFR § 440.20(a) title Outpatient Hospital Services. Such services include Clinic Treatment Services, Partial Hospitalization, Continuing Day Treatment, and Day Treatment Services for Children, as set forth in item 9a of the Supplement to Attachment 3.1-A of the Plan.
2a. **Outpatient Hospital Services (continued)**

Outpatient Hospital Services provided by hospitals licensed pursuant to Article 28 of the Public Health Law are in accordance with 42 CFR § 440.20(a) title Outpatient Hospital Services. Effective January 1, 2015, such services include Collaborative Care Services as set forth in item 9 of the Supplement to Attachment 3.1-A of the Plan.
4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for
difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or
have not applied for certification to participate in Medicare.

Care days in nursing facilities is reimbursed for Medicaid patients requiring and receiving
medically necessary lower level of care services. Medical Assistance is provided until
such time as the appropriate level of care becomes available.

4d.i. **Face-to-Face Counseling Services**
4d.ii. **Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women**

Effective October 1, 2013, Medicaid coverage of comprehensive counseling and
pharmacotherapy for cessation of tobacco use by all Medicaid eligible recipients,
including pregnant women, will be provided. Such services will be provided face-to-face,
by or under the supervision of a physician and no cost sharing (co-pays) will apply. In
accordance with section 4107 of the Patient Protection and Affordable Care Act, current
coverage of smoking cessation services for all Medicaid recipients, including pregnant
women, will be modified to include a maximum of two quit attempts per 12 months,
which will include a maximum of four face-to-face counseling sessions per quit attempt.

5. Prior approval is required for certain procedures which may be considered cosmetic or
experimental. Physicians are informed of the specific prior approval requirements in the
MMIS Physician Provider Manual.

5a. **Lactation consultant services**: effective September 1, 2012, reimbursement will be
provided to physicians for breastfeeding health education and counseling services.
Physicians 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.

**Collaborative Care Services**: Effective January 1, 2015, Physician services shall
include Collaborative Care Services as set forth in item 9 of the Supplement to
Attachment 3.1-A of the Plan. Physician Services are in accordance with 42 CFR §440.50
and requirements for claim submission comply with the State Medicaid Manual, §4281
titled Restriction on Payments for Physician Services.

6. Care and services will be provided only if they are in accordance with regulations of the
Department of Health.
New York
2(xii)(A)

4b. Early and periodic screening, diagnostic and treatment services (EPSDT).

School Supportive Health Services and Pre-School Supportive Health Services

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are services provided by or through a school district[, a Section 4201 school], a county in the State, or New York City to children with disabilities, who attend public or State Education Department approved schools or preschools. The services must be:

• medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
• ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
• included in the child's Individualized Education Program (IEP);
• provided by qualified professionals under contract with or employed by a school district[, a Section 4201 school,] or a county in the State or the City of New York;
• furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions; and
• included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Effective September 1, 2009, the services covered by the SSHS and PSSHS Program for Medicaid eligible children under the age of 21 who are eligible for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) include medically necessary physical therapy services, occupational therapy services, speech therapy services, psychological counseling, skilled nursing services, psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation within the limits of EPSDT services. A school district[, Section 4201 school,] a county in the State, and New York City must be enrolled as a Medicaid provider in order to bill Medicaid.

1. Physical Therapy Services

Definition: Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(a).
New York
2(xii)(B)

Services: Physical therapy services provided by or through: a school district[; a Section 4201 school]; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and must be provided to a child by or under the direction of a qualified physical therapist. Physical therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Physical therapy services include but are not limited to:

- Identification of children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to, heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices, and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

Physical therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or

- a certified physical therapy assistant “under the direction of” such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.
“Under the direction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

2. Occupational Therapy Services

**Definition:** Occupational therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(b).

**Services:** Occupational therapy services provided by or through: a school district[; a Section 4201 school]; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the
New York
2(xii)(D)

scope of his or her practice under New York State Law and must be provided to a child by or under the direction of a qualified occupational therapist. Occupational therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention, initial or further impairment or loss of function; and
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximal physical and mental functioning of the student in daily life tasks.

Occupational therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified occupational therapy assistant (COTA) “under the direction of” such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

“Under the direction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment.
New York
2(xii)(E)

- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the settings in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

3. Speech Therapy Services

Definition: Speech therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(c).

Services: Speech therapy services provided by or through: a school district[; a Section 4201 school]; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, nurse practitioner, or a speech-language pathologist who is acting within his or her scope of practice under New York State law and must be provided to a child by or under the direction of a qualified speech-language pathologist. Speech therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.
Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders;
- Evaluation and application of principles, methods and procedures of measurement, prediction, diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to the development of disorders of speech, voice, and/or language, and
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

Speech therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a licensed and registered speech-language pathologist qualified in accordance with 42CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- a teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech language pathologist (ASHA-Certified or equivalent), acting within his or her scope of practice under New York State Law.

“Under the direction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

4. Psychological Counseling

**Definition:** Psychological counseling services outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.60(a) and 440.50(a)(2).

**Services:** Psychological counseling provided by or through a school district; a county in the State or the City of New York must have a referral from a physician, physician assistant, or a nurse practitioner who is acting within the scope of his or her practice under NYS law or an appropriate school official or other voluntary health or social agency and must be provided to a child by or under the direction of a qualified practitioner. Psychological counseling services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological counseling services include:

- treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are severe enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.
New York
2(xii)(H)

Providers: Psychological counseling services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State Law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services in the community.

Services may be provided by:

- a New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed clinical social worker (LCSW), qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- the licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- the licensed master social worker's cases are discussed;
- the supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- the supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- the supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision.

TN #09-61 Approval Date April 26, 2010
Supersedes TN NEW Effective Date September 1, 2009
Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

5. **Skilled Nursing**

**Definition:** Skilled nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.60(a).

**Services:** Skilled nursing services provided by or through: a school district[; a Section 4201 school][; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law and must be provided to a child by a registered nurse acting within his or her scope of practice under New York State law, or by a NYS licensed practical nurse acting within his or her scope of practice under New York State law “under the direction of” a NYS licensed and registered nurse or licensed physician, dentist or other licensed health care provider authorized under the Nurse Practice Act. Skilled nursing services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE) when there is a specific need based on a medical condition of the child.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Skilled nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Skilled nursing services may include:

- health assessments and evaluations;
- medical treatments and procedures;
- administering and/or monitoring medication needed by the student during school hours; and
- consultation with licensed physicians, parents and staff regarding the effects of medication.
Providers: Skilled nursing services must be provided by:

- a New York State licensed registered nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or

- a New York State licensed practical nurse qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice “under the direction of” a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

“Under the direction of” means that the licensed registered nurse, physician or other licensed health care provider authorized under the Nurse Practice Act:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be provided by:

- a New York State licensed and registered nurse; or

- a New York State licensed practical nurse, under the direction of a New York State licensed and registered nurse, or licensed physician, dentist or other licensed health care practitioner legally authorized under the Nurse Practice Act.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES)
programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

6. Psychological Evaluations

**Definition:** Psychological evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a) and 42CFR Section 440.60(a).

Psychological evaluations provided by or through a school district[; a Section 4201 school]; a county in the State or the City of New York must have a referral from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law or an appropriate school official or other voluntary health or social agency and must be provided to a child by a qualified practitioner. Psychological evaluations must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results, and
- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

**Providers:** Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.
New York
2(xii)(L)

Services may be provided by:

- a New York State licensed and registered psychiatrist, qualified in accordance with 42CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or

- a New York State licensed and registered psychologist, qualified in accordance with 42CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

7. Medical Evaluations

**Definition:** Medical evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a).

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Medical evaluations provided by or through: a school district[; a Section 4201 school]; a county in the State or the City of New York must be performed by a physician, physician assistant, or nurse practitioner acting within the scope of his or her practice under New York State law. A medical evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

A medical evaluation is the recording of:

- chief complaints;
- present illness;

TN #17-0057
Supersedes TN #09-0061
Approval Date November 28, 2017
Effective Date July 1, 2017
• past medical history;
• personal history and social history;
• a system review;
• a complete physical evaluation;
• ordering of appropriate diagnostic tests and procedures, and
• recommended plan of treatment

Providers: A medical evaluation must be provided by a New York State licensed and registered, physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR Section 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

8. Medical Specialist Evaluations

Definition: Medical specialist evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a).

Services: Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Medical specialist evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner specialist acting within his or her scope of practice and related area of specialization. A medical specialist evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.
A medical specialist evaluation is:

- an examination of the affected bodily area or organ system and other symptomatic or related organ systems;
- the ordering of appropriate diagnostic tests and procedures, and
- the reviewing of the results and reporting on the tests and procedures.

**Providers:** A medical specialist evaluation must be provided by a qualified New York State licensed and registered physician, physician assistant, or nurse practitioner specialist practicing in the related area of specialization within his or her scope of practice under NYS law, in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a) and other applicable state and federal laws and regulations.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

**9. Audiological Evaluations**

**Definition:** Audiological evaluations as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.60(a) and 42CFR Section 440.110(c)(3).

**Services:** Audiological evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must have a written order from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and provided to a child by a qualified practitioner. An audiological evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If an audiological evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.
Medically necessary audiology services include but are not limited to:

- Identification of children with hearing loss;
- Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing; and
- Determination of the child’s need for group and individual amplification.

An audiological evaluation is the determination of the range, nature and degree of hearing loss including:

- Measurement of hearing acuity;
- Tests relating to air and bone conduction;
- Speech reception threshold;
- Speech discrimination;
- Conformity evaluations;
- Pure tone audiometry.

**Providers:** Audiology evaluation services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.60(a) and 42 CFR Section 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

**10. Special Transportation**

**Definition:** Special transportation outlined in this section of the State Plan is available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.
New York
2(xii)(P)

Services: Special transportation provided by or through a school district[; a Section 4201 school]; a county in the State or the City of New York must be included in the IEP as recommended by the Committee on Special Education (CSE), or the Committee on Preschool Special Education (CPSE). Special transportation arrangements must be identified in the IEP.

Special transportation is provided when a child requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR 300.34(c)(16)(iii).

Special transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered service (other than transportation), and both the Medicaid covered service and the need for special transportation are included in the child’s IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one way trip.

Providers: Special transportation services must be provided by a qualified Medicaid provider. Attendance documentation (bus logs) is required in order to bill Medicaid. In order to receive payment for services provided to a Medicaid recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered.

TN #17-0057 Approval Date November 28, 2017
Supersedes TN #09-0061 Effective Date July 1, 2017
6b. Prior approval is required for orthoptic training.

6c. Chiropractor services. Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient’s physician or primary care clinic.

6d. Clinical psychologists. Provision of clinical psychology services shall require referral by:
   1. The patient’s personal physician or medical resource, such as a clinic, acting as the patient’s physician;
   2. the medical director in an industrial concern;
   3. an appropriate school official;
   4. an official or voluntary health or social agency.
6d. Other Practitioner Services (Continued)

**Pharmacists as Immunizers**

1. Reimbursement will be provided to pharmacies for vaccines and anaphylaxis agents administered by certified pharmacists within the scope of their practice.

2. Service setting.

   Services will be provided by a certified pharmacist in a pharmacy or in other locations where mass immunization may take place, such as retail stores/outlets, assisted living centers, and health fairs.

3. Provider qualifications.

   Pharmacists must be currently licensed, registered and certified by the NYS Department of Education Board of Pharmacy to administer immunizations.

**Diabetes Self-Management Training by Pharmacists**

1. Reimbursement will be provided to pharmacies for Diabetes Self-Management Training (DSMT) when provided by licensed pharmacists within the scope of their practice.

2. Service setting: Services will be provided by a licensed pharmacist in a pharmacy that is accredited by a CMS approved national accreditation organization (NAO), such as the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), or Indian Health Services (IHS).

3. Provider qualifications: Pharmacists must be currently licensed and registered by the NYS Department of Education Board of Pharmacy. Pharmacies must be accredited by a CMS approved national accreditation organization.

4. Coverage parameters: A beneficiary with newly diagnosed diabetes or a beneficiary with diabetes who has a medically complex condition will be allowed up to 10 hours of Diabetes Self-Management Training (DSMT) during a continuous 6-month period. A beneficiary with diabetes who is medically stable may receive up to 1 hour of DSMT in a continuous 6-month period.
New York
2(xv)

6d. **Nurse Practitioner’s Services**

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.
6.d(i). **Other Licensed Practitioners (EPSDT only).** A non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law.

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist; or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

Inpatient hospital visits by these licensed practitioners are limited to those ordered by the child’s physician. Visits to nursing facilities are allowed for licensed professionals other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately. Visits to ICF-IDD facilities are non-covered. All NP-LBHP services provided while a person is a resident of an (Institution for Mental Diseases) (IMD), such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.

Non-physician licensed behavioral health practitioners (NP-LBHPs) will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

**Assurances:**

The State assures that all NP-LBHP services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

The State assures that NP-LBHP services do not include and FFP is not available for any of the following:

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR § 435.1010;
E. services to individuals residing in institutions for mental diseases as describe in 42 CFR § 435.1009;
F. recreational and social activities; and
G. services that must be covered elsewhere in the state Medicaid plan.
New York
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6a. **Medicaid does not cover routine hygienic care of the feet in the absence of pathology.**

Payment for podiatry services will be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife. Effective September 1, 2012, payment for podiatry services will include services provided to Medicaid recipients age 21 and older with a diagnosis of diabetes mellitus and only with a written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife. Date of implementation will occur on the first day of the month following 30 days after Federal approval of this provision in the State Plan.

Only a qualified podiatrist, per 18 NYCRR Section 505.12(a)(1), who is licensed and currently registered to practice podiatry in New York State by the State Education Department, can provide podiatry services.

Such podiatry care and services may only be provided upon written referral by a physician, physician’s assistant, nurse practitioner or nurse midwife, per their individual scope of practice consistent with New York State Education Law and the rules of the Commissioner of Education.

Nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescription drugs) for all recipients when ordered by a private practicing podiatrist.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.

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**TN #13-10**

**Supersedes TN #12-16**

**Approval Date** November 6, 2013

**Effective Date** October 1, 2013
New York
2(a)

[6b. Prior approval is required for orthoptic training.

6c. Chiropractor services.

Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient's physician or primary care clinic.

6d. Clinical psychologists.

Provision of clinical psychology services shall require referral by:

1. the patient's personal physician or medical resource, such as a clinic, acting as the patient's physician;
2. the medical director in an industrial concern;
3. an appropriate school official;
4. an official or voluntary health or social agency.]

7a. Home care services are medically necessary services (physician order required) provided by a Certified Home Health Agency (CHHA) to individuals, regardless of residence, in the home and community. Such services include both part time and intermittent skilled health care [and long-term] nursing and home health aide services. Home (health) care services include nursing, home health aide, physical therapy, occupational therapy, and speech therapy. [Patients must be assessed as being appropriate for intermittent or part-time nursing services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service].

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 or the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.
7b. Home Health aide will mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides will have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies (CHHA) may provide home health services pursuant to the requirements of 42 CFR 440.70(b)(2). Home health services may be provided to income and/or medically eligible participants in home and community based settings, which could be the individual's home.
AIDS home care services providers qualifications are provided pursuant to Article 36 of the PHL.

The State assures the provision of AIDS home care services will be provided in accordance with 42 CFR 440.70 (for the provision of home health services).
Home Telehealth Services

Beginning on 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 and enteral feeding.
Telehealth Services - Remote Patient Monitoring

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth services provided by remote patient monitoring.

The purpose of providing telehealth remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Telehealth remote patient monitoring services use synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an “originating site”; this information is then transmitted to a provider at a “distant site” for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding. Telehealth remote patient monitoring services [may be provided] will be ordered by a [facility licensed under Article 28 of Public Health Law or by a] physician, nurse practitioner, or [a] midwife [, or physician assistant who has examined the patient and] with whom the patient has [an established,] substantial and ongoing relationship. [Payment for remote patient monitoring while receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to public health law 3614 section (3-c) (a-d).] Telehealth remote patient monitoring services are based on medical necessity and should be discontinued when the patient’s condition is determined to be stable/controlled.

[The Commissioner will reimburse for telehealth remote patient monitoring services 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.]

All services delivered via telehealth remote patient monitoring must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.
Telehealth Services – Store and Forward

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth store and forward technology.

Telehealth store and forward technology is 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.

[Telehealth store and forward technology may be utilized in the specialty areas of dermatology, ophthalmology and other disciplines, as determined by the Commissioner.]

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 services, specifically 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.]

All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.
7c. **Certain specialty items require prior approval.**

These items are identified for equipment dealers in the MMIS DME Provider Manual. Prior approval is required for most repairs to durable medical equipment. Personal Emergency Response Services (PERS) are provided according to [LDSS] Local Social Services District (LSSD) written authorization for recipients of personal care services and home health services ordered by a physician pursuant to a written plan of care.

7d. Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department. The state assures the provision of physical therapy services will be provided in accordance with 42 CFR 440.110(a)(2)(i) and 440.110(a)(2)(ii).

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association. The state assures the provision of occupational therapy services will be provided in accordance with 42 CFR 440.110(b)(2)(i) and 440.110(b)(2)(ii).

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law. The state assures the provision of speech therapy services will be provided in accordance with 42 CFR 440.110(c)(2).

8. Private Duty Nursing (PDN) is medically necessary nursing services, ordered by and in accordance with a written physician's treatment plan, provided in a person's home on a continuous basis normally considered beyond such nursing services available from a Certified Home Health Agency (CHHA) or intermittent nursing services normally provided through a CHHA but which are unavailable. Prior approval is required for private duty nursing services either in a person's home or in a hospital except in an urgent situation in which the attending physician may order the services for no more than two nursing days.

Care and services of a private duty nurse will be provided only if they are in accordance with the regulations of the Department of Health.

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New York  
2(a)(iv)

Service providers who provide private duty nursing include a Licensed Home Care Services Agency’s (LHCSA) registered nurses (NS) or licensed practical nurses (LPN) enrolled on an independent practitioner basis.

Nurses providing PDN must possess a license to practice in the State of New York and be currently registered by the New York State Education Department (NYSED). In addition, nurses providing an appropriate attestation regarding their training and ability to care for medically fragile children receive a Specialty code on their file entitling them to increased reimbursement for the provision of such care.

The State assures that the provision of PDN will be provided in accordance with 42 CFR 440.80.

9. Clinic services provided in Article 28 clinics are in accordance with 42 CFR §440.90 title clinical services. Requirements for physicians supervision comply with the State Medicaid Manual, §4320B titled Physician Direction Requirement.
New York
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Collaborative Care Services: Freestanding Clinics

Effective January 1, 2015, Freestanding Clinics licensed pursuant to Article 28 of the Public Health Law will provide Collaborative Care Services for purposes of providing integrated physical and mental health care to patients diagnosed with mental illness. Freestanding Clinics must obtain prior approval from the New York State Department of Health and the New York State Office of Mental Health to furnish Collaborative Care Services. Collaborative Care Services include screening, diagnostic, preventative and therapeutic services to treat the symptoms of mental illness.

Collaborative Care Services include a minimum of one clinical contact between the Collaborative Care Manager and the patient per month, and the completion of the screening tool for the patient’s specific mental illness diagnosis specified by the New York State Office of Mental Health. The clinical contact with the Collaborative Care Manager may be by phone or in person. Collaborative Care Services also include a minimum of at least one face-to-face contact between a licensed provider and the patient once every three months.

A patient is limited to 12 months of Collaborative Care Services, which are not required to be consecutive. With the prior approval of the New York State Office of Mental Health, a patient may receive an additional 12 months of Collaborative Care Services, which are not required to be consecutive.
9a. Clinic Services provided in Article 31 clinics licensed by the New York State Office of Mental Health (OMH) are in accordance with 42 CFR § 440.90 title clinic services. Such services include Clinic Treatment Services, Partial Hospitalization, Continuing Day Treatment, and Day Treatment Services for Children. Any limitations on the amount, duration or scope of these services may be exceeded based on medical necessity for Medicaid beneficiaries under the age of 21.

OMH-licensed clinic services are provided under the direction of a physician in accordance with 42 CFR § 440.90 and comply with § 4320B of the State Medicaid Manual. A physician must see the patient at least once, approve the patient's treatment plan, and periodically review the need for continued care. The physician assumes professional responsibility for the services provided and assures that the services are medically appropriate and provided in a safe and efficient manner in accordance with accepted medical standards. The physician may be either an employee of the OMH-licensed clinic service provider or affiliated with the provider. OMH-licensed clinic service providers choosing to utilize affiliated physicians must enter into a contractual agreement or some other type of formal arrangement obligating the physician to supervise the care provided to the OMH-licensed clinic service provider's patients.

1. **Clinic Treatment Services**

Clinic Treatment Services are preventive, diagnostic, therapeutic, and rehabilitative mental health services. Clinic Treatment Services are provided based upon the clinical assessment of an individual's mental, physical and behavioral condition and history, which is the basis for establishing the individual's diagnosis. Medically necessary Clinic Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Clinic Treatment Services include: Initial Assessment; Psychiatric Assessment; Psychotherapy; Psychotropic Medication Treatment; Injectable Psychotropic Administration and Monitoring; Crisis Intervention; Complex Care Management; Developmental Testing, Psychological Testing; Psychiatric Consultation; Health Physical; Health Monitoring; Smoking Cessation Treatment; and Screening, Brief Intervention, and Referral to Treatment.

2. **Partial Hospitalization Services**

Partial Hospitalization Services are preventive, diagnostic, therapeutic, and rehabilitative intensive mental health services which are designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay within a medically supervised program. Partial Hospitalization Services are provided based upon the clinical assessment of an individual's mental, physical and behavioral condition and history, which is the basis for establishing the individual's diagnosis, functional deficits, and recovery goals. Medically necessary Partial Hospitalization Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Partial Hospitalization Services include: Health Screening and Referral; Preadmission
Screening; Symptom Management; Medication Therapy; Medication Skill-Building; Verbal Therapy; Rehabilitation Readiness Assessment and Development; Crisis Intervention Services; Functional Skill Development; Clinical Support Services; and Discharge Planning Services.

Partial Hospitalization services are provided in preadmission visits for individuals prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may also be provided to collaterals, who are members of the individual’s family or household, or others who regularly interact with the individual and are directly affected by or can affect the individual’s condition and are identified in the treatment plan as having a role in the individual’s treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary. Collateral and group collateral visits are limited to two hours per day.

Other limitations on amount and duration of Partial Hospitalization Services include:

i. Reimbursement is limited to no more than 180 hours per course of treatment. A course of treatment shall not exceed six calendar weeks, unless during the course of treatment the recipient is admitted to an inpatient psychiatric facility. Such course of treatment may be extended to include the number of days of inpatient treatment, up to a maximum of 30 days. Partial Hospitalization Services provided during crisis, collateral or group collateral visits do not count towards the 180 hour maximum.

ii. Reimbursement is limited to 360 hours per calendar year. Services provided during crisis, collateral or group collateral visits do not count towards the 360 hour maximum.

iii. Reimbursement is limited to one visit, including preadmission visits (of up to 7 hours) and one individual or group collateral visit (of up to 2 hours) per individual per day. Additional Partial Hospitalization Services may be provided on the same day during a crisis visit.

3. Continuing Day Treatment Services

Continuing Day Treatment Services are mental health preventive, diagnostic, therapeutic, and rehabilitative services. Continuing Day Treatment Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. Medically necessary Continuing Day Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Continuing Day
Treatment Services include: Health Screening and Referral; Preadmission Screening; Symptom Management; Medication Therapy; Medication Skill-Building; Verbal therapy; Rehabilitation Readiness Assessment and Development; Crisis Intervention Services; Functional Skill Development; Clinical Support services; and, Discharge Planning Services.

Continuing Day Treatment Preadmission Screening services are provided in preadmission visits for individuals prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may be provided to collaterals, who are members of the individual’s family or household, or others who regularly interact with the individual and are directly affected by or can affect the individual’s condition and are identified in the treatment plan as having a role in the individual’s treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary.

Other limitations on amount and duration of Continuing Day Treatment Services include:

i. Reimbursement is limited to one visit, including preadmission visits and one individual or group collateral visit per recipient per day. Additional Continuing Day Treatment Services may be provided on the same day during a crisis visit.

ii. Continuing Day Treatment services are not reimbursable if an individual is concurrently receiving Clinic Treatment Services, except where either:
   a. an individual is in transition from Clinic Treatment Services to Continuing Day Treatment Services, in which case reimbursement is permitted for a maximum of three Continuing Day Treatment preadmission visits; or
   b. an individual is enrolled in Clinic Treatment Services solely for the purpose of Clozapine Medication Therapy.

4. **Day Treatment Services for Children**

Day Treatment Services for Children are preventive, diagnostic, therapeutic, and rehabilitative mental health services designed to stabilize children’s adjustment to educational settings, prepare children for return to educational settings, and transition children to educational settings. Medicaid reimbursement is not available for educational activities, which are the sole responsibility of the school district of the child’s residence. Day Treatment Services for Children may be provided in free-standing clinics located within schools. Medically necessary Day Treatment Services for Children include: Medication Therapy; Verbal Therapy; Crisis

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TN #10-0018

Approval Date November 1, 2017

Supersedes TN NEW

Effective Date July 1, 2010
Intervention Services; Clinical Support Services; Task and Skill Development; Social Skill Development; Recreational Rehabilitation Services; and Discharge Planning Services.

Day Treatment Services for Children are provided in preadmission visits for children prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may also be provided to collaterals, who are members of the child’s family or household, or others who regularly interact with the child and are directly affected by or can affect the child’s condition and are identified in the treatment plan as having a role in the child’s treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary.

Other limitations on amount and duration of Day Treatment Services for Children include:

i. Reimbursement is limited to one visit, including preadmission visits and one collateral visit per child per day. Additional Day Treatment Services for Children may be provided on the same day during a crisis visit.

ii. Day Treatment Services for Children are not reimbursable if a child is concurrently receiving Clinic Treatment Services, except where either:
   a. a child is in transition from Clinic Treatment Services to Day Treatment Services for Children, in which case reimbursement is permitted for a maximum of three Day Treatment Services for Children preadmission visits; or
   b. a child is enrolled in Clinic Treatment Services solely for the purpose of Clozapine Medication Therapy.
10. Prior approval is required for all dental care except preventive prophylactic and other routine dental care services and supplies.

12a. Prior authorization or dispensing validation is required for some prescription drugs. The State has established a preferred drug program with prior authorization for drugs not included on the preferred drug list. The prior authorization complies with the requirements of Section 1927(d)(5) of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health. Prior authorization is required for a generic equivalent of a brand name drug, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. Outpatient drugs of any manufacturer which has entered into and complies with a rebate agreement under Sections 1902(a)(54) and 1927(a) of the Act with the Centers for Medicare and Medicaid Services (CMS) which are prescribed for a medically accepted indication. All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. Drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. §1396r-8(d)(2)(K), are not a covered service, on and after April 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration.

2. Supplemental Rebate Programs

The State is in compliance with Section 1927 of the Social Security Act. The State has the following policies for the Supplemental Rebate Programs for the Medicaid population.

a) CMS has authorized the State of New York to enter into the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on March 30, 2006 have been authorized for pharmaceutical manufacturers’ existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on June 30, 2013 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

b) CMS has authorized the State of New York to enter into Medicaid State-specific Supplemental Rebate Agreement directly with manufacturers to receive supplemental rebates of covered outpatient drugs for Medicaid beneficiaries. The State-specific Supplemental Rebate Agreement was submitted to CMS on [March 31, 2010] December 31, 2014 and has been authorized by CMS.
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c) The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turn-around response by either telephone or telecommunications device from the receipt of a prior authorization request. In emergency situations, providers may dispense a 72-hour supply of medications.

d) The terms of the supplemental rebate programs apply only to covered outpatient drugs for which the State is eligible for federal financial participation. Supplemental rebates received by the State in excess of those required under the National Drug Rebate Program will be shared with the Federal Government on the same percentage basis as applied under the National Drug Rebate Agreement.

e) Any Supplemental Rebate Agreement not authorized by CMS will be submitted to CMS for authorization.

f) All drugs covered by the programs will comply with the provisions of the national drug rebate agreement.

3. Any changes to the NMPI Supplemental Rebate Agreement must be submitted to CMS for authorization. Any changes to the State-specific Supplemental Rebate Agreement NY State holds directly with the manufacturer must be submitted to CMS for authorization.

4. As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

5. As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.
6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

- The following excluded drugs are covered:
  - (a) agents when used for anorexia, weight loss, weight gain
  - (b) agents when used to promote fertility: Some - bromocriptine, clomiphene citrate, letrozole, and tamoxifen only.
  - (c) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
  - (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
  - (e) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products, minerals and vitamin combinations
  - (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
8. The State will cover APIs that are included in extemporaneously compounded prescriptions when the API serves as the active drug component in the compounded formulation. A current list of covered APIs can be found at the following at:

https://www.emedny.org/info/formfile.aspx

13c. Preventive Services

New York State Medicaid covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing, when provided in a practitioner’s office.

Preventive Services specified in section 4106 of the Affordable Care Act are all available under the State Plan and are covered under the physician, other practitioner, nurse-midwife and nurse practitioner service benefits and are reimbursed according to the methodologies provided in Attachment 4.19-B.

The State will maintain documentation supporting expenditures claimed for these Preventive Services and ensure that coverage and billing codes comply with any changes made to the USPSTF or ACIP recommendations.
13d. **Harm Reduction Services**

Harm reduction services represent a fully integrated client-oriented approach to care. Such services are remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. The role of the harm reduction service is to ensure that clients obtain needed services at the appropriate time by assessing and reducing any barriers to accessing these programs. Harm reduction services begin immediately as service needs are assessed. The determination of the type(s) of service, frequency, and intensity is an ongoing responsibility of the harm reduction staff, and there is no limitation in the amount, duration, and scope of services. Harm reduction services continue until the staff determine that the service goals have been met or if the client decides he/she no longer wants to participate in programming.

Harm reduction programs will provide the following:

1. Development of a Treatment Plan
2. Individual/Group Supportive Counseling
3. Medication management and Treatment Adherence Counseling
4. Psychoeducation - Support groups

**1. Development of a Treatment Plan**

**Definition:** Development of a treatment plan through either an initial assessment or a scheduled or event-generated reassessment for harm reduction services is part of a package of remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. Referrals may be made for more intensive behavioral interventions, support groups, wellness services, substance use disorder (SUD) treatment, and overdose prevention as needed.

A reassessment is a scheduled or event-generated formal re-examination of the client’s situation, functioning, substance use, and medical and psychosocial needs to identify changes which have occurred since the initial or most recent assessment. The reassessment measures progress toward the desired goals and is used to prepare a new or revised harm reduction program plan or confirm that current services remain appropriate.

There are no limitations on the amount, duration, and scope of these services.

**Providers:** Services must be provided by:

- a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience either
  1) providing community-based services to active substance users or persons living with a history of substance use or
  2) providing harm reduction or community-based social services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations;

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TN _____#13-0019  Approval Date _August 10, 2017_  
Supersedes TN _____NEW_____  Effective Date __April 01, 2014__
• or a case worker who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience in case management or related supportive services position serving women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations, including one year of HIV-related experience; or

• director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor’s degree and at least three (3) years’ experience in the provision of supportive services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations; or

• a peer who has been certified through a Department-approved certification program or one conducted by another entity recognized by the Department and who is supervised by the director of harm reduction services. A person seeking harm reduction peer certification is required to complete 68 training hours of core courses such as Introduction to HIV, STIs, and Viral Hepatitis; Sex, Gender, and HIV; and Overview of Harm Reduction Counseling, as well as courses addressing health and medical needs and cultural competency among at-risk populations and health literacy. An additional 22 hours of training are required in topics specific to harm reduction among substance users and include promoting PrEP; retention in care; opioid overdose prevention; HCV prevention; safer injection and wound care; and addressing sexual risk. Other requirements for certification include completing a 500-hour practicum and passing a knowledge assessment. Certified peers must complete at least 10 hours of training annually to maintain their certification.

2. Individual/Group Supportive Counseling

Definition: Supportive counseling services are part of a package of remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. Effective supportive counseling assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and to restore them to their best possible functional level. Supportive counseling may be provided to an individual or in a group setting and can cover such topics as HIV/HCV/STD status or substance use disclosure to family members and friends; addressing stigma for drug users in accessing services; how to maximize health care services interactions; how to reduce substance use or use more safely and avoid overdose; and how to address anxiety, anger, and depressive episodes. There are no limitations on the amount, duration, and scope of these services.

Providers: Services must be provided by:

• a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience either 1) providing community-based services to active substance users or persons living with a history of substance use or 2) providing harm reduction or community-based social services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations;
• or a case worker who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience in case management or related supportive services position serving women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations, including one year of HIV-related experience; or

• director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor’s degree and at least three (3) years’ experience in the provision of supportive services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations.

3. Medication Management and Treatment Adherence Counseling
Medication management and treatment adherence counseling assists clients to recognize the need for medication to address substance use or psychiatric issues, reinforce the importance of adherence to treatment regimens, and identify tools to follow the prescribed regimens. Such services are remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. There are no limitations on the amount, duration, and scope of these services.

Providers: Services must be provided by:
• a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential and has at least three (3) years’ experience in case management or related supportive services position; or

• director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor’s degree and has at least three (3) years’ experience in the provision of supportive services and supervision of staff; or

• a peer who has achieved Department-approved certification and is supervised by the director of harm reduction services.

4. Psychoeducation - Support Groups
Definition: Support groups are stand-alone services that may also be used to supplement individual and/or group supportive counseling. Such services are remedial services recommended by a physician or other licensed practitioner. Support groups restore individuals to his or her best possible functional level by focusing on group members’ issues and experiences relative to substance use, finances, medical/health care, support system, incarceration history and other factors that contribute to risk behaviors for HIV/STD/HCV. Support groups may be facilitated by a direct service provider, a case worker, or the director of harm reduction services or co-facilitated by a peer. There are no limitations on the amount, duration, and scope of these services.
Providers: Services must be provided by:

- a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience as a direct service provider in a supportive services position; or
- a case worker who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience in case management or a related supportive services position; or
- director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor's degree and at least three (3) years’ experience in the provision of supportive services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations and
- a peer who has achieved Department-approved certification and is supervised by the director of harm reduction services.

Qualifications of Provider Organizations

Community-based organizations, including local health units, facilities licensed under Article 28 of New York State Public Health Law, and non-profit organizations that have been approved by the Commissioner of Health with a waiver to conduct a comprehensive harm reduction program, including syringe exchange.

Freedom of Choice - Access to Services

The State assures that the provision of harm reduction services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.
1. Access to services will be limited to the authorized syringe exchange programs.
2. Eligible recipients will have free choice of the providers of harm reduction services within the specified geographic area identified in this Plan.
3. Eligible recipients will have free choice of the providers of other medical care under the Plan.
4. Eligible recipients who refuse harm reduction services will not be denied access to other services offered under the Plan.
5. Harm reduction program services will not be used to restrict an individual's access to other services under the Plan.
Limitations

Harm reduction program services do not include the following:

- case management activities that are an integral component of another covered Medicaid service; and
- substance use disorder treatment services.

Harm reduction program services:

- must not be utilized to restrict the choice of services a recipient can obtain, including medical care or services from any provider participating in the Medical Assistance program that is qualified to provide such or who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis; and
- must not duplicate certain services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care program, AIDS Home Care program under 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).
“Off-site” services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

“Early Intervention” Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

1. Screening  
2. Evaluation  
3. Audiology  
4. Nursing  
5. Nutrition Services  
6. Occupational Therapy  
7. Physical Therapy  
8. Psychological Services  
9. Social Work Services  
10. Anticipatory Guidance (Special Instruction and Allied Health Professional Assistance)  
11. Speech Pathology Services  
12. Assistive Technology Services  
13. Vision Services  
14. Collateral contacts for all of the above services
New York Supplement

10. Prior approval is required for all dental care except preventive prophylactic and other routine dental care services and supplies.

12a. Prior authorization or dispensing validation is required for some prescription drugs. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. those non-prescription drugs contained on a list established by the New York State Commissioner of Health.
2. covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Sections 1902(a) (54) and 1927 (a) of the Act which are prescribed for a medically accepted indication. (As provided by Section 1927 (d) (2) of the Act certain outpatient drugs may be excluded from coverage).

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual. Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.


13b. Screening Services (see 13.d Rehabilitative Services - Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services - Early Intervention).

13d. Rehabilitative Services

(1) Directly Observed Therapy (DOT) - Clients must be assessed as medically appropriate for DOT based upon the client’s risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

"Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679. Coverage of “off-site” services shall end effective December 31, 2015.

“Early Intervention” Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

5. Nutrition Services  10. Anticipatory Guidance
(Special Instruction and Allied Health Professional Assistance)

TN #10-0018 Approval Date November 1, 2017
Supersedes TN #04-41 Effective Date July 1, 2010
New York
3.1

[13d. Rehabilitative Services:

School Supportive Health Services

School Supportive Health Services are services provided by or through local school districts or the New York City Board of Education to children with, or suspected of having disabilities, who attend public or State Education Department approved private schools. These services, which are provided to children with special needs pursuant to an Individualized Education Program (IEP) and are limited to EPSDT, are:

1. Physical therapy services
2. Occupational therapy services
3. Speech pathology services
4. Audiological evaluations
5. Evaluations for all available services
6. Nursing Services
7. Psychological and social work services (psychological counseling)
8. Transportation see Supplement to Attachment 3.1.A, Item 24a
9. Medical evaluations (physician, physician assistant and nurse practitioner)

Preschool Supportive Health Services

Preschool Supportive Health Services are services provided by or through counties or the New York City Board of Education to children, with or suspected of having disabilities, who attend State Education Department approved preschools. These services, which are provided to children with special needs pursuant to an Individual Education Program (IEP) and are limited to EPSDT, are:

1. Physical therapy services
2. Occupational therapy services
3. Speech pathology services
4. Audiological evaluation
5. Evaluations for all available services
6. Nursing services
7. Psychological and social work services (psychological counseling)
8. Transportation see Supplement to Attachment 3.1.A, Item 24a
9. Medical evaluations (physician, physician assistant and nurse practitioner)
13.d  (Cont’d) Rehabilitative services for residents of community-based residential programs licensed by the Office of Mental Health (OMH) are of three types:

1. Community residences of sixteen beds or less;
2. Family-based treatment and
3. Teaching family homes.

1. Community Residences

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person’s mental illness. Community residences for adults may be either a congregate-type arrangement or apartment-based. Community residence services are also provided to children.

Limitations on services include the following:

- All providers must be currently licensed by OMH as community residences under 14 NYCRR 586 and 594. Congregate locations have sixteen beds or less.
- Adults admitted must be determined to have a severe and persistent mental illness, as defined by the Commissioner of OMH.
- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.
- Services are limited to those described in 14 NYCRR 593.
- All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

2. Family-based treatment

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child’s developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.
Limitations on services include the following:

- All providers must be currently licensed by OMH as family-based treatment programs under 14 NYCRR 594.

- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.

- Services are limited to those described in 14 NYCRR 593.

- All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

3. Teaching Family Homes

Rehabilitative services in teaching family homes are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child’s developmental stage. Eligible children are placed in small congregate care homes (4 children or less) in a supervised living arrangement with approved teaching parents, based on the National Teaching Family Model.

This program is different from family based treatment because some children are not able to tolerate the family closeness of family based treatment programs, and, therefore, are more appropriately treated in teaching family homes.

Limitations on services include the following:

- All providers must be currently licensed by OMH as teaching family homes under 14 NYCRR 594.

- Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.

- Services are limited to those described in 14 NYCRR 593.

- All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.
13.d. Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) programs will provide case management, treatment and rehabilitation to persons with a serious psychiatric disorder who exhibit a pattern of institutional utilization and/or are at risk of a severely dysfunctional lifestyle; present symptoms and impairments not effectively remedied by other available treatment; do not or cannot be engaged in treatment in other outpatient settings as a result of their mental illness; or cannot maintain consistency in treatment through other outpatient services.

Programs will be licensed under 14 NYCRR Part 508. Services will be provided primarily in the community. Services will be provided 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. Of these six contacts, at least three of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of two face to face contacts per month. Individuals shall be allowed to alternate between the full ACT team services and step-down services depending on the level of services needed to remain in the community.
13d. **Rehabilitative Services**

**Personalized Recovery Oriented Services**

A comprehensive Personalized Recovery Oriented Services (PROS) program will provide Community Rehabilitation and Support, Intensive Rehabilitation and Ongoing Rehabilitation and Support. A “limited license” will be made available for free-standing Intensive Rehabilitation and Ongoing Rehabilitation and Support programs that are operated by a provider that does not have the capability to offer Community Rehabilitation and Support.

Community Rehabilitation and Support (CRS) is designed to engage and assist individuals in managing their mental illness and in restoring those skills and supports necessary to live successfully in the community. Intensive Rehabilitation (IR) is a customized package of rehabilitation and support services designed to intensely assist an individual in attaining specific life goals such as successful completion of school, attainment of stable and independent housing, and gainful employment. Intensive Rehabilitation services may also be used to provide targeted interventions to reduce the risk of hospitalization, loss of housing, involvement in the criminal justice system, and to help individuals manage their symptoms. Ongoing Rehabilitation and Support (ORS) will provide interventions designed to assist in managing symptoms in an integrated workplace setting.

PROS programs will offer a comprehensive menu of services, customized for each client through development of an individualized recovery plan. Services provided by the CRS component of a PROS program will include but are not limited to: engagement; assessment; wellness self-management; basic living skills training; benefits and financial management; community living skills exploration; crisis intervention; individual recovery planning; information and education regarding self help; and structured skill development and support. Services provided by the IR component of a PROS program will include but are not limited to: family psychoeducation; intensive rehabilitation goal acquisition; clinical counseling and therapy; and intensive relapse prevention. Service provided in the IR component of a “limited license” PROS program will include, but is not limited to, intensive rehabilitation goal acquisition for employment and education-oriented goals. Services provided by the ORS component of a PROS program will include, but not limited to, vocational support services, defined as the ongoing provision of counseling, mentoring and advocacy services designed to sustain an individual’s role in integrated employment by providing supports which assist the individual in symptom management. PROS services will be provided both onsite and offsite, but ORS services will always be provided off-site in the community.

Programs may, at their option, provide clinical treatment services designed to stabilize ameliorate and control the disabling symptoms of mental illness. Programs that provide clinical treatment services will be reimbursed at a higher rate for the clinic component than programs which do not provide clinical treatment services.
13d. Rehabilitative Services

**Personalized Recovery Oriented Services - continued**

The goal of the program is to provide integrated services, but clients can choose to receive service from different service components in more than one program. Clients enrolled in a PROS program which provides clinical treatment services will be given free choice as to whether they wish to receive clinical treatment through the PROS program, or receive those services from a clinic licensed under 14 NYCRR Part 587.

Programs will be licensed and reimbursed under criteria set forth in 14 NYCRR Part 512. Staffing requirements will include differing staff to client ratios depending on the component of services the program offers.
Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services
1905(a) (13)
42 CFR 440.130(d)

Item 4.b, EPSDT services - **Rehabilitative Services: 42 CFR 440.130(d)**

The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

Provided as an Early and Periodic Screening, Diagnostic and Treatment service for individuals who are eligible under the plan and are under the age of 21 1902(a) (43), 1905(a) (4) (B) and 1905(r)).

**Rehabilitative Services Description**

The rehabilitative service (or services) described below is:
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Family Peer Support

**Assurances:**

The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902 (a) (10)(A)(i) of the Act.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a) (13) of the Act.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR §435.1010;
E. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
F. recreational and social activities; and-
G. services that must be covered elsewhere in the state Medicaid plan.
Crisis Intervention (Continued):

Description (Continued):

not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically sensitive and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Licensed Psychologist. CI is a face-to-face intervention and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically sensitive, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.

Practitioner qualifications: Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (of at least two professionals unless noted below), for programmatic or safety purposes. One member of a two-person crisis intervention team must be a behavioral health professional and have experience with crisis intervention service delivery. If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed practitioner must be available via phone. A peer support specialist may not respond alone. Behavioral health professionals are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. For Crisis Intervention, these behavioral health professionals include: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders OR one practitioner from the above list and one practitioner from the following who is]
[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

not considered a behavioral health professional: Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential/certification as either:
1) An OMH established Family Peer Advocate credential, or
2) An OASAS established Certified Recovery Peer Advocate - Family.

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:

• Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child (ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
• Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
• Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates training or approved comparable training.
• Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
• Documented 1000 hours of experience providing Family Peer Support services.
• Agreed to practice according to the Family Peer Advocate Code of Ethics.
• Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential and complete all other requirements of the professional family peer advocate credential that will allow services they provide to be billed if the applicant has:
• Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.]
[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

An FPA may obtain a provisional credential if the applicant has (Continued)
• Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
• Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
• Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a provisional credential must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA OR Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

To be certified as CRPA-Family, the individual must be at least 18 years of age and have the following:
• Have ‘lived experience’ as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
• Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
• Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication assisted treatment and ethical responsibility.
• Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor’s degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour Recovery Coach Academy training.
• Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
• Passed the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
• Submitted two letters of recommendation.
• Demonstrated a minimum of 16 hours in the area of Family Support.
• Completed 20 hours of continuing education earned every two years, including six hours of Ethics.]
[13d. Rehabilitative Services: EPSDT only (Continued):
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient’s treatment/recovery plan.

Crisis Intervention Team Training: All members of the Crisis Intervention team are required to have training in first aid, CPR, Mandated Reporting, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SAFETALK), and crisis plan development.

Supervisor Qualifications: The supervisor is a competent mental health professional and must provide regularly scheduled supervision for all team members including peers. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. The supervisor must practice within the State health practice laws and ensure that providers are supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services or any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide comparable and appropriate crisis services referenced in the definition.]
[13d. Rehabilitative Services: EPSDT only (Continued)

Crisis Intervention Components:

**Mental Health and Substance Abuse Services Assessment:**
**Description:** Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.

**Practitioner qualifications:** Assessments may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

**Service Planning:**
**Description:** Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases.

**Practitioner qualifications:** Service Planning may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

**Individual Counseling/Therapy**
**Describe:** Crisis resolution and debriefing with the identified Medicaid eligible child, the child’s family/caregiver and treatment provider.

**Practitioner qualifications:** Individual Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.]
Family Counseling/Therapy

Describe: Crisis resolution and debriefing with the child’s family/caregiver and the treatment provider.

Practitioner qualifications: Family Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Care Coordination:

Description: Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child’s specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.

Practitioner qualifications: Care Coordination may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Peer/Family Peer Support:

Describe: Crisis resolution with the identified Medicaid eligible child, the child’s family/caregiver and the treatment provider.

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family as defined above in this section.]
13d. Rehabilitative Services: EPSDT only (Continued)

Program Name: Community Psychiatric Support and Treatment (CPST)

Description: Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child’s treatment plan. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions approved by New York State. CPST is a face-to-face intervention with the child, family/caregiver or other collateral supports. This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Counselor, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the child lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. CPST face-to-face interventions may include other collateral supports beyond the individual or family/caregiver, as necessary.

Practitioner qualifications: CPST may be provided by an individual who has at least a bachelor’s degree level with a minimum of two years of applicable experience in children’s mental health, addiction, and/or foster care/child welfare/juvenile justice. These practitioners may include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license.

Practitioners with a bachelor's degree may only perform the following activities under CPST: Family and Group Counseling/Therapy (Rehabilitative psychoeducation), Service Planning (Strengths-based treatment planning), or the Rehabilitative Supports portion of Individual and Group Counseling/Therapy.

Practitioners with at least a bachelor’s degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master’s degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice may perform any of the activities under CPST listed above without any exclusions.

The interventions and skill building identified by the CPST practitioner and family may be implemented by the child and family with the assistance of a peer (under Peer Supports Services), Psychosocial Rehabilitation practitioner (under Psychosocial Rehabilitation Services) or the CPST practitioner, if necessary.

TN #19-0003 Approval Date 02/07/2019
Supersedes TN #18-0053 Effective Date 01/01/2019
13d. **Rehabilitative Services: EPSDT only (Continued)**

**Community Psychiatric Support and Treatment (CPST) Description (Continued)**

**Practitioner Qualifications (Continued)**

**Supervisor Qualifications:** Individuals providing services under CPST must receive regularly scheduled supervision from a professional meeting the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

**Provider Agency Qualifications:** Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. CPST service delivery may also include collateral contact. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.

**Service Planning (Strengths-based treatment planning):**

**Description:** Strengths-based treatment planning - Facilitate participation in and utilization of strengths-based planning for Medicaid services and treatments related to child’s behavioral health/health needs which include assisting the child and family members, caregiver or other collateral supports with identifying strengths and needs, resources, natural supports, within the context of the client’s culture and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health disorder.

**Practitioner Qualifications:** Strengths-based treatment planning may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children’s mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR A master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
13d. Rehabilitative Services: EPSDT only (Continued)
Program Name: Community Psychiatric Support and Treatment (CPST) (Continued):

**Individual Counseling/Therapy (Intensive Interventions):**
**Description:** Intensive Interventions - Provide individual supportive treatment and counseling; solution-focused interventions consistent with cognitive behavior therapy and psycho-educational therapy; harm reduction; emotional, cognitive and behavioral management; and problem behavior analysis with the child and family/caregiver, with the goal of assisting the child with social, interpersonal, self-care, daily functioning, and independent living skills to restore stability, to support functional gains and to adapt to community living. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence based psychotherapeutic interventions with prior authorization from NYS that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

**Individual Counseling/Therapy (Crisis Avoidance):**
**Description:** Crisis Avoidance - Assist the child and family/caregiver with effectively responding to or preventing identified precursors or triggers that would risk their ability to remain in a natural community location, including assisting the child and family members, caregivers or other collateral supports with identifying a potential psychiatric or personal crisis; practicing de-escalation skills; developing a crisis management plan; assessing the step-by-step plan before a crisis occurs; developing strategies to take medication regularly; and seeking other supports to restore stability and functioning.

**Individual Counseling/Therapy (Rehabilitative Supports):**
**Description:** Rehabilitative Supports - Restoration, rehabilitation, and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the individual's daily functioning. Counseling helps restore life safety skills such as ability to access emergency services, basic safety practices and evacuation, physical and behavioral health care (maintenance, scheduling physicians appointments) recognizing when to contact a physician, self-administration of medication for physical and mental health or substance use disorder conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses. Group face-to-face counseling may occur in rehabilitative supports.

**Practitioner qualifications:**
Rehabilitative Supports components of Individual Counseling/Therapy may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/ juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Individual, family and Group Counseling/Therapy (Rehabilitative Supports) (Continued):
Practitioner Qualifications (Continued):

Intensive Interventions and Crisis avoidance may only be performed by practitioners who have at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative psychoeducation):
Description: Rehabilitative psychoeducation - Assist the child and family members, caregivers or other collateral supports to identify appropriate strategies or treatment options for the child’s behavioral health needs, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances, substance use or associated behavioral health stressors that interfere with the child’s life.

Practitioner qualifications: Rehabilitative psychoeducation may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children’s mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor’s degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master’s degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative supports in the community):
Description: Rehabilitative supports in the community - Provide restoration, rehabilitation, and support to the child and family members, caregivers or other collateral supports to develop skills necessary to meet the child’s goals and to sustain the identified community goals.

Practitioner qualifications: Rehabilitative supports in the community may be provided by an individual with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master’s degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
13d. Rehabilitative Services: EPSDT only (Continued)

Community Psychiatric Support and Treatment (CPST) (Continued):

CPST Components (Continued):

Crisis Intervention (Intermediate term crisis management):

Description: Intermediate term crisis management - Provide intermediate-term crisis management to the child and family following a crisis (beyond 72 hour period) as stated in the crisis management plan. The purpose of this activity is to stabilize the child/youth in the home and natural environment. Goal setting is focused upon the issues identified from crisis intervention, emergency room crisis and other referral. The service is intended to be stability focused and for existing clients of CPST services or for children needing longer term crisis managements services.

Practitioner qualifications: Intermediate term crisis management may be provided by an individual who has at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Rehabilitative Services: EPSDT only

Program Name: Psychosocial Rehabilitation

Description: Psychosocial Rehabilitation Services (PSR) are designed for children and their families to assist with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth’s behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth’s functional level as possible and as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional intervention. PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth individualized treatment plan. PSR is an individual or group face-to-face intervention and may include collateral contact. PSR is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner.
Rehabilitative Services: EPSDT only (Continued)
Psychosocial Rehabilitation (Continued)

Description (Continued):

The professional uses partnerships and mutual support, as well as hands-on implementation of rehabilitation interventions to improve personal independence and autonomy including:

1) Restoration, rehabilitation and support to reduce the effect of the child’s behavioral health diagnosis and re-establish social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual’s social environment, including home, work and school. This includes learning to confidently manage stress, unexpected daily events and disruptions, and behavioral health and physical health symptoms. It also includes support to establish and maintain friendships/supportive social networks, improve interpersonal skills such as social etiquette and anger management.

2) Restoration, rehabilitation and support to reduce the effect of the child’s diagnosis and reestablish daily functioning skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person’s daily functioning. This includes supporting the individual with implementation of interventions to re-establish daily functioning skills and daily routines necessary to remain in home, school, work and community, including managing medications and learning self-care. It also includes development of constructive and comfortable interactions with healthcare professionals, develop relapse prevention strategies, and re-establishing good health routines and practices.

3) Restoration, rehabilitation and support to reduce the effect of the child’s diagnosis and re-establish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the individuals community integration in areas of personal interests as well as other domains of community life including home, work and school. This includes assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings. The professional may assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Practitioner Qualifications: Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years’ experience in children’s mental health, addiction and/or foster care.

Attachment 3.1-A
Supplement

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[Reserved]
13d. **Rehabilitative Services: EPSDT only (Continued)**

**Psychosocial Rehabilitation (Continued):**

**Description (Continued):**

**Supervisor Qualifications:**
The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

**Provider Agency qualifications:** Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition. The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the interventions identified on the services/plan. Group should not exceed more than 8 members. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
Youth Peer Support and Training is recommended by any following licensed practitioners of the healing arts operating within the scope of their practice under State license: a Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner, operating within the scope of their practice with the youth, family/caregiver or other collateral supports. Activities may include: Restoration, rehabilitation, and support to develop skills for coping with and managing psychiatric symptoms, trauma and substance use disorders; promote skills for wellness and recovery support; develop skills to independently navigate the service systems; develop skills to set goals; and build community living skills. To enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy; Self-Advocacy & Empowerment skill building to develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community; serve as an advocate, mentor or facilitator for resolution of issues; and, assist in navigating the service system including assisting with engagement and bridging during transitions in care.

Practitioner qualifications:
YPST is delivered by a New York State Credentialed Youth Peer Advocate. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:

• Be an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
• Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the credentialing agency if the person has demonstrated competencies and has relevant life experience sufficient for the youth peer-credential.
• Completed Level One (online) and Level Two (online and in person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
• Submitted three letters of reference attesting to proficiency in and suitability for the role of a YPA including one from YPAs supervisor.
• Agree to practice according to the Youth Peer Advocate Code of Ethics.
• Documented 600 hours of experience providing Youth Peer Support services.
• Completed 20 hours of continuing education every 2 years.
• Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
• Is able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
• Be supervised by a credentialed YPA OR a credentialed Family Peer Advocate, both with four years direct service experience OR an individual who meets the criteria for a “qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595.
[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training (Continued):
Practitioner qualifications (Continued):

A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:
• Is an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
• Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational credential can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
• Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
• Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
• Is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
• Submits two letters of reference attesting to proficiency in and suitability for the role of an YPA.
• Be supervised by a credentialed YPA OR a credentialed FPA, both with four years direct service experience OR an individual who meets the criteria for a “qualified mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595. Refer to Supervisor Qualifications for specificity.
• Agree to practice according to the YPA Code of Ethics.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate - Youth who is an individual 18 to 30 years of age and has:
• Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
• Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS).
• Completed a minimum of 46 hours content specific training, covering topics of advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
• Documented 1,000 hours of relative work experience or document at least 500 hours of related work experience if they:
  • Have a Bachelor’s Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training.]
[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate - Youth who is an individual 18 to 30 years of age and has:

(Continued)

• Provided evidence of at least 25 hours of supervision specific to the domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
• Passed the NYCB/IC & RC Peer Advocate exam or other exam by an OASAS designated certifying body.
• Submitted two letters of recommendations.
• Demonstrated a minimum of 16 hours specifically related to Youth Peer Support.
• Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

Supervisor Qualifications: YPAs will be supervised by:
1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization OR
2) A credentialed FPA with 4 years of experience providing FPSS that has been trained in YPST services and the role of the YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPAs within the organization.
3) A qualified “mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPA within the organization.

Additional Supervisor Qualifications:
• The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
• Supervision of these activities may be delivered in person or by distance communication methods.
• It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
• There may be an administrative supervisor who signs the youth peer specialist's timesheet and is the primary contact on other related human resource management issues.
• Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.]
[13d. Rehabilitative Services: EPSDT only (Continued):
  Youth Peer Support and Training (Continued):

Provider Agency Qualifications: Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Group should not exceed more than 8 members. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA’s, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary’s authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary’s treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support:**

**Description:** Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth’s treatment plan. FPSS is a face-to-face intervention, a group face-to-face intervention. A group is a composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals. The Service is directed to the child, and includes contacts necessary for treatment with the family/caregiver or other collateral supports. FPSS is recommended by a licensed practitioner of the healing arts including: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner, operating within the scope of their practice. FPSS can be provided through individual and group face-to-face work and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Components of FPSS include:

- **Engagement, Bridging and Transition Support:** Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- **Self-Advocacy, Self-Efficacy and Empowerment:** Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- **Parent Skill Development:** Support the efforts of families in caring for and strengthening their children’s mental, and physical health, development and well-being.
- **Community Connections and Natural Supports:** Enhance the quality of life by supporting the integration of families into their own communities.
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Practitioner qualifications:** Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA); FPA with a provisional credential; or a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

- **FPA Credential:** To be eligible for the FPA Credential, the individual must:
  - Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
  - Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates approved comparable training.
  - Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
  - Documented 1000 hours of experience providing Family Peer Support services.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.
  - Completed 20 hours of continuing education and renew their FPA certification every two years.

- **A provisional FPA credential:**
  - Demonstrated ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
  - Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
  - Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA). The provisional FPA must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Certified Recovery Peer Advocate (CRPA) with a Family Specialty:**

To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:

- Have ‘lived experience’ as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor's Degree; Are certified by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of Ethics.

**Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS:** An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient’s treatment/recovery plan.

**Supervisor Qualifications:** FPAs will be supervised by:

1) Individuals who have a minimum of 4 years’ experience providing FPSS services, at least 1 year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract OR
2) A “qualified mental health staff person” with a) training in FPSS and the role of FPAs b) efforts are made as the FPSS service gains maturity in NYS to transition to supervision by experienced credentialed FPA within the organization OR
3) From a competent behavioral health professional meeting the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 OR
4) A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Supervisor Qualifications: (Continued)** The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. **Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision be delivered for every 40 hours of Family Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist’s timesheet and is the primary contact on other related human resource management issues.**

**Provider Agency Qualifications:** Any practitioner providing behavioral health services must operate within an agency licensed, certified, designated and/or approved by any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. **Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. A group is composed may not exceed more than 12 individuals total. Medicaid family support programs will not reimburse for the following:**

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA’s, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- **Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.**
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary’s authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
New York
3b-35

[Reserved]

13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Limitations:

• Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.

• Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.
New York
3(c)

[Rehabilitative Services (cont.)]

“Off-site” services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.]

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified by a physician as being terminally ill, with a life expectancy of approximately [six] twelve months or less.

Recipients must sign an informed consent electing hospice over conventional care, subject to periodic review.

Services provided are palliative in nature as opposed to curative: Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home, in a hospital, or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. A Medicaid or Children’s Health Insurance Program (CHIP) eligible child, under age 21, electing hospice is not required to forego curative treatment for the treatment of the terminal illness.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.
Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department.

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association.

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Personal care aide shall mean a person who, under professional supervision, provides patients assistance with nutritional and environmental support and personal hygiene, feeding and dressings and/or, as an extension of self-directed patients, selects health-related tasks. A personal care aide shall have successfully completed:

(i) a training program in home health aide services or equivalent exam as specified in the description for home health aide above; or

(ii) one full year of experience in providing personal care services through a home care services agency within three years preceding the effective date of an initial license issued pursuant to Article 36 of the Public Health Law; or

(iii) a training program in personal care services approved by the New York State Department of Health, which shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision; and
In those instances where the personal care aide is to be providing assistance with health-related tasks, such aide shall be trained as described in subparagraph (iii) of this paragraph and training in health-related tasks shall be completed in full prior to the personal care aide's assignment to any patient, as evidenced by written documentation of such completion.

Homemaker shall mean a person who meets the standards established by the Department of Social Services and assists and instructs persons at home because of illness, incapacity or absence of a caretaker relative in providing assistance with environmental and nutritional tasks.

Pastoral care coordinator shall mean a person who has had a minimum of one year of training and experience in pastoral/spiritual counseling, and has a baccalaureate degree from a regionally accredited college or university or one recognized by the New York State Department of Education.

Social worker shall mean a person who holds a master's degree in social work after successfully completing a prescribed course of study at a graduate school of social work accredited by the Council on Social Work Education and the Education Department, and who is certified or licensed by the Education Department to practice social work in the State of New York. When employed by a certified home health agency, long-term home health care program or hospice, such social worker must have had one year of social work experience in a health care setting.

Nutritionist shall mean a person who applies the principles of normal and therapeutic nutrition and of the physical, biological, social and behavioral sciences to the assessment and management of those factors in the personal community environment which influence nutritional status. A nutritionist must possess a baccalaureate degree, with major studies in food and nutrition, for a regionally accredited or New York State registered four-year college or university, and be registered or be eligible for registration by the American Dietetic Association.
Audiologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Respiratory therapist shall mean a person who is licensed and currently registered as a respiratory therapist pursuant to Article 164 of the New York State Education Law.

Providers of Hospice Services must be certified in accordance with Article 40 of the PHL. Services are provided in accordance with 42 CFR Part 418.

The State assures the provision of Hospice services will be provided in accordance with 42 CFR Part 418.

19. **Limitations on Tuberculosis related services:**

Directly Observed Therapy (DOT) – will be provided to clients who are being treated for Tuberculosis Disease.

21. **Lactation consultant services:** effective September 1, 2012, reimbursement will be provided for breastfeeding health education and counseling services by pediatric or family nurse practitioners. Pediatric or family 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.

22. **Limitation on Respiratory Care:**

Services may be rendered to EPSDT population by medical necessity and that services is furnished through the clinic and home benefits to this population.
New York
3(d)

24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient’s choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner’s choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county’s local department of social services manages transportation services on behalf of recipient’s assigned to the county.

2. The Commissioner of Health is authorized to assume the responsibility of managing transportation services from any local social services district. If the Commissioner elects to assume this responsibility, the Commissioner may choose to contract with a transportation manager or managers to manage transportation services in any local social services district.

[2.]3. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

24d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments shall not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

26. Personal Care Services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient’s assessment.

Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient’s needs for assistance, and when prescribed by a physician, in accordance with the recipient’s plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient’s family, and furnished in the recipient’s home or other location.
Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of health requires for employees of certified home agencies;
- a criminal history record check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient’s home PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State’s Personal Care Services are provided in accordance with 42 CFR 440.167.
The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a Medicaid need for home care services and who choose to participate in this model. It has operated under the State’s Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local social services district (LSSD) contracts with home care agencies for the provision of services. The home care agency is responsible for hiring, training, supervising, and providing the home care worker with salary and benefits. In the CDPAP a local social services district contracts with a CDPAP agency and there is a co-employer relationship between the CDPAP agency and the consumer that encompasses these functions. The CDPAP consumer is responsible for hiring/training/supervising and firing his/her aides. The CPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department’s agent that processes and pays claims for services provided to Medicaid recipients.
27. The State elects to provide medical assistance services to eligible individuals through a Primary Care Case Management Program. PCCMs are responsible for locating, coordination, and monitoring covered primary care to all individuals enrolled with a case manager.

PCCM providers may be physicians, physician group practices, entities employing or having other arrangements with physicians to provide PCCM Services under the contract. Nurse practitioners may also be a PCCM provider.

A PCCM will provide for arrangements with, or referrals to a sufficient number of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

PCCMs are required to be accessible 24 hours/seven days per week to provide information, referral and treatment to enrollees. PCCMs may not restrict an enrollee's access to emergency services, or require prior authorization of emergency services.

A PCCM shall be geographically accessible to enrollees. Primary care providers must meet State standards for travel time and distance.
New York
4

General

a) Prior approval of the local professional director shall be required for medical care and services which are to be provided outside New York State, except in the following situations:

1. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside New York State.

2. When out-of-state care was provided in an emergency.

b) When a request subject to prior approval has been modified or denied in whole or in part because of disagreement with the proposed plan of treatment, recipients are notified that they may request a fair hearing.

March 4, 1988
TN #85-30
Supersedes TN #82-11
Approval Date March 4, 1988
Effective Date October 1, 1985
29. Lactation consultant services: effective September 1, 2012, reimbursement will be available for breastfeeding health education and counseling services by physician assistants. Physician assistants 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.

30. Lactation consultant services: effective September 1, 2012, reimbursement will be available for breastfeeding health education and counseling services by registered nurses. Registered nurses 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.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

In addition to the limitations specified on pages 1 through 4 regarding services, the following limitations also apply to the noted services:

2a.; 2b.; 2c.; 2d.;

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

3. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Laboratory Provider Manual. Such threshold requirements are applicable to specific provider service types including laboratories. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

5. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Physician Provider Manual. Such threshold requirements are applicable to specific provider service types including physicians, for services furnished in the office or patient’s home. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
New York  
5(a)

A utilization threshold service is decremented each time a patient is seen by a physician including those times when the patient is seen by a physician and an electronic prescription/fiscal order is transmitted for medically necessary pharmaceuticals and select over the counter medications.
New York

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Physical Therapy Services

11a. Effective on or after [October 1, 2011] July 1, 2018, services are limited to coverage of [twenty] forty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

Occupational Therapy Services

11b. Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.
Speech-Language Therapy Services

11c. [Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.] Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
Supplement 1 to Attachment 3.1-A  
OMB No.: 0939-0193  

New York  
1-A1  

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
CASE MANAGEMENT SERVICES]  

[A. Target Group: A]  

B. Areas of State in which services will be provided:  

[ ] Entire State.  

[X] Only in the following geographic area (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide):  


C. Comparability of Services  

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.  

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.  

D. Definition of Services:  

See attached.  

E. Qualification of Providers:  

See Page 1-A10.]  

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<th>TN</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>#15-0031</td>
<td>September 4, 2015</td>
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The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
CASE MANAGEMENT SERVICES

[A. TARGET GROUP

The primary targeted group consists of an adolescent, male or female, under 21 years of age who is a categorically needy or medically needy Medicaid eligible and is a parent and resides in the same household with his or her child(ren), or is pregnant.

The target group may also consist of any eligible child of an adolescent or any adolescent, male or female under 21 years of age, who is a categorically needy or medically needy Medicaid eligible and is deemed to be at risk of pregnancy or parenthood and meets one or more of the following at-risk criteria:

1) receives public assistance in his or her own right;
2) is homeless or at imminent risk of becoming homeless;
3) has had an abortion or miscarriage
4) has had a pregnancy test, even if the test outcome was negative;
5) is sexually active;
6) is the non-custodial mother or father of a child;
7) is the younger sibling of an individual who was or is a teenage parent;
8) is a rape or incest victim;
9) has dropped out of high school without graduating;
10) is having academic and/or disciplinary problems in school;
11) requests case management activities, or his or her authorized representative requests such activities on behalf of the adolescent; or
12) is the child of adolescent parent(s).

Sixty percent of the current ADC cases in New York State are headed by mothers who were teenagers when they gave birth to their first child. The goal of case management for this target population is to provide access for youth to medical, educational, employment and other services which will increase their potential to become financially independent. Case management services continue for this target population through age 21.]

Supersedes TN #90-0007
Effective Date April 1, 2015

Approval Date September 4, 2015

TN #15-0031
[B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP A]

Case management services will be provided to residents of the following counties: Albany, Allegany, Cattaraugus, Cayuga, Chemung, Columbia, Cortland, Dutchess, Franklin, Fulton, Genesee, Herkimer, Jefferson, Livingston, Madison, Monroe (zip codes 14605, 14621, and 14609), Onondaga, Orange, Orleans, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tompkins, Ulster, Washington, Westchester, Wyoming, Yates and New York City (Bronx Commun. Dist. 1-4, Brooklyn Commun. Dist. 5, 8, 9, 16-18, Manhattan Commun. Dist. 9-12, Queens Commun. Dist. 3, 4, 6, 7, 8, 11-13, and Richmond Commun. Dist. 1-3)

[D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID]

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychological, educational, financial, and other services.

2. Case management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service, or having problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective management is concerned with service: the quality, adequacy and continuity of service, and a concern for cost effectiveness to assure each eligible individual served receives the services appropriate to their needs. Targeted groups consist of persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.]
[3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in their most appropriate environment. Case managers do not have the authority to prior authorize Medicaid service or to limit the amount, duration or scope of Medicaid services.

4. Case management empowers the individual by encouragement in the decision making process, allowing choice among all available options as a means of moving the individual to the optimum situation where the person and/or his/her support system can address his/her needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP A

Case management for Target Group A means those activities performed by case management staff, in consultation with an adolescent parent of an eligible child or with a eligible adolescent and other individuals involved with the child or adolescent if appropriate, related to ensuring that the adolescent and child have full access to the comprehensive array of services and assistance available in the community which the adolescent needs to maintain and strengthen family life and to attain or retain capability for maximum self support and personal independence.

Case management for Target Group A requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, legal and child care services available within the community appropriate to the needs of the adolescent.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient’s circumstances and therefore must be determined specifically in each case and with each recipient’s involvement. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including:]

Supplement 1 to Attachment 3.1-A

New York
1-A4

TN       #15-0031
Approval Date  September 4, 2015
Supersedes TN    #90-0007
Effective Date  April 1, 2015
[A. Intake and screening.

This function consists of: the initial contact with the recipient providing information concerning case management; exploring the recipient's interest in the case management process; determining that the recipient is a member of the provider's targeted population; and, identifying potential payors for services.

B. Assessment and reassessment.

The case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and, a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case Management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, duration and cost of the case management services required by a particular recipient; selection of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient, the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers, through case conferences to encourage exchange of clinical information and to assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,]
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[4. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the recipient.

D. Implementation of the case management plan includes: securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention by a case manager or practitioner when necessary, includes: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up of case management services includes: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring that the recipient is adhering to the case management plan; ascertaining the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by a practitioner; collecting data and documenting in the case record the progress of the recipient making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementations of the case management plan.

G. Counseling and exit planning include: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient’s family and informal providers of services; mediating amount the recipient, the family network and/or other informal providers of services when problems with]
PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.**

The case management process must be initiated by the recipient and case manager through a written assessment of the recipient’s need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient’s current functioning and continuing need for services, the service priorities and evaluation of the recipient’s ability to benefit from such services. The assessment process includes those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS.**

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for the service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient’s need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient’s condition or circumstances.

2. **Case management plan.**

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS.**
[The recipient’s case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient’s service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan; and each time the case management plan is reviewed, the goals established in the initial case management plan must be maintained or revised, and new goals and new time-frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred.

d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient’s related goal and objective; and

e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

3. **Continuity of service.**

Case management services must be ongoing from the time recipient is accepted by the case management agent for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district to a district in which case management services are not provided; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.]
[Contact with the recipient or with a collateral source on the recipient’s behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider’s agreement with New York State Department of Social Services.

**LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES**

Case management services:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. must not duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority; and,

4. must not be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a Federal Home and Community Based Services Waiver.

While the activities of case management services secure access to, including referral to and arrangement for, an individual’s needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;]
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[3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNF’s, ICF’s and ICF/MR’s; and

9. client outreach.

LIMITATIONS SPECIFIC TO TARGET GROUP A

Case managers and case management staff with respect to any eligible child of an adolescent or adolescent in Target Group A for whom case management activities are being performed and the child(ren) of such adolescent, are prohibited from and do not have the authority to:

1. provide, authorize or purchase services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social services district;

2. accept or deny any application for public assistance or for services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social service district; or,

3. place the adolescent or his or her child(ren) in foster care, or remove the adolescent or his or her child(ren) from the home of his or her parent or guardian.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

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[a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. State and local governmental agencies; and

d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor’s or master’s degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group A*

1. Providers

Providers of case management to the adolescents in Target Group A may be public or private agencies and organizations, whether operated on a profit-making or not-for-profit basis.

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to assess the needs and capabilities of, and to assist pregnant, parenting or at-risk adolescents access to services and assistance needed to maintain and strengthen]
[family life, to attain or retain the capability for maximum self support and personal independence including, but not limited to the areas of adolescent development, adolescent sexuality, and effective interviewing techniques.

Primary responsibility for performing case management activities must be given to case managers. Para-professional and volunteers may be used as case management staff to assist the case managers and may perform those activities which are appropriate based on their training and experience.]

[* (18 NYCRR 361.0-361.13 NYS DSS Regulatory requirements for implementation of the New York State Teenage Services Act of 1984.)*]
Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through TASA — Target Group A described on pages 1-A1 through 1-A12.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group B.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached
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F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
CASE MANAGEMENT SERVICES

A. 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 and 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.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET

Entire State

C. DEFINITION OF MEDICAID SERVICE COORDINATION TO TARGET GROUP B

Medicaid Service Coordination (MSC) for Target Group B is a service which assists persons with developmental disabilities in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person-centered approach to planning, developing, maintaining, and monitoring an Individualized Service Plan (ISP) with and for a person with developmental disabilities. MSC promotes the concepts of choice, individualized services and supports and consumer satisfaction.
D. **Medicaid Service Coordination Functions**

**General Service Description**

Medicaid Service Coordination helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential and legal services available and in accordance with the person’s valued outcomes as expressed in the Individualized Service Plan (ISP).

Medicaid Service coordination functions are:

- Enrollment ("Intake")
- Development of the Individualized Service Plan (ISP)
- Implementation of the ISP
- Maintenance of the ISP

**Enrollment**

The service coordinator assesses eligibility for MSC based on the criteria specified in A above. The service coordinator completes necessary enrollment documents.

**Development of the Individualized Service Plan (ISP)**

The Individualized Service Plan (ISP) is developed using a person-centered approach. The service coordinator helps the person plan by choosing personal valued outcomes, and developing a personal network of activities, supports and services. The plan identifies those supports and services chosen by the consumer with the service coordinator’s assistance, as well as the entities that will supply them. The resulting planning information is written in the appropriate ISP format.

ISP development also includes the execution of a Service Coordination Agreement. This agreement, between the person served and the service coordinator, describes the service coordination activities the person wants and needs to meet his or her individualized goals as described in the ISP.
Implementation of the Individualized Service Plan (ISP)

Using the ISP as a blueprint, the service coordinator works with the person to achieve his or her valued outcomes. Chosen activities, supports, and the full array of services are accessed as identified in the plan. The service coordinator uses knowledge of the community and available resources and employs specialized skills to successfully implement the ISP. The service coordinator:

- Locates or creates natural supports and community resources.
- Locates funded services, helps determine eligibility, completes referrals, facilitates visits and interviews.
- Helps arrange for transportation to the community activities and services as necessary.
- Assists in communicating the content of the ISP, including valued outcomes, to service providers and assists providers in designing and implementing services consistent with the ISP.

Maintenance of the ISP

This is the ongoing service provided by the service coordinator. It includes:

- Assessing the person’s satisfaction with his or her ISP, including the Service Coordination Agreement, and making adjustments as necessary.
- Supporting the person towards achievement of valued outcomes.
- Establishing and maintaining an effective communication network with service providers.
- Keeping up to date with changes, choices, temporary setbacks and accomplishments relating to the ISP
- Managing through difficulties or problems or crises as they occur.
- Assisting the consumer in assuring that rights, protections and health and safety needs are met pursuant to state law and regulations.
- Keeping the ISP document, including the Service Coordination Agreement, current by adapting it to change.
- Reviewing the ISP at least semi-annually.

Supersedes TN #89-16

Supplement 1 to Attachment 3.1-A

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TN #00-07

Approval Date January 10, 2001

Supersedes TN #89-16

Effective Date March 1, 2000
Systemic Features and Functions

OMRDD centrally and through its local DDSOs will:

- Ensure access to the service for all eligible people.
- Assist people served in choosing a service coordination provider by making the full range of provider options known to the person and his/her family.
- Match individual needs of people with special provider capabilities and characteristics.
- Ensure uniformity in service coordinator and service coordinator supervisor basic training.
- Provide standardized curricula for service coordinators’ ongoing training.
- Organize and schedule training and carry out training.
- Carry out functions necessary to ensure quality of service and proper management of the program.
- Monitor Service Coordination Agreements between the service coordinator and the person served to ensure service coordinator fulfillment of commitments according to the agreed upon time frame.
- Make referrals to other service coordination providers when a person is dissatisfied with the current service provider.
- Monitor complaints of persons served and their families to detect patterns of poor service quality.
- Require provider corrective action as necessary.
- Oversee provider terminations and necessary referrals to other service coordination providers as necessary.

E. LIMITATIONS ON THE PROVISION OF MEDICAID SERVICE COORDINATION

Medicaid service coordination will not:

1. Be utilized to restrict the choice of a service coordination consumer to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis.

2. Duplicate case management services currently provided under the Medical Assistance Program or under any other program.
3. Be utilized by providers of service coordination to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority and

4. Be provided to persons receiving institutional care reimbursed under the Medical Assistance Program, except that Medicaid service coordination may be provided for up to 30 days to persons who are temporarily institutionalized, when the admission to the institution is initially expected to be 30 days or less.

While the activities of Medicaid Service Coordination secure access to an individual's needed service, the activities of service coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. EPSDT administration;
7. Activities in connection with “lock-in” provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, SNF’s, and ICFs/MR and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.
New York  
1-B7

F. QUALIFICATIONS

1. Providers

Pursuant to §1915(g)(1) of the Social Security Act, Medicaid service coordination will be provided by New York State OMRDD through a network of OMRDD employees and contractors.

2. Service Coordinators

Service coordinators must:

(a) either;

(1) have experience providing OMRDD Comprehensive Medicaid Case Management (CMCM) or OMRHH Home and Community Based (HCBS) Waiver Service coordination or

(2) (i) be a registered nurse or have at least an associate's degree (or equivalent accredited college credit hours) in a health or human services field, and

(ii) have at least one year’s experience working with persons with developmental disabilities or at least one year’s experience providing service coordination to any population, and

(b) attend professional development courses required by OMRDD.
G. **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.

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2. **Case Managers**

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rate basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human service field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. **Qualifications of Providers Specific to Target Group “B”**

1. **Providers**

Providers of Comprehensive Medicaid Case Management to developmentally disabled persons in Target Group “B” shall only be the Borough/District Developmental Services Offices (B/DDSO) of CMRDD and voluntary non-profit agencies and organizations authorized by CMRDD as CMCM/CMRDD providers, and identified by CMRDD to SDSS.

2. **Case Managers**

Case managers serving Target Group “B” must meet the minimum qualifications described above.
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

Persons enrolled in Medical Assistance who:
1. Have a developmental disability as defined in New York Mental Hygiene Law §1.03, and
2. Are in need of ongoing and comprehensive service coordination, which means that the person requires the assistance of Medicaid Service Coordination to assist in coordinating the Medicaid-funded Long Term Supports that the person receives or would benefit from receiving, and
3. Have chosen to receive the services, and
4. Reside in their own or family home, live in an OPWDD certified residence (Individualized Residential Alternative, Community Residence or Family Care Home).

However, persons who receive MSC and are receiving institutional care reimbursed under the Medical Assistance Program may continue to receive Medicaid service coordination for up to 30 days when persons are temporarily institutionalized, and when the admission to the institution is initially expected to be 30 days or less.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 0 (zero) consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
X Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

TN # __ 12-0030_____________ Approval Date _4/16/18__________
Supersedes TN #_NEW_________ Effective Date _4/01/13___________
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) - Individuals with Intellectual and Developmental Disabilities (II/DD)

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - Gathering pertinent individual and family history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  [Specify and justify the frequency of assessments.]

Assessment activities include taking the person’s history, identifying needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, clinical assessments, educators, and other individuals/providers associated with the person, if necessary, to form a complete assessment (i.e., picture) of the person and his/her needs and goals. Re-assessment should occur when the Individualized Service Plan (ISP) is reviewed semi-annually or more frequently if necessary based on the changing needs of the person or his or her request for a reassessment.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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Supersedes TN # _NEW___________ Effective Date _4/01/13___________
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

- activities that help link the individual with medical, social, educational
  providers, or other programs and services that are capable of providing
  needed services to address identified needs and achieve goals specified in the
  care plan; and

Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is
  implemented and adequately addresses the eligible individual's needs, and
  which may be with the individual, family members, service providers, or other
  entities or individuals and conducted as frequently as necessary, and
  including at least one annual monitoring, to determine whether the following
  conditions are met:
  o services are being furnished in accordance with the individual's care
    plan;
  o services in the care plan are adequate; and
  o changes in the needs or status of the individual are reflected in the
    care plan. Monitoring and follow-up activities include making
    necessary adjustments in the care plan and service arrangements with
    providers. [Specify the type of monitoring and justify the frequency of
    monitoring.]

This is the ongoing service provided by the service coordinator. It includes:
- Assessing the person's satisfaction with his or her supports and services as
  identified within the ISP, including the Service Coordination Agreement, and
  making adjustments as necessary;
- Supporting the person towards achievement of valued outcomes;
- Establishing and maintaining an effective communication network with service
  providers;
- Keeping up to date with changes, choices, temporary setbacks;
- Accomplishments relating to the persons supports and services as reflected in
  the ISP;
- Managing through difficulties or problems or crises as they occur;
- Assisting the person in assuring that his or her rights, protections and health and
  safety needs are met pursuant to state law and regulations;
- Keeping the ISP document including the Service Coordination Agreement, current
  by adapting it to change; and
- Reviewing the ISP at least semi-annually.

TN # 12-0030 Approval Date 04/16/18
Supersedes TN # NEW Effective Date 04/01/13
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) - Individuals with Intellectual and Developmental Disabilities (II/DD)

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

OPWDD approval of MSC providers is based on the following factors:
• The applying agency is a non-profit or a government agency. Through December 31, 2014, governmental agencies eligible to provide MSC included the Office for People With Developmental Disabilities.
• Effective January 1, 2015, the Office for People With Developmental Disabilities ceased provision of Medicaid Service Coordination.
• The applying agency has experience serving persons with developmental disabilities.
• The applying agency is fiscally viable.
• The applying agency has a history of providing quality services and does not have ongoing program deficiencies.
• A need exists for MSC service providers.

Service Coordinators must possess the following minimum education:
• An associate's degree in a health or human services field from an accredited college or university or a degree in nursing as a Registered Nurse (RN).
• An individual with credits toward a bachelor's degree may meet this educational requirement by providing a letter from his or her college verifying that he/she has completed course work equivalent to an associate's degree both in the total number of credits received and the number of credits earned in a health or human services field. An associate's degree is usually equal to 60 credits.
• An individual with an associate's degree or a bachelor's degree or who has a minimum of 60 credits toward a bachelor's degree in a field other than health or human services may meet this educational requirement if a minimum of 20 of his/her college credits are in health and human services. The vendor agency should review the individual's college transcript to verify that the educational requirements have been met and retain this documentation.

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Supersedes TN # _NEW__________ Effective Date _04/01/13__________
TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

Service Coordinators who serve Willowbrook Class members must be Qualified Intellectual Disabilities Professionals (QIDP).

At a minimum, Service Coordinators must possess the following experience:
• One year experience working with people with developmental disabilities, or
• One year experience as a Service Coordinator/Case Manager with any population.

The minimum experiential level does not have to be met if the person has a master's degree in a health or human services field.

An exception to the education requirement is allowed for Service Coordinators with experience as a Service Coordinator beginning prior to March 1, 2000. MSC was implemented on March 1, 2000 and consolidated and replaced two earlier OPWDD service coordination programs, Comprehensive Medicaid Case Management (CMCM) and Home and Community Based Services Waiver Service Coordination. As of March 1, 2000, Service Coordinators who were qualified to provide services under one of these earlier programs were automatically eligible to provide MSC.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:
• Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt

TN # 12-0030 Approval Date 04/16/18
Supersedes TN # NEW Approval Date 04/01/13
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

- of other Medicaid services on receipt of case management (or targeted case
  management) services; and
- Providers of case management services do not exercise the agency’s
  authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the
plan does not duplicate payments made to public agencies or private entities under
other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case
management as follows: (i) The name of the individual; (ii) The dates of the case
management services; (iii) The name of the provider agency (if relevant) and the
person providing the case management service; (iv) The nature, content, units of
the case management services received and whether goals specified in the care plan
have been achieved; (v) Whether the individual has declined services in the care
plan; (vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of
the plan.

Limitations:

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities.
Providers are limited to qualified Medicaid providers of case management services
capable of ensuring that individuals with developmental disabilities or with chronic
mental illness receive needed services: [Identify any limitations to be imposed on
the providers and specify how these limitations enable providers to ensure that
individuals within the target groups receive needed services.]

Entities eligible for enrollment as a provider of Medicaid Service Coordination are non-profit or a
government agency. This limitation is based upon the need for Medicaid Service Coordination
providers to have experience in New York State coordinating services for individuals with
Intellectual and Developmental Disabilities.

TN # ___12-0030_____________ Approval Date _04/16/18__________
Supersedes TN #_NEW_________ Effective Date _04/01/13__________
State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B - Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

While the activities of Medicaid Service Coordination secure access to an individual's needed services, the activities of service coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, Skilled Nursing Facilities (SNFs), and ICFs/IIDs; and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

TN # ___12-0030__________ Approval Date ___04/16/18__________
Supersedes TN #_NEW__________ Effective Date _04/01/13__________
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:
See attached Target Group C

B. Areas of State in which services will be provided:

[X] Entire State

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Service

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:
See attached

E. Qualification of Providers:
See attached

TN #90-42
Supersedes TN NEW

Approval Date October 10, 1991
Effective Date July 1, 1990
F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
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CASE MANAGEMENT SERVICES

A. Target Group C

This target group consists of any categorically needy or medically needy individual who meets one or more of the following criteria:

1. All HIV infected persons;

2. All HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; and

3. All high risk individuals for a temporary period of time not to exceed 6 months with transition to another appropriate case management program for individuals who are HIV negative or continued unknown status. High risk individuals as the term is used in the expanded target Group C AIDS CMCM population are those individuals who are members of the following category:

   Men who have sex with men (MSM), substance abusers, persons with history of sexually transmitted diseases, sex workers, bisexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex with HIV+ or high risk individuals.

Family members and coresidents (ie. collaterals) of the above targeted index clients may also receive case management services as necessary, to allow for the provision of necessary care and services to the targeted individual. Services for case collaterals shall be considered as one family unit in the case manager's caseload. Separate assessments and service plans are not required for collaterals, but may be incorporated into the case records of the primary client. Collaterals may have services arranged for by the case management provider. Case management services for collaterals should be limited to issues that directly affect the care of and services to the primary client.

The clients targeted under this proposal face enormous barriers to care, such as continuing drug and alcohol use, and their associated medical and social problems, domestic violence, mistrust of medical care and other services, fear of losing their children to foster care, fear of HIV infection and its consequences, lack of transportation and day care services, and lack of support in accessing care for their sexual partner and/or coresidents. These barriers to care can be overcome by the persistent efforts of indigenous community follow-up workers in cooperation with case managers. These workers must have special skills and strengths to deal with these problems, to win the trust and confidence of their clients in order to motivate them to return to care and to be continuously monitored thereafter. The magnitude of the effort required to accomplish this exceeds the capabilities of existing institutional bound and community case managers and requires the extensive frequent personal contact possible through an intensive case management program under Comprehensive Medicaid Case Management.

TN #94-42  
Supersedes TN #94-28  
Approval Date November 28, 1994  
Effective Date July 1, 1994
B. **AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED**

Services to this target group may be provided statewide.

C. **COMPARABILITY OF SERVICES**

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. **DEFINITION OF CASE MANAGEMENT UNDER THE COMMUNITY FOLLOW-UP PROGRAM (CFP)**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

Case management is a multi-step process comprised of the following activities:

1. **Intake**
2. **Assessment**
3. **Initial Care Plan Development**
4. **Initial Care Plan Implementation**
5. **Reassessment**
6. **Care Plan Update**
7. **Care Plan Update Implementation**
8. **Monitoring**
9. **Crisis Intervention Activities**
10. **Termination/Case Disposition Activities**
11. **Client Advocacy, Interagency Coordination and Systems Development Activities**
12. **Supervisory Review/Case Conferencing**

The sections below describe the specific functions in detail.

1. **Intake**

   The case manager should collect identifying information concerning the client, family, care givers and informal supports including the intake elements required on forms developed or approved by the State Department of Health. A list of family members, coresidents and children not currently living at home should be recorded including identification of the primary caregiver, primary contacts and legal guardian(s) of the child(ren). Client consent to case management, including home visitation, case conferencing, service acquisition and registration procedures, should be obtained and documented in the case records.

   **TN #90-42**
   **Approval Date: October 10, 1991**
   **Supersedes TN: NEW**
   **Effective Date: July 1, 1990**
Intake procedures should be initiated upon referral to the Community Follow-up Program provider and completed after the first visit. The Intake Procedures may be completed by the case manager, technician or the community follow-up worker. The intake includes confirmation that the case management program has been fully explained to the client. Clients have the right to choose care providers and, therefore, may choose whether or not to enroll in the case management program.

2. **Assessment**

Assessment is the collection of information about the client's medical, physical and psychosocial condition, resources, needs, and confirmation of eligibility for the program. The assessment process should include a home visit to evaluate the client's needs, informal supports, and general living conditions. All family members should be seen in the assessment interview(s), if possible. Direct caregivers and family members not able to be interviewed should be contacted by phone, if possible. The purpose of assessment is to identify the client's/family's problems and care needs, what care needs are being met and by whom, and what needs are not adequately met. The initial assessment will focus on immediate health and social services needs and address the client's history of underutilization of care, and the reasons for such underutilization. Assessments will be documented on forms required or approved by the State Department of Health, AIDS Institute.

Assessment activities should be completed following the second visit but no later than 15 days from the date of receipt of the referral. The assessment should be completed by the case manager with assistance from the case management technician.

3. **Initial Service Plan Development**

Development of the service plan is the translation of assessment information into specific goals and objectives, and specific services, providers and timeframes to reach each objective. The service plan is developed by the case manager, in coordination with the client, representative and other providers.

The service plan will reflect goals and services to be provided to the client and family members. If services actually provided differ, a note explaining the difference should be made. The costs and sources of payment for all services should be documented as required by Department of Social Services regulations 505.16. The client's response to the final plan, consent to case management and/or declination of any part of the plan by the client should be documented on forms approved by the Department of Health.

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**TN #90-42**

**Supersedes TN NEW**

**Approval Date** October 10, 1991

**Effective Date** July 1, 1990
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It is the intent of New York State that case management in the Community Follow-up Program represent a fully integrated case management approach. The case manager coordinates all necessary services along the continuum of care - both institutional and community based by both directly accessing services and by establishing linkages with other service programs including those under the jurisdiction of the local department of social services. The role of the case manager is to reduce the barriers in crossing administrative boundaries to ensure that clients obtain needed services at the appropriate time from wherever the services are available. Services accessed for the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources. In so doing, the case manager will access and coordinate services with other case managers who may also serve the client. The service plan will be developed following the second client contact. Immediate needs should be addressed by the case manager and such services should be implemented immediately after the intake. Other assessed needs should be addressed as soon as possible but in no case later than 30 days from the date of receipt of the referral. The service plan is to be developed by the case manager with the assistance of the technician or community follow-up worker.

4. Initial Service Plan Implementation

In implementation of the service plan, or service acquisition, the case manager assists the client and family or coresidents as needed, in contacting the support persons and other service providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, coresidents, support persons, and service providers. Any changes from the original plan should be noted in the record. These activities may be accomplished by the case manager or a member of the case management team.

The case manager, case management technician or community follow-up worker will (in accordance with the client’s assessed abilities):

a. contact providers, including support persons, by phone, in writing or in person

b. assist the client and family members or coresidents in making applications for services and entitlements, including basic needs such as transportation, child care, baby-sitting, etc.

c. confirm service delivery dates with providers, and supports

d. schedule multiple visits by family members on the same day to accommodate the needs of the family and children

e. document services that aren’t available or cannot be accessed

| TN #90-42 | Approval Date October 10, 1991 |
| Supersedes TN NEW | Effective Date July 1, 1990 |
f. gain assurance from other care providers that services will be initiated, and confirm the delivery of these services

g. decide, with the client and other providers, on the ongoing responsibilities of each provider

h. give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others.

Any changes to the service plan due to scheduling or availability of services will be documented. Service plan implementation should begin immediately after service needs are assessed and is an ongoing responsibility of the case manager. The case manager and support staff, in accordance with the client's assessed abilities, will assist the client by contacting providers and support persons when needs are identified. Assistance continues until the case manager or staff determines that the services have been arranged and received. Confirmation of need for, application for and receipt of services is required.

5. **Reassessment**

Reassessment is a scheduled or event generated formal re-examination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The reassessment should measure progress toward the desired goals outlined in the care plan and is used to prepare a new or revised service plan or confirm that current services remain appropriate. Reassessment is the responsibility of the case manager.

A formal reassessment under the program for clients who are receiving intensive case management is due within 90 days of admission and every 90 days thereafter or when a change in the client's status occurs which significantly effects the service plan. Significant changes in status include:

a. death, illness or hospitalization of a family member or care giver(s), or a condition or circumstance which impairs the client's ability to provide for the family's physical and/or emotional needs,

b. change in the client's clinical or functioning status,

c. loss of domicile, entitlement, or service.

e. document services that aren’t available or cannot be accessed
6. **Service Plan Update**

Updating the service plan means modification to or revision of the service plan based on reassessment. Update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not significant as to require a formal reassessment. Update of the service plan includes all activities of service plan development, described above in subsection c, relative to new or changed needs and services. The service plan should be updated at every reassessment or when a change in client status occurs which significantly affects the service plan. The service plan may be updated by the case manager with assistance from the members of the case management team.

7. **Service Plan Update Implementation**

Implementation of the updated service plan includes the same activities as described for service plan implementation noted in subsection d, and may be the responsibility of the technician or community follow-up worker under the supervision of a case manager.

8. **Monitoring**

Monitoring is contact between the case manager or support staff and the client or representative. Support persons and service providers will also be contacted if necessary. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts many include encounters in the agency, home, hospital or outpatient department, contacts by phone or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem.

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**TN #90-42 Approval Date October 10, 1991**

**Supersedes TN NEW Effective Date July 1, 1990**
The case manager and case management team will also coordinate the medical monitoring of all persons who are HIV positive with the primary care physician, clinic or AIDS Center responsible for the medical monitoring of asymptomatic HIV disease. This service includes the ongoing monitoring of preclinical HIV infection (asymptomatic) to determine the appropriate stage to initiate active prophylactic and secondary treatment for opportunistic infections. This service applies to HIV positive persons prior to clinical manifestations or laboratory evidence of HIV illness. The case manager should assure that CD4 (T4) testing is done every three or six months as appropriate, and if symptoms of HIV illness are identified, therapies provided by a referral to an AIDS Center hospital or appropriate outpatient department be arranged. Periodic testing for persons at risk, when requested, or when high risk behavior is reported or suspected should also be arranged by the case manager and case management team.

For clients receiving intensive case management in the Community Follow-up Program, a minimum of 9 contacts is required every 90 days. A minimum of six of these contacts must be face to face with the client. A minimum of four of these contacts must be home visits. Greater frequency of contacts in all categories will be arranged on an as needed basis and are in fact encouraged and anticipated in an intensive case management program. The case manager must personally have two contacts with the primary client every 90 days. Case conferences will be held for families with multiagency service plans including agencies such as Certified Home Health Agencies, local child welfare or community based organizations. Conferences will take place within 90 days of initial care plan implementation and every 180 days thereafter.

9. **Crisis Intervention**

The purpose of crisis service is to provide assessment and intensive short term treatment of acute medical, social, physical or emotional distress. Crisis intervention should be made available to all Community Follow-up Program clients on an emergency 24 hour basis through subcontract with a 24 hour crisis agency, or via direct provision by the case manager, by a crisis hotline, use of mobile crisis teams, or through referral to the Community Follow-up Program Director or supervisor. Crisis services may be needed for a variety of reasons. The crisis may relate to an emergency medical need, drug use or drug overdose, domestic violence or child abuse, etc. Irrespective of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client, family, coresident or lover in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.
10. **Exit Planning/Case Discontinuations**

Exit planning procedures are initiated when the client:

a. expires

b. loses Medicaid or programmatic eligibility, though Medicaid eligibility is not required for eligibility in the CFP, or

c. declines the case management services of CFP, or

d. desires to be referred to a different CFP provider agency or to an existing case management program such as the Long Term Home Health Care Program, AIDS Home Care Program, or

e. will be institutionalized for greater than 30 days if Medicaid is the payor for such hospitalization and discharge to community based care is not anticipated. For private pay and third party individuals, case management services may continue beyond the 30 day limit while hospitalized, or

f. the client relocates out of the CFP providers’ service area.

In all cases, except where the client expires, the provider must complete a referral process designed to link the client with appropriate ongoing case management and other vital services necessary to meet their care needs. The provider must refer the client to another eligible CFP provider if one exists within the geographic area in which the client resides. With the client’s consent, a case summary should be prepared for referral to the new provider. A final assessment noting disposition and measures of progress toward identified goals should be prepared and placed in the final record. The local Department of Social Services should be notified of the case disposition and can assist in referral of the client to alternate case management providers. Exit planning is a responsibility of the case manager with assistance from the members of the case management team.

11. **Patient Advocacy, Interagency Coordination and Systems Development**

The function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary institutionalization.
12. **Supervisory Review/ Case Conferencing**

An important component of the required quality assurance process for each CFP provider will be supervisory review of case management documentation, care plans and other products as well as peer review or case conferencing with other case managers. Therefore, for clients receiving case management, supervisory review of each client care plan by the designated supervisor or agency director will be conducted initially at the time of the development of the original service plan and every 90 days thereafter. In addition, each agency participating as a CFP provider will establish a peer review process wherein all case managers will present and discuss client specific case management plans with other case managers in the agency at least once annually. While we are requiring the supervisory function, we are not requiring a supervisory role. In this way agencies will have the flexibility to provide supervision with either in house staff or through an outside consultant.

Case managers will also be required to case conference with other agencies regarding specific clients at 90 days after service plan implementation and every 180 days thereafter, taking into consideration client consent, the client’s need for confidentiality and privacy, as well as Department of Health Regulations on confidentiality. This would include contacts with discharge planners, case managers from other agencies, etc. Supervisory review and case conferencing are billable on a direct patient specific basis in the community Follow-up Program. Agency conferences that are not patient specific are not directly billable; however, projected costs for these activities may be included in the administrative budget submitted by each provider.

13. **Program Limitations**

**Case Management under the Community Follow-up Program:**

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program that is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. must not duplicate certain case management services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care Program, AIDS, Home Care Program under Chapter 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).
3. must not be utilized by providers of case management to create a demand for unnecessary services or programs, particularly those services or programs within their scope of authority; and

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program. Case management services may be provided for children and family members during this period of hospitalization.

While the activities of case management services secure access to, including referrals to and arrangements for, an individual’s needed service, reimbursement for case management does not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. administration of Child-Teen Health Program Services;
7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNFs, ICFs and ICF/MRs; and
9. client outreach.

E. QUALIFICATIONS

1. Provider Qualifications

Provider agencies applying for participation in the Community Follow-up Program must meet one of the following requirements:

(a) have 2 years demonstrated experience in the care of the clients with HIV related illnesses or in providing case management or other services to clients with HIV illness. Examples of eligible agencies will include: Article 28 facilities, Community Based Organizations (CBOs), Community Health Centers (CHCs), or Community Service Programs (CSPs), Certified Home Health Agencies (CHHAs), or

(b) have 3 years demonstrated experience in the provision of maternal/pediatric services or in providing case management or care planning services to prenatal or post partum women and their children or families, or
New York
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(c) have 3 years demonstrated experience in the provision of drug abuse and/or drug treatment services, foster care preventive services or adult protective services including case management to clients and families that are at risk of foster care, including but not limited to local departments of social services, or

(d) be a hospital that has a provider agreement with the New York State Department of Health to participate in the Department’s Obstetrical HIV Counseling/Testing/Care Initiative.

2. **Staff Qualifications**

   **A. Case Manager Qualifications**

   To be eligible for reimbursement under this program, the case manager employed by the agency must meet the following required education/experience:

   1. a Bachelor's or Master's Degree which includes a practicum encompassing case management practices or a major in Psychology, Sociology, Social Work, or related subjects, or

   2. one year of qualified experience and an Associate Degree or 60 credit hours of college study from a regionally accredited college or university or one recognized by the New York State Education Department as following acceptable educational practices, or

   3. two years of qualified experience and/or of case management experience, or

   4. a degree in nursing or certification as a registered professional nurse or a licensed practical nurse with one year of qualified experience, or

   5. qualifications meeting the regulatory requirements of a state agency for case manager.

   Qualified Experience means verifiable full, part time or voluntary case management or case work with the following target populations:

   1. persons with HIV related illnesses
   2. women, children and families at risk of foster care
   3. substance using families

   **B. Case Management Technician Qualifications**

   Case management technicians must have a high school diploma or equivalent or must be working towards a high school equivalency diploma (GED) at the time of employment, have one year of qualified experience and have received intensive training in the Case Management Technician curriculum developed by Hunter College, and shall work under the supervision of the case manager.

   **TN #90-42**

   **Approval Date** October 10, 1991

   **Supersedes TN** NEW

   **Effective Date** July 1, 1990
C. **Community Follow-up Worker Qualifications**

The community follow-up worker, under the supervision of the case manager or case management technician, has no required educational or experiential requirements, but should have the following characteristics:

a. maturity, emotional and mental stability

b. ability to read and write, understand and carry out directions and instructions, record messages and keep simple records

c. be a resident or at least familiar with the local community and have knowledge of services and resources that are available

d. good physical health

e. a sympathetic attitude towards providing services to persons with HIV illness

f. fluency in local languages such as Spanish and Creole

g. experience working in the community preferable

In addition, the agency shall have the responsibility of assuring that all case managers, technicians and community follow-up workers employed (including volunteers) receive a 2-3 day orientation training within the first month of employment in the agency. Each agency must maintain a training log to document the provision of training to all employees.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group “D”

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TN #89-17 Approval Date August 23, 1990
Supersedes TN NEW Effective Date April 1, 1989
F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
A. **TARGET GROUP D**

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health’s Intensive Case Management Program and who:

(i) are seriously and persistently (chronically) mentally ill and

(ii) require intensive, personal and proactive intervention to help them obtain 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 are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

(1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;

(2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;

(3) mentally ill who are homeless and live on the streets or in shelters;

(4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized.

The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual’s quality of life within the community.

B. **AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D**

Entire State

D. **DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT**

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

**TN #89-17**

Approval Date **August 23, 1990**

Supersedes **NEW**

Effective Date **April 1, 1989**
2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service with assuring that eligible individuals receive the services appropriate to their needs. Target groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.

3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.

4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “D”

Case management for Target Group “D” means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group “D” requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient’s circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.
A. **Intake and screening.**

This function consists of: the initial contact to provide information concerning case management; exploring the recipient’s receptivity to the case management process; determining that the recipient is a member of the provider’s targeted population; and identifying potential payors for services.

B. **Assessment and reassessment.**

During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient’s permission: a determination of the nature and degree of the recipient’s functional impairment through a medical evaluation; a determination of the recipient’s functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient’s service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient’s strengths, informal support system and environmental factors relative to his/her care.

C. **Case management plan and coordination.**

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient’s informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other services providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. **Implementation of the case management plan.**

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

**TN #89-17**

**Approval Date** August 23, 1990

**Supersedes TN NEW**

**Effective Date** April 1, 1989
E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient’s circumstances; determination of the recipient’s emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. **Monitoring and follow-up.** As dictated by the client’s needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient’s satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient’s family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient’s access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

**PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICES**

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient’s need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient’s current functioning and continuing need for services, the service priorities and evaluation of the recipient’s ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.
An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.**

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS.**

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred;

d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

3. **Continuity of service.**

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services or, the recipient's case is appropriately transferred to another case manager.

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Supersedes TN NEW

Approval Date August 23, 1990
Effective Date April 1, 1989
Contact with the recipient or with a collateral source on the recipient’s behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider’s agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider’s incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each CMH entity is not capable of serving clients in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client’s community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available to the best substitute. Clients are free to choose among qualified providers within the State.

**LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES**

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

While the activities of case management services secure access to an individual’s needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligibility determinations/redeterminations;

3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP “D”

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients are seen a minimum of four times during a month. Active seriously emotionally disturbed children in the ICM program must receive four contacts during a month, three face-to-face and the fourth face-to-face may be with either the client or a collateral. Collaterals are defined in 14 NYCRR Part 587.4(a)(2) as members of the patient’s family or household, or significant others who regularly interact with the patient and are directly affected by or have the capability of affecting the patient’s condition and are identified in the treatment plan as having a role in treatment and/or identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the patient prior to admission. Each Office of Mental Health Regional Office shall maintain a listing by name (roster) of individuals meeting the basic participation criteria. These individuals may be referred to the roster by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager will determine which are viable to become active (i.e. that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for return to the roster. Clients returned to rostered status may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

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a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. state and local governmental agencies; and

d. home health agencies certified under New York State law.

2. **Case Managers**

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. **Qualifications of Providers Specific to Target Group “D”**

1. **Providers**

   The New York State Department of Social Services will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations determined by OMH and certified to SDSS to have the capacity to provide specialized Intensive Case Management Services.

2. **Case Manager**

   **Minimum Qualifications for Appointment As An Intensive Case Manager**

   A bachelor's degree in a human service field* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a

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Supersedes TN #89-17
Approval Date March 14, 1996
Effective Date October 1, 1995
broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master's degree in human services field* may be substituted for two years of the required experience.

**Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services**

A master’s degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, education, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

* For purposes of qualifying for these titles a “Human Services Field” includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.
STATE PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

Target Group D1

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic area (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

[X] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[ ] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualifications of Providers:

See attached

F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

TN #01-02 Approval Date June 19, 2001
Supersedes TN NEW Effective Date January 1, 2001
G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D1

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health’s (OMH) Flexible Intensive Case Management Program and who:

(i) are seriously and persistently (chronically) mentally ill and

(ii) require intensive, personal and proactive intervention to help them obtain 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 are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

(1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. They may also have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;

(2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;

(3) mentally ill who are homeless and live on the streets or in shelters;

(4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who might, without invention, be institutionalized, incarcerated or hospitalized.

The aim to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the individual’s quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D1

Statewide
C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable services while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.

3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing information regarding services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.

4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support systems can address their needs. Case management implies utilization and development of support networks that will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “D1”

Case management for Target Group “D1” means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.
Case management for Target Group “D1” requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

**CASE MANAGEMENT FUNCTIONS**

Case management functions are determined by the recipient’s circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

**A. Intake and screening.**

This function consists of: the initial contact to provide information concerning case management; exploring the recipient’s receptivity to the case management process; determining that the recipient is a member of the provider’s targeted population; and identifying potential payors for services.

**B. Assessment and reassessment.**

During this phase the case manager or case management team must secure directly, or indirectly through collateral sources, with the recipient’s permission: a determination of the nature and degree of the recipient’s functional impairment through a medical evaluation; a determination of the recipient’s functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient’s service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient’s strengths, informal support system and environmental factors relative to his/her care.

**C. Case management plan and coordination.**

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient’s informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

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**TN #01-02**

Supersedes TN **NEW**

Approval Date **June 19, 2001**

Effective Date **January 1, 2001**
1. the integration of clinical care plans throughout the case management process;

2. the continuity of service;

3. the avoidance of duplication of service (including case management services); and

4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of services; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient’s circumstances, determination of the recipient’s emergency service needs, and revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up.

As dictated by the client’s needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient’s satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient’s family and informal providers of services; mediating among the recipient, the family network and/or other
informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.**

   The case management process must be initiated by the recipient and case manager, case management team, or practitioners as appropriate, through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

   An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

   An assessment shall be initiated within fifteen days and must be completed by a case manager or case management team within 30 days or as specified in a referral agreement. The referral for services may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

   An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.**

   A written case management plan must be completed by the case manager or case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

   The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must address those needs necessary to achieve

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Supersedes TN NEW
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Effective Date January 1, 2001
and maintain stabilization. The case management plan must be reviewed and updated by the case manager or case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be renewed or revised, and new goals and new time frames may be established with participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred;

d. those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which those activities will be performed, and

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination or services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case by closed; the recipient is no longer eligible for services; or the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient’s behalf must be maintained by the case manager or case management team at least monthly or more frequently as specified in the provider’s agreement with the New York State Department of Health.
LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as provided for in July 25, 2000 HCFA letter to State Medicaid Directors (Olmstead Update No. 3) which informed the States that Targeted Case Management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligibility determinations/redeterminations;

3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;
5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP “D1”

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients must be seen a minimum of two times during a month, but the program must provide in the aggregate a minimum of four visits times the number of Medicaid eligible clients per month per case manager. Active seriously emotionally disturbed children in the ICM program must be seen a minimum of two times during a month, but a maximum of one-quarter of the required total aggregate face-to-face contacts may be with collaterals as defined in 14 NYCRR Part 587. Individuals may be referred to the program by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager or Case Management team will determine which clients are suitable candidates for Intensive Case Management (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for disenrollment. 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. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.
E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Office of Mental Health and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, so that DOH can enroll the providers in the Medicaid program. Providers may include:

   a. facilities licensed or certified under New York State law or regulation;

   b. health care or social work professionals licensed or certified in accordance with New York State law;

   c. state and local governmental agencies; and

   d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

   a. one year of case management experience and a degree in a health or human services field; or

   b. one year of case management experience and an additional year of experience in other activities with the target population; or
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c. a bachelor’s or master’s degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTION, including the performance of assessments and development or case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualification of Providers Specific to Target Group “D1”

1. Providers

The New York State Office of Mental Health will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations approved by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, in order for the DOH to enroll the providers in the Medicaid program.

2. Case Manager

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor’s degree in a human services field* or a NYS teacher’s certificate for which a bachelor’s degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master’s degree in human services field* may be substituted for two years of the required experience.

Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services

A master’s degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally
disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

* For purposes of qualifying for these titles a “Human Services Field” includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group D2

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

[X] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[ ] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualifications of Providers

See attached

F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to
public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D2

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health’s Blended and Flexible Case Management Program and who:

(i) are seriously and persistently (chronically) mentally ill, or seriously mentally ill and

(ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community, or 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 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.

These individuals include:

(1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. 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

(3) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community; or

(4) mentally ill who are homeless and live on the streets or in shelters; or

(5) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without invention, be institutionalized, incarcerated or hospitalized, or

(6) people in need of ongoing mental health support in order to maintain or enhance community tenure.
The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the client’s quality of life within the community.

B. **AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D2**

Entire State

C. **DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT**

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human service providers.

3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing them with information regarding the services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.

4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of
moving to the optimum situation in which these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “D2”

Case management for Target Group “D2” means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group “D2” requires referral to and coordination with medical, social, education, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient’s circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services which documents each case management function provided.

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient’s receptivity to the case management process; determining that the recipient is a member of the provider’s targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case management team must secure directly, or indirectly through collateral sources, with the recipient’s permission: a determination of the nature and degree of the recipient’s functional impairment through a medical evaluation; a determination of the recipient’s functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient’s service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient’s strengths, informal support system and environmental factors relative to his/her care.
**C. Case management plan and coordination.**

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient’s informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

**D. Implementation of the case management plan.**

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

**E. Crisis intervention.**

Crisis intervention by a case management team includes when necessary: assessment of the nature of the recipient’s circumstances; determination of the recipient’s emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

**F. Monitoring and follow-up.**

As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient’s satisfaction with the services provided and advising the preparer of the case.

**TN #01-02** 
Supersedes TN NEW

**Approval Date** June 19, 2001

**Effective Date** January 1, 2001
management plan whether the recipient is satisfied; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient’s family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient’s access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient’s need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient’s current functioning and continuing need for services, the service priorities and evaluation of the recipient’s ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case management team within 30 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the recipient’s need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient’s condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the
case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient’s case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient’s service needs and assessment and must be address those needs necessary to achieve and maintain stabilization.

The case management plan must be reviewed and updated by the case management team as required by changes in the recipient’s condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of time for purposes of accomplishing each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred;

d. the activities to be performed by a service provider or other person to achieve the recipient’s related goal and objective; and the method by which such services shall be provided;

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed; and

f. whether the program plans to place a client into transitional status during the next six month period covered by the plan.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is
no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Office of Mental Health.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as addressed in the July 25, 2000 HCFA letter to State Medicaid Directors which informed the States that Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.
While the activities of case management services secure access to an individual's needed service for the client, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSCT administration;
7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP “D2”

In order to support an intensive, personal and proactive service, Blended and Flexible Case Managers will carry case loads based on their designation as Intensive Case Managers or Supportive Case Managers. Intensive Case Managers are responsible to provide a minimum of 48 total monthly face to face contacts per manager. Supportive Case Managers are required to provide in the aggregate a minimum of twice the number of visits as the number of Supportive Case management clients. For children’s programs, a maximum of 25% of the total aggregate visits can be face-to-face contacts with collaterals as defined in 14 NYCRR Part 587.

Individuals may be referred to case management by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Blended and Flexible Case Management Program will determine which clients are appropriate for case management services and at what level (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)
Clients who appear ready for disenrollment from the program can be placed into transitional status for a period not to exceed two months. During that time period the program can bill for the client as long as at least one face-to-face contact per month is provided. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

New York State Office of Mental Health (OMH) will authorize as Case Management providers either OMH employees meeting the qualifications approved below or employees of those organizations determined by OMH and certified to the DOH to have the capacity to provide specialized Case Management Services and having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program. Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services that are approved by OMH. Providers may include:

a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. state and local governmental agencies; and

d. home health agencies certified under New York State law.

2. Case Managers

Intensive Case Managers:

The Intensive Case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:
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a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor’s or master’s degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development or case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Supportive Case Managers:

Must have two years in providing direct services or in a substantial number of activities outlined under “Case Management Functions” to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

a. One year of case management experience and an associate degree in a health or human services field: or

b. One year of case management experience and an additional year of experience in other activities with the target population; or

c. A bachelor’s or master’s degree which includes a practicum encompassing a substantial number of activities with the target population; or

d. The individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Appointment As A Coordinator of Blended and Flexible Case Management Services

A master's degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing

TN #01-02  
Supersedes TN NEW  
Approval Date June 19, 2001  
Effective Date January 1, 2001
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and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

* For purposes of qualifying for these titles a “Human Services Field” includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group E

B. Areas of State in which services will be provided:

[ ] Entire State.

[X] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

Services to this target population may be provided to residents of Kings County (Zip Codes 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11235), Bronx County (Zip Codes 10454, 10455, 10451, 10474 and 10459), New York County (Zip Codes 10026, 10027, 10030, 10031, 10037, 10039)

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached]
[A. TARGET GROUP

This target group consists of any categorically needy or medically needy individual who meets the following criteria:

1. Women of child bearing age who are pregnant or parenting, and

2. Infants under 1 year of age.

One of the most serious public health problems we are facing today is that of infant mortality. The problem is especially severe in certain urban areas among poor minority groups where the infant mortality rate is up to 3 times that of the population at large. Other factors which contribute to this problem are women who receive late or no prenatal care. Recent changes to Federal and New York State Law have expanded eligibility benefits to pregnant women and infants. Case management programs are expected to identify women who are at risk and assist them in accessing health care and other resources which they need to assure positive birth outcomes.

In some areas of New York City almost twenty percent of the infants born to minority women are low birth weight babies who are vulnerable to infections and sudden infant death syndrome as well as complications related to low birth weight itself.

Certain upstate cities mirror these rates in their center city areas. Case management will assist in assuring that mothers in these areas can avail themselves of health and social services to properly care for their infants.

In the areas in question, about 20% of the births are to teenage mothers and up to 75% are out of wedlock. The mothers in question are often inexperienced at heading a family and do not have the social supports available in an intact family, and as such have a great need for case management services to assist them in obtaining needed services for themselves and their infants.

After years of steady decline, infant mortality rates have once again begun to climb since 1987. Much of this increase can be laid at the feet of increasing use of illegal drugs and alcohol on the part of poor women in urban areas. In births where toxicity for illegal drugs is found, in New York City, infant mortality is an astronomical 34 in 1,000.

New York State hopes to attack these problems in a site-specific manner using case managers to pull together both Title XIX services and services from other funding streams to meet the needs of pregnant women and infants.]
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES]

[F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.]
[B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED]

Services to this target population may be provided to residents of Kings County (Zip Codes: 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11238), Bronx County (Zip Codes: 10454, 10455, 10451, 10474 and 10459), New York County (Zip Codes: 10026, 10027, 10030, 10031, 10037 and 10039) and Onondaga County, New York.

[C. COMPATIBILITY OF SERVICES]

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

[D. DEFINITION OF CASE MANAGEMENT SERVICES TO PREGNANT AND PARENTING WOMEN AND INFANTS]

Case management is a process which will assist persons eligible for medical assistance to access needed medical, social, educational, and other services in accordance with a written case management plan.

Case management for this target group will be provided in the following fashion.

1. Referral

Referrals of Medicaid eligible women and infants who are part of the target population are made by prenatal and pediatric care providers in the areas involved. Other possible referral sources include alcohol and substance abuse services providers, schools, social agencies and local governmental agencies administering the Medicaid program, child protective and preventive services, programs under Title V of the Social Security Act and Section 17 of the Child Nutrition Act.

Hospitals in the target areas are encouraged to refer women who deliver at their facilities, who have received little or no prenatal care, test positive for illicit drugs or deliver low birth weight babies to case management agencies. Other women from the target areas will also be encouraged to participate because of the higher level of risk which they and their infants face.

The referral activity as outlined is included to add dimension to the problems faced by the target population and to show the degree to which existing service providers will be involved in the identification and referral of such clients. Successful case management for these clients depends in great part on the ability of the case manager to develop good working relationships with service providers. This includes becoming a recognized resource within the broader provider community i.e., a service to which clients may be referred.]

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[These referral activities are not a function of the case manager; begin prior to the receipt of case management services; and are not billed as Medicaid case management.]

2. **Engagement**

Based on the referral from the hospital, prenatal care or other provider or local governmental agency, the case management agency attempts to interest the Medicaid eligible women/infant in case management services. Because women in high poverty areas, especially those who use illegal drugs or alcohol, are hard to engage for services, agencies are encouraged to make a number of attempts to contact the woman. If a woman accepts services, she is then enrolled by the case management agency. In areas where there are multiple agencies providing services, each agency will be required to explain to the woman that she has her choice of case management providers.

3. **Assessment/Reassessment**

Within 15 days of the acceptance of case management services, the case manager must complete an initial assessment. This will include an evaluation of the met and unmet needs of the woman and her children, her strengths and weaknesses, both formal and informal supports and identification of providers of service, including other case management resources.

It is anticipated that the initial assessment will concentrate on the immediate issues of the woman and her children's health and safety, substance abuse problems and family functioning. Subsequent reassessments (required at four month intervals) will likely deal with the family's longer term needs such as education, safe housing, training and employment for economic security.

4. **Case Management Plan Development**

Within 30 days of the acceptance of case management services; the case manager must complete development of an initial services plan for the woman and her family. Individuals residing together mutually impact upon each other in terms of their activities and their needs. To deliver effective case management, the family structure, whatever it may be, needs to be taken into account. Family supports and family stressors have a significant impact on the client. If a “parenting” woman (targeted) is having parenting problems with a 2 year old (non-targeted) or needs to arrange for child care in order to participate in a substance abuse treatment program, the case manager must address these needs in the woman’s case management plan.

Case managers will **not** do assessments or case management plans for non-Medicaid eligible persons and will only assist non-Medicaid eligibles in obtaining services, when obtaining that service has a direct impact on the Medicaid eligible member of the target group.]

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**Supersedes TN  #90-0056**

**Approval Date** September 4, 2015

**Effective Date** April 1, 2015
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1-E4

[Medicaid funding will not be used to provide case management services to non-Medicaid eligible family members. Based on the assessment and developed in conjunction with the client, the services plan should include the type and frequency of services needed and the method of obtaining them. Also included in the plan should be timeframes for achieving the objectives and the anticipated frequency of case management.

As in the case of the initial assessment, the initial plan will likely focus on the immediate service needs to insure health and safety of the woman and her children. Once these objectives are achieved, longer term planning for improvements in housing, education and employment will become basic to the plan.

The services plan in question must indicate where and by whom each service is to be delivered; the case manager will be responsible for assuring the delivery of services outlined in the plan. Each woman will have only one Medicaid reimbursed case manager. The services plan should be signed by the women to show her agreement and willingness to participate.

5. **Plan implementation**

The case manager assists the woman in acquiring those services which have been identified in the plan as being necessary. In many instances this will required an advocacy role on the part of the case manager in attempting to obtain priorities for the woman and her children within services networks which are already seriously taxed.

The case manager might be required to escort the woman to appointments, at least initially, until she becomes familiar with the parties and processes involved in service provision.

Service acquisition to implement the case management plan will be crucial to the success of the program. It will be necessary to develop priority consideration for such services as clinic appointments, substance abuse services and day care for the program.

6. **Monitoring**

Monitoring includes assuring that the services were received and that they are appropriate and of acceptable quality and that the client is satisfied that they are meeting the needs of herself and her family. The primary source for obtaining this information is from the woman herself, but case managers should also maintain contact with service providers to assure that the client is making progress and utilizing services properly.

Certain services are dependent on other services. For instance, the case manager will want to be certain that a woman using child care is actually getting active drug or alcohol treatment during the times that the child is being cared for.]
[7. Crisis Intervention]

With a population which engages in substance abuse, does not respond to health needs until they become emergent and lives in dangerous, unsafe and unhealthy housing, the potential for crisis is measurably increased. For this reason, case management agencies should prepare a crisis plan for individual clients to advise them where to turn in an emergency, as well as having an agency plan to assist clients on a 24 hour a day basis, if necessary.

It is not essential that the case manager be available on a 24 hour basis, but only that the agency have a viable plan for dealing with after hour emergencies.

In addition, the agency must be prepared to revise the services plan almost immediately if the crisis has lasting repercussions or requires a change in the mix or intensity of services.

8. Counseling and Exit Planning

The best case management practices help build self-esteem and improve the client’s ability to function more independently thus reducing or eliminating the need for further case management. As the case management becomes less intense, the client should be encouraged to participate in the development and implementation of her own plan objective.

When the case manager determines, in conjunction with the client, that case management is no longer necessary or if the woman loses program eligibility or moves to a different area or service system, the case manager should assist her in moving to new providers or sources of services. With the client’s consent, a final assessment and case summary should be prepared and forwarded to the new case manager or services source.

E. QUALIFICATIONS

1. Provider Agency Qualifications

Agencies may be qualified in one of the following ways.

a. One year of experience in providing case management services to pregnant or parenting women or infants.

b. Two years of experience in providing health care or social services to pregnant or parenting women or infants.

c. Two years of experience in providing drug or alcohol abuse treatment services to pregnant or parenting women.

d. Two years of experience in providing protective services for children or services to prevent their placement in foster care.]
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[These qualifications may be met by the agency itself or may be met by an individual who has management experience in such an agency and assumes responsibility for the overall administration of the case management program.

2. Staff Qualifications

a. Case Manager

An individual with a Bachelors or Masters degree in Nursing, Social Work, Health Education or a related field. If the degree is in a required field, one year of case management experience is required.

b. Associate Case Manager/Community Health Worker/Community Advocate

Associate Case Managers (ACM/Community Health Workers (CHW/Community Advocate (CA) describes persons residing in the community who assist case managers to monitor and reach clients who do not routinely access organized medical care or entitlements or who may be reluctant to access help from organizations. These individuals are not providers of case management, but are part of the team approach to case management encouraged by this program. They may assist case managers in locating individuals in the community, maintaining contact and gaining acceptance and cooperation for the program and its goals.

These individual's must have two years of experience as case aides or similar experience with the target group. One year of this experience may be fulfilled by an intensive training program, approved by the State Medicaid Agency.]
Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through CONNECT — Target Group E described on pages 1-E1 through 1-E6.
[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

CASE MANAGEMENT SERVICES]

[A. Target Group:

See attached Target Group F

B. Areas of State in which services will be provided:

[ ] Entire State.

[X] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

City of Newburgh, Orange County
City of Fulton, Oswego County
Addison School District, Steuben County

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See pages 1-F7 and 1-F8]
STATE PLAN UNDER TITLE XIIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

[F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.]
[A. TARGETED GROUP]

The targeted group consists of the categorically needy or medically needy who meet one or more of the following criteria.

Certain individuals residing in area 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 area who are experiencing chronic or significant individual or family dysfunctions which might be ameliorated through effective case management referral and monitoring of service provision. Such dysfunctions are assessed as chronic or significant by the case manager in accordance with an assessment tool approved by the State Department of Social Services. The assessment will determine chronic or significant dysfunction of 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

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP F

City of Newburgh, New York
Addison School District, New York
City of Fulton, New York

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “F”

Case managers will assess, and refer the target population to the existing services including these newly available resources and services concentrated in the defined NBA community.]

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[Case management for Target Group “F” means linkage and referral activities performed by case management staff for individuals who are struggling with the effects of multiple problems compounded by poverty and poor access to services. Through case management, clients will have improved access to the comprehensive array of services and assistance available in the community. Individual needs of the client will be assessed and a case management plan developed.

Case management for Target Group “F” requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community for the purpose of increasing the client’s ability to function independently in the community. The ultimate purpose is to increase the client’s level of self-sufficiency.

Case management services to individuals who are not Medicaid eligible will be supported by public and private grant funds. A sliding fee scale for clients based on income level will also be established. Case management will be the means to linking clients to the health, social, economic and educational resources of the community.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient’s circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including but not limited to:

A. **Intake and screening.**

   This function consists of: the initial contact to provide information concerning case management; exploring the recipient’s receptivity to the case management process; determining that the recipient is a member of the provider’s targeted population; and identifying potential payers for services.

B. **Assessment and reassessment.**

   During this phase the case manager will determine what services the individual needs to access. This determination requires the case manager to secure, as appropriate to the presenting problem, either directly, or indirectly through collateral sources, with the recipient’s permission: a determination of the nature and degree of the recipient’s functional impairment through a medical evaluation; a determination of the recipient’s functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient’s strengths, informal support]
system and environmental factors relative to his/her care. Medical/psychological evaluations shall be obtained indirectly through collateral sources with the permission of the recipient and are not a compensated component of case management.

C. Case management plan and coordination.

The activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with other service providers, including informal caregivers and other case managers. It also includes through case management conferences an exchange of clinical information which will assure:

1. case management plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan means assisting clients in gaining access to necessary services. Case managers must secure the services determined in the case management plan appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services. Implementation may mean assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing a plan to access alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up.

The case manager is responsible for: assuring that quality services, as identified in the case management plan, are delivered by the provider to whom referral was made; assuring the recipient's satisfaction with the services provided and, if the plan has been formulated by a practitioner]
Supplement 1 to Attachment 3.1-A

New York
1-F5

[advising the preparer of the case management plan of the findings; collecting data and documenting the progress of the recipient in the case record; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation and continuation of the case management plan.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient’s need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient’s current functioning and continuing need for services, the service priorities and evaluation of the recipient’s ability to benefit from such services. The assessment process includes those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient’s need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient’s condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient’s case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient’s service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient’s condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.]
Supplement 1 to Attachment 3.1-A

New York
1-F6

[The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of
time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members,
who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be
referred;

d. the method of provision and those activities to be performed by a service provider or
other person to achieve the recipient's related goal and objective; and

e. the type, amount, frequency, duration and cost of case management and other
services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case
management agency for services to the time when: the coordination of services provided
through case management is not required or is no longer required by the recipient; the
recipient moves from the target area; the long term goal has been reached; the recipient
refuses to accept case management services; the recipient request that his/her case be closed;
the recipient is no longer eligible for services; or, the recipient's case is appropriately
transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be
maintained by the case manager at least monthly or more frequently as specified in the
provider's agreement with the New York State Department of Social Services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical
care or services from any provider participating in the Medical Assistance Program who is
qualified to provide such care or services and who undertakes to provide such care or
services or which arranges for the delivery of such care or services on a prepayment
basis;

2. duplicate case management services currently provided under the Medical Assistance
Program or under and other program;

3. be utilized by providers of case management to create a demand for unnecessary services
or programs particularly those services or programs within their scope of authority.]
[While the activities of case management services secure access to an individual’s needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, NF’s;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

Contact with the client or with a collateral source on the client’s behalf must be maintained by the case manager at least monthly, or more frequently as specified in the proposal document submitted for each site.

E. Qualifications of Providers

1. Providers

Under New York State Regulations (18 NYCRR 505.16) case management services may be provided by social services agencies, facilities, persons and other groups possessing the capabilities to provide such services who are approved by the New York State Commissioner of Social Services based upon approved proposal submitted to the New York State Department of Social Services.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

   a. one year of case management experience and a degree in a health or human services field; or]
[b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor’s or master’s degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Provider Qualifications Specific to Target Group “F”

1. Providers

The State Department of Social Services designation of providers for this target group will be based upon a proposal document demonstrating the capacity to provide the described services to the target population. The proposal document must be submitted to SDSS, Division of Health and Long Term Care (HLTC) by the local social services district in which an NBA site is located. Qualified agencies will be enrolled as case management providers to serve target populations within the NBA service area.

The NBA lead agencies will provide case management themselves and/or solicit new case managers from community agencies with additional special expertise in the targeted subpopulations. New case managers solicited by the lead agency must meet all provider qualifications, must execute separate provider agreements with the State and must bill the Medicaid program in their own right. The NBA lead agencies are responsible for identification of clients needing case management and referral to the appropriate case management agency. Lead agencies will be responsible for recordkeeping and Medicaid claim preparation only for the case management services they themselves render.

2. Case Managers

Case managers will meet the general qualifications described in Item E.2.

Additionally, the staff recruited to work for the case management and crisis intervention program in both a supervisory and direct service capacity will be individuals who are highly committed to the community network concept and have experience working with the variety of cultural and ethnic groups represented in the community. A variety of educational, experiential, and cultural backgrounds will be sought.]
Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through NBA — Target Group F described on pages 1-F1 through 1-F8.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: G

See attached.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TN #93-50
Supersedes TN NEW

Approval Date: March 9, 1995
Effective Date: September 1, 1993
A. TARGET POPULATION G

The target group consists of any categorically needy or medically needy eligibles

1. who are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome.

2. who have been referred to the municipal early intervention agency and are known to the New York State Department of Health.

3. who are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child’s chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

1. a twelve month delay in one functional area, or

2. a 33% delay in one functional area or a 25% delay in each of two areas, or,

3. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standards deviations below the mean in each of two functional areas, or

4. if because of a child’s age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the informed clinical opinion of the multidisciplinary team. Criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of that child and family shall also be considered.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP G

Entire State

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D. DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “G”

Case management for Target Group “G” means those initial and ongoing activities performed by case management staff related to ensuring that developmentally delayed infants and toddlers are provided access to services allowing them to:

1. resolve problems which will interfere with their independence or self-sufficiency;
2. resolve problems which will interfere with attainment or maintenance of self support or economic independence;
3. maintain themselves in the community rather than reside in, or return to an institution; or
4. prevent institutionalization from occurring.

Case management is a process which will assist Medicaid eligible infants and toddlers and their families to access necessary medical, social, psychological, educational, financial and other services in accordance with the goals contained in a written individualized family services plan (IFSP).

CASE MANAGEMENT FUNCTIONS

Case Management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management service provided.

1. Intake.
   This function consists of: the initial contact to provide information concerning case management and early intervention to the parent of an eligible child or a child thought to be eligible for early intervention services at a time and place convenient to the family; exploration of the family's receptivity to the early intervention program and the case management process; determine that the recipient is a member of the targeted population; ascertain if the child and family are presently receiving case management services or other services from public or private agencies, identification of potential payers for services; and review of due process rights concerning mediation and impartial hearing.

2. Assessment.
   The case manager must secure directly, or indirectly through collateral sources, with the family's permission: a determination of the nature and degree of the recipient's developmental status; must assist the family in accessing screening and evaluation services; review evaluation reports with the family; assist the family to identify their priorities, concerns, and resources; explore options and assist the family's investigation of these options; inform the family of other program and services that may be of benefit and assist

TN #93-50 Approval Date March 9, 1995
Supersedes TN NEW Effective Date September 1, 1993
in making referrals; assist the recipient in obtaining interim early intervention services
when it is determined that the child has an obvious, immediate need and prepare an
interim family services plan.

3. **Case management plan and coordination.**

For purposes of early intervention, the case management plan will be known as the
individualized family services plan (IFSP). Development of the IFSP is the translation
of specific goals and objectives, and specific services, providers and timeframes to reach
each objective. The case manager shall convene a meeting at a time and place convenient
to the family with 45 days of the child’s referral to early intervention agency except under
exceptional documented circumstances. Participants shall include: parent(s); early
intervention official; case manager; the designated contact from the evaluation team; and
other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

a. A statement of the child’s levels of functioning in each of the following domains:
   physical development; cognitive development; communication development; social
   or emotional development; and adaptive development.

b. A physician’s order pertaining to early intervention services, which includes a
diagnostic statement and purpose of treatment.

c. With parental consent, a statement of the family’s strengths, priorities, concerns that
   relate to enhancing the development of their child.

d. A statement of the major outcomes expected to be achieved and for the child and
   family, including timelines, and criteria and procedures that will be used to
determine whether progress toward achieving the outcomes is being made and
whether modifications or revisions of the outcomes and services is necessary.

e. A statement of specific early intervention services necessary to meet the unique
   needs of the child and family, including the frequency, intensity, location and the
   method of delivering services.

f. A statement of the natural environments in which early intervention services will be
   provided.

g. When early intervention services are to be delivered to a recipient in a group setting
   without typically developing peers, the IFSP shall document the reason(s).

h. A statement of other services, including medical services, that are not required
   under the early intervention program but are needed by the child and the family and
   the payment mechanism for these services.

i. A statement of other public programs under which the child and family may be
   eligible for benefits, and a referral, where indicated.

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**Supersedes TN NEW**

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j. The projected dates for initiation of services and the anticipated duration of these services.

k. The name of the case manager who will be responsible for the implementation of the IFSP.

l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.

m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. Implementation of the IFSP.

In implementing the service plan, the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. Reassessment and IFSP update.

Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant, or if a parent requests such a review.

6. IFSP update implementation.

The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. Crisis intervention.

Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. Monitoring and follow-up.

The case manager is responsible for:

a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;

b. assuring the family's satisfaction with the services provided;

c. collecting data and documenting the progress of the recipient in a case record;

d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);
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e. making alternate arrangements when services have been denied or are unavailable; and

f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. Counseling and exit planning.

The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient’s family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient’s access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. Supervisory Review/Case Conferencing.

An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation. IFSPs and other products as well as peer review or case conferencing with other case managers.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the family and the case manager through a written assessment of the child and family’s need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient’s current functioning and continuing need for services, the service priorities and evaluation of the child’s ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of CASE MANAGEMENT FUNCTIONS.

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient’s need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child’s condition or circumstances.

2. Case management plan.

A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under CASE MANAGEMENT FUNCTIONS.

TN  #93-50  Approval Date  March 9, 1995
Supersedes TN  NEW  Effective Date  September 1, 1993
3. **Continuity of service.**

Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child’s case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child’s behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider’s agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider’s incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family’s new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

**LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES**

Case management services for Target Group “G”:

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;

2. must not duplicate certain case management services services currently provided under the Medical Assistance Program or under any other funding sources;

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:

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1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with “lock-in” provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP “G”

1. Provider qualifications

   Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

   a. character and competence, including fiscal viability;
   b. the capacity to provide case management services;
   c. availability to provide qualified personnel as defined in subsection 2 below;
   d. adherence to applicable federal and state laws and regulations;
   e. the capacity and willingness to ensure case managers participate in inservice training;
   f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;
   g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

   Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

   a. a minimum of one of the following educational or case management experience credentials:

      i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or

      ii. one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or

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iii. one year of case management experience and an associates degree in a health or human service field; or

iv. a bachelors degree in a health and human services field.

b. demonstrated knowledge and understanding in the following areas:

i. infants and toddlers who are eligible for early intervention services;

ii. State and federal laws and regulations pertaining to the Early Intervention Program;

iii. principles of family centered services;

iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,

v. other pertinent information.

3. Individual case managers

Qualified personnel with appropriate licensure, certification, or registration shall apply to the State Department of Health for approval to provide case management services. In addition to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

a. current licensure, certification or registration in a discipline eligible to deliver services to children;

b. adherence to applicable federal and State laws and regulations;

c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;

d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;

e. completion of an approved Medicaid provider agreement.

TN #93-50
Supersedes TN NEW
Approval Date March 9, 1995
Effective Date September 1, 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: H

See attached.

B. Areas of State in which services will be provided:

[x] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TN #94-40
Supersedes TN NEW
Approval Date July 20, 1995
Effective Date July 1, 1994
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F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
A. TARGET GROUP H

The targeted group consists of Medical Assistance eligibles who are served by the Office of Mental Health’s Supportive Case Management Program 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, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities, or,

(2) persons with recent hospitalization in either state psychiatric centers or acute care general hospital; or,

(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 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 compliance and generally improving the individual’s quality of life within the community.

Supportive Case Management will address the needs and desires of those persons in Target Group “H”. Target Group “H” persons will be identified through the screening and intake process. The eligibility determination will be made based on individual factors in each person’s life. Factors which will be considered during this process include: status of mental illness, case management options available in the community, residential situation and available options, current linkage to mental health services (including type of service, frequency and duration), linkage or lack thereof to the health care system and/or the Social Services system, the role of the criminal justice system in a person’s life, as well as the individual’s personal needs and goals. If

TN #94-40 Approval Date July 20, 1995
Supersedes TN NEW Effective Date July 1, 1994
an individual is generally not engaged in at least one of these service systems, he/she may be better served in an Intensive Case Management program and the SCM program will make the appropriate referral and work toward linking that person into ICM. Those persons determined to be in need of Intensive Case Management but who cannot be served due to lack of capacity in ICM program will be served by the SCM until the individual circumstances change or the ICM program has space available for the individual.

B. **AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP H**

Entire State

C. **DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID**

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

**DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP “H”**

Case management for Target Group “H” means those activities performed by case management staff related to ensuring that the individuals diagnosed with mental illness have full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group “H” requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the person diagnosed with mental illness.

Supportive case management establishes programming directed toward a comprehensive person-centered view of recovery from mental illness. The Office of Mental Health has designed the SCM initiative to extend the personalized planning, linking, monitoring, and advocacy available through the Intensive Case Management Program target group “D” toward a wider group of persons in need. Called Supportive Case Management, this new program will be available to persons living in the community, homeless persons and persons in community support programs. The intent of the program is to provide for these individuals a comprehensive approach toward meeting their treatment, rehabilitation and support needs.

**CASE MANAGEMENT FUNCTIONS**

The case manager will assist the recipient in gaining access to each individual's specific area of need (ie. medical, social, education or other service). The case manager will perform needs assessments, develop a plan of care to meet the recipient’s needs and interests,
assist the recipient in accessing the services and perform monitoring and follow-up functions. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the individual.
D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow up.

As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing linkages to support groups for the recipient, the recipient's family and informal providers of services; coordinating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

TN #94-40 Approval Date July 20, 1995
Supersedes TN NEW Effective Date July 1, 1994
An assessment provides verification of the individual’s current functioning and continuing need for services, the service priorities and evaluation of the individual’s ability to benefit from such services. The assessment process consists of those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the individual’s need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient’s condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each individual receiving case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C, under CASE MANAGEMENT FUNCTIONS.

The individual’s case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the individual’s condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the individual is expected to undertake within a given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the individual will be referred;

d. the method of provision and those activities to be performed by a service provider or other person to achieve the individual’s related goal and objective; and

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.
3. **Continuity of service.**

Case management services must be ongoing from the time the individual is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the individual; the recipient moves from the social services district*; the long term goal has been reached; the individual refuses to accept case management services; the individual requests that his/her case be closed; the individual is no longer eligible for services; or, the individual's case is appropriately transferred to another case manager. Contact with the individual or with a collateral source on the individual's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving individuals in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

**LIMITATIONS TO THE PROVISION OF MEDITAID CASE MANAGEMENT SERVICES**

Case management services must **not**:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers or case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.
While the activities of case management services secure access to an individual’s needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with “lock in” provisions under 1915 (a) of the Social Security Act;
8. institutional discharge planning required of hospitals, SNFS, ICFs and ICF/MRs;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan; and
10. representative payee services.

LIMITATIONS SPECIFIC TO TARGET GROUP “H”

In order to support a personal and proactive service, Supportive Case Managers will carry an average active case load of between 20-30 clients. Supportive Case Managers will see active clients a minimum of two times during a month. SCM employs a team approach to the provision of case management service. The inclusion of the SCM program in the service target group H will assure that the nature and intensity of services vary with individuals changing needs. These individuals may be referred to the SCM by various community agencies, mental health agencies, (including State psychiatric facilities), and human services agencies with whom the client has been in contact.

D. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP “H”

1. Providers

The New York State Office of Mental Health (OMH) will authorize as Case Management providers either employees of OMH meeting the qualifications described below or employees of those organizations determined by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Case Management Services and

TN #01-02 Approval Date June 19, 2001
Supersedes TN #94-40 Effective Date January 1, 2001
having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program.
SCM Teams will vary in size and composition and may consist of one individual who may be a paraprofessional with adequate clinical supervision. Each supportive case manager must meet the minimum qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload. The qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload are the same. While supportive case management programs may provide services to individuals with only one staff member and a supervisor in the program, the more common model will utilize a team approach. The team may be comprised of professionals and paraprofessionals. All members of the team must meet the minimum qualifications for the SCM and will receive professional supervision, as detailed in this document. SCM teams will have a professional supervisor with both clinical and supervisory experience.

2. **Case Managers**

**Minimum Qualifications for Supportive Case Manager:**

Two years of experience in providing direct services or in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

a) one year of case management experience and an associates degree in a health or human services field; or

b) one year of case management experience and an additional year of experience in other activities with the target population; or

c) a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or

d) the individual meets the regulatory requirements for case manager of a State Department within New York State.

**Minimum Qualifications for Coordinator of Supportive Case Management Services:**

**Education:**

1. a master's degree in one of the below listed fields*

or 2. a master's degree in public administration, business administration, health care or hospital administration and a bachelor's degree in one of the below listed fields*;

or 3. NYS licensure and registration as a Registered Nurse plus a master's degree in 1 or 2 above

**AND**

**Experience:**
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Four years of experience:

1. in providing direct services to persons diagnosed with mental disabilities**;

or 2. in linking persons diagnosed with mental disabilities** to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and financial services)

Two years of this experience must have involved:

1. supervisory or managerial experience for a mental health program or major mental health program component;

or 2. service as an Intensive Case Manager in a NYS Office of Mental Health registered ICM program.

* Qualifying education includes degrees in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing.

** The term “mental disabilities” refers to persons properly diagnosed with mental illness, mental retardation, alcoholism or substance abuse.

Minimum Qualifications for a Clinical Professional:

Clinical professional staff are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of mental illness and shall include: a credentialed alcoholism counselor; registered or certified creative arts therapist; certified nurse practitioner; licensed occupational therapist, physician, psychiatrist, psychologist, or registered professional nurse; registered physician’s assistant or specialist's assistant; rehabilitation counselor with a Master's Degree in this field or current certification, pastoral counselor with a Master's Degree or equivalent in this field, certified social worker currently licensed or with a Master’s Degree in this field, therapeutic recreation specialist who is registered or has a Master's Degree in this field.

Minimum Supervision Standard for Supportive Case Management Teams:

Supervision of the SCM team will be provided by the SCM Team Coordinator, or an appropriate clinical professional.

Routine review of tasks performed by the SCM team members will focus on enrollment, planning, and service linkage and advocacy. An SCM team meeting for case review will take place monthly or more frequently, if needed. Supervision of the SCM team members with paraprofessional job titles will be provided by a professional, who will be available at all times for consultation with the SCM and will provide direct supervision at frequent intervals to assure that recipient needs are being addressed. Supervision of a paraprofessionals by a professional staff member will occur on a bi-weekly basis at a minimum and more frequently, if needed.

TN #94-40 Approval Date July 20, 1995
Supersedes TN NEW Effective Date July 1, 1994
Additionally, the coordinator will review each recipient case record with the SCM team members on a semi-annual basis at a minimum and more frequently, as needed. The SCM Coordinator will post a progress note in the record at the time of the case record review.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: I

See attached Target Group

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TN #96-41 Approval Date January 21, 1998
Supersedes TN NEW Effective Date October 3, 1996
F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

See Attached
CASE MANAGEMENT SERVICES
SERVICE COORDINATION FOR CHILDREN WITH DISABILITIES

A. TARGET GROUP I:

Children 3 through 21 years old who are federally eligible Medical Assistance Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients and for whom free and appropriate education is provided under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

A child is eligible to receive the case management services, called Service Coordination for Children with Disabilities under New York’s Medical Assistance Program Comprehensive Medicaid Case Management regulations 18 NYCRR 505.16, when all of the following requirements are met:

1. It is determined through an assessment, in accordance with the New York State Education law and regulations for assuring a free, appropriate education for all students with disabilities, that:
   a. the child has temporary or long-term needs arising from cognitive, emotional, or physical factors, or any combination of these, which affects the child’s ability to learn, and
   b. the child’s ability to meet general education objectives is impaired to a degree whereby the services available in the general education program are inadequate in preparing the child to achieve his or her educational potential.

2. A multi-disciplinary team, called a Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) in the New York State Department of Education regulations for Programs for Students with Disabilities, or Multi-Disciplinary Team (MDT) for programs and activities under §504 of the Rehabilitation Act of 1973 determines that the recipient is a child with disabilities who:
   a. Is eligible for special education and/or related services that are provided through two school Medicaid programs; the Preschool Supportive Health Services Program (PSHSP) for children age 3 and 4 and the School Supportive Health Services Program (SSHSP) for children age 5 through 21, and
   b. Needs an Individualized Education Program (IEP) under Part B (IDEA) or an Accommodation Plan (AP) under Section 504 of the Rehabilitation Act of 1973.

3. The child elects, or the child’s parent or other responsible individual elects on the child’s behalf, to receive Service Coordination for Children and Disabilities; and

4. The child is not receiving similar case management services under another Medical Assistance Program authority.

TN #96-41 Approval Date January 21, 1998
Supersedes TN NEW Effective Date October 3, 1996
D. DEFINITION OF SERVICES:

Service Coordination for Children with Disabilities means those case management services which will assist children with or suspected of having disabilities in gaining access to evaluations and the services recommended in a child’s IEP or AP.

The New York Medical Assistance Program reimburses for the following services under Service Coordination for Children with Disabilities, when the following case management services have been documented as necessary and appropriate:

1. Initial IEP or AP

   a. A unit of service for the initial IEP or AP is defined as:

      (1) The activities leading up to and including writing a completed initial IEP or AP prepared by members of the CSE/CPSE/MDT, the multidisciplinary team. An initial IEP is a written recommendation identifying the handicapping condition, a description of the child’s strengths and weaknesses, a list of goals and objectives that the child should reach in a year’s time, and an identification of types of programs and services that the child will receive. An AP is a written document that describes the nature of the problem, evaluations completed, the basis for determining that the child has a disability, and the list of recommended accommodations; and

      (2) At least one contact by the child’s service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child’s parent or other responsible individual, on the child’s behalf, relating to the development of the initial IEP or AP.

   b. The covered services include convening and conducting the CSE/CPSE/MDT conference to develop an initial IEP or AP. The conference will result in all of the following:

      (1) A statement of the child’s special education needs, and/or related services needs or accommodation needs and services, including the need for medical, physical, mental health, social, financial assistance, counseling, and other support services;

      (2) A statement of measurable annual goals and measurable short-term objectives for the child;

      (3) A statement of the specific special education and related services to be provided to the child;

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(4) The projected dates for initiation of services and the anticipated duration of service;

(5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and

(6) Parental notification of the recommendation.

d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

2. Triennial Evaluation - IEP

a. A triennial evaluation may occur every three years to provide current assessment information on children in special education pursuant to IDEA. A unit of service is defined as:

(1) The activities leading up to a recommendation based on an appropriate reexamination of each child with a disability by a physician, a school psychologist, and to the extent required by the CSE, by other qualified appropriate professionals; and

(2) At least one contact by the child’s service coordinator or CSE, in person or by telephone with the child or the child’s parent or other responsible individual, on the child’s behalf, relating to updating the IEP.

b. The covered services include convening and conducting the CSE conference to review the results of the triennial evaluation, assessment and revising the IEP, as necessary, that will result in:

(1) A statement of the child’s special education needs and/or related service needs, including the need for medical, mental health, social, financial assistance, counseling, and other support services;

(2) A statement of measurable annual goals and measurable short-term objectives for the child;

(3) A statement of the specific special education and/or related services to be provided to the child;

(4) The projected dates for initiation of services and the anticipated duration of service;

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(5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and

(6) Parental notification of the recommendation.

c. Administrative, directive, supervisory, and monitoring services are included as part of the service.

3. Annual IEP or AP Review

a. An annual review is required CSE/CPSE/MDT meeting which must occur every year to determine whether the existing IEP or AP, is appropriately meeting the child’s needs. A unit of service is defined as follows:

(1) A CSE/CPSE/MDT meeting to discuss yearly progress and make recommendations to continue, change or terminate the program, and

(2) At least one contact by the child’s service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child’s parent or other responsible individual, on the child’s behalf, relating to updating the IEP or AP.

b. The covered services include convening and conducting the CSE/CPSE/MDT conference to revise the IEP or AP, as necessary, that will result in:

(1) A statement of the child’s special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;

(2) A statement of measurable annual goals and measurable short-term objectives for the child;

(3) A statement of the specific special education and/or related services to be provided to the child;

(4) The projected dates for initiation of services and the anticipated duration of service;

(5) Appropriate objective criteria and evaluation procedures for determining whether the objectives set forth in the IEP or AP are being achieved; and

(6) Parental notification of the recommendation.

c. Administrative, directive, supervisory, and monitoring services are included as part of the service.
4. **Requested IEP or AP (Interim) Review**

   a. Regulations of the New York State Department of Education require that a child’s IEP or AP be reviewed and, if appropriate, revised on an interim basis upon the request of the professionals on the CSE/CPSE/MDT or the request of the child’s parent(s) or other responsible individual.

   b. A unit of service for IEP or AP review is defined as:

      (1) Reconvening the CSE/CPSE/MDT, and

      (2) At least one contact by the service coordinator or CSE/CPSE/MDT in person or by telephone with the child or the child’s parent or other responsible individual, on the child’s behalf, relating to review of the IEP or AP.

   c. The covered services include convening and conducting a CSE/CPSE/MDT meeting to review and revise, as necessary, the child’s IEP or AP. The meeting will result in a review and parental notification, of the following:

      (1) The statement of the child’s special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;

      (2) The statement of measurable annual goals and measurable short-term objectives for the child;

      (3) The statement of the specific special education and/or related services to be provided to the child;

      (4) The projected dates for initiation of services and the anticipated duration of service; and

      (5) The appropriate objective criteria and evaluation procedures to determining whether the objectives set forth in the IEP or AP are being achieved.

   d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

5. **Ongoing Service Coordination**

   a. Ongoing service coordination is rendered subsequent to implementing a child’s IEP or AP by the service coordinator employed by or under contract to a school district.

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   Approval Date January 21, 1998
   Supersedes TN NEW
   Effective Date October 3, 1996
b. A unit of service for ongoing service coordination includes:

(1) At least two documented contacts per month by the service coordinator relating to the child’s ongoing service coordination, and

(2) The provision of all other necessary covered services under ongoing service coordination.

c. These services may include:

(1) Acting as a central point of contact relating to IEP or AP services for a child,

(2) Maintaining contact with direct service providers and with a child and the child’s parent or other responsible individual through home visits, office visits, school visits, telephone calls, and follow-up services as necessary,

(3) Assisting the child in gaining access to services specified in the IEP or AP, and providing linkage to agreed-upon direct service providers,

(4) Discussing with direct service providers that the appropriate services are being provided, following up to identify any obstacles to a child’s utilization of services, coordinating the service delivery, and performing ongoing reviews to determine whether the services are being delivered in a consolidated fashion as recommended in the IEP or AP and meet the child’s current needs,

(5) Providing a child and a child’s parent or other responsible individual with information and direction that will assist them in successfully accessing and using the services recommended in the IEP or AP, and

(6) Informing a child’s parent or other responsible individual of the child’s and the family’s rights and responsibilities in regard to specific programs and resources recommended in the IEP or AP.

d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

E. Qualifications of Providers of Service Coordination for Children with Disabilities:

1. A provider of Service Coordination for Children with Disabilities shall be a school district within the State that:

   a. Operates and contracts for programs with special education and/or related services/accommodations for children with disabilities, in accordance with Article 89 of Education Law, Section 504 of the Rehabilitation Act of 1973 and Programs for Students

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**TN #96-41**

Approval Date **January 21, 1998**

Supersedes TN **NEW**

Effective Date **October 3, 1996**
with Disabilities. (8 NYCRR 200); and

b. Is enrolled in MMIS as a SSHSP or PSHSP provider.

F. Qualifications of Service Coordinators:

1. An individual recommended as a child’s service coordinator shall be:

   a. Employed by or under contract to a school district;

   b. Chosen by the CSE/CPSE/MDT, taking into consideration the:

      (1) Primary disability manifested by the child;

      (2) Child’s needs, and

      (3) Services recommended in the IEP or AP.

2. A service coordinator must be appropriately licensed or certified and could include
   an audiologist, school counselor, rehabilitation counselor, registered nurse, practical nurse, occupational therapist, physical therapist, psychologist, social worker, speech therapist, speech pathologist, teacher, school administrator, or school supervisor.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Reimbursement for the development of the IEP or AP is available even if the child’s condition is reviewed and not classified, or the parent, on the child’s behalf, does not consent to the recommendation and the services are not provided.
The New York State Department of Health (NYSDOH) School Supportive Health Services Program (SSHSP) Targeted Case Management (TCM) for Target Group I, which became effective October 3, 1996, will be terminated on July 1, 2010.

TN #10-35
Supersedes TN NEW

Approval Date December 14, 2010
Effective Date July 1, 2010
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
For First-time Mothers and Newborns

Target Group: M - First-time Mothers and their Newborn

The primary target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child’s second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

The goals of this program are to improve pregnancy outcomes by providing comprehensive case management services including: 1) assessment of each woman’s need for medical, educational, social and other services; 2) development of a care plan for each woman with goals and activities to help the woman engage in good preventive health practices; and 3) referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child’s health and development and reducing quickly recurring and unintended pregnancies.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
___ Entire State.
__X_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

New York City, Monroe, Albany, Erie, Cayuga, Chautauqua, Nassau, Niagara, Chemung, Westchester, and Onondaga Counties

TN # 16-0021 Approval Date: July 11, 2016
Supersedes TN # 12-0005 Effective Date: April 01, 2016
Comparability of Services (Sections 1902(a)(10)(B) and 1915(g)(1))

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. (Section 1915(g)(1)). By enrolling in this targeted case management program, first-time mothers and their newborns will be receiving comprehensive case management services that are not comparable to the amount, duration and scope of services provided to all Medicaid eligible pregnant women.

Definition of Services (42 CFR 440.169):

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services through home visits by trained registered nurses. Case management services provided include the following:

1. **Comprehensive assessment and period reassessment of the first-time pregnant woman and her newborn to determine the need for medical, educational, social or other services. These assessment activities include:**

   a) taking the woman’s history and assessing her risk for poor birth outcomes;

   b) identifying the needs of the first-time mother and her newborn and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment.

2. **Development (and periodic revision) of a specific care plan.**

   A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman’s referral to the targeted case management program and must include, but not be limited to, the following activities:

   i. identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;

   ii. Selection of the long-term and short-term goals to be achieved through the case management process;

Approval Date April 6, 2010
Effective Date April 1, 2009
iii. Specification of the long-term and short-term goals to be achieved through the case management process;

iv. Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:

a. the integration of clinical care plans throughout the case management process;

b. the continuity of service;

c. the avoidance of duplication of services (including case management services) and

d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

a) goals and actions to address the medical, social, educational, and other services needed by the woman and child;

b) activities to ensure the active participation of the first-time mother (or the woman’s authorized health care decision maker) and others to develop the goals;

c) a course of action identified to respond to the assessed needs of the first-time mother and child;

d) an agreed upon schedule for re-evaluating goals and course of action.

The plan will be reviewed and updated by the case manager as required by changes in the recipient’s condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained or revised, and new goals and time frames established.

3. Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including:

a.) activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.
4. Monitoring and follow-up activities

Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn’s needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:

- services are being furnished in accordance with the care plan;
- services in the care plan are adequate and
- if there are changes in the needs or status of the woman and/or her child, then, necessary adjustments in the care plan and service arrangements with providers are made.

Case management includes contacts with non-eligible individuals (such as the newborn’s father) who are directly related to identifying the needs and care, for the purposes of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and altering case managers to changes in the mother or child’s needs (42 CFR 440.169(e)).

Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Provider Agencies

Providers of targeted case management to first-time mothers and their children in the target groups may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.
New York
1-M5

Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of the New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);

b) a county health department, including the health department of the City of New York;

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on the assessment; assist the first-time mother/child in obtaining access to medical, social, educational and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs. Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. In limited circumstances, an RN who does not have a BSN degree but is competent in a foreign language may be hired as a case manager in the First-time Mothers/Newborn program to provide TCM services to first-time mothers and their newborns who speak a language other than English (including, but not limited to Spanish, Chinese or Russian). There are specific criteria for this exception:

- The RN must be fluent in English and a foreign language (such as Spanish, Chinese etc.) and should work exclusively with participants who speak that same target language;

- The RN must be enrolled in a Bachelor’s degree program in nursing at an accredited institution of higher learning; and

- The RN must sign a memorandum of understanding with the provider agency which stipulates the expected completion date for obtaining the BSN degree. The provider agency will inform the county and the New York State Department of Health when the BSN degree is obtained.

Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

Approval Date September 6, 2012
Effective Date January 1, 2012
New York  
1-M6

The two years of experience may be substituted by:

a) one year of case management experience and a degree in a health or human services field;

b) one year case management experience and an additional year of experience in other activities with the target population; or

c) a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population.

As a single state Medicaid agency, criteria for case managers is stated in Administrative Directive 89 ADM-29 for case management provider entities and case management staff under section D entitled Provider Qualifications and Participation Standards.

**Freedom of Choice (42 CFR 441.18(a)(1))**:  
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

**Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b))**:  
[ ] Target group consists of eligible individuals with development disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

**Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6))**:  
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
New York
1-M7

- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**Payment (42 CFR 441.18(a)(4)):**

Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

**Case Records (42 CFR.18(a)(7)):**

Providers maintain case records that document for all recipients receiving targeted case management services as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.
Limitations

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities are an integral and inseparable component of another Medicaid service (State Medicaid Manual (SMM) 4302.F.).

Case management does not include, and Federal Financial participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements (42 CFR 441.18(c)). First-time mothers who are in foster care or under the jurisdiction of the juvenile justice system or the criminal justice system will not be eligible for targeted case management services under this program.

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social educational or other program except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c)).

TN #09-57}

Supersedes TN NEW

Approval Date April 6, 2010

Effective Date April 1, 2009
New York

PACE Services

Name and address of State Administering Agency, if different from the State Medicaid Agency:

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

**Institutionalized spouses under Section 1924 of the SSA**

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – PACE Program Agreement)

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State’s approved HCBS waiver(s).

**Regular Post Eligibility**

1. ___ SSI State.

The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.

**TN #02-01**

Approval Date September 3, 2002

Effective Date January 1, 2002
New York
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(a). Sec. 435.726—States which do not use more restrictive eligibility requirements than SSI.

1. **Allowances for the needs of the:**

   **(A.) Individual (check one)**

   1. ___ The following standard included under the State plan (check one):

      (a) ___ SSI
      (b) ___ Medically Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level: ____%
      (e) ___ Other (specify):____________________

   2. ___ The following dollar amount: $_______

      Note: If this amount changes, this item will be revised.

   3. ___ The following formula is used to determine the needs allowance:

      Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   **(B.) Spouse only (check one):**

   1. ___ SSI Standard
   2. ___ Optional State Supplement Standard
   3. ___ Medically needy Income Standard
   4. ___ The following dollar amount: $_______

      Note: If this amount changes, this item will be revised.

   5. ___ The following percentage of the following standard that is not greater than the standards above: ____% of ___ standard.

   6. ___ The amount is determined using the following formula:

   7 ___ Not applicable (N/A)

**C.) Family (check one):**

<table>
<thead>
<tr>
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New York

1. ___ AFDC need standard
2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $______
   Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: ___% of _____ standard.
5. ___ The amount is determined using the following formula:
   __________________________________________________________
   __________________________________________________________
6. ___ Other
7. ___ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.

(a) 42 CFR 435.735 - States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

   (A.) Individual (check one)

   1. ___ The following standard included under the State Plan (check one):

      (a) ___ SSI
      (b) ___ Medically Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level: ____%
      (e) ___ Other (specify): _______________________

TN #02-01 Approval Date September 3, 2002
Supersedes TN NEW Effective Date January 1, 2002
2. ___ The following dollar amount: $___________

   Note: If this amount changes, this item will be revised.

3. ___ The following formula is used to determine the needs allowance:

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. ___ The following standard under 42 CFR 435.121:

2. ___ The Medically needy income standard

3. ___ The following dollar amount: $ _______

   Note: If this amount changes, this item will be revised.

4. ___ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.

5. ___ The amount is determined using the following formula:

6. ___ Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard

2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State’s approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $_____

   Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.

5. ___ The amount is determined using the following formula:

6. ___ Other

7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. _X_ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

   (A). ___ The following standard included under the State plan (check one):

   1. ___ SSI
   2. ___ Medically Needy
   3. ___ The special income level for the institutionalized
   4. ___ Percent of the Federal Poverty Level: ____%
   5. ___ Other (specify): _______________________

   (B). _X_ The following dollar amount: $ 50*

       Note: If this amount changes, this item will be revised.

       * For non-institutionalized participants, the PNA is equal to the difference between the amount of the
Supplement 3 to Attachment 3.1-A

New York

6

medical assistance eligibility standard for one person and two person households.

(C) ___ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

The amount for non-institutionalized participants is the same incremental difference used under the community eligible rules when a household of one increases to a household of two. The amount covers the additional cost for food, shelter and personal incidental of a second individual in the household. Married couples not living together will be determined as individuals under the Medically Needy criteria.

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

Refer to Attachment 4.19-B, page 17

1. ___ Rates are set at a percent of fee-for-service costs

2. ___ Experience-based (contractors/State's cost experience or encounter date) (please describe)

TN #02-01
Supersedes TN NEW
Approval Date September 3, 2002
Effective Date January 1, 2002
3. ___ Adjusted Community Rate (please describe)
4. _X_ Other (please describe)

Refer to Attachment 4.19-B, page 17

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State’s management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

TN #02-01
Supersedes TN NEW

Approval Date September 3, 2002
Effective Date January 1, 2002
New York

State/Territory: ___New York_______________________________________________

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP (S): _______________________________________________________

The following ambulatory services are provided.

* Description provided on attachment.

TN ___ #86-30 __________ Approval Date __September 11, 1990________
Supersedes TN ___ #82-9 __________ Effective Date __October 1, 1986________
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   ☑ Provided: ☐ No limitations ☑ With limitations*

2. a. Outpatient hospital services.
   ☑ Provided: ☐ No limitations ☑ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
      ☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
      ☑ Provided: ☐ No limitations ☑ With limitations*

   d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Acct to a pregnant woman or individual under 18 years of age.
      ☑ Provided: ☐ No limitations ☑ With limitations*

3. Other laboratory and x-ray services.
   ☑ Provided: ☐ No limitations ☑ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
   ☑ Provided: ☐ No limitations ☑ With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (Limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.)
      ☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided.

   c.i. Family planning services and supplies for individuals of childbearing age and for individuals eligible pursuant to Attachments 2.2-A and 2.2-B, if this eligibility option is elected by the State.
      ☑ Provided: ☑ No limitations ☐ With limitations*

   c.ii. Family planning-related services provided under the above State Eligibility Option.
      ☑ Provided: ☑ No limitations ☐ With limitations*

   *Description provided on attachment.

   c.iii. Fertility services for women ages 21 through 44
      ☑ Provided: ☐ No limitations ☑ With limitations*
      *Limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.

TN #17-0058 Approval Date November 2, 2017
Supersedes TN #12-0012 Effective Date July 1, 2017
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY

4.d.1. **Face-to-Face Counseling Services provided:**
- ☑ (i) By or under supervision of a physician;
- ☑ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
- ☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (none are designated at this time)

4.d.2. **Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women**
- ☑ Provided: ☑ No limitations ☐ With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

All Medicaid recipients, including pregnant women, receiving tobacco cessation counseling services can receive these services without any limitation as stated above.

Please describe any limitations: ☐

5.a. Physicians’ services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

- ☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

i. Lactation counseling services.

- ☑ Provided: ☑ No limitations ☐ With limitations* ☐ Not provided

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a) (5)(B) of the Act).

- ☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

* Description provided on attachment

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TN #13-10 Approval Date November 6, 2013
Supersedes TN #12-16 Effective Date October 1, 2013
New York
2b

List of Available Organ Transplants - medically needy

- heart  - bone  - heart/lung
- kidney  - skin  - bone marrow
- liver  - cornea

TN #91-39
Supersedes TN NEW
Approval Date February 18, 1992
Effective Date July 1, 1991
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists’ services.

[X] Provided:  [ ] No limitations  [X] With limitations *

c. Chiropractors’ services. (EPSDT only.)

[X] Provided:  [ ] No limitations  [X] With limitations *

[ ] Not Provided.

d. Other practitioners’ services.

[X] Provided:  Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

(i). Other Licensed Practitioner services. (EPSDT only.)

[X] Provided:  Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided:  [ ] No limitations  [X] With limitations *

b. Home health aide services provided by a home health agency.

Provided:  [ ] No limitations  [X] With limitations *

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided:  [ ] No limitations  [X] With limitations *

* Description provided on attachment.
New York

State/Territory: ___New York__________________________________________

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDED GROUP (S): _______________________________________________________

8. Private duty nursing services.
   [x] Provided: [ ] No limitations [x] With limitations *

9. Clinical services.
   [x] Provided: [ ] No limitations [x] With limitations *

10. Dental services.
    [x] Provided: [ ] No limitations [x] With limitations *

11. Physical therapy and related services.
    a. Physical therapy.
       [x] Provided: [ ] No limitations [x] With limitations *
    b. Occupational therapy.
       [x] Provided: [ ] No limitations [x] With limitations *
    c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist
       [x] Provided: [ ] No limitations [x] With limitations *

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
    a. Prescribed drugs.
       [x] Provided: [ ] No limitations [x] With limitations *
    b. Dentures.
       [x] Provided: [ ] No limitations [x] With limitations *

*Description provided on attachment.

TN #91-52 Approval Date December 3, 1991
Supersedes TN #86-30 Effective Date July 1, 1991
New York

State/Territory: ___New York_______________________________________________

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP (S): _______________________________________________________

c. Prosthetic devices.
   [x] Provided: [ ] No limitations  [x] With limitations *

d. Eyeglasses.
   [x] Provided: [ ] No limitations  [x] With limitations *

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those
    provided elsewhere in this plan.

   a. Diagnostic services.
      [x] Provided: [ ] No limitations  [x] With limitations *

   b. Screening services.
      [x] Provided: [ ] No limitations  [x] With limitations *

   c. Preventive services.
      [x] Provided: [ ] No limitations  [x] With limitations *

   d. Rehabilitative services.
      [x] Provided: [ ] No limitations  [x] With limitations *

14. Services for individuals age 65 or older in institutions for mental diseases.

   a. Inpatient hospital services.
      [x] Provided: [ ] No limitations  [ ] With limitations *

   b. Skilled nursing facility services.
      [ ] Provided: [ ] No limitations  [ ] With limitations *

*Description provided on attachment.

TN  #93-49  Approval Date  March 8, 1995
Supersedes TN  #92-10  Effective Date  September 1, 1993
State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP (S):

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902 (a) (31) (a) of the Act, to be in need of such care.

   [x] Provided: [x] No limitations  [ ] With limitations  *  [ ] Not provided.

15. b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

   [x] Provided: [x] No limitations  [ ] With limitations  *  [ ] Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

   [x] Provided: [x] No limitations  [ ] With limitations  *  [ ] Not provided.

17. Nurse-midwife services.

   [x] Provided: [x] No limitations  [ ] With limitations  *  [ ] Not provided.


   [x] Provided:  [ ] No limitations  [x] With limitations  *  [ ] Not provided.

*Description provided on attachment.
19. Case management services and Tuberculosis related services.
   a. Case management services as defined in, and to the group specified in Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
      ☒ Provided: ☐ No limitations ☐ With limitations* ☐ Not provided
   b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
      ☒ Provided: ☐ No limitations ☐ With limitations* ☐ Not provided

20. Extended services for pregnant women.
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.
      ☒ Provided:† ☐ No limitations ☐ With limitations* ☐ Not provided
         ☐ Additional coverage:++
   b. Services for any other medical conditions that may complicate pregnancy.
      ☒ Provided:† ☐ No limitations ☐ With limitations* ☐ Not provided
         ☐ Additional coverage:++ [☐ Not provided]

21. Certified pediatric or family nurse practitioners’ services.
    ☒ Provided: ☐ No limitations ☐ With limitations* ☐ Not provided
    a. Lactation counseling services.
       ☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

TN#: 12-16 ___  ___     Approval Date: ___ December 28, 2012___
Supersedes TN#: 94-39_______ Effective Date: ___ September 1, 2012___
State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP (S): ________________________________

*22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations *

[x] Not provided

*23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[ ] Provided: [ ] No limitations [x] With limitations *

[x] Not provided

b. Services provided in Religious Nonmedical Health Care Institutions.

[ ] Provided: [ ] No limitations [ ] With limitations *

[x] Not provided

c. Reserved

d. Nursing facility services for patients under 21 years of age.

[ ] Provided: [ ] No limitations [x] With limitations *

[x] Not provided

e. Emergency hospital services.

[ ] Provided: [ ] No limitations [x] With limitations *

[x] Not provided

f. Personal care services in recipient’s home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

[ ] Provided: [ ] No limitations [x] With limitations *

[x] Not provided

*Description provided on attachment.

TN #01-40 Approval Date February 8, 2002
Supersedes TN #87-47 #91-39 Effective Date January 1, 2002
New York

State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP (S):

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

[ ] Provided  [x] Not provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

[x] Provided    [ ] State Approved (Not Physician) Service Plan Allowed

[x] Services Outside the Home Also Allowed

[x] Limitations Described on Attachment

[ ] Not Provided

26. Primary Care Case Management

[x] Provided  [ ] Not Provided
New York

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

[x] Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

[ ] No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TN #02-01 Approval Date September 3, 2002
Supersedes TN NEW Effective Date January 1, 2002
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| *Pregnant women enrolled in a managed care plan, regardless of income level, will receive the full managed care service package without exclusions. A full listing of services is available from each managed care plan.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Physician’s assistants.

☒ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

a. Lactation counseling services.

☒ Provided: ☑ No limitations ☐ With limitations* ☐ Not provided

29. Registered Nurses.

☒ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided

a. Lactation counseling services.

☒ Provided: ☑ No limitations ☐ With limitations* ☐ Not provided

* Description provided on attachment.

TN#: 12-16 Approval Date: __December 28, 2012_______
Supersedes TN#: ____ NEW ______ Effective Date: _September 01, 2012_______
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

☑ Provided: ☑ No limitations ☐ With limitations ☐ None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☑ Provided: ☑ No limitations ☐ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:
☑ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.). *

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:
NEW YORK STATE - TITLE XI X STATE PLAN

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS: all

NOTE: By prior approval, when indicated below, is meant that prior approval/authorization of the local professional director and/or the local social services commissioner is required for that service.

1. Inpatient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those inpatient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of section 363a of the Social Services Law, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, inpatient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate.

Inpatient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an outpatient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an inpatient basis.

1. Limits other than medical necessity are not applicable to EPSDT recipients in accord with 1905 (r) 3.
2. We have received the State plan and reviewed it and determined that we are in compliance with EPSDT requirements.

TN ___ #91-39 __________ Approval Date __________
Supersedes TN ___ #85-30 __________ Effective Date __________

February 18, 1992
July 1, 1991


New York
1(a)

2a. **Outpatient Hospital Services**

Outpatient Hospital Services provided by hospitals licensed pursuant to Article 31 of the Mental Hygiene Law and Article 28 of the Public Health Law are in accordance with 42 CFR § 440.20(a) title Outpatient Hospital Services. Such services include Clinic Treatment Services, Partial Hospitalization, Continuing Day Treatment, and Day Treatment Services for Children, as set forth in item 9a of the Supplement to Attachment 3.1-A of the Plan.
2a. **Outpatient Hospital Services (continued)**

Outpatient Hospital Services provided by hospitals licensed pursuant to Article 28 of the Public Health Law are in accordance with 42 CFR § 440.20(a) title Outpatient Hospital Services. Effective January 1, 2015, such services include Collaborative Care Services as set forth in item 9 of the Supplement to Attachment 3.1-B of the Plan.
New York

4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or have not applied for certification to participate in Medicare.

Care days in nursing facilities is reimbursed for Medicaid patients requiring and receiving medically necessary lower level of care services. Medical Assistance is provided until such time as the appropriate level of care becomes available.

4d.i. **Face-to-Face Counseling Services**

4d.ii. **Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women**

Effective October 1, 2013, Medicaid coverage of comprehensive counseling and pharmacotherapy for cessation of tobacco use by all Medicaid eligible recipients, including pregnant women, will be provided. Such services will be provided face-to-face, by or under the supervision of a physician and no cost sharing (co-pays) will apply. In accordance with section 4107 of the Patient Protection and Affordable Care Act, current coverage of smoking cessation services for all Medicaid recipients, including pregnant women, will be modified to include a maximum of two quit attempts per 12 months, which will include a maximum of four face-to-face counseling sessions per quit attempt.

5. Prior approval is required for certain procedures which may be considered cosmetic or experimental. Physicians are informed of the specific prior approval requirements in the MMIS Physician Provider Manual.

5a. **Lactation consultant services**: effective September 1, 2012, reimbursement will be provided to physicians for breastfeeding health education and counseling services. Physicians 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.

**Collaborative Care Services**: Effective January 1, 2015, Physician services shall include Collaborative Care Services as set forth in item 9 of the Supplement to Attachment 3.1-B of the Plan. Physician Services are in accordance with 42 CFR §440.50 and requirements for claim submission comply with the State Medicaid Manual, §4281 titled Restriction on Payments for Physician Services.

6. Care and services will be provided only if they are in accordance with regulations of the Department of Health.

TN#: 14-0027 Approval Date: November 28, 2017
Supersedes TN#: 13-0010 Effective Date: January 1, 2015
New York
[Page] 2.1

6a. Medicaid does not cover routine hygienic care of the feet in the absence of pathology.

Payment for podiatry services will be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife. Effective September 1, 2012, payment for podiatry services will include services provided to Medicaid recipients age 21 and older with a diagnosis of diabetes mellitus and only with a written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife. Date of implementation will occur on the first day of the month following 30 days after Federal approval of this provision in the State Plan.

Only a qualified podiatrist, per 18 NYCRR Section 505.12(a)(1), who is licensed and currently registered to practice podiatry in New York State by the State Education Department, can provide podiatry services.

Such podiatry care and services may only be provided upon written referral by a physician, physician’s assistant, nurse practitioner or nurse midwife, per their individual scope of practice consistent with New York State Education Law and the rules of the Commissioner of Education.

Nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescription drugs) for all recipients when ordered by a private practicing podiatrist.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.
4b. Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).

School Supportive Health Services and Pre-School Supportive Health Services

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are services provided by or through a school district, a Section 4201 school, a county in the State, or New York City to children with disabilities, who attend public or State Education Department approved schools or preschools. The services must be:

- medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905 (r)(5), 1903(c) of the Social Security Act;
- ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
- included in the child’s Individualized Education Program (IEP);
- provided by qualified professionals under contract with or employed by a school district, a Section 4201 school, or a county in the State or the City of New York;
- furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations; including those for provider qualifications, comparability of services, and the amount, duration and scope of provisions; and
- included in the state’s plan or available under Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Effective September 1, 2009, the services covered by the SSHS and PSSHS Program for Medicaid eligible children under the age of 21 who are eligible for Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) include medically necessary physical therapy services, occupational therapy services, speech therapy services, psychological counseling, skilled nursing services, psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation within the limits of EPSDT services. A school district, a Section 4201 school, a county in the State, and New York City must be enrolled as a Medicaid provider in order to bill Medicaid.

1. Physical Therapy Services

Definition: Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(a).
Services: Physical therapy services provided by or through; a school district[: a Section 4201 school]; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and must be provided to a child by or under the direction of a qualified physical therapist. Physical therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Physical therapy services include but are not limited to:

- Identification of children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices, and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

Physical therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified physical therapy assistant “under the direction of” such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.

TN #17-0057
Supersedes TN #09-0061
Approval Date November 28, 2017
Effective Date July 1, 2017
“Under the direction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

2. **Occupational Therapy Services**

**Definition:** Occupational therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(b).

**Services:** Occupational therapy services provided by or through; a school district; a Section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, or nurse practitioner who is acting within the
New York
2(xii)(D)

scope of his or her practice under New York State Law and must be provided to a child by or under the direction of a qualified occupational therapist. Occupational therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention initial or further impairment or loss of function; and
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximal physical and mental functioning of the student in daily life tasks.

Occupational therapy services may be provided in an individual or group setting.

Providers: Services must be provided by:

- a New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or
- a certified occupational therapy assistant (COTA) “under the direction of” such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

“Under the direction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;

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• is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
• has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
• assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
• spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
• ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
• keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the settings in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Education Services (BOCES) programs, approved preschool programs, public schools, approved private schools, 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

3. Speech Therapy Services

Definition: Speech therapy services as outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(c).

Services: Speech therapy services provided by or through: a school district; a section 4201 school; a county in the State or the City of New York must have a written order or prescription from a physician, physician assistant, nurse practitioner, or a speech-language pathologist who is acting within his or her scope of practice under New York State law and must be provided to a child by or under the direction of a qualified speech-language pathologist. Speech therapy services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.
Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention as necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders;
- Evaluation and application of principles, methods and procedures of measurement, prediction, diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to development of disorders of speech, voice, and/or language, and;
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

Speech therapy services may be provided in an individual or group setting.

**Providers:** Services must be provided by:

- a licensed and registered speech-language pathologist qualified in accordance with 42CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- a teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech language pathologist (ASHA-Certified or equivalent), acting within his or her scope of practice under New York State Law.

“Under the reaction of” means that, with respect to each Medicaid beneficiary, the qualified therapist:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided; and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
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- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

4. Psychological Counseling

**Definition:** Psychological counseling services outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.60(a) and 440.50(a)(2).

**Services:** Psychological counseling provided by or through a school district[, a Section 4201 school]; a county in the State or City of New York must have a referral from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law or an appropriate school official or other voluntary health or social agency and must be provided to a child by or under the direction of a qualified practitioner. Psychological counseling services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological counseling services include:

- treatment services using a variety of techniques to assist the child in ameliorating behavior and emotional problems that are severe enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.

TN #17-0057 Approval Date November 28, 2017
Supersedes TN #09-0061 Effective Date July 1, 2017
Providers: Psychological counseling services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State Law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services within the community.

Services may be provided by:

- a New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law;
- a New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations acting within his or her scope of practice under New York State Law;
- a New York State licensed clinical social worker (LCSW), qualified in accordance 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a licensed master social worker (LMSW), qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- the licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- the licensed master social worker’s cases are discussed;
- the supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- the supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- the supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision.
Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, at home and/or in community based settings.

5. Skilled Nursing

**Definition:** Skilled nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.60(a).

**Services:** Skilled nursing services provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York, must have a written order or prescription from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law and must be provided to a child by a registered nurse acting within his or her scope of practice under New York State law, or by a NYS licensed practical nurse acting within his or her scope of practice under New York State law “under the direction of” a NYS licensed and registered nurse or licensed physician, dentist or other licensed health care provider authorized under the Nurse Practice Act. Skilled nursing services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE) when there is a specific need based on a medical condition of the child.

Medically necessary EPSDT services health care, diagnostic services, treatments and other measures necessary to correct ameliorate physical defects, mental illnesses and other disabilities.

Skilled nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Skilled nursing services may include:

- health assessments and evaluations;
- medical treatments and procedures;
- administering and/or monitoring medication needed by the student during school hours; and
- consultation with licensed physicians, parents and staff regarding the effects of medication.
Providers: Skilled nursing services must be provided by:

- a New York State licensed registered nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or
- a New York State licensed practical nurse qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice “under the direction of” a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

“Under the direction of” means that the licensed registered nurse, physician or other licensed health care provider authorized under the Nurse Practice Act:

- sees the participant at the beginning of and periodically during the course of treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- has continued involvement in the care provided; and reviews the need for continued services throughout treatment;
- assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services may be provided by:

- a New York State licensed and registered nurse; or
- a New York State licensed practical nurse, under the direction of a New York State licensed and registered nurse, or licensed physician, dentist or other licensed health care practitioner legally authorized under the Nurse Practice Act.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES)
programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

6. Psychological Evaluations

Definition: Psychological evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.50(a) and 42 CFR Section 440.60(a).

Psychological evaluations provided by or through a school district[; a Section 4201 school]; a county in the State or the City of New York must have a referral from a physician, physician assistant, or a nurse practitioner acting within his or her scope of practice under New York State law or an appropriate school official or other voluntary health or social agency and must be provided to a child by a qualified practitioner. Psychological evaluations must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

Services: Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results, and
- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

Providers: Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.
Services may be provided by:

- a New York State licensed and registered psychiatrist, qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- a New York State licensed and registered psychologist, qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Education Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

7. Medical Evaluations

**Definition:** Medical evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a).

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses and other disabilities.

Medical evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be performed by a physician, physician assistant, or nurse practitioner acting within the scope of his or her practice under New York State law. A medical evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child’s health related needs as a part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

A medical evaluation is the recording of:

- chief complaints;
- present illness;


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- past medical history;  
- personal history and social history;  
- a system review;  
- a complete physical evaluation;  
- ordering of appropriate diagnostic tests and procedures, and  
- recommended plan of treatment.

**Providers:** A medical evaluation must be provided by a New York State licensed and registered, physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR Section 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s officers, and/or in community based settings.

8. **Medical Specialist Evaluations**

**Definition:** Medical specialist evaluations outlined in this section of the State plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a), 440.60(a), and 440.166(a).

**Services:** Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.

Medical specialist evaluations provided by or through: a school district; a Section 4201 school; a county in the State or the City of New York must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner specialist acting within his or her scope of practice and related area of specialization. A medical specialist evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

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**TN #17-0057**  
Supersedes TN **#09-0061**  
**Approval Date** November 28, 2017  
**Effective Date** July 1, 2017
A medical specialist evaluation is:

- an examination of the affected bodily area or organ system and other symptomatic or related organ systems;
- the ordering of appropriate diagnostic tests and procedures, and
- the reviewing of the results and reporting on the tests and procedures.

Providers: A medical specialist evaluation must be provided by a qualified New York State licensed and registered physician, physician assistant, or nurse practitioner specialist practicing in the related area of specialization within his or her scope of practice under NYS law, in accordance with 42 CFR Section 440.50(a), 440.60(a), and 440.166(a) and other applicable state and federal laws and regulations.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

9. Audiological Evaluations

Definition: Audiological evaluations as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.60(a) and 42CFR Section 440.110(c)(3).

Services: Audiological evaluations provided by or through: a school district(; a Section 4201 school); a county in the State or the City of New York must have a written order from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law and provided to a child by a qualified practitioner. An audiological evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If an audiological evaluation is used to identify a child’s health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child’s IEP.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.
Medically necessary audiology services include but are not limited to:

- Identification of children with hearing loss;
- Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing; and
- Determination of the child’s need for group and individual amplification.

An audiological evaluation is the determination of the range, nature and degree of the hearing loss including:

- measurement of hearing acuity;
- tests related to air and bone conduction;
- speech reception threshold;
- speech discrimination;
- conformity evaluations;
- pure tone audiometry.

**Providers:** Audiology evaluation services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.60(a) and 42 CFR Section 440.110 (c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services may be rendered in the setting in which the child’s IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner’s offices, and/or in community based settings.

**10. Special Transportation**

**Definition:** Special transportation outlined in this section of the State Plan is available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct and ameliorate physical defects, mental illnesses, and other disabilities.
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**Services:** Special transportation provided by or through a school district; a section 4201 school; a county in the State or the City of New York must be included in the IEP as recommended by the Committee on Special Education (CSE), or the Committee on Preschool Special Education (CPSE). Special transportation arrangements must be identified in the IEP.

Special transportation is provided when a child requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR 300.34 (c) (16) (iii).

Special transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered service (other than transportation), and both the Medicaid covered service and the need for special transportation are included in the child’s IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one way trip.

**Providers:** Special transportation services must be provided by a qualified Medicaid provider. Attendance documentation (bus logs) is required in order to bill Medicaid. In order to receive payment for services provided to a Medicaid recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered.

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TN #17-0057 Approval Date November 28, 2017
Supersedes TN #09-0061 Effective Date July 1, 2017
6b. Prior approval is required for orthoptic training.

6c. Chiropractor services. Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient’s physician or primary care clinic.

6d. Clinical psychologists. Provision of clinical psychology services shall require referral by:
   1. The patient’s personal physician or medical resource, such as a clinic, acting as the patient’s physician;
   2. the medical director in an industrial concern;
   3. an appropriate school official;
   4. an official or voluntary health or social agency.
6d. **Other Practitioner Services** (Continued)

**Pharmacists as Immunizers**
1. Reimbursement will be provided to pharmacies for vaccines and anaphylaxis agents administered by certified pharmacists within the scope of their practice.

2. **Service setting**
   Services will be provided by a certified pharmacist in a pharmacy or in other locations where mass immunization may take place, such as retail stores/outlets, assisted living centers, and health fairs.

3. **Provider qualifications**
   Pharmacists must be currently licensed, registered and certified by the NYS Department of Education Board of Pharmacy to administer immunizations.

**Diabetes Self-Management Training by Pharmacists**
1. Reimbursement will be provided to pharmacies for Diabetes Self-Management Training (DSMT) when provided by licensed pharmacists within the scope of their practice.

2. **Service setting:** Services will be provided by a licensed pharmacist in a pharmacy that is accredited by a CMS approved national accreditation organization (NAO), such as the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), or Indian Health Services (IHS).

3. **Provider qualifications:** Pharmacists must be currently licensed and registered by the NYS Department of Education Board of Pharmacy. Pharmacies must be accredited by a CMS approved national accreditation organization.

4. **Coverage parameters:** A beneficiary with newly diagnosed diabetes or a beneficiary with diabetes who has a medically complex condition will be allowed up to 10 hours of Diabetes Self-Management Training (DSMT) during a continuous 6-month period. A beneficiary with diabetes who is medically stable may receive up to 1 hour of DSMT in a continuous 6-month period.

**TN#: #11-73**  
**Approval Date: December 16, 2011**

**Supersedes TN#: #09-63**  
**Effective Date: July 1, 2011**
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6d. Nurse Practitioners’ Services

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.
6.d(i). **Other Licensed Practitioners (EPSDT only).** A non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law.

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist; or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

Inpatient hospital visits by these licensed practitioners are limited to those ordered by the child’s physician. Visits to nursing facilities are allowed for licensed professionals other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately. Visits to ICF-IDD facilities are non-covered. All NP-LBHP services provided while a person is a resident of an (Institution for Mental Diseases) (IMD), such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.

Non-physician licensed behavioral health practitioners (NP-LBHPs) will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

**Assurances:**
The State assures that all NP-LBHP services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

The State assures that NP-LBHP services do not include and FFP is not available for any of the following.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR § 435.1010;
E. services to individuals residing in institutions for mental diseases as describe in 42 CFR § 435.1009;
F. recreational and social activities; and
G. services that must be covered elsewhere in the state Medicaid plan.
[6b. Prior approval is required for orthoptic training.]

6c. Chiropractor services.

Provision of chiropractic services shall be limited to EPSDT recipients by medical necessity. Services shall be provided to the extent that such services result from the referral of the recipient's physician or primary care clinic.

6d. Clinical psychologists.

Provision of clinical psychology services shall require referral by:

1. the patient's personal physician or medical resource, such as a clinic, acting as the patient's physician;
2. the medical director in an industrial concern;
3. an appropriate school official;
4. an official or voluntary health or social agency.]

7a. Home care services are medically necessary services (physician order required) provided by a Certified Home Health Agency (CHHA) to individuals, regardless of residence, in the home and community. Such services include both part time and intermittent skilled health care [and long-term] nursing and home health aide services. Home (health) care services include nursing, home health aide, physical therapy, occupational therapy, and speech therapy. [Patients must be assessed as being appropriate for intermittent or part-time nursing services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service].

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 or the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

TN #09-0023B Approval Date July 10, 2017
Supersedes TN #07-0013 Effective Date April 1, 2009
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7b. Home Health aide will mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides will have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies (CHHA) may provide home health services pursuant to the requirements of 42 CFR 440.70(b)(2). Home health services may be provided to income and/or medically eligible participants in home and community based settings, which could be the individual's home.
AIDS home health care services providers qualifications are provided pursuant to Article 36 of the PHL.

The [S]tate assures the provision of AIDS home care services will be provided in accordance with 42 CFR 440.70 (for the provision of home health services).
Home Telehealth Services

Beginning on 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 the 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 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.

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<td>December 14, 2010</td>
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Supersedes TN NEW

<table>
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<th>Effective Date</th>
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Telehealth Services - Remote Patient Monitoring

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth services provided by remote patient monitoring.

The purpose of providing telehealth remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Telehealth remote patient monitoring services use synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an “originating site”; this information is then transmitted to a provider at a “distant site” for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Telehealth remote patient monitoring services [may be provided] will be ordered by a [facility licensed under Article 28 of Public Health Law or by a] physician, nurse practitioner, or a midwife [, or physician assistant who has examined the patient and] with whom the patient has a[n established,] substantial and ongoing relationship. [Payment for remote patient monitoring while receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to public health law 3614 section (3-c) (a-d).] Telehealth remote patient monitoring services are based on medical necessity and should be discontinued when the patient's condition is determined to be stable/controlled.

[The Commissioner will reimburse for telehealth remote patient monitoring services 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.]

All services delivered via telehealth remote patient monitoring must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.
Telehealth Services – Store and Forward

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth store and forward technology.

Telehealth store and forward technology is 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.

[Telehealth store and forward technology may be utilized in the specialty areas of dermatology, ophthalmology and other disciplines, as determined by the Commissioner.]

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 services, specifically 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.]

All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.
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7c. Certain specialty items require prior approval. These items are identified for equipment dealers in the MMIS DME Provider Manual. Prior approval is required for most repairs to durable medical equipment. Personal Emergency Response Services (PERS) are provided according to [LDSS] Local Social Services District (LSSD) written authorization for recipients of personal care services and home health services ordered by a physician pursuant to a written plan of care.

7d. Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department. The state assures the provision of physical therapy services will be provided in accordance with 42 CFR 440.110 (a)(2)(i) and 440.110(a)(2)(ii).

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association. The state assures the provision of occupational therapy services will be provided in accordance with 42 CFR 440.110 (b)(2)(i) and 440.110 (b)(2)(ii).

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law. The state assures the provision of speech therapy services will be provided in accordance with 42 CFR 440.110 (c)(2).

8. Private Duty Nursing (PDN) is medically necessary nursing services, ordered by and in accordance with a written physician’s treatment plan, provided in a person’s home on a continuous basis normally considered beyond such nursing services available from a Certified Home Health Agency (CHHA) or intermittent nursing services normally provided through a CHHA but which are unavailable. Prior approval is required for private duty nursing services either in a person’s home or in a hospital except in an urgent situation in which the attending physician may order the services for no more than two nursing days.

Care and services of a private duty nurse will be provided only if they are in accordance with the regulations of the Department of Health.
Service providers who provide private duty nursing include a Licensed Home Care Services Agency’s (LHCSA) registered nurses (RN) or licensed practical nurses (LPN) enrolled on an independent practitioner basis.

Nurses providing PDN must possess a license to practice in the State of New York and be currently registered by the New York State Education Department (NYSED). In addition, nurses providing an appropriate attestation regarding their training and ability to care for medically fragile children may receive a Specialty code on their file entitling them to increased reimbursement for the provision of such care.

The [S]tate assures that the provision of PDN will be provided in accordance with 42 CFR 440.80.

9. Clinic services provided in Article 28 clinics are in accordance with 42 CFR §440.90 titled clinic services. Requirements for physicians supervision comply with the [S]tate Medicaid Manual, §4320B titled Physician Direction Requirement.
Collaborative Care Services: Freestanding Clinics

Effective January 1, 2015, Freestanding Clinics licensed pursuant to Article 28 of the Public Health Law will provide Collaborative Care Services for purposes of providing integrated physical and mental health care to patients diagnosed with mental illness. Freestanding Clinics must obtain prior approval from the New York State Department of Health and the New York State Office of Mental Health to furnish Collaborative Care Services. Collaborative Care Services include screening, diagnostic, preventative and therapeutic services to treat the symptoms of mental illness.

Collaborative Care Services include a minimum of one clinical contact between the Collaborative Care Manager and the patient per month, and the completion of the screening tool for the patient’s specific mental illness diagnosis specified by the New York State Office of Mental Health. The clinical contact with the Collaborative Care Manager may be by phone or in person. Collaborative Care Services also include a minimum of at least one face-to-face contact between a licensed provider and the patient once every three months.

A patient is limited to 12 months of Collaborative Care Services, which are not required to be consecutive. With the prior approval of the New York State Office of Mental Health, a patient may receive an additional 12 months of Collaborative Care Services, which are not required to be consecutive.
Clinic Services provided in Article 31 clinics licensed by the New York State Office of Mental Health (OMH) are in accordance with 42 CFR § 440.90 title clinic services. Such services include Clinic Treatment Services, Partial Hospitalization, Continuing Day Treatment, and Day Treatment Services for Children. Any limitations on the amount, duration or scope of these services may be exceeded based on medical necessity for Medicaid beneficiaries under the age of 21.

OMH-licensed clinic services are provided under the direction of a physician in accordance with 42 CFR § 440.90 and comply with § 4320B of the State Medicaid Manual. A physician must see the patient at least once, approve the patient's treatment plan, and periodically review the need for continued care. The physician assumes professional responsibility for the services provided and assures that the services are medically appropriate and provided in a safe and efficient manner in accordance with accepted medical standards. The physician may be either an employee of the OMH-licensed clinic service provider or affiliated with the provider. OMH-licensed clinic service providers choosing to utilize affiliated physicians must enter into a contractual agreement or some other type of formal arrangement obligating the physician to supervise the care provided to the OMH-licensed clinic service provider's patients.

1. **Clinic Treatment Services**

Clinic Treatment Services are preventive, diagnostic, therapeutic, and rehabilitative mental health services. Clinic Treatment Services are provided based upon the clinical assessment of an individual's mental, physical and behavioral condition and history, which is the basis for establishing the individual's diagnosis. Medically necessary Clinic Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Clinic Treatment Services include: Initial Assessment; Psychiatric Assessment; Psychotherapy; Psychotropic Medication Treatment; Injectable Psychotropic Administration and Monitoring; Crisis Intervention; Complex Care Management; Developmental Testing, Psychological Testing; Psychiatric Consultation; Health Physical; Health Monitoring; Smoking Cessation Treatment; and Screening, Brief Intervention, and Referral to Treatment.

2. **Partial Hospitalization Services**

Partial Hospitalization Services are preventive, diagnostic, therapeutic, and rehabilitative intensive mental health services which are designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay within a medically supervised program. Partial Hospitalization Services are provided based upon the clinical assessment of an individual's mental, physical and behavioral condition and history, which is the basis for establishing the individual's diagnosis, functional deficits, and recovery goals. Medically necessary Partial Hospitalization Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Partial Hospitalization Services include: Health Screening and Referral; Preadmission
Screening; Symptom Management; Medication Therapy; Medication Skill-Building; Verbal Therapy; Rehabilitation Readiness Assessment and Development; Crisis Intervention Services; Functional Skill Development; Clinical Support Services; and Discharge Planning Services.

Partial Hospitalization services are provided in preadmission visits for individuals prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may also be provided to collaterals, who are members of the individual’s family or household, or others who regularly interact with the individual and are directly affected by or can affect the individual’s condition and are identified in the treatment plan as having a role in the individual’s treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary. Collateral and group collateral visits are limited to two hours per day.

Other limitations on amount and duration of Partial Hospitalization Services include:

i. Reimbursement is limited to no more than 180 hours per course of treatment. A course of treatment shall not exceed six calendar weeks, unless during the course of treatment the recipient is admitted to an inpatient psychiatric facility. Such course of treatment may be extended to include the number of days of inpatient treatment, up to a maximum of 30 days. Partial Hospitalization Services provided during crisis, collateral or group collateral visits do not count towards the 180 hour maximum.

ii. Reimbursement is limited to 360 hours per calendar year. Services provided during crisis, collateral or group collateral visits do not count towards the 360 hour maximum.

iii. Reimbursement is limited to one visit, including preadmission visits (of up to 7 hours) and one individual or group collateral visit (of up to 2 hours) per individual per day. Additional Partial Hospitalization Services may be provided on the same day during a crisis visit.

3. Continuing Day Treatment Services

Continuing Day Treatment Services are mental health preventive, diagnostic, therapeutic, and rehabilitative services. Continuing Day Treatment Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. Medically necessary Continuing Day Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. Medically necessary Continuing Day
Treatment Services include: Health Screening and Referral; Preadmission Screening; Symptom Management; Medication Therapy; Medication Skill-Building; Verbal therapy; Rehabilitation Readiness Assessment and Development; Crisis Intervention Services; Functional Skill Development; Clinical Support services; and, Discharge Planning Services.

Continuing Day Treatment Preadmission Screening services are provided in preadmission visits for individuals prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may be provided to collaterals, who are members of the individual's family or household, or others who regularly interact with the individual and are directly affected by or can affect the individual's condition and are identified in the treatment plan as having a role in the individual's treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary.

Other limitations on amount and duration of Continuing Day Treatment Services include:

i. Reimbursement is limited to one visit, including preadmission visits and one individual or group collateral visit per recipient per day. Additional Continuing Day Treatment Services may be provided on the same day during a crisis visit.

ii. Continuing Day Treatment services are not reimbursable if an individual is concurrently receiving Clinic Treatment Services, except where either:
   a. an individual is in transition from Clinic Treatment Services to Continuing Day Treatment Services, in which case reimbursement is permitted for a maximum of three Continuing Day Treatment preadmission visits; or
   b. an individual is enrolled in Clinic Treatment Services solely for the purpose of Clozapine Medication Therapy.

4. **Day Treatment Services for Children**

Day Treatment Services for Children are preventive, diagnostic, therapeutic, and rehabilitative mental health services designed to stabilize children's adjustment to educational settings, prepare children for return to educational settings, and transition children to educational settings. Medicaid reimbursement is not available for educational activities, which are the sole responsibility of the school district of the child’s residence. Day Treatment Services for Children may be provided in free-standing clinics located within schools. Medically necessary Day Treatment Services for Children include: Medication Therapy; Verbal Therapy; Crisis

**TN #10-0018**

**Approval Date November 1, 2017**

**Supersedes TN NEW**

**Effective Date July 1, 2010**
Intervention Services; Clinical Support Services; Task and Skill Development; Social Skill Development; Recreational Rehabilitation Services; and Discharge Planning Services.

Day Treatment Services for Children are provided in preadmission visits for children prior to formal enrollment. Preadmission visits are limited to a maximum of three visits which must occur over a period of time not to exceed the remaining days of the month in which the first preadmission visit occurred and the next full calendar month.

Clinical Support Services may also be provided to collaterals, who are members of the child’s family or household, or others who regularly interact with the child and are directly affected by or can affect the child’s condition and are identified in the treatment plan as having a role in the child’s treatment. Clinical support services that are provided to collaterals are for the direct benefit of the Medicaid beneficiary.

Other limitations on amount and duration of Day Treatment Services for Children include:

i. Reimbursement is limited to one visit, including preadmission visits and one collateral visit per child per day. Additional Day Treatment Services for Children may be provided on the same day during a crisis visit.

ii. Day Treatment Services for Children are not reimbursable if a child is concurrently receiving Clinic Treatment Services, except where either:
   a. a child is in transition from Clinic Treatment Services to Day Treatment Services for Children, in which case reimbursement is permitted for a maximum of three Day Treatment Services for Children preadmission visits; or
   b. a child is enrolled in Clinic Treatment Services solely for the purpose of Clozapine Medication Therapy.

TN #10-0018________________ Approval Date November 1, 2017______________
Supersedes TN NEW________________ Effective Date July 1, 2010__________________
12a. Prior authorization or dispensing validation is required for some prescription drugs. The State has established a preferred drug program with prior authorization for drugs not included on the preferred drug list. The prior authorization complies with the requirements of Section 1927(d)(5) of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health. Prior authorization is required for a generic equivalent of a brand name drug, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. Outpatient drugs of any manufacturer which has entered into and complies with a rebate agreement under Sections 1902(a)(54) and 1927(a) of the Act with the Centers for Medicare and Medicaid Services (CMS) which are prescribed for a medically accepted indication. All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. Drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. §1396r-8(d)(2)(K), are not a covered service, on and after April 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration.

2. Supplemental Rebate Programs

The State is in compliance with Section 1927 of the Social Security Act. The State has the following policies for the Supplemental Rebate Programs for the Medicaid population.

a) CMS has authorized the State of New York to enter into the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on March 30, 2006 have been authorized for pharmaceutical manufacturers’ existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on June 30, 2013 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

b) CMS has authorized the State of New York to enter into Medicaid State-specific Supplemental Rebate Agreement directly with manufacturers to receive supplemental rebates of covered outpatient drugs for Medicaid beneficiaries. The State-specific Supplemental Rebate Agreement was submitted to CMS on [March 31, 2010] December 31, 2014 and has been authorized by CMS.

**TN #14-0038**

**Supersedes TN #13-0029**

**Approval Date** April 24, 2015

**Effective Date** October 1, 2014
c) The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turn-around response by either telephone or telecommunications device from the receipt of a prior authorization request. In emergency situations, providers may dispense a 72-hour supply of medications.

d) The terms of the supplemental rebate programs apply only to covered outpatient drugs for which the State is eligible for federal financial participation. Supplemental rebates received by the State in excess of those required under the National Drug Rebate Program will be shared with the Federal Government on the same percentage basis as applied under the National Drug Rebate Agreement.

e) Any Supplemental Rebate Agreement not authorized by CMS will be submitted to CMS for authorization.

f) All drugs covered by the programs will comply with the provisions of the national drug rebate agreement.

3. Any changes to the NMPI Supplemental Rebate Agreement must be submitted to CMS for authorization. Any changes to the State-specific Supplemental Rebate Agreement NY State holds directly with the manufacturer must be submitted to CMS for authorization.

4. As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

5. As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.
6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit—Part D.

- **The following excluded drugs are covered:**
  - (a) agents when used for anorexia, weight loss, weight gain
  - (b) agents when used to promote fertility: Some – bromocriptine, clomiphene citrate, letrozole, and tamoxifen only.
  - (c) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
  - (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
  - (e) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products, minerals and vitamin combinations
  - (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

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**TN#: #17-0058**

**Approval Date: November 2, 2017**

**Supersedes TN#: #17-0047**

**Effective Date: July 1, 2017**
8. The State will cover APIs that are included in extemporaneously compounded prescriptions when the API serves as the active drug component in the compounded formulation. A current list of covered APIs can be found at the following at:

https://www.emedny.org/info/formfile.aspx

13c. Preventive Services

New York State Medicaid covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing, when provided in a practitioner’s office.

Preventive Services specified in section 4106 of the Affordable Care Act are all available under the State Plan and are covered under the physician, other practitioner, nurse-midwife and nurse practitioner service benefits and are reimbursed according to the methodologies provided in Attachment 4.19-B.

The State will maintain documentation supporting expenditures claimed for these Preventive Services and ensure that coverage and billing codes comply with any changes made to the USPSTF or ACIP recommendations.
13d. Harm Reduction Services

Harm reduction services represent a fully integrated client-oriented approach to care. Such services are remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. The role of the harm reduction service is to ensure that clients obtain needed services at the appropriate time by assessing and reducing any barriers to accessing these programs. Harm reduction services begin immediately as service needs are assessed. The determination of the type(s) of service, frequency, and intensity is an ongoing responsibility of the harm reduction staff, and there is no limitation in the amount, duration, and scope of services. Harm reduction services continue until the staff determine that the service goals have been met or if the client decides he/she no longer wants to participate in programming.

Harm reduction programs will provide the following:
1. Development of a Treatment Plan
2. Individual/Group Supportive Counseling
3. Medication management and Treatment Adherence Counseling
4. Psychoeducation - Support groups

1. Development of a Treatment Plan

**Definition:** Development of a treatment plan through either an initial assessment or a scheduled or event-generated reassessment for harm reduction services is part of a package of remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. Referrals may be made for more intensive behavioral interventions, support groups, wellness services, substance use disorder (SUD) treatment, and overdose prevention as needed.

A reassessment is a scheduled or event-generated formal re-examination of the client’s situation, functioning, substance use, and medical and psychosocial needs to identify changes which have occurred since the initial or most recent assessment. The reassessment measures progress toward the desired goals and is used to prepare a new or revised harm reduction program plan or confirm that current services remain appropriate.

There are no limitations on the amount, duration, and scope of these services.

**Providers:** Services must be provided by:

- a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience either
  1) providing community-based services to active substance users or persons living with a history of substance use or 2) providing harm reduction or community-based social services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations;

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TN _____#13-0019_________ Approval Date __August 10, 2017_______
Supersedes TN _____NEW______ Effective Date __April 01, 2014_________
or a case worker who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience in case management or related supportive services position serving women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations, including one year of HIV-related experience; or

- director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor’s degree and at least three (3) years’ experience in the provision of supportive services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations; or

- a peer who has been certified through a Department-approved certification program or one conducted by another entity recognized by the Department and who is supervised by the director of harm reduction services. A person seeking harm reduction peer certification is required to complete 68 training hours of core courses such as Introduction to HIV, STIs, and Viral Hepatitis; Sex, Gender, and HIV; and Overview of Harm Reduction Counseling, as well as courses addressing health and medical needs and cultural competency among at-risk populations and health literacy. An additional 22 hours of training are required in topics specific to harm reduction among substance users and include promoting PrEP; retention in care; opioid overdose prevention; HCV prevention; safer injection and wound care; and addressing sexual risk. Other requirements for certification include completing a 500-hour practicum and passing a knowledge assessment. Certified peers must complete at least 10 hours of training annually to maintain their certification.

2. Individual/ Group Supportive Counseling

**Definition:** Supportive counseling services are part of a package of remedial services recommended by a physician or other licensed practitioner and are for maximum restoration of a beneficiary to his or her best possible functional level. Effective supportive counseling assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and to restore them to their best possible functional level. Supportive counseling may be provided to an individual or in a group setting and can cover such topics as HIV/HCV/STD status or substance use disclosure to family members and friends; addressing stigma for drug users in accessing services; how to maximize health care services interactions; how to reduce substance use or use more safely and avoid overdose; and how to address anxiety, anger, and depressive episodes. There are no limitations on the amount, duration, and scope of these services.

**Providers:** Services must be provided by:

- a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience either 1) providing community-based services to active substance users or persons living with a history of substance use or 2) providing harm reduction or community-based social services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations;
or a case worker who has a high school diploma or has passed the general educational
development (GED) test or the Test Assessing Secondary Completion (TASC™) and has
earned a high school equivalency credential or has at least three (3) years’ experience in
case management or related supportive services position serving women, children and
families; substance users; mentally ill chemical abusing clients; homeless persons;
adolescents; or parolees and other high-risk populations, including one year of HIV-related
experience; or
director of harm reduction services who may be a clinical social worker; possess a master of
social work degree; be a licensed clinical or masters social worker; or has a bachelor’s
degree and at least three (3) years’ experience in the provision of supportive services to
women, children and families; substance users; mentally ill chemical abusing clients;
homeless persons; adolescents; or parolees and other high-risk populations.

3. Medication Management and Treatment Adherence Counseling
Medication management and treatment adherence counseling assists clients to recognize the
need for medication to address substance use or psychiatric issues, reinforce the importance of
adherence to treatment regimens, and identify tools to follow the prescribed regimens. Such
services are remedial services recommended by a physician or other licensed practitioner and
are for maximum restoration of a beneficiary to his or her best possible functional level. There
are no limitations on the amount, duration, and scope of these services.

Providers: Services must be provided by:
- a direct service provider who has a high school diploma or has passed the general
educational development (GED) test or the Test Assessing Secondary Completion (TASC™)
and has earned a high school equivalency credential and has at least three (3) years’
experience in case management or related supportive services position; or
- director of harm reduction services who may be a clinical social worker; possess a master of
social work degree; be a licensed clinical or masters social worker; or has a bachelor’s
degree and has at least three (3) years’ experience in the provision of supportive services
and supervision of staff; or
- a peer who has achieved Department-approved certification and is supervised by the director
of harm reduction services.

4. Psychoeducation - Support Groups
Definition: Support groups are stand-alone services that may also be used to supplement
individual and/or group supportive counseling. Such services are remedial services
recommended by a physician or other licensed practitioner. Support groups restore individuals
to his or her best possible functional level by focusing on group members’ issues and
experiences relative to substance use, finances, medical/health care, support system,
incarceration history and other factors that contribute to risk behaviors for HIV/STD/HCV.
Support groups may be facilitated by a direct service provider, a case worker, or the director of
harm reduction services or co-facilitated by a peer. There are no limitations on the amount,
duration, and scope of these services.

TN _____ #13-0019 Approval Date August 10, 2017
Supersedes TN _____ NEW_ Effective Date April 01, 2014
Providers: Services must be provided by:

- a direct service provider who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience as a direct service provider in a supportive services position; or
- a case worker who has a high school diploma or has passed the general educational development (GED) test or the Test Assessing Secondary Completion (TASC™) and has earned a high school equivalency credential or has at least three (3) years’ experience in case management or a related supportive services position; or
- director of harm reduction services who may be a clinical social worker; possess a master of social work degree; be a licensed clinical or masters social worker; or has a bachelor’s degree and at least three (3) years’ experience in the provision of supportive services to women, children and families; substance users; mentally ill chemical abusing clients; homeless persons; adolescents; or parolees and other high-risk populations and
- a peer who has achieved Department-approved certification and is supervised by the director of harm reduction services.

Qualifications of Provider Organizations

Community-based organizations, including local health units, facilities licensed under Article 28 of New York State Public Health Law, and non-profit organizations that have been approved by the Commissioner of Health with a waiver to conduct a comprehensive harm reduction program, including syringe exchange.

Freedom of Choice - Access to Services

The State assures that the provision of harm reduction services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Access to services will be limited to the authorized syringe exchange programs.
2. Eligible recipients will have free choice of the providers of harm reduction services within the specified geographic area identified in this Plan.
3. Eligible recipients will have free choice of the providers of other medical care under the Plan.
4. Eligible recipients who refuse harm reduction services will not be denied access to other services offered under the Plan.
5. Harm reduction program services will not be used to restrict an individual's access to other services under the Plan.

TN _____#13-0019______ Approval Date _____August 10, 2017_______
Supercedes TN _____NEW__ Effective Date _____April 01, 2014_______
Limitations

Harm reduction program services do not include the following:

- case management activities that are an integral component of another covered Medicaid service; and
- substance use disorder treatment services.

Harm reduction program services:

- must not be utilized to restrict the choice of services a recipient can obtain, including medical care or services from any provider participating in the Medical Assistance program that is qualified to provide such or who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis; and
- must not duplicate certain services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care program, AIDS Home Care program under 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).
[ (1) Directly Observed Therapy (DOT) - Clients must be accessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

“Off-site” services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.

“Early Intervention” Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

1. Screening  
2. Evaluation  
3. Audiology  
4. Nursing  
5. Nutrition Services  
6. Occupational Therapy  
7. Physical Therapy  
8. Psychological Services  
9. Social Work Services  
10. Anticipatory Guidance (Special Instruction and Allied Health Professional Assistance)  
11. Speech Pathology Services  
12. Assistive Technology Services  
13. Vision Services  
14. Collateral contacts for all of the above services

Supersedes TN #06-0012  
Effective Date July 1, 2010  
Approval Date November 1, 2017  
TN #10-0018
12a. Prior authorization or dispensing validation is required for some prescription drugs. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. those non-prescription drugs contained on a list established by the New York State Commissioner of Health.
2. covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Sections 1902(a) (54) and 1927 (a) of the Act which are prescribed for a medically accepted indication. (As provided by Section 1927 (d) (2) of the Act certain outpatient drugs may be excluded from coverage).

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.

Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.


13b. Screening Services (see 13.d Rehabilitative Services - Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services - Early Intervention).

13d. Rehabilitative Services

(1) Directly Observed Therapy (DOT) - Clients must be assessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679. Coverage of "off-site" services shall end effective December 31, 2015.

“Early Intervention” Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

5. Nutrition Services 10. Anticipatory Guidance
   (Special Instruction and Allied Health Professional Assistance)

TN #10-0018 Supersedes TN #04-41 Approval Date November 1, 2017
Effective Date July 1, 2010
[13d. Rehabilitative Services:

School Supportive Health Services

School Supportive Health Services are services provided by or through local school districts or the New York City Board of Education to children with, or suspected of having disabilities, who attend public or State Education Department approved private schools. These services, which are provided to children with special needs pursuant to an Individualized Education Program (IEP) and are limited to EPSDT, are:

1. Physical therapy services
2. Occupational therapy services
3. Speech pathology services
4. Audiological evaluations
5. Evaluations for all available services
6. Nursing services
7. Psychological and social work services (psychological counseling)
8. Transportation see Supplement to Attachment 3.1.A, Item 24a
9. Medical evaluations (physician, physician assistant and nurse practitioner)

Preschool Supportive Health Services

Preschool Supportive Health Services are services provided by or through counties or the New York City Board of Education to children, with or suspected of having disabilities, who attend State Education Department approved preschools. These services, which are provided to children with special needs pursuant to an Individual Education Program (IEP) and are limited to EPSDT, are:

1. Physical therapy services
2. Occupational therapy services
3. Speech pathology services
4. Audiological evaluation
5. Evaluations for all available services
6. Nursing services
7. Psychological and social work services (psychological counseling)
8. Transportation see Supplement to Attachment 3.1.A, Item 24a
9. Medical evaluations (physician, physician assistant and nurse practitioner)
13d. (Cont'd) Rehabilitative services for residents of community-based residential programs licensed by the Office of Mental Health (CMH) are of three types:

1. Community residences of sixteen beds or less;
2. Family-based treatment and
3. Teaching family homes.

1. **Community Residences**

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness. Community residences for adults may be either a congregate-type arrangement or apartment-based. Community residence services are also provided to children.

Limitations on services include the following:

[ ] All providers must be currently licensed by CMH as community residences under 14 NYCRR 586 and 594. Congregate locations have sixteen beds or less.

[ ] Adults admitted must be determined to have a severe and persistent mental illness, as defined by the Commissioner of CMH.

[ ] Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of CMH.

[ ] Services are limited to those described in 14 NYCRR 593.

[ ] All services must be provided pursuant to a physician's written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

2. **Family-based treatment**

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.
Limitations on services include the following:

[ ] all providers must be currently licensed by CMH as family-based treatment programs under 14 NYCRR 594.

[ ] children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of CMH.

[ ] services are limited to those described in 14 NYCRR 593.

[ ] all services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.

3. Teaching Family Homes

Rehabilitative services in teaching family homes are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child’s developmental state. Eligible children are placed in small congregate care homes (4 children or less) in a supervised living arrangement with approved teaching parents, based on the National Teaching Family Model.

This program is different from family based treatment because some children are not able to tolerate the family closeness of family based treatment programs, and, therefore, are more appropriately treated in teaching family homes.

Limitations on services include the following:

[ ] All providers must be currently licensed by OMH as teaching family homes under 14 NYCRR 594.

[ ] Children admitted must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH.

[ ] Services are limited to those described in 14 NYCRR 593.

[ ] All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593.
Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) programs will provide case management, treatment and rehabilitation to persons with a serious psychiatric disorder who exhibit a pattern of institutional utilization and/or are at risk of a severely dysfunctional lifestyle; present symptoms and impairments not effectively remedied by other available treatment; do not or cannot be engaged in treatment in other outpatient settings as a result of their mental illness; or cannot maintain consistency in treatment through other outpatient services.

Programs will be licensed under 14 NYCRR Part 508. Services will be provided primarily in the community. Services will be provided under the supervision of a psychiatrist by a multi-disciplinary team which meets with the recipient or the recipients significant others a minimum of six times per month. Of these six contacts, at least three of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of two face to face contacts per month. Individuals shall be allowed to alternate between the full ACT team services and step-down services depending on the level of services needed to remain in the community.
13d. Rehabilitative Services

Personalized Recovery Oriented Services

A comprehensive Personalized Recovery Oriented Services (PROS) program will provide Community Rehabilitation and Support, Intensive Rehabilitation and Ongoing Rehabilitation and Support. A “limited license” will be made available for free-standing Intensive Rehabilitation and Ongoing Rehabilitation and Support programs that are operated by a provider that does not have the capability to offer Community Rehabilitation and Support.

Community Rehabilitation and Support (CRS) is designed to engage and assist individuals in managing their mental illness and in restoring those skills and supports necessary to live successfully in the community. Intensive Rehabilitation (IR) is a customized package of rehabilitation and support services designed to intensely assist an individual in attaining specific life goals such as successful completion of school, attainment of stable and independent housing, and gainful employment. Intensive Rehabilitation services may also be used to provide targeted interventions to reduce the risk of hospitalization, loss of housing, involvement in the criminal justice system, and to help individuals manage their symptoms. Ongoing Rehabilitation and Support (ORS) will provide interventions designed to assist in managing symptoms in an integrated workplace setting.

PROS programs will offer a comprehensive menu of services, customized for each client through development of an individualized recovery plan. Services provided by the CRS component of a PROS program will include but are not limited to: engagement; assessment; wellness self-management; basic living skills training; benefits and financial management; community living skills exploration; crisis intervention; individual recovery planning; information and education regarding self help; and structured skill development and support. Services provided by the IR component of a PROS program will include but are not limited to: family psychoeducation; intensive rehabilitation goal acquisition; clinical counseling and therapy; and intensive relapse prevention. Service provided in the IR component of a “limited license” PROS program will include but is not limited to, intensive rehabilitation goal acquisition for employment and education-oriented goals. Services provided by the ORS component of a PROS program will include, but are not limited to, vocational support services, defined as the ongoing provision of counseling, mentoring and advocacy services designed to sustain an individual's role in integrated employment by providing supports which assist the individual in symptom management. PROS services will be provided both onsite and offsite, but ORS services will always be provided off-site in the community.

Programs may, at their option, provide clinical treatment services designed to stabilize, ameliorate and control the disabling symptoms of mental illness. Programs that provide clinical treatment services will be reimbursed at a higher rate for the clinic component than programs which do not provide clinical treatment services.

Attachment 3.1-B
Supplement
13 d. Rehabilitative Services
Personalized Recovery Oriented Services-continued

The goal of the program is to provide integrated services, but client can choose to receive services from different service components in more than program. Clients enrolled in a PROS program which provides clinical treatment through the PROS program, or receive those services from a clinic licensed under 14 NYCRR Part 587.

Programs will be licensed and reimbursed under criteria set forth in 14 NYCRR Part 512. Staffing requirements will include differing staff to client ratios depending on the component of services the program offers.
New York
3b-13

[Reserved]

Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services
1905(a) (13)
42 CFR 440.130(d)

Item 4.b, EPSDT services - Rehabilitative Services: 42 CFR 440.130(d)

The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

Provided as an Early and Periodic Screening, Diagnostic and Treatment service for individuals who are eligible under the plan and are under the age of 21 1902(a) (43), 1905(a) (4) (B) and 1905(r)).

Rehabilitative Services Description

The rehabilitative service (or services) described below is:

• Community Psychiatric Support and Treatment
• Psychosocial Rehabilitation
• Family Peer Support

Assurances:
The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902 (a) (10)(A)(i) of the Act.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a) (13) of the Act.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR §435.1010;
E. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
F. recreational and social activities; and-
G. services that must be covered elsewhere in the state Medicaid plan.
not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically sensitive and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Licensed Psychologist. CI is a face-to-face intervention and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically sensitive, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.

**Practitioner qualifications:** Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (of at least two professionals unless noted below), for programmatic or safety purposes. One member of a two-person crisis intervention team must be a behavioral health professional and have experience with crisis intervention service delivery. If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed practitioner must be available via phone. A peer support specialist may not respond alone. Behavioral health professionals are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. For Crisis Intervention, these behavioral health professionals include: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders OR one practitioner from the above list and one practitioner from the following who is]
not considered a behavioral health professional: Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential/certification as either:
1) An OMH established Family Peer Advocate credential, or
2) An OASAS established Certified Recovery Peer Advocate - Family.

**Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:**

- Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child (ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates training or approved comparable training.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
- Documented 1000 hours of experience providing Family Peer Support services.
- Agreed to practice according to the Family Peer Advocate Code of Ethics.
- Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential and complete all other requirements of the professional family peer advocate credential that will allow services they provide to be billed if the applicant has:
- Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.]
[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

An FPA may obtain a provisional credential if the applicant has (Continued)
• Have a high school diploma, high school equivalency preferred or a State Education
Commencement Credential (e.g. SACC or CDOS). This educational requirement can be
waived by the State if the person has demonstrated competencies and has relevant life
experience sufficient for the peer credential.
• Completed Level One of the Parent Empowerment Program Training for Family Peer
Advocates or approved comparable training.
• Submitted two letters of reference attesting to proficiency in and suitability for the role
of a Family Peer Advocate (FPA).

An FPA with a provisional credential must complete all other requirements of the Professional
Family Peer Advocate Credential within 18 months of commencing employment as an FPA OR
Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a
Family Specialty.

To be certified as CRPA-Family, the individual must be at least 18 years of age and
have the following:
• Have ‘lived experience’ as a family member impacted by youth substance use
disorders. The CRPA – Family may be in recovery themselves.
• Have a high school diploma or a State Education Commencement Credential or General
Equivalency Degree (GED).
• Completed a minimum of 46 hours of content specific training, covering the topics:
advocacy, mentoring/education, recovery/wellness support, medication assisted
treatment and ethical responsibility.
• Documented 1,000 hours of related work experience, or document at least 500 hours
of related work experience if they: have a bachelor’s degree; are credentialed by OASAS
as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour
Recovery Coach Academy training.
• Provided evidence of at least 25 hours of supervision specific to the performance
domains of advocacy, mentoring/education, recovery/wellness support, and ethical
responsibility. Supervision must be provided by an organization documented and
qualified to provide supervision per job description.
• Passed the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated
certifying body.
• Submitted two letters of recommendation.
• Demonstrated a minimum of 16 hours in the area of Family Support.
• Completed 20 hours of continuing education earned every two years, including six
hours of Ethics.]
[13d. Rehabilitative Services: EPSDT only (Continued):
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient’s treatment/recovery plan

Crisis Intervention Team Training: All members of the Crisis Intervention team are required to have training in first aid, CPR, Mandated Reporting, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SAFETALK), and crisis plan development.

Supervisor Qualifications: The supervisor is a competent mental health professional and must provide regularly scheduled supervision for all team members including peers. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. The supervisor must practice within the State health practice laws and ensure that providers are supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services or any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide comparable and appropriate crisis services referenced in the definition.]
[13d. Rehabilitative Services: EPSDT only (Continued)

Crisis Intervention Components:

Mental Health and Substance Abuse Services Assessment:
Description: Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.

Practitioner qualifications: Assessments may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Service Planning:
Description: Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases.

Practitioner qualifications: Service Planning may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Individual Counseling/Therapy
Describe: Crisis resolution and debriefing with the identified Medicaid eligible child, the child’s family/caregiver and treatment provider.

Practitioner qualifications: Individual Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.]
[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued)

Family Counseling/Therapy
Describe: Crisis resolution and debriefing with the child’s family/caregiver and the treatment provider.

Practitioner qualifications: Family Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialled family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Care Coordination:
Description: Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child’s specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.

Practitioner qualifications: Care Coordination may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Peer/ Family Peer Support:
Describe: Crisis resolution with the identified Medicaid eligible child, the child’s family/caregiver and the treatment provider.

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialled Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family as defined above in this section.]
Rehabilitative Services: EPSDT only (Continued)

Program Name: Community Psychiatric Support and Treatment (CPST)

Description: Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child’s treatment plan. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions approved by New York State. CPST is a face-to-face intervention with the child, family/caregiver or other collateral supports. This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Counselor, Licensed Psychoanalyst, Licensed Psychiatrist, Physician's Assistant, Physician, Registered Professional Nurse, or Nurse Practitioner. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the child lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child (ren) even if the individual is living outside of the home. CPST face-to-face interventions may include other collateral supports beyond the individual or family/caregiver, as necessary.

Practitioner qualifications: CPST may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/ juvenile justice. These practitioners may include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license.

Practitioners with a bachelor's degree may only perform the following activities under CPST: Family and Group Counseling/Therapy (Rehabilitative psychoeducation), Service Planning (Strengths-based treatment planning), or the Rehabilitative Supports portion of Individual and Group Counseling/Therapy.

Practitioners with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice may perform any of the activities under CPST listed above without any exclusions.

The interventions and skill building identified by the CPST practitioner and family may be implemented by the child and family with the assistance of a peer (under Peer Supports Services), Psychosocial Rehabilitation practitioner (under Psychosocial Rehabilitation Services) or the CPST practitioner, if necessary.
Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) Description (Continued)
Practitioner Qualifications (Continued)

Supervisor Qualifications: Individuals providing services under CPST must receive regularly scheduled supervision from a professional meeting the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. CPST service delivery may also include collateral contact. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.

Service Planning (Strengths-based treatment planning):
Description: Strengths-based treatment planning - Facilitate participation in and utilization of strengths-based planning for Medicaid services and treatments related to child’s behavioral health/health needs which include assisting the child and family members, caregiver or other collateral supports with identifying strengths and needs, resources, natural supports, within the context of the client's culture and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health disorder.

Practitioner Qualifications: Strengths-based treatment planning may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children’s mental health, addiction, and/or foster care/child welfare/ juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR A master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
13d. Rehabilitative Services: EPSDT only (Continued)

Program Name: Community Psychiatric Support and Treatment (CPST) (Continued):

**Individual Counseling/Therapy (Intensive Interventions):**
**Description:** Intensive Interventions - Provide individual supportive treatment and counseling; solution-focused interventions consistent with cognitive behavior therapy and psycho-educational therapy; harm reduction; emotional, cognitive and behavioral management; and problem behavior analysis with the child and family/caregiver, with the goal of assisting the child with social, interpersonal, self-care, daily functioning, and independent living skills to restore stability, to support functional gains and to adapt to community living. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence based psychotherapeutic interventions with prior authorization from NYS that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

**Individual Counseling/Therapy (Crisis Avoidance):**
**Description:** Crisis Avoidance - Assist the child and family/caregiver with effectively responding to or preventing identified precursors or triggers that would risk their ability to remain in a natural community location, including assisting the child and family members, caregivers or other collateral supports with identifying a potential psychiatric or personal crisis; practicing de-escalation skills; developing a crisis management plan; assessing the step-by-step plan before a crisis occurs; developing strategies to take medication regularly; and seeking other supports to restore stability and functioning.

**Individual Counseling/Therapy (Rehabilitative Supports):**
**Description:** Rehabilitative Supports - Restoration, rehabilitation, and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the individual's daily functioning. Counseling helps restore life safety skills such as ability to access emergency services, basic safety practices and evacuation, physical and behavioral health care (maintenance, scheduling physicians appointments) recognizing when to contact a physician, self-administration of medication for physical and mental health or substance use disorder conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses. Group face-to-face counseling may occur in rehabilitative supports.

**Practitioner qualifications:**
Rehabilitative Supports components of Individual Counseling/Therapy may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
13d. Rehabilitative Services: EPSDT only (Continued)

Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Individual, family and Group Counseling/Therapy (Rehabilitative Supports) (Continued):
Practitioner Qualifications (Continued):

Intensive Interventions and Crisis avoidance may only be performed by practitioners who have at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative psychoeducation):
Description: Rehabilitative psychoeducation - Assist the child and family members, caregivers or other collateral supports to identify appropriate strategies or treatment options for the child's behavioral health needs, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances, substance use or associated behavioral health stressors that interfere with the child's life.

Practitioner qualifications: Rehabilitative psychoeducation may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative supports in the community):
Description: Rehabilitative supports in the community - Provide restoration, rehabilitation, and support to the child and family members, caregivers or other collateral supports to develop skills necessary to meet the child's goals and to sustain the identified community goals.

Practitioner qualifications: Rehabilitative supports in the community may be provided by an individual with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.
Crisis Intervention (Intermediate term crisis management):

**Description:** Intermediate term crisis management - Provide intermediate-term crisis management to the child and family following a crisis (beyond 72 hour period) as stated in the crisis management plan. The purpose of this activity is to stabilize the child/youth in the home and natural environment. Goal setting is focused upon the issues identified from crisis intervention, emergency room crisis and other referral. The service is intended to be stability focused and for existing clients of CPST services or for children needing longer term crisis managements services.

**Practitioner qualifications:** Intermediate term crisis management may be provided by an individual who has at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

**Rehabilitative Services: EPSDT only**

**Program Name:** Psychosocial Rehabilitation

**Description:** Psychosocial Rehabilitation Services (PSR) are designed for children and their families to assist with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth’s behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth’s functional level as possible and as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional intervention. PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth individualized treatment plan. PSR is an individual or group face-to-face intervention and may include collateral contact. PSR is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner.
13d. **Rehabilitative Services: EPSDT only (Continued)**

**Psychosocial Rehabilitation (Continued)**

**Description (Continued):**

The professional uses partnerships and mutual support, as well as hands-on implementation of rehabilitation interventions to improve personal independence and autonomy including:

1) **Restoration, rehabilitation and support to reduce the effect of the child’s behavioral health diagnosis and re-establish social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual’s social environment, including home, work and school. This includes learning to confidently manage stress, unexpected daily events and disruptions, and behavioral health and physical health symptoms. It also includes support to establish and maintain friendships/supportive social networks, improve interpersonal skills such as social etiquette and anger management.**

2) **Restoration, rehabilitation and support to reduce the effect of the child’s diagnosis and reestablish daily functioning skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person’s daily functioning. This includes supporting the individual with implementation of interventions to re-establish daily functioning skills and daily routines necessary to remain in home, school, work and community, including managing medications and learning self-care. It also includes development of constructive and comfortable interactions with healthcare professionals, develop relapse prevention strategies, and re-establishing good health routines and practices.**

3) **Restoration, rehabilitation and support to reduce the effect of the child’s diagnosis and re-establish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the individuals community integration in areas of personal interests as well as other domains of community life including home, work and school. This includes assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings. The professional may assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.**

**Practitioner Qualifications:** Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years’ experience in children’s mental health, addiction and/or foster care.
13d. **Rehabilitative Services: EPSDT only (Continued)**

**Psychosocial Rehabilitation (Continued):**

**Description (Continued):**

**Supervisor Qualifications:**
The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

**Provider Agency qualifications:** Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition. The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the interventions identified on the services/plan. Group should not exceed more than 8 members. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
Youth Peer Support and Training is recommended by any following licensed practitioners of the healing arts operating within the scope of their practice under State license: a Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner, operating within the scope of their practice with the youth, family/caregiver or other collateral supports. Activities may include: Restoration, rehabilitation, and support to develop skills for coping with and managing psychiatric symptoms, trauma and substance use disorders; promote skills for wellness and recovery support; develop skills to independently navigate the service systems; develop skills to set goals; and build community living skills. To enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy; Self-Advocacy & Empowerment skill building to develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community; serve as an advocate, mentor or facilitator for resolution of issues; and, assist in navigating the service system including assisting with engagement and bridging during transitions in care.

**Practitioner qualifications:**
YPST is delivered by a New York State Credentialed Youth Peer Advocate. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:

- Be an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the credentialing agency if the person has demonstrated competencies and has relevant life experience sufficient for the youth peer-credential.
- Completed Level One (online) and Level Two (online and in person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Documented 600 hours of experience providing Youth Peer Support services.
- Completed 20 hours of continuing education every 2 years.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Be supervised by a credentialed YPA OR a credentialed Family Peer Advocate, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595.
[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training (Continued):
Practitioner qualifications (Continued):

A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:

- Is an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational credential can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Submits two letters of reference attesting to proficiency in and suitability for the role of an YPA.
- Be supervised by a credentialed YPA OR a credentialed FPA, both with four years direct service experience OR an individual who meets the criteria for a “qualified mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595. Refer to Supervisor Qualifications for specificity.
- Agree to practice according to the YPA Code of Ethics.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate - Youth who is an individual 18 to 30 years of age and has:

- Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS).
- Completed a minimum of 46 hours content specific training, covering topics of advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of relative work experience or document at least 500 hours of related work experience if they:
  - Have a Bachelor’s Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training.]
[13d. Rehabilitative Services: EPSDT only (Continued):

Youth Peer Support and Training (Continued):

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has:

(Continued)

• Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
• Passed the NYCB/IC & RC Peer Advocate exam or other exam by an OASAS designated certifying body.
• Submitted two letters of recommendations.
• Demonstrated a minimum of 16 hours specifically related to Youth Peer Support.
• Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

Supervisor Qualifications: YPAs will be supervised by:

1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization OR
2) A credentialed FPA with 4 years of experience providing FPSS that has been trained in YPST services and the role of the YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPAs within the organization.
3) A qualified “mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPA within the organization.

Additional Supervisor Qualifications:

• The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
• Supervision of these activities may be delivered in person or by distance communication methods.
• It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
• There may be an administrative supervisor who signs the youth peer specialist's timesheet and is the primary contact on other related human resource management issues.
• Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.]
[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

Provider Agency Qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Group should not exceed more than 8 members. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]
13d. Rehabilitative Services: EPSDT only (Continued):

Family Peer Support:

Description: Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth’s treatment plan. FPSS is a face-to-face intervention, a group face-to-face intervention. A group is a composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals. The Service is directed to the child, and includes contacts necessary for treatment with the family/caregiver or other collateral supports. FPSS is recommended by a licensed practitioner of the healing arts including: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner, operating within the scope of their practice. FPSS can be provided through individual and group face-to-face work and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Components of FPSS include:

- **Engagement, Bridging and Transition Support:** Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- **Self-Advocacy, Self-Efficacy and Empowerment:** Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- **Parent Skill Development:** Support the efforts of families in caring for and strengthening their children’s mental, and physical health, development and well-being.
- **Community Connections and Natural Supports:** Enhance the quality of life by supporting the integration of families into their own communities.
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[Reserved]

13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Practitioner qualifications:** Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA); FPA with a provisional credential; or a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

- **FPA Credential:** To be eligible for the FPA Credential, the individual must:
  - Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
  - Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates approved comparable training.
  - Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
  - Documented 1000 hours of experience providing Family Peer Support services.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.
  - Completed 20 hours of continuing education and renew their FPA certification every two years.

- **A provisional FPA credential:**
  - Demonstrated ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
  - Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
  - Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA). The provisional FPA must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Certified Recovery Peer Advocate (CRPA) with a Family Specialty:**

To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:

- Have ‘lived experience’ as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor’s Degree; Are certified by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of Ethics.

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient’s treatment/recovery plan.

**Supervisor Qualifications:** FPAs will be supervised by:

1) Individuals who have a minimum of 4 years’ experience providing FPSS services, at least 1 year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract OR

2) A “qualified mental health staff person” with a) training in FPSS and the role of FPAs b) efforts are made as the FPSS service gains maturity in NYS to transition to supervision by experienced credentialed FPA within the organization OR

3) From a competent behavioral health professional meeting the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 OR

4) A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.

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TN #19-0003
Supersedes TN #18-0053
Approval Date 02/07/2019
Effective Date 01/01/2019
13d. **Rehabilitative Services: EPSDT only (Continued):**

**Family Peer Support (Continued):**

**Supervisor Qualifications: (Continued)**  The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision be delivered for every 40 hours of Family Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist’s timesheet and is the primary contact on other related human resource management issues.

**Provider Agency Qualifications:** Any practitioner providing behavioral health services must operate within an agency licensed, certified, designated and/or approved by

Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. A group is composed may not exceed more than 12 individuals total. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA’s, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary’s authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.

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**TN #19-0003**

**Supersedes TN #18-0053**

**Approval Date 02/07/2019**

**Effective Date 01/01/2019**
13d. **Rehabilitative Services: EPSDT only (Continued):**  
**Family Peer Support (Continued):**

**Limitations:**
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary’s treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.
“Off-site” services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. “Off-site” services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679.]

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified [Recipients must be diagnosed] by a physician as being, terminally ill, [that is, having] with a life expectancy of approximately six months or less [to live].

Recipients must sign an informed consent electing hospice over conventional care, subject to periodic review.

Services [must be] provided [In accordance with pertinent Department of Health regulations are palliative in nature as opposed to curative; Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or related condition.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist, personal care aid housekeeper/homemaker, pastoral care coordinator, social workers, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.
Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Physical therapist shall mean a person who is licensed by and currently registered with the New York State Education Department or who has been issued a valid limited permit by that Department.

Occupational therapist shall mean a person who is registered with the American Occupational Therapy Association, or either a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association or a graduate of a curriculum in occupational therapy which is recognized by the World Federation of Occupational Therapists and is eligible for a registration with the American Occupational Therapy Association.

Speech pathologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Personal care aide shall mean a person who, under professional supervision, provides patients assistance with nutritional and environmental support and personal hygiene, feeding and dressing and/or, as an extension of self-directed patients, selects health-related tasks. A personal care aide shall have successfully completed:

(i) a training program in home health aide services or equivalent exam as specified in the description for home health aide above; or
(ii) one full year of experience in providing personal care services through a home care services agency within three years preceding the effective date of an initial license issued pursuant to Article 36 of the Public Health Law; or
(iii) a training program in personal care services approved by the New York State Department of Health, which shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision; and
in those instances where the personal care aide is to be providing assistance with health-related
tasks, such aide shall be trained as described in subparagraph (iii) of this paragraph and
training in health-related tasks shall be completed in full prior to the personal care aide’s
assignment to any patient, as evidenced by written documentation of such completion.

Homemaker shall mean a person who meets the standards established by the Department of
Social Services and assists and instructs persons at home because of illness, incapacity or
absence of a caretaker relative in providing assistance with environmental and nutritional tasks.

Pastoral care coordinator shall mean a person who has had a minimum of one year of training
and experience in pastoral/spiritual counseling, and has a baccalaureate degree from a
regionally accredited college or university or one recognized by the New York State Department
of Education.

Social worker shall mean a person who holds a master’s degree in social work after successfully
completing a prescribed course of study at a graduate school of social work accredited by the
Council on Social Work Education and the Education Department, and who is certified or
licensed by the Education Department to practice social work in the State of New York. When
employed by a certified home health agency, long-term home health care program or hospice,
such social worker must have had one year of social work experience in a health care setting.

Nutritionist shall mean a person who applies the principles of normal and therapeutic nutrition
and of the physical, biological, social and behavioral sciences to the assessment and
management of those factors in the personal community environment which influence
nutritional status. A nutritionist must possess a baccalaureate degree, with major studies in
food and nutrition, from a regionally accredited or New York State registered four-year college
or university and be registered or be eligible for registration by the American Dietetic
Association.
Audiologist shall mean a person who is licensed as required by Article 159 of the New York State Education Law.

Respiratory therapist shall mean a person who is licensed and currently registered as a respiratory therapist pursuant to Article 164 of the New York State Education Law.

Providers of Hospice Services must be certified in accordance with Article 40 of the PHL. Services are provided in accordance with 42 CFR Part 418.

The State assures the provision of Hospice services will be provided in accordance with 42 CFR Part 418.

19. **Limitations on Tuberculosis related services:** Directly Observed Therapy (DOT) - will be provided to clients who are being treated for Tuberculosis Disease.

21. **Lactation consultant services:** effective September 1, 2012, reimbursement will be provided for breastfeeding health education and counseling services by pediatric or family nurse practitioners. Pediatric or family 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.

22. **Limitation on Respiratory Care:** Services may be rendered to EPSDT population by medical necessity and that services is furnished through the clinic and home benefits to this population.

TN#: 12-16 Approval Date: December 28, 2012

Supersedes TN#: 07-13 Effective Date: September 2, 2012
23a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of a recipient's assigned to the county.

2. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

23d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments shall not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

25. Personal care services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment.
Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personal file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of Health requires for employees of certified home agencies’
- a criminal history check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient's homes PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State's Personal Care Services are provided in accordance with 42 CFR 440.167.
New York
3(d)(i)

25 (Cont.) Consumer Directed Personal Assistance Program

The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a medical need for home care services and who choose to participate in this model. It has operated under the State’s Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local social services district (LSSD) contracts with home care agencies for provision of services. The home care agency is responsible for hiring, training, supervising and providing the home care worker with salary and benefits. In the CDPAP a local social services district contracts with a CDPAP agency and there is a co-employer relationship between the CDPAP agency and the consumer that encompasses these functions. The CDPAP consumer is responsible for hiring/training/supervising/and firing his/her aides. The CDPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department’s agent that processes and pays claims for services provided to Medicaid recipients.
26. The State elects to provide medical assistance services to eligible individuals through a Primary Care Case Management Program. PCCMs are responsible for locating, coordinating, and monitoring covered primary care to all individuals enrolled with a case manager.

PCCM providers may be physicians, physician group practices, entities employing or having other arrangements with physicians to provide PCCM Services under contract. Nurse practitioners may also be a PCCM provider.

A PCCM will provide for arrangements with, or referrals to a sufficient number of physicians and other appropriate health care professional to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

PCCMs are required to be accessible 24 hours/seven days per week to provide information, referral and treatment to enrollees. PCCMs may not restrict an enrollee’s access to emergency services, or require prior authorization of emergency services.

A PCCM shall be geographically accessible to enrollees. Primary care providers must meet State standards for travel time and distance.
General

a) Prior approval of the local professional director shall be required for medical care and services which are to be provided outside New York State, except in the following situations:

1. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside New York State.

2. When out-of-state care was provided in an emergency.

b) When a request subject to prior approval has been modified or denied in whole or in part because of disagreement with the proposed plan of treatment, recipients are notified that they may request a fair hearing.
28. **Lactation consultant services**: effective September 1, 2012, reimbursement will be available for breastfeeding health education and counseling services by physician assistants. Physician assistants 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.

29. **Lactation consultant services**: effective September 1, 2012, reimbursement will be available for breastfeeding health education and counseling services by registered nurses. Registered nurses 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.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

In addition to the limitations specified on pages 1 through 4 regarding services, the following limitations also apply to the noted services:

2a; 2b; 2c; 2d;

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

3.

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Laboratory Provider Manual. Such threshold requirements are applicable to specific provider service types including laboratories. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

5.

Services will be provided in accordance with the utilization threshold requirements described in departmental regulations, which are based on medical necessity and identified for providers in the MMIS Physician Provider Manual. Such threshold requirements are applicable to specific provider service types including physicians, for services furnished in the office or patient’s home. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.
A utilization threshold service is decremented each time a patient is seen by a physician including those times when the patient is seen by a physician and an electronic prescription/fiscal order is transmitted for medically necessary pharmaceuticals and select over the counter medications.
9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Physical Therapy Services

11a. Effective on or after [October 1, 2011] July 1, 2018, services are limited to coverage of [twenty] forty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

Occupational Therapy Services

11b. Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.
Speech-Language Therapy Services

11c. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispenses by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Attachment 3.1-B
Supplement

New York
7

September 14, 2011
Approval Date
October 1, 2011
Effective Date

TN #11-37
Supersedes TN #06-61
STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The following is a description of the methods that will be used to assure that the medical care and services are of high quality, and a description of the standards established by the State to assure high quality care:

a. Medical assistance will be provided in accordance with the individual’s medical needs based on the prescription or recommendation of the attending physician, dentist or other licensed practitioner eligible to participate in the program.

b. All professional persons providing service must be properly licensed under State Law. For certain paramedical services such as occupational therapy, speech therapy, etc., where there are no State licensing requirements, the persons providing such services must be qualified or certified by the appropriate national professional association.

c. Medical institutions such as hospitals, nursing homes, etc.; health related facilities such as intermediate care facilities, medical facilities such as clinics, private laboratories, etc.; and health agencies (such as community visiting nurse associations) which provide care to recipients in the medical assistance program must be licensed or approved by the appropriate State authority.

d. Services ordinarily interpreted to be specialist’s procedures or care must be provided by practitioners who are qualified specialists.

e. Home nursing services provided must conform to standards approved by the State Department of Health.

f. For certain care or services the recommendation of an appropriate specialist is required. (i.e., the more unusual prosthetic devices, rehabilitation therapies, orthodontic care, etc.).

g. Requirement that each local welfare district establish and maintain an adequate system of individual patient medical records showing diagnoses and services provided.

h. Collection of other medical information such as, at the State level, expenditures for various items of medical care and gross utilization data by categories. At the local level similar expenditure data related to individual medical attendants and vendors, and utilization data, particularly for physicians and hospital care. Drug records for individual patients are also maintained in a number of local welfare districts.
Section 3 - Services: General Provisions

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1902(z), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929 and 1933 of the Act; section 245(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State elects to provide alternative benefits:

<table>
<thead>
<tr>
<th></th>
<th>Provided</th>
<th>Not Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Title of Alternative Benefit Plan A- Medication Therapy Management (MTM) Program</td>
<td></td>
</tr>
<tr>
<td>[ ]</td>
<td>Title of Alternative Benefit Plan B</td>
<td></td>
</tr>
</tbody>
</table>

1. Populations and geographic area covered

The State will provide the benefit package to the following populations:

a) X Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, that may be required to enroll in an alternative benefit plan to obtain medical assistance.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the state will require to enroll in the alternative benefit plan;
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.
## New York

### Required Enrollment

<table>
<thead>
<tr>
<th>Full-Benefit Eligibility Group and Federal Citation</th>
<th>Targeting Criteria</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance</td>
<td>See Box Below</td>
<td>Bronx County</td>
</tr>
<tr>
<td>Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)</td>
<td></td>
<td></td>
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</table>

### Opt-In Enrollment

<table>
<thead>
<tr>
<th>Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group:</th>
<th>Targeting Criteria</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Box Below</td>
<td>Bronx County</td>
<td></td>
</tr>
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</table>

### Optional Enrollment

<table>
<thead>
<tr>
<th>Full-Benefit Eligibility Group and Federal Citation</th>
<th>Targeting Criteria</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)</td>
<td>See Box Below</td>
<td>Bronx County</td>
</tr>
<tr>
<td>Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)</td>
<td>See Box Below</td>
<td>Bronx County</td>
</tr>
<tr>
<td>Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Box Below</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Targeting Criteria:**
The MTM program will provide focused one-on-one, face-to-face medication management by a qualified pharmacist to Medicaid enrollees (voluntarily enrolled) to improve overall health outcomes and to decrease overall healthcare costs.

**TN #09-08 Approval Date December 16, 2009**

**Supersedes TN NEW Effective Date June 11, 2009**
Asthma will be the initial chronic medical condition to be addressed in the Medicaid MTM program. Beginning as a pilot program, MTM will be offered to Medicaid enrollees with continuous coverage under Medicaid for the last 180 days and who are ages 21-63 with asthma, living in the Bronx. Excluded from the program are dual eligible Medicaid/Medicare enrollees, institutionalized enrollees and managed care enrollees. The MTM program will be offered to eligible individuals meeting program criteria. Medicaid enrollees will be identified as eligible for MTM services using the following selection criteria, based on an analysis of Medicaid medication claims and other Medicaid paid claims including hospital and emergency room claims. This group will be refined to contain patients with persistent asthma by applying determinants of disease severity based on resource utilization or suboptimal chronic therapy. All target enrollees must have at least one asthma related hospital or emergency room visit during the past year or suboptimal chronic medication therapy related to asthma.

b). The following populations will be given the option to voluntarily enroll in an alternative benefit plan:

Please indicate in the chart below:
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

<table>
<thead>
<tr>
<th>Opt-In Enrollment</th>
<th>Included Eligibility Group and Federal Citation</th>
<th>Targeting Criteria</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Mandatory categorically needy low-income parents eligible under 1931 of the Act</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td>X</td>
<td>Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td>X</td>
<td>Basic TWWIIA working individuals with disabilities eligible under 1902(a)(10)(A)(ii)(XV)</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td>X</td>
<td>Individuals qualifying for Medicaid on the basis of blindness under:</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td>X</td>
<td>Individuals qualifying for Medicaid on the basis of disability under:</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td>X</td>
<td>Individuals eligible for Social Security benefits under title XVIII of the Act (Health Insurance for the Aged and Disabled)</td>
<td>Same as Section 1a.</td>
<td>Bronx County</td>
</tr>
<tr>
<td></td>
<td>Individuals who are terminally ill and receiving Medicaid hospice benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Institutionalized individuals assessed a patient contribution towards the costs of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individuals dually eligible for Medicare and Medicaid</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### New York

<table>
<thead>
<tr>
<th>Enrollment Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children younger than age 19 who are eligible for SSI</td>
<td></td>
</tr>
<tr>
<td>Disabled children eligible under the TEFRA option – section 1902(e)(3)</td>
<td></td>
</tr>
<tr>
<td>Children receiving foster care or adoption assistance under title IV-E of the Act</td>
<td></td>
</tr>
<tr>
<td>Children in foster care or other out-of-home placement</td>
<td></td>
</tr>
<tr>
<td>Children receiving non-IV-E foster care or adoption assistance</td>
<td></td>
</tr>
<tr>
<td>Individuals receiving services through a family-centered, community-based,</td>
<td></td>
</tr>
<tr>
<td>coordinated care system that receives grant funds under section 501(a)(1)(D) of</td>
<td></td>
</tr>
<tr>
<td>title V of the Act (Maternal and Child Health Services Block Grant)</td>
<td></td>
</tr>
<tr>
<td>Individuals who qualify based on medical condition for Medicaid coverage of</td>
<td></td>
</tr>
<tr>
<td>institutional or community-based long term care services</td>
<td></td>
</tr>
<tr>
<td>Women needing treatment for breast or cervical cancer who are eligible under</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10)(A)(ii)(XVIII)</td>
<td></td>
</tr>
<tr>
<td>TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)</td>
<td></td>
</tr>
<tr>
<td>Illegal or otherwise ineligible aliens who are only covered for emergency medical</td>
<td></td>
</tr>
<tr>
<td>services under section 1903(v)</td>
<td></td>
</tr>
<tr>
<td>Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)</td>
<td></td>
</tr>
</tbody>
</table>

### c) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

The New York State Medicaid program is sending an invitation letter to all eligible enrollees residing in the Bronx stating MTM services are available and enrollment is voluntary. Enrollees are also advised that if they choose to enroll in the MTM program, they may opt out of this program at any time. Invitation letters and enrollment materials will be available in Spanish. All State Plan services will continue to be included for enrollees opting to participate in the MTM program; no State Plan services will be excluded.

**TN #09-08**  
Approval Date: December 16, 2009  
Supersedes TN NEW  
Effective Date: June 11, 2009
2. Description of the Benefits

[ ] The State will provide the following alternative benefit package (check the one that applies).

a) [ ] Benchmark Benefits

[ ] **FEHBP-equivalent Health Insurance Coverage** - The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

[ ] **State Employee Coverage** - A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State's Employee Benefit Package.

[ ] **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** - The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

[ ] **X Secretary-approved Coverage** - Any other health benefits coverage that the Secretary determines provides an appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

1) The new State Plan service, MTM, will be available to all eligible enrollees, identified in the SPA, residing in the Bronx meeting specific State defined inclusion criteria. MTM services will be provided in addition to all State Plan services. These services will continue to be included for enrollees opting to participate in the MTM program; no State Plan services will be excluded.

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<thead>
<tr>
<th>TN #09-08</th>
<th>Approval Date</th>
<th>December 16, 2009</th>
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</thead>
<tbody>
<tr>
<td>Supersedes TN NEW</td>
<td>Effective Date</td>
<td>June 11, 2009</td>
</tr>
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</table>
2) **Medication Therapy Management** will provide one-on-one, face-to-face medication therapy services provided by trained, qualified NYS Medicaid MTM pharmacists who possess a New York State Pharmacy license. The services will be rendered in Medicaid enrolled retail pharmacies that have received a NYS Medicaid MTM-designation. Asthma will be the initial chronic medical condition to be addressed in the Medicaid MTM program. The services to be provided include:

- patient assessment (medical history as related by the patient);
- comprehensive patient medication therapy review;
- personal medication record (retained by the patient);
- medication action plan (for the patient to follow);
- assistance in finding a primary care physician (if needed);
- documentation of problems, resolutions, education and evaluation of patient response to medication therapy including adverse events; and
- follow-up to ensure patient adherence with medication action plan and;
- encourage patient self-management.

Enrollees will be provided MTM services from State trained, qualified Medicaid MTM pharmacists performing within their scope of practice pursuant to NYS Education Law. Pharmacists will not be providing medical advice to enrollees but will be conferring with the enrollee’s prescriber to share recommendations. These pharmacists are expected to also facilitate linkage of the enrollee with a primary care provider (PCP) when the enrollee does not have a PCP.

3) **Enrollee choice and consent**

The MTM program will be offered to eligible individuals meeting program criteria. Enrollee eligibility for MTM services is based on specific inclusion criteria developed by the New York State Medicaid program described in the targeting criteria. Eligible enrollees will be invited to voluntarily opt into the Medicaid MTM program and will receive notification containing the name and contact information for Medicaid MTM-designated pharmacies in their area. The notification will encourage the enrollee to contact the Medicaid MTM-designated pharmacy of their choice to set up their initial visit.

Medicaid enrollees who agree to participate in the MTM program will be required to sign a consent form, prior to the enrollee’s first visit with a qualified Medicaid MTM pharmacist, releasing identifiable health information to practitioners and pharmacists involved in the enrollee’s care and MTM program. Enrollees receiving MTM services may choose to change either their Medicaid MTM designated pharmacy, change their qualified Medicaid MTM pharmacist at any time or opt out of MTM services at any time.

4) **Service setting**

Services will be provided face-to-face by a qualified pharmacist in an area of Medicaid MTM-designated community pharmacy separate from the dispensing area to afford privacy for discussion of the enrollee’s medical and pharmaceutical issues. MTM services will only be available at designated MTM pharmacies in the Bronx.

5) **Frequency of service**

Enrollees will be eligible for one initial visit and 6 subsequent visits per 12 month period.
6) Provider qualifications

Medicaid MTM-designated Pharmacies- In order to participate in the MTM program, a pharmacy must: (1) be licensed and registered and in good standing with the Department of Education Board of Pharmacy, (2) be enrolled and in good standing with the NYS Medicaid program, (3) provide a current (and updated, as required) list of qualified MTM pharmacist(s) in its employment and (4) provide a separate and private MTM counseling area.

Qualified Medicaid MTM Pharmacists- In order to participate in the New York State Medicaid MTM program, a pharmacist must: (1) be registered and in good standing with the New York State Department of Education Board of Pharmacy and (2) be in good standing with the NYS Medicaid program and (3) have completed the NYS Medicaid MTM training.

b) [ ] Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

[ ] Inpatient and outpatient hospital services;

[ ] Physicians’ surgical and medical services;

[ ] Laboratory and x-ray services;

[ ] Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

[ ] Other appropriate preventive services including emergency services and family planning services included under this section.

(ii) [ ] Additional services

Insert a full description of the benefits in the plan including any limitations.
(iii) N\A The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

(iv) N\A The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes and of the following four categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75% of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Prescription drugs;
- Mental health services;
- Vision services, and/or
- Hearing services,

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

[c] Additional Benefits

[ ] Insert a full description of the additional benefits including any limitations.

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TN #09-08 Approval Date December 16, 2009
Supersedes TN NEW Effective Date June 11, 2009
3. Service Delivery System

Check all that apply.

X The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

[ ] The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t).

[ ] The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements. (42 CFR 438, 1903(m), and 1932).

[ ] The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR 438.

[ ] The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

[ ] The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished.

4. Employer Sponsored Insurance

[ ] The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

TN #09-08 Approval Date December 16, 2009
Supersedes TN NEW Effective Date June 11, 2009
5. Assurances

**N/A** The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

[ ] Through Benchmark only

[ ] As an Additional benefit under section 1937 of the Act

**X** The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

**X** The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

**X** The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

All modes of transportation are available to Medicaid enrollees, when necessary to access care and service covered under the Medicaid Program. Medicaid transportation is an optional item of medical assistance, per New York Social Services Law at § 365-a. Implementation of this law is found at Title 18 New York Code of Rules and Regulation at section 505.10 and is on file in New York’s State Plan.

6. Economy and Efficiency of Plans

**X** The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

**X** The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

**X** The State will implement this State Plan amendment on **January 6, 2010** (date).

TN #12-08 Approval Date June 7, 2012
Supersedes TN #09-08 Effective Date April 2, 2012
New York
1

Provisions for Providing
Medical Assistance Transportation

The following provisions set forth the Department's policy concerning transportation services provided to Medical Assistance (MA) recipients for the purpose of obtaining necessary medical care and services which can be paid for under the MA program. These provisions set forth the standards which the Department will use in determining when the MA program will pay for transportation and describes the prior authorization process for obtaining payment.

The MA program covers all modes of transportation, including, but not limited to: emergency ambulance and non-emergency modes of transportation. Transportation is provided by service providers at Department-established fee schedules set at levels where the Department can successfully assure the availability of medically necessary transportation to services covered by the MA program.

A. Prior Authorization

1. Prior authorization is required for the following:

   a. all transportation to obtain medical care and services, except emergency ambulance transportation or Medicare approved transportation by ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments.

   b. transportation expenses of an attendant for the MA recipient.

The provisions set forth the standards to be used in evaluating prior authorization requests and provides the prior authorization official (i.e., the Department or its contracted agents, the county department of social services[,] or their designated agents) with the authority to approve or deny reimbursement to MA recipients for the use of private vehicles (personal cars) or mass transportation which the recipient uses for the usual activities of daily living. A prior authorization official may approve reimbursement for the use of personal cars or mass transportation, however, if, in the opinion of the prior authorization official, circumstances so warrant. A prior authorization official may also approve reimbursement for the use of some other mode of transportation, such as ambulance, wheelchair or stretcher van, or taxi/livery, as required by the MA recipient.

2. Criteria to be used by the prior authorization official in making prior authorization determinations are:

   a. the MA recipient has access to necessary medical care or services by use of a private vehicle or by means of mass transportation which is used by the recipient for the usual activities of daily living;

   b. the frequency of visits or treatments within a short period of time whereby the recipient would suffer financial hardship if required to make payment for the transportation;

   c. the nature and severity of the MA recipient's illness which necessitates transportation by a mode other than that ordinarily used by the MA recipient (such as an acute event wherein an otherwise ambulatory recipient becomes physically disabled);

TN#: 12-33 Approval Date: ___December 20, 2012__
Supersedes TN#: 09-47 Effective Date: ____September 1, 2012_ _
d. the geographic locations of the MA recipient and the provider of medical care and services;

e. the medical care and services available within the common medical marketing area of the MA recipient's community;

f. the need to continue a regimen of medical care or service with a specific provider; and,

g. any other circumstances which are unique to a particular MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation services.

The decision to require the MA recipient to travel using a personal vehicle, public transit, or taxi is made by the prior authorization official based upon the prior authorization official's knowledge of personal vehicle ownership and the local public transit routes. When a more specialized mode of transportation is required, such as wheelchair or stretcher van, or ambulance, the prior authorization official will make a decision on the proper mode of transport after consideration of information obtained from a medical practitioner, supervisors, the Department, program guidance materials, and any other source available, that will help the official to make a reasoned decision.

B. Payment

1. Criteria to be used when establishing payment for medical assistance transportation:

   a. Social services districts, except those where the Commissioner of Health has assumed the management of transportation services, have the authority to establish payment rates with vendors of transportation services which will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services. Social services districts may establish such rates in a number of ways, which may include negotiation with the vendors. However, no established rate will be reimbursed unless that rate has been approved by the Department as the Department established rate.

      i. The State defines “department established rate” as the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care and services.

      ii. The department may either establish rate schedules at which transportation services can be assured or delegate such authority to the social services districts. Delegation of authority exists only in episodic circumstances in which immediate transportation is needed at a cost not considered in the established fee schedule. In order to ensure access to needed medical care and service, the social services districts will approve a rate to satisfy the immediate need.

      iii. Plans, rate schedules or amendments may not be implemented without departmental approval.

      iv. Social services districts have no authority to establish a fee schedule without the Department's involvement; there is no incongruity between the Department's and social services district's fee schedules.
v. Payment for reimbursement of the MA recipient's use of a personal vehicle will be made at the Internal Revenue Service's established rate for Medical Mileage. Payment of reimbursement for use of a personal vehicle of a volunteer driver or family member of a MA recipient will be made at the Internal Revenue Service's established rate for Standard Mileage.

b. Payment for transportation is only available for transportation to and from providers of necessary medical care and services which can be paid for under the MA program. MA payment for transportation will not be made if the care or services are not covered under the MA program.

c. MA payment to vendors of transportation services is limited to situations where an MA recipient is actually being transported in the vehicle.

d. MA payment will not generally be made for transportation which is ordinarily made available to other persons in the community without charge. If federal financial participation is available for the costs of such transportation, the MA program is permitted to pay for the transportation.

e. Vendors of transportation services must provide pertinent cost data to a social services district upon request or risk termination from participation in the MA program.

Finally, the provisions require social services districts to notify applicants for and recipients of MA of the procedures for obtaining prior authorization of transportation services.

C. Transportation Management

The following table depicts, for each county, whether the county department of social services or State manages the transportation program.

<table>
<thead>
<tr>
<th>Allegany</th>
<th>Monroe</th>
<th>Albany</th>
<th>Queens</th>
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TN#: 13-23 Approval Date: December 4, 2013
Supersedes TN#: #12-33 Effective Date: July 1, 2013
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<th>Managed by Department of Health Under Contract</th>
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TN  #15-0052  
Supersedes TN  #14-0037  
Approval Date  November 30, 2015  
Effective Date  July 1, 2015
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

- Organ and tissue transplantation services must be performed in hospitals approved by the Commissioner of Health and the hospital must be a member of the Organ Procurement and Transplantation Network approved by the Secretary, U.S. Department of Health and Human Services and must abide by its rules and requirements.

- The hospital must participate in a patient registry program with an organ procurement organization designated by the Secretary, U.S. Department of Health and Human Services.

- The hospital must ensure that written policies are developed and that the written criteria used for the selection of patients for transplant services must be consistent with professional standards of practice and applied consistently.

- Chapter 589 of the Laws of 1990 amended the Public Health Law to provide for more equitable access to donated organs. To ensure equitable access to human organs to persons in need of transplants:

  - Each Organ Procurement Organization (OPO) must maintain a single waiting list for each type of organ and the policies and procedures for distributing organs to potential recipients must take into account patient factors such as tissue type.

  - No OPO designated to serve any part of New York State shall place any person on a waiting list for the allocation of organ(s) for transplantation if that person is listed on another waiting list for the same organ. The OPO must insure that the patient is not already listed by another OPO.

  - Each facility performing transplant services shall inform every transplant candidate that no patient may place his or her name on a waiting list maintained by an OPO designated to serve any part of New York State if the person is listed on any other waiting list maintained by another such OPO.

- The hospital must maintain a record of all patients who are referred for transplantation and the date of their referral, the results of the evaluation of all candidates for transplantation which documents the reasons a candidate is determined to be either suitable or unsuitable for transplantation, the date suitable candidates are selected for transplantation, the date the transplantation surgery occurred, the organs utilized, and the donor.
### New York

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
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<tr>
<td><strong>A.</strong> Section 1932(a)(1)(A) of the Social Security Act</td>
<td>The State of New York enrolls Medicaid beneficiaries into managed care entities (managed care organizations (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans-see D.2.ii. below), or who meet certain categories of &quot;special needs&quot; beneficiaries (see D.2.iii.-vii. below).</td>
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<tr>
<td><strong>B.</strong> General Description of the Program and Public Process</td>
<td>In April 2007, the New York legislature authorized the Department of Health (DOH) to establish Chronic Illness Demonstration Projects (CIDPs) to test models of care management and coordination to address the complex health and social needs of Medicaid fee-for-service recipients with complex behavioral and medical health conditions. Enrollment into the program will be voluntary in select geographical areas across the state. NY DOH will award a contract to a CIDP entity that will function as the overall Primary Care Case Management entity. Each CIDP entity will be responsible for ensuring the provision of primary care services in accordance with 1905(t)(1). CIDP entities will be responsible for the following functions: locate eligible beneficiaries; complete an initial health assessment and periodic reassessments; develop and update a care/service plan; coordinate care/discharge/referral among multiple providers; maintain state-specified frequency of contact (telephonic and in-home/provider office) with beneficiaries; and report specified process and outcome measures.</td>
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</table>

For B.1 and B.2, place a check mark on any or all that apply.

1. The State will contract with an 
   - i. MCO

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**TN #08-62**  
Supersedes TN ____ NEW  
Approval Date **November 13, 2008**  
Effective Date **July 1, 2008**
## New York

### Citation Condition or Requirement

<table>
<thead>
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<tr>
<td>42 CFR 438.50(b)(2)</td>
<td>✓ ii. PCCM (including capitated PCCMs that qualify as PAHPs)</td>
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<tr>
<td>42 CFR 438.50(b)(3)</td>
<td>✓ iii. Both</td>
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2. The payment method to the contracting entity will be:

- ✓ i. fee for service;
- ✓ ii. capitation;
- ✓ iii. a case management fee;
- ✓ iv. a bonus/incentive payment;
- ✓ v. a supplemental payment, or
- ✓ vi. other. (Please provide a description below).

Contractors will be at-risk for a portion of the monthly care coordination fee (MCCF) if quality, reporting and performance standards are not achieved. Any necessary recoupment of the MCCF will be withheld from future payments due to the contractor, and the federal portion of the recoupment will be returned to CMS.

In addition, the DOH will make available funds for shared cost savings incentive payments. Only contractors that have met all quality, reporting and performance standards will be eligible to participate in the shared savings. Shared savings incentive payments will not exceed 105% of the aggregate payment for Medicaid services received.

Reconciliation of at-risk and shared savings will be done annually, after the first contract year.

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM’s case management fee, if certain conditions are met.

   If applicable to this state plan, place check mark to affirm the state has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

   ✓ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

   ✓ ii. Incentives will be based upon specific activities and targets.
### New York

#### 3

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<td></td>
<td>✓ iii. Incentives will be based upon a fixed period of time.</td>
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<td>✓ iv. Incentives will not be renewed automatically.</td>
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<td>✓ v. Incentives will be made available to both public and private PCCMs.</td>
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<td></td>
<td>✓ vi. Incentives will not be conditioned on intergovernmental transfer agreements.</td>
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<td></td>
<td>___ vii. Not applicable to this 1932 state plan amendment.</td>
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</table>

| CFR 438.50(b)(4) | 4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* |

The demonstrations are to be established by a competitive procurement or discretionary grant. Prior to the development of the RFP document the DOH Office of Health Insurance Programs (OHIP) consulted with many stakeholders, including: New York State (NYS) DOH public health experts in chronic disease, sister agencies such as the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS); experts in public health policy; experts in Medicaid quality improvement, public health research scientists; and medical and behavioral health providers. The purpose of this collaboration was to solicit input and expertise to assist in the design of a solicitation document that would support the development of CIDP programs that would address the complex needs of this population and fulfill the intent of the legislation. Based upon the input received, the RFP document was developed and made available for comment to many of the aforementioned entities.

In accordance with procurement regulations, an advertisement was placed in the “New York State Contract Reporter” informing the public that the CIDP RFP was to be released. The RFP and supportive documentation were also made available on the DOH website. Interested parties and potential bidders were sent letters via both the US Postal system and electronic mail informing them of the release of the RFP and inviting them to the Pre-Bid Conference. The Pre-Bid Conference, held after the RFP release, offered interested parties and potential bidders an opportunity to seek clarification and ask questions regarding the solicitation. All questions and answers discussed at the Pre-Bid Conference or submitted post-Conference were made public on the DOH website and sent to all interested parties, potential bidders and those entities that had submitted a letter of interest. A press release was issued from

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**TN #08-62**

Supersedes TN **NEW**

**Approval Date** **November 13, 2008**

**Effective Date** **July 1, 2008**
New York

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(a)(1)(A)</td>
<td>the Commissioner of Health, with supportive comments from both the Commissioners of OMH and OASAS, promoting the goals and availability of funding for the CIDPs. In accordance with the guidelines for bidder proposal submission evaluation and selection, applicants were competitively selected for contract award. During the implementation and operations of the CIDPs DOH will maintain a highly collaborative and coordinated working relationship with each of the CIDP programs. During the course of the demonstrations there will be opportunities for stakeholders to provide ongoing feedback. For example, DOH will conduct semiannual multistakeholder collaborative meetings to foster learning, information sharing, problem solving and to provide technical assistance to the CIDPs. Medical and behavioral providers, social service agencies, community based organization, local government, OMH and OASAS representatives staff and other interested parties will also be included in the collaborative sessions. Additionally DOH will solicit input on a quarterly basis at the Medical Advisory Committee meetings.</td>
</tr>
</tbody>
</table>

5. The state plan program will ___/will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___/voluntary ___ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory)______________________
   ii. county/counties (voluntary)  ✓ See county list-5.iv.
   iii. area/areas (mandatory)______________________
   iv. area/areas –(by voluntary)  ✓ Portions of these counties

Albany
Bronx
Erie
Kings
Nassau
New York
Queens
Rensselaer

TN #08-62 Approval Date November 13, 2008
Supersedes TN ___ NEW Effective Date July 1, 2008
### New York

#### C. State Assurances and Compliance with the Statute and Regulations

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1932(a)(1)(A)(i)(I) | Saratoga  
| 1903(m) | Schenectady  
| 42 CFR 438.50(c)(1) | Suffolk  
| 1932(a)(1)(A)(i)(I) | Westchester |

1. The State assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

2. The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

3. The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A) of the Act, for the state’s option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

4. The state assures that all applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

5. The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

6. The state assures that all applicable requirements of 43 CFR 438.6(c) for payments under any risk contracts will be met.

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</thead>
<tbody>
<tr>
<td>1932(a)(1)(A) 42 CFR 447.362</td>
<td>7. __The state assures that all applicable requirements of 42 CFR 447.362 for payments</td>
</tr>
<tr>
<td>42 CFR 438.50(c)(6)</td>
<td>under any nonrisk contracts will be met.</td>
</tr>
<tr>
<td>45 CFR 74.40</td>
<td>8. ✓ The state assures that all applicable requirements of 45 CFR 92.36 for procurement</td>
</tr>
<tr>
<td></td>
<td>of contracts will be met.</td>
</tr>
</tbody>
</table>

D. Eligible Groups

**Enrollment will be voluntary**

1. List all eligible groups that will be enrolled on a mandatory basis.


   Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

   i. __Recipients who are also eligible for Medicare.

      If enrollment is voluntary, describe the circumstances of the enrollment.

      *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

   ii. __Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.*

   iii. __Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under Title XVI.*

   iv. __Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.*

   v. __Children under the age of 19 years who are in foster care or other out-of-ground__

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**Effective Date** July 1, 2008
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 438.50(3)(iii)</td>
<td>the-home placement.</td>
</tr>
<tr>
<td>1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)</td>
<td>vi. Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E.</td>
</tr>
<tr>
<td>1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)</td>
<td>vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.</td>
</tr>
</tbody>
</table>

**E. Identification of Mandatory Exempt Groups**

*Enrollment will be voluntary; children under age 19 are excluded*

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

2. Place a check mark to affirm if the state's definition of title V children is determined by:

- _i._ program participation,  
- _ii._ special health care needs, or  
- _iii._ both

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

- _i._ yes  
- _ii._ no

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self-identification)*

   - _i._ Children under 19 years of age who are eligible for SSI under title XVI;  
   - _ii._ Children under 19 years of age who are eligible under section 1902(e)(3) of the Act;
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>iii. Children under 19 years of age who are in foster care or other out-of home placement;</td>
</tr>
<tr>
<td></td>
<td>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</td>
</tr>
<tr>
<td>1932(a)(2) 42 CFR 438.50(d)</td>
<td>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt (Example: self-identification)</td>
</tr>
<tr>
<td>1932(a)(2) 42 CFR 438.50(d)</td>
<td>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care (Examples: usage of aid codes in the eligibility system, self-identification)</td>
</tr>
<tr>
<td></td>
<td>i. Recipients who are also eligible for Medicare.</td>
</tr>
<tr>
<td></td>
<td>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</td>
</tr>
<tr>
<td>42 CFR 438.50</td>
<td>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment <strong>Enrollment will be voluntary</strong></td>
</tr>
<tr>
<td>42 CFR 438.50</td>
<td>G. List all other eligible groups who will be permitted to enroll on a voluntary basis</td>
</tr>
</tbody>
</table>

The eligible group for voluntary enrollment includes disabled Medicaid FFS recipients, exempt or excluded from managed care, who are medically and behaviorally complex and receive services across multiple provider agencies, and:
- Have full Medicaid coverage,
- Have multiple co-morbid chronic conditions, such as, but not limited to: asthma, cardiovascular disease, chronic kidney disease and end stage renal

**TN #08-62**
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failure, congestive heart failure, coronary atherosclerosis, diabetes, history of acute myocardial infarctions, HIV/AIDS, hypertension, obstructive pulmonary disease, and sickle cell anemia;
- Are 19 years of age or older;
- Are within the geographic catchment area of the CIDP;
- May have mental illness and chemical dependence, either singularly or co-occurring;
- May be in the Recipient Restriction Program;
- May be homeless;
- May be a Native American;
- Are not dually eligible for Medicare and Medicaid;
- Are not enrolled in a Managed Care Plan, Special Needs Plan, Managed Long Term Care Plan, or Family Health Plus;
- Are not residing in a State-operated psychiatric center or free standing psychiatric hospital, Intermediate Care Facility, Residential Health Care Facility, Skilled Nursing Facility, Alcohol and Substance Abuse or Chemical Dependence Long Term Residential treatment program, or hospice;
- Are not in receipt of Medicaid Home and Community Based Waiver (HCBW) services; and
- Are not individuals who have a documented diagnosis of mental retardation or a developmental disability based on NYS Mental Hygiene Law.

H. Enrollment process

Not Applicable (no default enrollment)

1. Definitions

   i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

   ii. A provider is considered to have “traditionally served” Medicaid recipients if it has experience in serving the Medicaid population.

2. State process for enrollment by default.
### Citation

<table>
<thead>
<tr>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe how the state's default enrollment process will preserve:</td>
</tr>
<tr>
<td>i. the existing provider-recipient relationship (as defined in H.1.i).</td>
</tr>
<tr>
<td>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</td>
</tr>
<tr>
<td>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</td>
</tr>
</tbody>
</table>

3. As part of the state's discussion on the default enrollment process, include the following information:

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>i. The state will ____ will not ____ use a lock-in for managed care.</td>
</tr>
<tr>
<td>ii. The time frame for recipients to choose a health plan before being auto-assigned will be ______________.</td>
</tr>
<tr>
<td>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)</td>
</tr>
<tr>
<td>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets, etc.)</td>
</tr>
<tr>
<td>v. Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</td>
</tr>
</tbody>
</table>
### New York

#### Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(a)(4) 42 CFR 438.50</td>
<td>vi. Describe how the state will monitor any changes in the rate of default assignment. <em>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</em></td>
</tr>
<tr>
<td></td>
<td>I. State assurances on the enrollment process</td>
</tr>
<tr>
<td></td>
<td>Recipient enrollment in a CIDP will be on an “opt-in”, voluntary basis. Recipients will be notified by two consecutive mailings, first from the DOH and second from the CIDP contractor regarding their eligibility to enroll in a CIDP and providing information on the demonstration program. Other Department approved methods of outreach to recipients not responsive to mailings will be utilized as needed, e.g. telephoning, utilizing community outreach workers, and outreach and enrollment during network provider visits. All contractor communications with recipients will be approved by the DOH, including letters of notification, brochures and educational materials and telephonic scripts.</td>
</tr>
<tr>
<td></td>
<td>Recipient enrollment may be conducted face to face or telephonically. At the time of enrollment the recipient must provide their written consent to participate in the CIDP program. At the time of enrollment each enrollee will be notified of their right to disenroll or “opt out” of the CIDP at anytime. The enrollee will be notified that enrollment in a CIDP will not limit or impair their ability to access Medicaid services to which they are entitled.</td>
</tr>
<tr>
<td></td>
<td>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</td>
</tr>
<tr>
<td></td>
<td>1. ✓ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</td>
</tr>
<tr>
<td></td>
<td>2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of a least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</td>
</tr>
<tr>
<td></td>
<td>3. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</td>
</tr>
</tbody>
</table>

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**Attachment 3.1-F**  
**OMB NO.: 0938-933**  
**New York**  
**11**

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<p>| TN #08-62 | Approval Date | November 13, 2008 |
| Supersedes TN | Effective Date | July 1, 2008 |
| NEW | | |</p>
<table>
<thead>
<tr>
<th>Citation</th>
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<tbody>
<tr>
<td>1932(a)(4) 42 CFR 438.50</td>
<td>✓ This provision is not applicable to this 1932 State Plan Amendment.</td>
</tr>
<tr>
<td>1932(a)(5) 42 CFR 438.50</td>
<td>4. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) ✓ This provision is not applicable to this 1932 State Plan Amendment.</td>
</tr>
<tr>
<td>1932(a)(5) 42 CFR 438.10</td>
<td>5. The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ✓ This provision is not applicable to this 1932 State Plan Amendment.</td>
</tr>
<tr>
<td>1932(a)(5)(D) 1905(t)</td>
<td>J. Disenrollment</td>
</tr>
<tr>
<td></td>
<td>1. The state will ✓/will not use lock-in for managed care.</td>
</tr>
<tr>
<td></td>
<td>2. The lock-in will apply for ___ months (up to 12 months).</td>
</tr>
<tr>
<td></td>
<td>3. Place a check mark to affirm state compliance. ✓ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</td>
</tr>
<tr>
<td></td>
<td>4. Describe any additional circumstances of “cause” for disenrollment (if any).</td>
</tr>
<tr>
<td></td>
<td>K. Information requirements for beneficiaries</td>
</tr>
<tr>
<td></td>
<td>Place a check mark to affirm state compliance. ✓ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance).</td>
</tr>
<tr>
<td></td>
<td>L. List all services that are excluded for each model (MCO &amp; PCCM)</td>
</tr>
</tbody>
</table>

Attachment 3.1-F
OMB NO.: 0938-933

New York
12

Citation | Condition or Requirement
---|---
1932(a)(4) 42 CFR 438.50 | ✓ This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(5) 42 CFR 438.50 | 4. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) ✓ This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(5) 42 CFR 438.10 | 5. The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ✓ This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(5)(D) 1905(t) | J. Disenrollment
| | 1. The state will ✓/will not use lock-in for managed care.
| | 2. The lock-in will apply for ___ months (up to 12 months).
| | 3. Place a check mark to affirm state compliance. ✓ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).
| | 4. Describe any additional circumstances of “cause” for disenrollment (if any).
| | K. Information requirements for beneficiaries
| | Place a check mark to affirm state compliance. ✓ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance).
| | L. List all services that are excluded for each model (MCO & PCCM)
<table>
<thead>
<tr>
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<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(a)(1)(A)(ii)</td>
<td>There are no Medicaid covered services excluded for CIDP enrollees. Recipients/enrollees will continue to receive all Medicaid covered services via the fee-for-service program.</td>
</tr>
</tbody>
</table>

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ✓ /will not ___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ✓ the state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and enrollees.)*

To establish the CIDP programs NYS utilized a request for proposal (RFP) competitive procurement. Eligible bidders authorized to submit a proposal submission for a CIDP were mandated in Social Services Law § 364-1 that authorized the demonstrations. The RFP document included detailed specifications and technical requirements. Each bidder was required to submit a Technical Proposal and a Financial Proposal, which were evaluated by separate teams following criteria developed from RFP requirements, detailed specification and cost requirements. All evaluation and selection documents were reviewed and approved by the DOH Procurement Division prior to receipt of the proposals. The results of the evaluation were then reported to the selection committee, who made the final award(s) determination. Oversight of the procurement and contractor selection process is done by the NYS Office of the State Comptroller who must review and approve all processes, documents and contracts for accuracy and compliance with NYS financial and procurement laws.

4. The selective contracting provision is not eligible to this state plan.

TN #08-62 Approval Date November 13, 2008
Supersedes TN NEW Effective Date July 1, 2008
NY - Submission Package - NY2016MH00020 - (NY-16-0034)

Submission - Summary
MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

Package Header
Package ID: NY2016MH00020
Submission Type: Official - Review 1
Approval Date: 12/22/2016
Superseded SPA ID: N/A
SPA ID: NY-16-0034
Initial Submission Date: 9/29/2016
Effective Date: N/A

State Information
State/Territory Name: New York
Medicaid Agency Name: Department of Health

Submission Component

State Plan Amendment

Medicaid CHIP

Submission Type

Official Submission Package

Draft Submission Package

Allow this official package to be viewable by other states?
Yes
No

Key Contacts

Name: Gallagher, Regina
Title: NYS Medicaid State Plan Coordinator
Phone Number: (518) 473-3958
Email Address: regina.gallagher@health.ny.gov

SPA ID and Effective Date

https://macpro.cms.gov/suite/tempo/records/type/EZhOsA/item/isB9Co0jzmkfJLyQCg3q05... 1/3/2017

TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
New York 2

Attachment 3.1-H

NY - Submission Package - NY2016MH0002O - (NY-16-0034)  Page 2 of 3

SPA ID: NY-16-0034

<table>
<thead>
<tr>
<th>Reviewable Unit</th>
<th>Proposed Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Homes Intro</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Health Homes Population and Enrollment Criteria</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Health Homes Geographic Limitations</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Health Homes Services</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Health Homes Providers</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Health Homes Service Delivery Systems</td>
<td>10/1/2016</td>
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<tr>
<td>Health Homes Payment Methodologies</td>
<td>9/1/2016</td>
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<tr>
<td>Health Homes Monitoring, Quality Measurement and Evaluation</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>

Executive Summary

Summary

Description
Including Goals and Objectives

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

Disaster-Related Submission

This submission is related to a disaster
- Yes
- No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>First 2016</td>
<td>$2,508,900.00</td>
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<tr>
<td>Second 2017</td>
<td>$5,905,500.00</td>
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Federal Statute / Regulation Citation
§1902(a) of the Social Security Act and 42 CFR 447

Governor's Office Review

- No comment
- Comments received

https://macpro.cms.gov/suite/tempo/records/type/EZhOsA/item/isB9Co0jznkfJLyQCg3q05...  1/3/2017

TN# 16-0034  Approval Date: 12/22/16
Supersedes TN # 15-0020  Effective Date: 09/01/16
New York

NY - Submission Package - NY2016MH0002O - (NY-16-0034)

Submission - Medicaid State Plan

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10404 OMB 0938-1188

Package Header

Package ID: NY2016MH0002O
Submission Type: Official - Review 1
Approval Date: 12/22/2016
Superseded SPA ID: N/A

SPA ID: NY-16-0034
Initial Submission Date: 9/29/2016
Effective Date: N/A

Submission - Medicaid State Plan

The submission includes the following:

- Benefits:
  - Health Homes Program

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program
- Copy from existing Health Homes program
- Create new program from blank form

Name of Health Home Program: NYS Health Home Program

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response. Including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: OMB, Paperwork Clearance Officer, Main Desk C4-3600, Baltimore, Maryland 21244-1800.

https://macpro.cms.gov/suite/tempo/records/type/EZbOsA/item/isB9Co0jznkfJLyQCg3q05...

1/3/2017

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
Records / Submission Packages

NY - Submission Package - NY2016MH0002O - (NY-16-0034)

-- All Reviewable Units

Submission - Public Comment
/EDICAID - Health Homes - NYS Health Home Program - NY - 2016

CWS-10434 02/16/110b

<table>
<thead>
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<th>Not Started</th>
<th>In Progress</th>
<th>Complete</th>
</tr>
</thead>
</table>

Package Header

Submission Type  Official - Review 1
Approval Date  12/22/2016
Superseded SPA ID  N/A

SPA ID  NY-16-0034
Initial Submission Date  9/29/2016
Effective Date  N/A

Name of Health Homes Program
NYS Health Home Program

Indicate whether public comment was solicited with respect to this submission.
☐ Public notice was not required and comment was not solicited
☐ Public notice was not required, but comment was solicited
☒ Public notice was required and comment was solicited

Indicate how the public notice was issued and public comment was solicited
☐ Newspaper Announcement
☑ Publication in state’s administrative record, in accordance with the administrative procedures requirements
☐ Email to Electronic Mailing list or Similar Mechanism
☐ Website Notice
☐ Public Hearing or Meeting
☐ Other method

Upload copies of public notices and other documents used

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Upload with this application a written summary of public comments received (optional)

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TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
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Indicate the key issues raised during the public comment period (optional)
- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits
- Service delivery
- Other issue

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1980, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1162. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1560.
Submission - Tribal Input

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CN#: 10434 CMS 0030-1188

--- All Reviewable Units

Not Started In Progress Complete

Package Header

Package ID NY2016MH0002O
Submission Type Official - Review 1
Approval Date 12/22/2015
Superseded SPA ID N/A

SPA ID NY-16-0034
Initial Submission Date 9/29/2016
Effective Date N/A

View Implementation Guide

Name of Health Homes Program
NYS Health Home Program

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state
* Yes
□ No

This state plan is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations
* Yes
□ No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations

* Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA. The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA.

Complete the following information regarding any tribal consultation conducted with respect to this submission

Tribal consultation was conducted in the following manner
✓ Indian Health Programs

Name of Program
Health Clinic
Date of consultation 9/2/2016
Method/Location of consultation tribal consultation sent, no comment recvd

Urban Indian Organizations
States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation
✓ Indian Tribes

https://macpro.cms.gov/suite/tempo/records/type/EZbOsA/item/lsB9Co0jznkfJLlyQCg3q05...
1/3/2017

TN# 16-0034 Approval Date: 12/22/16
Supersedes TN # 15-0020 Effective Date: 09/01/16
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The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

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Indicate the key issues raised (optional):
- Access
- Quality
- Cost
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- Service delivery
- Other issue

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TN# 16-0034  
Supersedes TN # 15-0020  
Approval Date: 12/22/16  
Effective Date: 09/01/16
Attachment 3.1-H

NY - Submission Package - NY2016MH0002O - (NY-16-0034)

-- All Reviewable Units

Submission - SAMHSA Consultation
MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OMB 0938-1186

Package Header

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SPA ID NY-16-0034

Initial Submission Date 9/29/2016
Effective Date N/A

Name of Health Homes Program NYS Health Home Program

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation 11/20/2014

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1186. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate and suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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1/3/2017

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
NY - Submission Package - NY2016MH0002O - (NY-16-0034)

--- All Reviewable Units

Health Homes Intro
MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 OM9 0938-1188

Package Header

Package ID NY2016MH0002O
Submission Type Official - Review 1
Approval Date 12/22/2016
Superseded SPA ID N/A

SPA ID NY-10-0034
Initial Submission Date 9/26/2016
Effective Date 10/1/2016

Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Program
NYS Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used.

Summary description including goals and objectives:

New state plan amendment:
Supersedes transmittal # 15-0020
Transmittal # 16-0034

This State Plan Amendment is in Attachment 3.1-H of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B of the State Plan.

Part I: Summary of new State Plan Amendment (SPA) #16-0034
The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services. The following changes are proposed:

Effective September 1, 2016 through November 30, 2016 the State will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home Legacy rates. Health Home per member rates, for Health Home providers including TCM providers, that are based on three tiers “High, Medium, Low”, acuity, functional status, and region and a uniform case finding fee, which were currently scheduled to take effect on September 1, 2016, will now become effective on December 1, 2016. Health Home per member rates to implement court orders for Assisted Outpatient population (Health Home Plus) and the Adult Home population will remain in effect and unchanged.

Amendment change located in MACPRO Unit 7 p. 2 of 3
Key: [ ] represents deleted text and underlined represents new text.

On [September 1, 2016] December 1, 2016, the case finding fee will be set at $135.
Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until [August 31, 2016] November 30, 2016.

Part II: Summary of Changes Concerning MMDL to MACPro Conversion

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TN# 16-0034 Approval Date: 12/22/16
Supersedes TN # 15-0020 Effective Date: 09/01/16
In migrating information from New York State Health Home approved SPA #15-0020 housed in CMS' MMDL application to the newly released MACPro
application, the following transactions/edits were executed with the assistance and agreement of CMS. Highlights of this conversion and subsequent decisions
have been summarized in the following categories:
- Omitted language from previously approved SPA #15-0020;
- Suggested changes by CMS and NYS response;
- Acceptance of all assurances - new CMS requirement in MACPro that all assurances must be accepted in order to validate and complete submission;
- Completion of Monitoring, Quality Measurement and Evaluation; and
- Other: Required documentation, flowcharts, etc.

General Assurances

✓ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
✓ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
✓ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
✓ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After
   the first eight quarters, expenditures will be claimed at the regular matching rate.
✓ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
✓ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid
OCS control number. This valid OCS control number for this information collection is 0935-1188. The time required to complete this information collection is estimated to
average 40 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information
collection. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn:
PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Health Homes Population and Enrollment Criteria

The state will make Health Homes services available to the following categories of Medicaid participants:
- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups

Population Criteria:
- Two or more chronic conditions

Mandatory Medically Needy:
- Medically Needy Pregnant Women
- Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population):
- Families and Adults
- Medically Needy Children Age 16 through 20
- Medically Needy Parents and Other Caretaker Relatives
- Aged, Blind and Disabled
- Medically Needy Aged, Blind or Disabled
- Medically Needy Blind or Disabled Individuals Eligible in 1973

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TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
New York
Attachment 3.1-H

NY - Submission Package - NY2016MH00020O - (NY-16-0034)
Page 2 of 5

- Heart Disease
- BMI over 25
- Other (specify)

Name | Description
-----|-------------------
BMI over 25 | BMI is defined as at or above 25 for adults, and BMI at or above the 85 percentile for children.

- One chronic condition and the risk of developing another

Specify the conditions included
- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name | Description
-----|-------------------
HIV/AIDS | see description below
One Serious Mental illness | see description below
SED/Complex Trauma | see description below

Specify the criteria for at risk of developing another chronic condition
HIV, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and complex trauma are each single qualifying conditions for which NYS was approved. Providers do not need to document a risk of developing another condition in these cases.

New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. While many Medicaid enrollees are relatively healthy and access practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental illness. These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.

The NYS Medicaid program plans to certify health homes that build on current provider partnerships. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty and behavioral health care that support the integration and coordination of all care. Recently passed New York State Law provides the Commissioners of Health, Mental Health, Alcoholism and Substance Abuse Services, and People with Developmental Disabilities the authority to integrate care delivery by synching health care, substance abuse services, and mental health certification requirements for health homes. Approved health homes will directly provide, or contract for, health home services to the identified eligible beneficiaries. To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollee access to needed services.

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

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TN# 16-0034  Approval Date: 12/22/16
Supersedes TN # 15-0020  Effective Date: 09/01/16
To the extent possible health care providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e., hospitals, TCs). Health care providers will be encouraged to utilize HIT as feasible to create, document, execute, and update a plan of care that is accessible to the interdisciplinary team of providers for each patient. Health care providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community-based services, and provider referrals.

NY will target populations for health homes services in the major categories and the associated 3M Clinical Risk Group categories of chronic behavioral and medical conditions listed below:

Major Category: Alcohol and Substance Abuse
3M Clinical Risk Group (3M CRGs) Category
1. Alcohol Use Disorder
2. Chronic Alcohol Abuse
3. Cocaine Abuse
4. Drug Abuse - Cannabis/NOS/NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

Major Category: Mental Health
3M Clinical Risk Group (3M CRGs) Category
1. Bipolar Disorder
2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
3. Dementing Disease
4. Depressive and Other Psychoses
5. Eating Disorder
6. Major Personality Disorders
7. Psychiatric Disease (Except Schizophrenia)
8. Schizophrenia

Major Category: Cardiovascular Disease
3M Clinical Risk Group (3M CRGs) Category
1. Advanced Coronary Artery Disease
2. Cerebrovascular Disease
3. Congestive Heart Failure
4. Hypertension
5. Peripheral Vascular Disease

Major Category: HIV/AIDS
3M Clinical Risk Group (3M CRGs) Category
1. HIV Disease

Major Category: Metabolic Disease
3M Clinical Risk Group (3M CRGs) Category
1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease
3M Clinical Risk Group (3M CRGs) Category
1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other
3M Clinical Risk Group (3M CRGs) Category
1. Other Chronic Disease - conditions listed above as well as other specific diagnoses of the population.

Description of population selection criteria

The target population to receive health homes services under this amendment includes categorically needy and medically needy beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria. NY will offer Health Homes Services to individuals with two or more chronic conditions, individuals with HIV/AIDS, individuals with one serious mental illness, individuals with SED, and individuals with complex trauma.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to those individuals over their health care conditions. Enrollees in the chronic medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

Complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or
chronic diseases in adolescence and adulthood. Children who have experienced complex trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable. Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse, are often traumatic events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child's relationship with a caregiver, the child's ability to form secure attachment bonds, sense of safety and stability are disrupted. Without timely and effective intervention during childhood, a growing body of research shows that a child's experience of these events (simultaneous or sequential maltreatment) can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. Enrolling children who are experiencing complex trauma in Health Homes will work to prevent, while an individual is still in childhood, the development of other more complex chronic conditions in adulthood.

Enroles in the complex trauma category will be identified for referral to Health Homes by various entities, including child welfare systems (i.e., foster care and local departments of social services), health and behavioral health care providers, and other systems (e.g., education) that impact children.

Enroles in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enroles often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enroles have social issues, such as lack of permanent housing, that take priority to these individuals over their health care conditions. Enroles in the chronic medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

Specify the criteria for a serious and persistent mental health condition

The guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses. 1. Definition of Complex Trauma a. The term complex trauma incorporates at least:
   i. Infants/children/adolescents: exposure to multiple traumatic events, often of an invasive, interpersonal nature, and ii. the wide ranging long-term impact of this exposure. b. Nature of the traumatic event: i. often severe and pervasive, such as abuse or profound neglect. ii. usually begins early in life. iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.). iv. often occur in the context of the child's relationship with a caregiver. v. can interfere with the child's ability to form a secure attachment bond which is considered a prerequisite for healthy social-emotional functioning. c. Many aspects of a child's healthy physical and mental development rely on the secure attachment, a primary source of safety and stability. d. Wide-ranging, long-term adverse effects can include impairments in i. physiological responses and related neurodevelopment ii. emotional responses iii. cognitive processes including the ability to think, learn, and concentrate iv. impulse control and other self-regulating behavior v. self-image, and vi. relationships with others. Effective October 1, 2016 complex trauma and SED will each be a single qualifying condition.

Enrollment of Participants

Participation in a Health Home is voluntary. Indicate the method the state will use to enroll eligible adult Medicaid individuals into a Health Home.

- Opt-In to Health Home provider
- Referral and assignment to Health Home provider with opt-out
- Other (describe)

Describe the process used

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home. Individuals will be notified by U.S. mail of their health home enrollment. The notification letter will identify the assigned health home, describe the individual's option to select another health home or opt out of receiving health home services with a designated time period, and briefly describe health home services. The State will provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

Individuals that are under 21 years of age, including those for which consent to enroll in a health home will be provided by a parent or guardian, will be referred to health homes by health homes, care managers, managed care plans and other providers and entities, including local departments of social...
services, and local government units. Referrals will be processed for assignment, and such assignments will take into account existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Such individuals/parents/guardians will be given the option to choose another health home when available, or opt out of enrollment of a health home.

✓ The state provides assurance that it will clearly communicate the individual’s right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

Name: NY Health Home Brochure  
Date Created: 9/14/2016 10:08 AM EDT  
Type: 

FRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to OMB, 7000 Security Boulevard, Attn: FRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21224-1000.
Health Homes Geographic Limitations

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 CMS 0239-1186

Not Started In Progress Complete

Package Header

Package ID NY2016MH0002O SPA ID NY-10-0034
Submission Type Official - Review 1 Initial Submission Date 9/29/2016
Approval Date 12/22/2016 Effective Date 10/1/2016
Superseded SPA ID N/A

* Health Homes services will be available statewide
  - Health Homes services will be limited to the following geographic areas
  - Health Homes services will be provided in a geographic phased-in approach

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TN# 16-0034 Approval Date: 12/22/16
Supersedes TN # 15-0020 Effective Date: 09/01/16
Health Homes Services
MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition
A comprehensive individualized patient centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrolled physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify the primary care physician/nurse practitioner, specialists, and behavioral health care provider(s), care manager and other providers directly involved in the individual's care. The individual's plan of care must also identify community networks and supports that will be utilized to address their needs. Goals and timetables for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the patient’s care should be identified and included in the plan and execution of care as requested by the individual.

The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting goals.

Changes in the plan of care will be made based on changes in patient need.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum:

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home, as feasible. NY anticipates that a portion of health home providers may not utilize HIT in their current programs. These providers will be encouraged to utilize regional health information organizations (RHIOs) or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMA). Applicants must provide a plan in order to achieve the final HIT standards within eighteen months of program initiation in order to be approved as a health home provider.

Health home providers will be encouraged to utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types:

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TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
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NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Care Coordination

Definition
The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee’s needs. The individualized plan of care will identify all the services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate.

In order to fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee’s plan of care. The enrolled’s health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual’s care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee’s care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

The health home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers and community-based organizations.

The health home provider policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities.

The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Health home providers will utilize HIT as feasible to create, document and execute and update a plan of care for every patient who is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians

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Health Promotion

Definition
Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community “in reach” and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The health home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The health home provider will promote evidence-based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self-management of their chronic condition.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum.
Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home providers will utilize HIT as feasible to promote, link, manage and follow up on enrollee health promotion activities.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Attachment 3.1-H

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow-up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care.

The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The health home care manager will be an active participant in all phases of care transition including discharge planning and follow-up to assure that enrollees receive follow up care and services and re-engagement of patients who have become lost to care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e., hospitals, TCMs). The health home provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers and local supports.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)
- Provider Type
- Description

multidisciplinary teams

NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Individual and Family Support (which includes authorized representatives)

Definition

The patient’s individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual’s preferences), the individualized plan of care by presenting options for accessing the enrollee’s clinical information.

Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients and caregivers knowledge about the individual’s disease(s), promote the enrollee’s engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee’s family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time.

The health home provider will ensure that all communication and information shared with the enrollee, the enrollee’s family and caregivers is language, literacy and culturally appropriate so it can be understood.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e., hospitals, TCMs). The health home provider will utilize HIT as feasible to provide the patient access to care plans and options for accessing clinical information.

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TN# 16-0034
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Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☐ Other (specify)

Provider Type | Description
---|---
multidisciplinary teams | NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.

Referral to Community and Social Support Services

Definition
The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home providers will utilize HIT as feasible to initiate, manage and follow up on community-based and other social service referrals.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
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<td>NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.</td>
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Health Homes Patient Flow

Describe the patient flow through the state’s Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter.

See NY Health Home Patient flow chart below

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Health Homes Providers
MEDICAID - Health Homes - NY State Health Home Program - NY - 2016

Not Started | In Progress | Complete

Package Header

Package ID: NY2016MH0002O
Submission Type: Official - Review 1
Approval Date: 12/22/2016
Superseded SPA ID: N/A

SPA ID: NY-16-0034
Initial Submission Date: 9/29/2016
Effective Date: 10/1/2016

Types of Health Homes Providers

- Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Provider Type: Designated Providers as described in section 1945 (NYS)

Teams of Health Care Professionals

Health Teams

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TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services.

New York’s health home provider infrastructure will include designated providers working with multidisciplinary teams as described below. NYS Medicaid practitioners, case managers, QHCs, Targeted Case Management (TCM) providers, certified home health care agencies, and any other Medicaid enrolled providers, home health provider qualification standards were developed. The standards were reviewed with input from a variety of stakeholders including Health’s Offices of Health Management Systems, Health IT Transformation, and the AIDS Institute and the NYS Offices of Mental Health and Homecare.

NYC health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses, and other home providers led by a dedicated care manager who will assure the NHE will receive needed medical, behavioral, and social services in accordance with a single program to meet the needs of housing and substance abuse services. All members of the team will be responsible for ensuring that care is person-centered, culturally competent, and linguistically capable.

A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The care manager will be responsible for overall management of the enrollee’s care plan which will include both medical/behavioral health and social services needs.

In order to ensure the delivery of quality home health services, the State will provide educational opportunities for health home providers, such as webinars, training meetings, and meetings with practice specialists. The NYS Office of Mental Health and Substance Abuse Services will ensure that the enrollee’s care plan which will include both medical/behavioral health and social services needs.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
2. Coordinate access to high-quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate access to preventive and health promotion services, including substance use disorders.
4. Coordinate access to mental health and substance abuse services.
5. Coordinate access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to outpatient, including participation in discharge planning.
6. Coordinate access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate access to individual and family supports, including referral to community, social support, and recovery services.
8. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
9. Demonstrate a capacity to use health information technology to link services, facilitate communication among care providers, and provide feedback to practices, as feasible and appropriate, and coordinate access to individual and family supports, including referral to community, social support, and recovery services.
10. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

The Department of Health in partnership with the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will closely monitor health home providers to ensure that health home services are being provided that meet the NYS health home provider standards and CMS’ health home care functional requirements. Oversight activities will include, but not be limited to: medical chart and care management record reviews, site audits, team composition analysis, and review of types and number of contacts, etc.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services.
2. Coordinate access to high-quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate access to mental health and substance abuse services.
5. Coordinate access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to outpatient, including participation in discharge planning and facilitating transfer from a pediatric to an adult system of care.
6. Coordinate access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate access to individual and family supports, including referral to community, social support, and recovery services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members, and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, and coordinate access to individual and family supports, including referral to community, social support, and recovery services.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

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TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
Other Health Homes Provider Standards

The state's requirements and expectations for Health Home providers are as follows:
The state's minimum requirements and expectations for Health Home providers are as follows. Under New York State's approach to health home implementation, a health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/emergencies and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of health care services will be provided to all health enrollees by an interdisciplinary team of providers, where each individual enrollee is directed by a designated care manager who is accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.

4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5. Health home providers must demonstrate their ability to perform each of the eleven CMS health home core functional components. (Refer to section ii. Provider Infrastructure) including:

- Processes used to perform these functions;
- Processes and timeframes used to assure service delivery takes place in the described manner; and
- Description of validated health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

6. Health home providers must meet the following core health home requirements in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

* Please note whenever the individual patient /enrollee is stated when applicable, the term is interchangeable with guardian.

i. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

1c. The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health, health care status and the interventions that will produce the effect.

1g. The individual's plan of care must include outreach and engagement activities that will support engaging patients in care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

ii. Care Coordination and Health Promotion

2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations, and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate throughout the creation of an individual plan of care.

2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

2c. The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders or prescriptions).

2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.

2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

2f. The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g. The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology-empowering tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect PHI.

2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
2. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

3. The health home provider promotes evidence-based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual’s admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The health home provider has policies and procedures in place with local practitioners, facilities including emergency rooms, hospitals, and transfers in the site of care.

3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post-discharge that includes a minimum care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and reengage the patient in care if the appointment was missed.

IV. Patient and Family Support

4a. Patient’s individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

4b. Patient’s individualized plan of care is accessible to the individual and their families or other caregivers based on the patient’s preferences.

4c. The health home provider utilizes peer support, support groups and self-care programs to increase patients’ knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

IV. Patient and Family Support

4d. The health home provider discusses advance directives with enrollees and their families or caregivers.

4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

5a. The health home provider identifies available community-based resources and actively provides appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The health home provider has policies, procedures and accountability (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient’s needs and preferences and contribute to achieving the patient’s goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and access data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible, to comply with the initial standards cited in item 6a-6d for implementation of health homes. In order to be approved as health home provider applicants must provide a plan to achieve the final standards cited in items 6e-6i, within eighteen (18) months of program initiation.

Initial Standards

6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health home provider has a systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the patient’s plan of care.

6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health home provider makes use of available HIT and access data through the RHIO/QE to conduct these processes, as feasible.

Final Standards

6e. Final Standards

6f. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution and ongoing evaluation, execution, and ongoing evaluation of a plan of care for every patient.

6g. Health home provider uses an electronic health record system that satisfies the Meaningful Use provisions of the HITECH Act, which allows the patient’s health information and plan of care to be accessible to the interdisciplinary team of providers.

6h. Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance:

Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

6i. Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to sharing information and including all providers participating in a care plan.

6j. Health home provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIP-NY).

6k. Health home provider supports the use of evidence-based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYC4KES.

VII. Quality Measures Reporting to State

7a. The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by WSH and CMS.

7b. The health home provider is accountable for reducing avoidable health care costs significantly preventable hospital admissions/emissions and avoidable emergency room visits, providing timely post discharge follow up, and improving patient outcomes as measured by WSH and CMS required quality measures.

Name Date Created Type

No items available

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1/3/2017

TN# 16-0034 Approval Date: 12/22/16
Supersedes TN # 15-0020 Effective Date: 09/01/16
Attachment 3.1-H

New York
Attachment 3.1-H

NY - Submission Package - NY2016MH0002O - (NY-16-0034)

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1199. The time required to complete this information collection is estimated to average 45 hours per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimation or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop CA-20-03, Baltimore, Maryland 21244-6099.

https://macpro.cms.gov/suite/tempo/records/type/EZhOsA/item/isB9Co0jznkfJLYQCg3q05... 1/3/2017

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
Health Homes Service Delivery Systems
MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services
✓ Fee for Service

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

Managed Care Considerations

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

✓ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name: Unit 8 - Material on Quality Measures from previously approved 16-20 SPA
Date Created: 9/9/2016 3:43 PM EDT
Type: Unit 8 Material on Monitoring omitted from MMOL p.54
Date Created: 9/14/2016 9:40 AM EDT

https://macpro.cms.gov/suite/tempo/records/type/EZhOsA/item/isB9Co0jznkfJlyQG3q05... 1/3/2017

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
Health Homes Payment Methodologies

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CWS-10434 OMB 0938-1488

Package Header

Package ID: NY2016MH0002O
Submission Type: Official - Review 1
Approval Date: 12/22/2016
Superseded SPA ID: N/A

SPA ID: NY-16-0034
Initial Submission Date: 9/29/2016
Effective Date: 9/1/2016

Payment Methodology

The State’s Health Homes payment methodology will contain the following features:

- Fee for Service:
  - Individual Rates Per Service
  - Per Member, Per Month Rates
  - Fee for Service Rates based on:
    - Severity of each individual’s chronic conditions
    - Capabilities of the team of health care professionals, designated provider, or health team
    - Other
    - Describe below: see text box below regarding rates

- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement
- Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided
- PCCM (description included in Service Delivery section)

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Approval Date: 12/22/16
Effective Date: 09/01/16
NY - Submission Package - NY2016MH0002O - (NY-16-0034)

New York
Attachment 3.1-H

Agency Rates

Describe the rates used
- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set:
1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates.
2. Identify the reimbursable unit(s) of service.
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit.
4. Please describe the state's standards and process required for service documentation.
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
   - the frequency with which the state will review the rates.
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans, hospitals, medical, mental and chemical dependency treatment clinics, primary care practitioners, PCMHs, PCMHs. Targeted Case Management (TCM) providers, certified home health care agencies and any other Medicaid enrolled provider that meet health home provider standards.

Care Management Fee:

Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix from 3M Clinical Risk Groups (CRG) method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) assessment for children age 0 through 20. This fee will eventually be adjusted by (after the data is available) patient functional status. Until such time as the behavioral health benefit is moved to managed care the fee will include a fee for conducting the CANS-NY assessment. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient’s current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016 through September 30, 2018. Rates for Health Home services furnished to other populations are set October 1, 2016 and apply to services furnished on and after that date.

State Health Home rates may be found at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (60%) of the active care management PMPM through [August 31, 2016] November 30, 2016. On [September 1, 2016] December 1, 2016, the case finding fee will be set at $735. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This PMPM is intended to cover the cost of outreach and engagement.

Effective August 1, 2014, the per member per month care management fee will be adjusted by a temporary rate add-on to distribute the annual amounts authorized under the State's Medicaid Redesign Team (MRT) Waiver and as shown below

<table>
<thead>
<tr>
<th>Period</th>
<th>Fee (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 2014 to March 31, 2015</td>
<td>$80 million</td>
</tr>
<tr>
<td>April 1, 2015 to December 31, 2015</td>
<td>$667.7 million</td>
</tr>
<tr>
<td>January 1, 2016 to December 31, 2016</td>
<td>$439.9 million</td>
</tr>
</tbody>
</table>

(SEE TABLE LOCATED UNDER SECTION ON NON-DUPLICATION OF PAYMENT MOVED DUE TO SPACE CONSTRAINTS)

The temporary rate add on will be paid to State-designated Health Homes. Funds received through this rate add-on must be used to support costs related to one or more of the following authorized purposes: 1) Member engagement and promotion of Health Homes, 2) Workforce training and retaining, 3) Health information technology (HIT) and clinical connectivity, and 4) Joint governance technical assistance.

Each Health Home will be required to submit semi-annual reports documenting how the funds were used in accordance with the four authorized purposes. Semi-annual reports shall be submitted until such time as it is verified that all funds have been used in accordance with authorized purposes. Funds that are not disbursed in accordance with authorized purposes will be recouped by the Department within 90 days of such finding.

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TN# 16-0034 Approval Date: 12/22/16
Supersedes TN # 15-0020 Effective Date: 09/01/16
A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month, health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the case finding and active care management PMPM. Once a patient has been assigned a care manager and is enrolled in the health home program, the active care management PMPM may be billed.

Managed Care Considerations: Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services, in the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHIP Model Contract will be modified at the next scheduled amendment to include language similar to that outlined below which will address any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed Health Home services for members participating in the State’s Health Home program.
- The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access.
- Plans will need to have signed contracts including clearly established responsibilities with the provider based health homes.
- The managed care plan will be required to inform either the individual’s Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services.
- Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed.
- Plans will be appropriate, assist with the collection of required care management and patient experience of care data from State designated Health Home providers in its network.

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct.

Targeted Case Management (TCM) and Chronic Illness Demonstration Projects (CIDPs) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes and/or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015, all TCM programs for adults will be paid their existing TCM rates until August 31, 2016. Effective October 1, 2016 through September 30, 2018, TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

Health Home care management services may be provided to children that are eligible and enrolled in both the Early Intervention Program and Health Home, and will meet and fulfill the requirements of the ongoing service coordination required to be provided to children enrolled in the Early Intervention Program.

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. This existing TCM rate will be paid for both case finding and active care management. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. The, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This rate would be paid for both case finding and active care management.

New York State’s health home services are set as of January 1, 2012 and are effective for services on or after that date. All rates will be published on the DCH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services.

CIDP information has been moved to non-duplication of payment for similar services section.

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covers under a different statutory authority such as 1515(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

All rates are published on the DCH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

The State anticipates that most of the six CIDPs will convert to health homes. The CIDP providers are well positioned to become health homes and meet State and Federal health home standards. The CIDPs that convert to health homes will be paid at their existing CIDP rate for a period of one (1) year from the effective date of the SPA if they convert to health home for their existing patients. For new patients that may be assigned to a CIDP program that has converted to health home the State will pay the State set health home PMPM. At the beginning of the second year after the effective date of the SPA these converted programs will be paid for all patients under the State set health home PMPM. CIDPs that do not convert to health homes, if any, will end operations as CIDP's on March 29, 2012 when the contract with the State terminates.

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Attachment 3.1-H

TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
HEALTH HOME DEVELOPMENT RATE ADD ON SCHEDULE FROM PREVIOUS SECTION PLACED HERE DUE TO SPACE CONSTRAINTS:

Payments will be applicable to claims with dates of service on or after August 1, 2014 and will be paid beginning March 2015, and quarterly thereafter as shown below. The rate add-on for each period will be calculated by dividing the authorized payment amount by total number of claims for such period.

<table>
<thead>
<tr>
<th>Date of Payment</th>
<th>Payment Date</th>
<th>Rate Add-on</th>
<th>Amount of Payment Authorized Under the Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1/14 to 2/28/15</td>
<td>March 2015</td>
<td>$80 million</td>
<td>$80 million</td>
</tr>
<tr>
<td>3/1/15 to 5/31/15</td>
<td>June 2015</td>
<td>$22.2 million</td>
<td>$22.2 million</td>
</tr>
<tr>
<td>6/1/15 to 8/31/15</td>
<td>September 2015</td>
<td>$22.2 million</td>
<td>$22.2 million</td>
</tr>
<tr>
<td>9/1/15 to 11/30/15</td>
<td>December 2015</td>
<td>$22.3 million</td>
<td>$22.3 million</td>
</tr>
<tr>
<td>12/1/15 to 2/28/16</td>
<td>March 2016</td>
<td>$10.9 million</td>
<td>$10.9 million</td>
</tr>
<tr>
<td>3/1/16 to 5/31/16</td>
<td>June 2016</td>
<td>$10.9 million</td>
<td>$10.9 million</td>
</tr>
<tr>
<td>6/1/16 to 8/31/16</td>
<td>September 2016</td>
<td>$10.9 million</td>
<td>$10.9 million</td>
</tr>
<tr>
<td>9/1/16 to 11/30/16</td>
<td>December 2016</td>
<td>$11.2 million</td>
<td>$11.2 million</td>
</tr>
</tbody>
</table>

✓ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(40)(A), and 1902 with respect to non-payment for provider preventable conditions.

✓ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

✓ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

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Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - NYS Health Home Program - NY - 2016

CMS-10434 CMS-0928-1188

Not Started In Progress Complete

Package Header

Package ID NY2016MH0002O
Submission Type Official - Review 1
Approval Date 12/22/2016
Superseded SPA ID N/A
SPA ID NY-15-0034
Initial Submission Date 8/29/2016
Effective Date 10/1/2016

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report), include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at the cost-saving estimates.

NYS will monitor cost savings from health homes through measures of preventable events, including PPRs, potentially preventable hospital admissions and hospitalizations, and potentially avoidable ER visits. These metrics are the same metrics for evaluation in section IX. Measures of preventable hospitalizations and avoidable ER visits will be calculated for the entire Medicaid program. Similar to Section VII. A, NYS will use health home rosters to calculate potential cost savings for enrollees in health homes.

NYS will also compare total costs of care for enrollees in health homes, including all services costs, health home costs and managed care coordination to similar cohorts that are not receiving health home services.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home. In addition, providers must provide a plan in to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

The initial standards require health home providers to make use of available HIT for the following processes, as feasible:

1. Have a structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient;
2. Have a systematic process to follow-up on tests, treatments, services and, and referral which is incorporated into the patient's plan of care;
3. Have a health record system which allows the patient health information and plan of care to be accessible to the interdisciplinary team of providers and allow for population management and identification of gaps in care including preventive services, and
4. Is required to make use of available HIT and access members' data through the RHO or QI to conduct all processes, as feasible.

The final standards require health home provider to use HIT for the following:

1. Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient;
2. Utilize an electronic health record system that complies with the Meaningful Use provisions of the HITECH Act which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will have to provide a plan for when and how they will implement it. Health home providers will comply with all current and future versions of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange;
3. Join regional health information networks or qualified health IT entities for data exchange and make a commitment to share information with all providers.

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TN# 16-0034
Supersedes TN # 15-0020
Approval Date: 12/22/16
Effective Date: 09/01/16
participating in a care plan. Regional Health Information Organization (Qualifed Entities will be provided policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY), and:

4. Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. For example, in New York the Office of Mental Health has a web and evidence based practices system, known as Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which utilizes information to improve the quality of care, accountability, and cost-effectiveness of mental health prescribing practices in psychiatric centers.

NY health home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access patient care management records, as feasible.

To facilitate state reporting requirements to CMS, NY is working toward the development of a single portal to be used by health homes for submission of functional assessment and quality measure reporting to the State. Consideration is being given to also include a case management record, also accessed via the portal as an option for health home providers who currently do not have an electronic case management record system.

Significant investment has been made in New York’s Health Information Infrastructure to ensure that medical information is in the hands of clinicians and New Yorkers to guide medical decisions and supports the delivery of coordinated, preventive, patient-centered and high quality care. Ongoing statewide evaluation designed to evaluate the impact of HIT on quality and outcomes of care is underway by the Office of Health Information Technology and Transformation.

Quality Measurement and Evaluation

✓ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.

✓ The state provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

✓ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

✓ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

Go to HHOM Reports.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1190. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop 04-05-05, Baltimore, Maryland 21244-1820.

https://macpro.cms.gov/suite/tempo/records/type/EZhOsA/item/isB9Co0jzmkfJLyQCg3q05... 1/3/2017

TN# 16-0034
Supersedes TN # 15-0020

Approval Date: 12/22/16
Effective Date: 09/01/16
Community First Choice Option

On December 18, 2013, New York State convened a meeting of its appointed Development and Implementation Council, comprised of a majority of individuals who are aged and/or physically, mentally/behaviorally, or developmentally/intellectually disabled or their representatives, as required by federal statute. The Council reviewed and unanimously approved the below proposed State Plan Amendment to implement the Community First Choice Option in New York State.

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by Centers for Medicare and Medicaid Services (CMS) through interpretive issuance or final regulation.

i. Eligibility

Community First Choice Option (CFCO) services are available to (New York) State Plan eligible groups as described in Section 2.2-A of the State Plan. These individuals are eligible for medical assistance under the State plan and are in an eligibility group that includes nursing facility services, or, if an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether 150% of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act.

Individuals who are receiving medical assistance under the special Home and Community-Based (HCB) waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one HCB waivered service per month. Individuals receiving services through CFCO will not be precluded from receiving other HCB Long Term Care (LTC) services and supports through other Medicaid State Plan, waiver, grant or demonstration, as appropriate, but will not be allowed to receive duplicative services in CFCO or any other available community-based services.

During the five year period that begins January 1, 2014, spousal improvement rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community based services provided under 1915(k), as directed by the guidance in the CMS State Medicaid Directors’ letter#15-001, ACA #32, dated May 7, 2015.

For individuals eligible under section 1902(a)(10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving the minimum frequency services needed – at least monthly or require monthly monitoring when services are furnished on less than a monthly basis, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the

TN #13-0035 Approval Date October 23, 2015
Supersedes TN NEW Effective Date July 1, 2015
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

The cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The State will ensure that a determination is made initially, and at least annually, that individuals require the Level of Care (LOC) provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. LOC for individuals between ages 21 and 65 needing psychiatric services is determined using hospital, ICF or nursing facility LOC criteria. Various functional assessment tools in use across disability populations in New York State (NYS) will include a LOC outcome either as part of the assessment or separately and will also be used to inform a person-centered plan of care. Different tools are utilized in order to accurately assess an individual's specific needs based on the relevant institutional LOC being assessed (i.e. a skilled nursing facility, hospital, intermediate care facility, institute for mental disease, etc.).

A person-centered plan of care, also known as the Service Plan (SP) will be developed for CFCO-eligible individuals based on a comprehensive functional assessment that, in part, identifies the individual's needs and goals related to living independently in the community. The agent of state government (i.e. local district for social services, regional developmental disability office or service coordinator or their delegate, etc.) or managed care entity must review the individual's service needs at least annually, upon a significant change in the individual's condition or if requested by the individual. The date of review and signature is required on the SP. The update to the SP will occur no less than annually and as informed by the assessment. Also, annually a review is conducted to assure that the individual continues to meet the LOC criteria.

ii. Service Delivery Models

Service delivery model options under CFCO are described below. New York State will offer both an Agency Model and an Agency with Choice model. These are described in detail below.

X Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by personal care aides, personal attendants, home health aides, or direct service professionals (collectively referred to as direct care workers throughout the SPA pages) employed by a traditional agency or provider. CFCO participants will still exercise as much control over the selection, management and, if necessary, dismissal of their direct care worker as they desire. The Local Department of
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Social Services, a managed care entity, or a non-profit organization, which includes not-for-profit corporations formed under New York State Law or authorized to do business in New York, may contract with home care agencies or providers to deliver CFCO services.

**X  Agency with Choice Model** – this model is also based on the person-centered assessment of need and will be used when the individual seeking CFCO services wants to directly hire his or her own attendant. This attendant may be a relative other than a parent or a spouse, a neighbor, a friend or an independent attendant. In this delivery model, the individual will select, manage, train and, if necessary, dismiss his or her own attendant. A fiscal intermediary will be used to keep track of the attendant’s hours, pay the attendant and deduct required amounts for taxes and insurance from the attendant’s check. Fiscal intermediaries can be licensed home care services agencies, independent living centers, or other entities that pay attendants/direct care workers who are employed directly by the recipient of CFCO LTSS. CFCO participants must have a free choice of fiscal intermediaries.

There is no budget authority under either of these models.

Self-Directed Model with service budget – This Model is one in which the individual has both a SP and service budget based on the person-centered assessment of need.

- Direct Cash
- Vouchers
- Financial Management Services in accordance with 441.545(b)(1)
- Other Service Delivery Model as described below:

**iii. Service Package**

**A. The following are included CFCO services (including service limitations):**

Services may be provided in the individual’s home and in the community by direct care workers.

1. **Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.**

   The State will cover personal care services and supports related to core ADLs including: assistance with bathing/personal hygiene/grooming, dressing, eating, mobility (ambulation, transferring and positioning), and toileting.
In addition, personal care services and supports will be available related to core IADLs including:
managing finances; providing or assisting with transportation (in conjunction with approved service
noted in service plan); shopping for food, clothes and other essentials; meal preparation; using the
telephone and/or other communication devices; medication management; light housekeeping; and
laundry.

Health-related tasks are specific tasks related to the needs of an individual, which can be delegated
or assigned by licensed health-care professionals under State law to be performed by a direct care
worker. These tasks include, but are not limited to: performing simple measurements and tests;
assisting with the preparation of complex modified diets; assisting with a prescribed exercise
program; pouring, administering and recording the administration of medications; assisting with the
use of prescribed medical equipment, supplies and devices; assisting with special skin care;
assisting with a dressing change; and assisting with Ostomy Care.

CFCO participants will have continued access to other health-related services and long term
services and supports through the State plan, waivers or demonstrations, for which the
enhanced FMAP available under CFCO will not accrue.

Providers: 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.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to
accomplish ADLs, IADLs and health-related tasks.

The State will cover services and supports related to assistance with functional skills training
through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-
related tasks. Services will be specifically tied to the functional needs assessment and person-
centered SP and are a means to maximize independence and integration in the community,
preserve functioning and defer or eliminate the likelihood of future institutional placement.
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These services may include: assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, life safety, medication management, communication skills, mobility, community transportation skills, community integration, reduction/elimination of maladaptive behaviors including inappropriate social behaviors, problem solving skills, money management, and skills to maintain a household, as it relates to the provision of ADLs, IADLs, and health related tasks.

A direct care worker whose qualifications are approved by the Department of Health (DOH), the Office for People With Developmental Disabilities (OPWDD) or the Office of Mental Health (OMH) may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the person-centered SP;

- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFCO services;

- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;

- The activities provided are consistent with the stated preferences and outcomes in the person-centered SP;

- The activities provided are concurrent with the performance of ADLs, IADLs and health-related tasks as described in the earlier section;

- Training and skill maintenance activities that involve the management of behavior during the training of skills must use positive reinforcement techniques; and

- The provider is authorized to perform these services for CFCO recipients and has met any required training, certification and/or licensure requirements.

Providers: Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCRR Title 18 and the guidance of the Department of Health and/or the Office

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for People With Developmental Disabilities and the Office of Mental Health are qualified providers of functional skills training under CFCO.

3. **Back-up systems or mechanisms to ensure continuity of services and supports.**

The State will cover back-up systems and mechanisms to ensure the continuity of services and supports and the safety and well-being of the individual. These systems and mechanisms include:

- **Electronic back-up systems:**
  - Personal Emergency Response Systems (PERS) provide back-up for individuals who live alone or are alone for significant periods of time in their own homes.
  - Electronic devices to secure help in an emergency for safety in the community and other reminders that will help an individual with activities such as medication management, eating or other monitoring activities.
  - Examples of electronic devices include PERS, medication reminders, medical monitoring devices, and alert systems for meal preparation, ADL and IADL supports that increase an individual's independence.
  - Mobile electronic devices and other assistive technology will be reviewed on a case-by-case basis to determine the potential to replace human interventions as identified in the person-centered SP.

**Relief Care:** Service Coordinators (SC) will assist with identifying regularly-scheduled direct care workers as part of the Service Plan (SP). Identified back-up direct care workers or care setting alternatives (such as the home of a relative or other private home) are part of the plan of care.

**Providers:** 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 relief care services and supports under CFCO.
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4. Voluntary training on how to select, manage and dismiss attendants:

The State will make a training program to assist individuals in selecting, managing and dismissing personal care attendants available to CFCO participants. During the initial functional needs assessment, training programs will be identified and made available to individuals. In addition, on an annual basis, training programs will again be identified and made available to individuals. Training formats range from in-person to web-based and will be made specific to CFCO. All formats suggested will be deemed appropriate and accessible to individuals.

iv. Support System Activities

The following steps will be taken to support an individual in both a fee-for-service model and a managed care model. Fee-for-service: services provided by a local district or a regional office of OPWDD or its delegates. Managed Care (MC) or Managed Long Term Care (MLTC) plans conduct these activities on their own. The State ensures that these activities take place through its model contracts, MOUs, Administrative Agreements, and quality assurance efforts.

Support activities will include the following:

a) Functional needs assessment and counseling prior to enrollment in CFCO;

b) Information, counseling, training and assistance to ensure that an individual is able to manage the services;

c) Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services;

d) Conducting person-centered planning;

e) Range and scope of available choices and options;

f) Process for changing the person-centered SP;

g) Grievance process;

h) Risks and responsibilities of self-direction;

i) Free Choice of Providers;

j) Individual rights and appeal rights;

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k) Reassessment and review schedules;
l) Defining goals, needs and preferences;
m) Identifying and accessing services, supports and resources;
n) Development of risk management agreements;
o) Development of personalized backup plan;
p) Recognizing and reporting critical events, including abuse investigations; and
q) Information about advocates or advocacy systems and how to access advocates and advocacy systems.

Conflict of Interest Standards
The State will ensure that the individuals conducting the functional needs assessment and person-centered SP for CFCO participants are not:

a) A parent or spouse of the individual, or to any paid caregiver of the individual.
b) Financially responsible for the individual.
c) Empowered to make financial or health-related decisions on behalf of the individual.
d) Individuals who would benefit financially from the provision of assessed needs and services.
e) Providers of State Plan HCBS for the individual, or those who have an interest in or are employed by a provider of State Plan HCBS for the individual [unless the CFCO recipient chooses to receive State Plan HCBS services from the same agency as employs the Care Coordinator who develops the SP.] The State invokes the Conflict of Interest Exception when the only willing and qualified entity performing assessments of functional need and/or developing the person-centered service plan also provide home and community-based services.

Firewalls exist in both the FFS and MC/MLTC environments. First, standardized assessments determine the individual recipient's level of care and functional needs. In addition, all recipients of personal care are required to have a doctor's order establishing the need to address specific ADLs, IADLs and health-related tasks. These protections ensure that objective criteria inform the service plan for individuals participating in the Community First Choice Option.

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Additional firewalls help the State ensure that those conducting the functional needs assessment and person-centered SP for CFCO participants do so independent of those providing services. In many cases under the managed care model, this is assured through managed care entities contracting out for services. By sub-contracting out for the provision of CFCO services and supports, such as personal care, the managed care organization remains conflict-free by only conducting the functional needs assessment and developing the person-centered SP with the consumer. [Where this is not the practice, and the Service Coordinator or assessor works for the Plan, the State will assure that there is separation of the roles between the Coordinator and other duties at the provider agency accordingly:

- The Service Coordinator will not be employed as a CFCO direct care worker at the provider agency;
- The Service Coordinator will not have the authority to authorize CFCO services except on a temporary basis where presumed eligibility is permitted (not to exceed 29 days); and
- The Service Coordinator will not have a majority ownership stake in the provider agency.]

In the FFS environment, the Local Department of Social Services (LDSS) will assure that there is separation between the function as Coordinator or assessor and the other functions the same individual performs at the LDSS or agency/provider. Firewalls ensure that the individual conducting the functional needs assessment and/or developing the person-centered SP is independent of those who are providing the services. Accordingly, the Coordinator or assessor will not:

- provide services as a CFCO direct care worker for the CFCO consumer; nor
- have a majority ownership stake in the provider agency.

In all cases, service recipients are made aware of appeals processes and due process protections to assure their needs are met in the fairest manner possible.

[Providers: Service Coordinators have a masters of social work or psychology, are a registered professional nurse, or a licensed or certified teacher, rehabilitation counselor and/or therapist with a minimum of one year of experience providing service coordination and information, linkages and referrals to the elderly and/or disabled regarding community based services or an individual with a bachelor's degree and two years of related experience or someone with none of the educational requirements with three years of related experience. Individuals who do not meet the requirements may be supervised by those who meet both experience and educational requirements.

Care Managers typically have a background in nursing, social work and/or human services. Case Managers have similar backgrounds and the title is used interchangeably.

Risk Management Plans

An in-person risk assessment is conducted for all individuals during the person-centered care planning process. Based on the results of the risk assessment, a risk management plan is developed for each individual and is detailed in the SP.

Safeguards are supports needed to keep the participant safe from risk and harm and actions to be taken when the health or welfare of the participant is at risk.]
In the FFS environment, consumers are informed of their Medicaid Fair Hearing Rights with any Notice of Decision, including denial of their application, denial of requested provider, reduction in services, or termination from the waiver. An informal discussion (Administrative Meeting) is also offered to explain the reasoning behind a decision and negotiate an agreement prior to the Fair Hearing.

In the Managed Care environment, members are also informed of their Medicaid Fair Hearing Rights. In addition, Managed Care Organizations are contractually obligated to provide its members with a grievance system. The Grievance System regulations in Subpart F of 42 CFR Part 438 apply to both “expressions of dissatisfaction” by Enrollees (grievances) and to requests for a review of an “action” (as defined in 438.400) by a managed long term care plan (an appeal). For managed care plans, the Grievance System processes identified in Subpart F have been combined with the grievance requirements in New York State Public Health Law (PHL) 4408-a and the utilization review and appeal requirements in Article 49 of the PHL.

The State provides direct oversight of the Managed Care plans and the LDSSs to ensure that all conflicts are avoided and firewalls are in place. It is the responsibility of the Managed Care plans and the LDSSs to ensure that there are appropriate firewalls in place between the entity that is developing the plan of care and the entity providing the services.

In the fee-for-service and managed care environments, the state monitors service plan development through surveillance efforts that are aimed at identifying non-compliance with State mandates. These efforts include the ongoing review of a sample of person-centered service plans, on-site LDSS audits, and routine monitoring of the quality assurance and performance improvement program that both Managed Care plans and the LDSSs must develop, receive state approval, and successfully implement. Plans and LDSSs are expected to comply with all State mandates.

If the State identifies deficiencies in service plan development by the managed care organizations, the plans will be subject to actions that include but are not limited to, statements of deficiency and corrective action plans.

If the State identifies deficiencies in service plan development by the LDSSs, the local districts will receive notices of deficiency and will be subject to actions that include but are not limited to, statements of deficiency and corrective action plans.

In all occurrences of inadequacies and/or deficiencies in service plan development, the State will conduct a follow up training on person-centered service planning to ensure compliance going forward.

Providers: Service Coordinators have a masters of social work or psychology, are a registered professional nurse, or a licensed or certified teacher, rehabilitation counselor and/or therapist with a minimum of one year of experience providing service coordination and information, linkages and referrals to the elderly and/or disabled regarding community based services or an individual with a...

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bachelor's degree and two years of related experience or someone with none of the educational requirements with three years of related experience. Individuals who do not meet the requirements may be supervised by those who meet both experience and educational requirements.

Care Managers typically have a background in nursing, social work and/or human services. Case Managers have similar backgrounds and the title is used interchangeably.

**Risk Management Plans**

An in-person risk assessment is conducted for all individuals during the person-centered care planning process. Based on the results of the risk assessment, a risk management plan is developed for each individual and is detailed in the SP.

Safeguards are supports needed to keep the participant safe from risk and harm and actions to be taken when the health or welfare of the participant is at risk.

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Safeguards are significant issues discovered during the planning process that are individualized and specific to the participant. The SP includes a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, community inclusion activities, diet, behavioral concerns, financial transactions, natural disaster preparation, bathing safety and vulnerabilities at home and in the community. Providers monitor and document safeguards as services are provided and through routine checks by direct care workers and their supervisors in accordance with the schedule established by the local district or the (managed or managed long term care) plan. In addition, they must report incidents to state authorities.

Providers: The risk assessment is conducted by the nurse or social worker conducting the functional assessment and/or the individual developing the person-centered service plan.

v. The State elects to include the following CFCO permissible service(s):

✓ 1. Expenditures relating to a need identified in an individual's person-centered plan of services that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

   Environmental Modifications: Modifications are provided in accordance with 441.520(b)(2).

   Assistive Devices: Any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Examples of assistive technology include, but are not limited to: motion and sound sensors, two way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors.

   Congregate and/or home delivered meal services: up to two meals per day for individuals who cannot prepare or access nutritionally adequate meals for themselves and the cost of this service is less than it would be to have someone provide in-home meal preparation.

✓ 2. Expenditures for transition costs in accordance with 441.520(b)(1) such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with developmental/intellectual disabilities, or a provider controlled residence certified by OPWDD to a community-based non-certified home setting where the individual resides. These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/IID to a home or community-based setting where the individual resides.
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Providers: Environmental modifications and Vehicle modifications must be completed by individuals who are qualified and/or licensed to comply with State and local rules; all materials and products used must meet any State and local construction requirements and providers must adhere to any State and local safety standards pursuant to Article 18 of the New York State Uniform Fire Prevention and Build Code Act as well as local building codes.

Assistive Technology (AT) services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of AT must be:
1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers of AT services approved by OPWDD;
3. A licensed pharmacy; or
4. For Personal Emergency Response Systems (PERS), an approved provider of PERS which have existing contracts with the LDSS or managed care organization.

Providers of AT must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with FCC Regulations, if appropriate. The provider is responsible for training the CFCO participant, natural and paid supports who will be assisting the participant in using the equipment and/or supplies.

Congregate and Home Delivered Meal providers include Meals on Wheels and other meal delivery services contracted by local area agencies on aging or arranged by managed care organizations or local departments of social services. Any facility or agency used to provide this service must comply with 10 NYCRR Part 14 for Food Service Establishments.

Moving services are provided by moving companies appropriately licensed/certified by the New York State Department of Transportation.

vi. Service Limits

Service levels for community based services and allowable activities for in-home services are based on the individualized functional assessment of service needs and are to be provided without other limitation on their scope, duration or cost. See 18 NYCRR 505.14(a)(6)(i)(b).

1 Except where individuals require only services and supports to address environmental and nutritional supports (light housekeeping tasks; shopping and/or meal preparation). These services and supports will be limited to 8 hours per week. Any changes in an individual’s condition or service needs will result in a reassessment to determine the need for additional services.
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Transition services will be limited to necessary services for individuals transitioning from an institution into a community-based or in-home program. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. Costs will be limited to a one-time expense of up to $5,000 and service coordinators will fill out and maintain forms detailing the projected and final expenses and what items and/or services were purchased.

Transition services will be limited to: moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for apartments, heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home.

Contracts for environmental modifications may not exceed $15,000 without prior approval of DOH. Contracts for vehicle modifications are limited to the primary vehicle of the recipient and may not exceed $15,000 without prior approval of DOH.

Assistive Technology costs cannot exceed $15,000 per year. Items that cost up to $1,000 a year only require one bid; those over $1,000 a year require three bids. Coverage will be limited to assistive technology devices that are not available through the State Plan Durable Medical Equipment included in the eMedNY Manual at https://www.emedny.org/ProviderManuals/DME/index.aspx, and cannot duplicate a device purchased through a 1915(c) waiver.

In all cases, service limits are soft limits that may be exceeded due to medical necessity.

Individuals will work with their service planners and/or care managers to determine whether or not their needs can be met within the limits established under the Community First Choice Option as they are completing the person-centered service plan. If the individual’s needs cannot be met within these limits, the individual may appeal to the Department of Health for consideration of the additional costs.

Distinct service elements, procedure codes and claim modifiers will differentiate whether the services are State plan services or other Medicaid Services under 1915(c) or other authorities. This will control and mitigate duplication of services.

vii. Use of Direct Cash Payments

_ a) _ The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

✓ b) _ The State elects not to disburse cash prospectively to CFCO participants.
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viii. **Assurances**

A. The State assures that any individual meeting the eligibility criteria for CFCO will receive CFCO services.

B. The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid program.

C. The State assures the provision of eligible individual controlled HCB attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of HCB attendant services and supports that the individual requires in order to lead an independent life.

D. With respect to expenditures during the first full 12 months in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for HCB attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

E. The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that includes:
   
i. A quality improvement strategy;

   ii. Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.

F. The State assures the collection and reporting of information, including data regarding how the State provides HCB attendant services and supports and other HCBS, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under CFCO the choice to instead receive HCBS in lieu of institutional care.

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G. The State will provide the Secretary with the following information regarding the provision of HCB attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:
   i. The number of individuals who are estimated to receive HCB attendant services and supports under this option during the federal fiscal year.
   ii. The number of individuals that received such services and supports during the preceding federal fiscal year.
   iii. The specific number of individuals served by type of disability, age, gender, education level, and employment status.
   iv. The specific number of individuals previously served under any other home and community based services program under the State plan or under a CFCO.
   v. Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.
   vi. Other data as determined by the Secretary.

H. The State assures that HCB attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws consistent with 441.570(d)(1)-(5).

I. The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of eligible individuals who are individuals with disabilities, elderly individuals and their representatives. The membership and meeting dates are available at this link: http://www.health.ny.gov/facilities/long_term_care/#cfc.

J. The State assures that individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State Plan, waiver, grant or demonstration authorities.

K. The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification, a separate Community First Choice section which outlines the following:
   i. Any program changes based on the inclusion of Community First Choice services in the health plan benefits
   ii. Estimates of, or actual (base) costs to provide Community First Choice services (including detailed a description of the data used for the cost estimates)
   iii. Assumptions on the expected utilization of Community First Choice services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
   iv. Any risk adjustments made by plan that may be different than overall risk adjustments
   v. How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM.

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L. Transportation services will only be available to a location that is identified in the person-centered service plan pursuant to a functional need identified in the person’s assessment. Specifically, New York makes the following assurances:

i. The functional needs assessment and the person-centered service plan indicate the need for a medical escort, the need for transportation to medical appointments and traveling around and participating in the community;

ii. There is a checks and balances system in place to monitor services to ensure that duplicate billing doesn’t take place; and

iii. CFCO SPAs that allow personal care attendants to provide transportation to medical appointments should follow the guidelines that Non-Emergency Medical Transportation (NEMT) uses to ensure the integrity of the transportation services.

ix. Assessment and the SP

Assessment Process

Eligibility for New York State’s Medicaid-supported home and community based long term services and supports is determined by a number of federally-approved assessments. The State will not seek additional FMAP for this administrative function.

These assessment tools will assess individuals across dozens of critical domains such as: function, cognition, behavior, communication, informal supports, clinical, etc. While the UAS-NY determines LOC, not all functional needs assessments in use do, so it will be determined separately. All functional needs assessments will record the individual’s needs, strengths, preferences and goals for maximizing their independence and community integration through questions geared to elicit this information, which is essential to the person-centered planning process. They will be completed face-to-face with each individual by assessor(s) who are specifically trained in the use of the functional needs assessment. The service recipient will be able to request the participation of any one he or she wants involved in the functional needs assessment and service planning process.

Registered nurses or a Qualified Intellectual Disabilities Professional (QIDP) will conduct the functional needs assessment prior to the person centered planning process in a face-to-face meeting with the individual in his or her home or chosen community or service setting, in an institutional setting from which he or she wishes to transfer to the community, or as part of his or her discharge from clinical or acute care. Depending on whether the individual is enrolled in a Care Management for All environment (managed care, managed long term care, health home, ACO, waiver, etc.) or is receiving or seeking fee-for-service assistance, the nurse or QIDP will be employed by a provider agency, the State, county or local government or designee, or the managed care entity.

Individuals will be reassessed at least annually, or as needed when the individual’s support needs or
circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual. Individuals will be informed that if they would like to be reassessed due to such changes, they need to notify their coordinator of the change and request a reassessment.

**Development of the Person-Centered Service Plan (SP)**

The results of the assessments will inform the development of a SP. The State will also not seek additional FMAP for this administrative function. The individual selects the people he or she wants to participate in the service planning process. A trained service coordinator will meet with each individual to assist them in identifying strengths and needs as well as identifying measurable goals and desired outcomes utilizing the results of the standardized assessment tool(s) and the person centered planning process. The SP will identify specific services and service providers used to meet stated goals; as well as their frequency, amount, and duration. During this process, natural supports will be identified and contingency plans will be developed. Natural Supports are defined as resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Natural supports are determined to be available when an individual is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. Nothing in the natural support determination prevents DOH from paying qualified family members who are performing paid work. The State will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.

If natural supports that were available and willingly provided become unavailable for any reason, this would be an event that would trigger a call to the service coordinator for immediate attention. The individual may require back-up supports or relief care and/or reassessment to ensure his or her continued safety and well-being as well as the maximization of independence and community integration. The individual and his or her natural supports will be made aware of the process to follow in the case of a change in the supports’ availability during the person-centered planning process.

As noted in the previous section, a risk assessment plan will also be completed and considered a key component of the SP. Most importantly, the SP will be person-centered and understandable to the individual. Service Plans will be reviewed at least annually, and more often as indicated. The State will assure that the person-centered SP is completed in a manner that:

i. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

ii. Is timely and occurs at times and locations of convenience to the individual;

iii. Reflects cultural considerations of the individual;

iv. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

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**TN #13-0035**

**Supersedes TN NEW**

**Approval Date** October 23, 2015

**Effective Date** July 1, 2015
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v. Offers choices to the individual regarding the services and supports they receive and from whom;

vi. Includes a method for the individual to request updates to the plan; and

vii. Records the alternative home and community-based settings that were considered by the individual.

**Person-Centered SP Requirements:** The person-centered SP will reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The plan must:

1. Reflect that the setting in which the individual resides is chosen by the individual;
2. Reflect the individual’s strengths and preferences;
3. Reflect clinical and support needs as identified through an assessment of functional need;
4. Include individually identified goals and desired outcomes;
5. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. (Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.);
6. Reflect risk factors and measures in place to minimize them, including individualized backup plans;
7. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
8. Identify the individual and/or entity responsible for monitoring the plan; and
9. Be finalized and agreed to in writing by the individual and signed by all individuals and the staff person responsible for writing the person-centered service plan.
10. Be distributed to the individual and other people involved in the plan.
11. Incorporate the service plan requirements for the self-directed model with service budget at § 441.550, when applicable.
12. Prevent the provision of unnecessary or inappropriate care.
13. Other requirements as determined by the Secretary.

**TN #13-0035**

**Approval Date:** October 23, 2015

**Effective Date:** July 1, 2015
State Plan under Title XIX of the Social Security Act
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x. **HCBS Settings**

All CFCO services will be provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease, intermediate care facility for individuals with an intellectual disability or related condition, or setting with the characteristics of an institution. All services will be provided in settings that will comply with 42 CFR §441.530. The State has processes and procedures to ensure ongoing compliance with the setting requirements outlined in 42 CFR 441.530. Settings include the individual’s own home or a family member’s home that meets the settings criteria outlined in 42 CFR 441.530. Settings do not include provider-owned or controlled residential settings. The State will amend this SPA once it determines that other settings meet the settings criteria outlined in 42 CFR 441.530.

xi. **Qualifications of Providers of CFCO Services**

The State CFCO utilizes the agency-provider model for the provision of service delivery. As such, contracted entities must be approved by DOH, OPWDD or OMH. Approved agencies must meet and maintain standards for CFCO and all related state and federal regulations.

Personal Care Aides, also called personal care attendants, are certified by the State Education Department and must complete a minimum 40 hour training course with 6 hours of continuing education annually.

Home health aides are also certified by the State Education Department and must complete a minimum 75 hour training course with 12 hours of continuing education annually.

Aides in each of the above titles must meet the following minimum requirements in addition to the training requirements described above:

(i) maturity, emotional and mental stability, and experience in personal care or homemaking;

(ii) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;

(iii) sympathetic attitude toward providing services for individuals at home who have medical problems;

(iv) good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services;

(v) a criminal history record check to the extent required by 10 NYCRR Part 402; and

(vi) compliance with Part 403 of Title 10 NYCRR (Home Care Registry), as required in that Part.

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All of these aides provide personal care under the direction of a registered professional nurse or licensed practical nurse or therapist if the aide is to carry out simple procedures as an extension of physical, occupational, speech or language therapy. Supervising personnel visits are not eligible for the additional FMAP under CFCO.

Personal assistants are individuals that are directly hired by an individual in the agency with choice model. While they may be certified personal care or home health aides, they are not required to have these credentials. They must be adults that are not parent/guardians or spouses of the CFCO recipient. They are not required to undergo a criminal background check under state law unless they are certified aides.

Direct service professionals must be cleared through existing background check systems (ex. DOH, OPWDD and the Justice Center) where required by law and meet the additional qualifications listed below:

18 years or older and ability to:

- Follow both oral and written directions;
- Maintain simple records;
- Communicate effectively;
- Provide appropriate care;
- Safeguard personal information and maintain confidentiality; and
- Understand and follow emergency procedures.

Direct Service Professionals may work under the direction of supervising clinical personnel and these supervisory activities will not accrue the additional FMAP under CFCO.

Registered Nurses licensed by the State Education Department or Qualified Intellectual Disabilities Providers assessing individuals for services. The QIDP title is reserved for individuals with a bachelor’s degree in a human services field and one year experience working with people with developmental or intellectual disabilities.

Medicaid Service Coordinators (who are involved in the person-centered planning process and development and monitoring of an individual’s service plan) must complete training in the individual service plan, and in three of the following areas: home and community based waiver, introduction to person centered planning, self advocacy/self determination, quality assurance, and benefits and entitlements. They also must complete professional development hours annually.

New York State will also permit individuals to hire their own aide directly in addition to using agencies and/or the registry and in this case may waive the qualifications above to give the service recipient flexibility to hire a relative or someone in his or her personal network who can meet his or her needs without specific prior training.
xii. Quality Assurance and Improvement Plans

The State's quality assurance and improvement plan is described below. It includes a quality improvement strategy, standards for agency-based models, feedback mechanisms for ensuring and maximizing consumer independence and consumer control, and risk management agreements established to monitor the health and well-being of each individual receiving CFCO supports and services.

A. Quality Improvement Strategy:

The primary measure of success of the quality assurance and improvement plan is whether the individual has been able to achieve his/her desired outcomes. Is the individual getting what he/she needs to live life as independently as possible and fully integrate into the community? The philosophy of CFCO, its policies and procedures have been developed to assure the greatest opportunity for individuals to be successful in the pursuit of their desired outcomes.

CFCO will adopt a Quality Management Program (QMP) that assures participant access, participant-centered service planning, provider capacity and capabilities, and participant safeguards, rights and responsibilities. CFCO will have a QMP designed to review operations on an ongoing basis, discover issues with operations, remediate those issues, and develop quality improvement initiatives to prevent the repeat of operational problems.

Entities involved in every aspect of CFCO will have responsibilities in implementing this QMP from the state in a policy development and oversight role, to providers, managed care and managed long term care plans and local representatives of the state (such as fiscal intermediaries, regional resource centers, and contracted agencies) in training service coordinators and other care managers and monitoring both service plans and participant satisfaction, to participants themselves, who retain the authority to dismiss attendants who fail to meet the standard established by the participant for his or her care as described in the service plan.

B. Standards for service delivery models for:

i. Training. Local representatives of the state office/agency and contracted entities are responsible for person-centered planning and other critical care management activities. Among these activities are monitoring the progress of each participant to ensure that the services provided are appropriate and in accord with the person-centered service plan and that the service plan continues to meet the participants needs.

ii. Denials and Reconsiderations. The State has standardized processes for informing individuals/representatives of their rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/representatives of fair hearing outcomes. Data reflecting these issues will be maintained.

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The State communicates additions or revisions to processes to local, state or contracted case management entities through formal electronic transmittals and/or written guidance.

Individual service recipients and applicants, and their representatives, are provided timely written notices of any planned change in services or benefits, including denial, closure or reduction. For denials, the time frame varies between 30 and 90 days depending on the oversight agency/office in the State. For closure or reduction of benefits or services the time frame is 10 calendar days prior to the effective date of the proposed action. The notice includes the reason for the decision, administrative rules that support the decision and the individual's/representative's right to due process through a fair hearing process.

iii. Appeals. The local district or contracted entity notifies the individual about the Fair Hearing process during the initial assessment/service planning. As part of the notification of Fair Hearings procedure, the Service coordinator informs the individual that continuation of services must be requested by the individual within the specified timeframes. Results of the hearing are provided to the individual.

Service coordinators fully inform individuals of all available choices and service options. Documentation requirements and automated systems support QA efforts.

C. Feedback Mechanisms to ensure and maximize consumer independence and consumer control

The service planning process of CFCO participants will assure that individuals receive information, and assistance if necessary, to make a determination regarding the level of control they wish to exercise over their long term services and supports, either directly or through a chosen representative. Regular meetings with service coordinators will assure that the goals established in the service plan, including the level of control over these services and supports, are realized. Surveys and/or questions posed during assessment and reassessment will capture the degree to which each participant is satisfied with their independence and control, and measures chosen will reflect both quality of care and recipient satisfaction.

In 2012, DOH convened the Commissioner's Advisory Group on the Community First Choice Option, the majority of which was comprised of individuals with disabilities, elderly individuals and their representatives. In December of 2013, this group was designated the official Development and Implementation Council to consult and collaborate with the state in implementing CFCO. The state consults and collaborates with the Council periodically to inform and elicit feedback regarding the services and supports provided to individuals receiving CFCO services.

D. The methods used to continuously monitor the health and welfare of CFCO individuals.

Local entities, OPWDD or contracted entities will regularly monitor Service Plans to ensure the health and welfare of individuals receiving CFCO services. Through the use of risk management agreements, a monitoring plan will be developed with the individual to review services and supports. Individuals

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receiving CFCO services will be informed of their right to request a review of their SP to ensure that their health and safety needs are being met through their self-directed SP.

In accordance with the NYS Protection of People with Special Needs Act, all entities associated with CFCO are required to report alleged or actual neglect, abuse, or exploitation in connection with the provision of such services and supports. Additionally, abuse investigation service is provided through the NYS Justice Center as a means of monitoring the health and welfare of all vulnerable populations in NYS, including CFCO service recipients.

In addition, participants in CFCO will have access to the federally mandated Home Health Hotline (1-800-628-5972), which can be called 24 hours per day, seven days per week. Alternatively, complaints may be mailed to the Department of Health or faxed. All complaints are investigated by the Department's regional office with jurisdiction over the area from which the call originated. The most serious complaints require Department investigators to conduct interviews, review clinical/patient care records and other provider documentation, and perform other activities during the onsite visit to the agency.

Finally, through self-direction, CFCO participants have the ability to seek alternative aides to assist with their ADLs, IADLs and health-related tasks that may be performed under state law. The power to control your own attendant services to the extent desired may best maximize the individual’s ability to ensure that his or her needs are being met and goals advanced.

E. The methods for assuring that individuals are given a choice between institutional and community-based services

The State assures all individuals eligible for services under CFCO are informed of feasible alternatives for community-based services. Consistent with the Olmstead Report filed with Governor Andrew Cuomo in October of 2013, self-direction is a critical goal of assuring that individuals are served in the most integrated setting whenever possible and individuals who are determined to be able to self-direct their services directly or through a representative will be determined potential candidates for New York's CFC State Plan Option. When an individual is determined to require the LOC provided in an institution, the individual or his or her representative will be:

1. Informed of any feasible alternatives available under CFCO or other HCB Service, and
2. Given the choice of either institutional or HCB services. The choice of institutional or HCB services is documented on each eligible individual’s SP. The service coordinator is responsible for completion of the appropriate Freedom of Choice documentation.

F. The individual outcome measures associated with the receipt of community-based attendant services and supports that the State will monitor and evaluate.

The State has decided to choose measures that represent both quality of care and recipient satisfaction.
State Plan under Title XIX of the Social Security Act  
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1. Consumer Satisfaction Survey

On an annual basis, a statistically significant number representing individuals in all level of care who receive CFCO services and supports will be surveyed. The survey will be a comprehensive tool employed to gain valuable information related to consumer satisfaction and quality of care. In addition, the survey will also include an assessment of the individual’s opinion in progress towards goals identified by the individual in their person-centered service plan. The State has chosen to implement the Money Follows the Person (MFP) Quality of Life survey amended with several questions from the Participant Experience Survey (PES). The State may use the services of an independent contractor to perform these surveys with CFC participants to address staff needs and objectivity. Upon completion of each survey, percentages will be calculated and reviewed, and the results analyzed to determine if CFCO recipients are indeed satisfied with their home and community-based service and support needs. Are their support needs being met by the program? Are they able to satisfactorily self-direct their services? A report of survey findings will be disseminated to all CFCO participants, contracted service providers, county departments of social services, relevant state agencies and offices, and lastly, posted on the state’s CFCO website.

2. UAS-NY utilization

The State has elected to use the Uniform Assessment System of New York (UAS-NY), a tool customized for the state’s aged and physically disabled population based on the InterRAI Suite, to measure the individual outcomes associated with the receipt of community-based attendant services and supports. The UAS-NY provides the State with access to quality data reports that will allow us to monitor and track pertinent information such as the individual’s needs, strengths, preferences and goals for maximizing their independence and community integration. We will also be able to generate reports to determine if these personal goals are being met related to living an independent life integrated to the fullest extent in the community. Because the UAS-NY assessment tool is equipped to track data across years and report based on aggregate data by jurisdiction or program, as well as tracking individual participant outcomes and changes throughout time, we will be able to monitor and track long term changes in the clinical/functional status and needs of CFCO participants.
Alternative Benefit Plan

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Enrollment is mandatory or voluntary?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Group</td>
<td>Yes</td>
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</table>

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

Attached is the public notice for the Alternative Benefit Plan published on October 23, 2013.
http://docs.dos.ny.gov/info/register/2013/oct23/pdf/misc.pdf (see section 96)

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 440.305(d), the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for public health insurance coverage that will impact certain non-disabled, non-pregnant adults, ages 19 - 64 for whom New York already provides public health insurance coverage to comply with federal requirements under the Patient Protection and Affordable Care Act (ACA). The following Medicaid Benefit Changes under the ACA are proposed:

The ACA established a new Medicaid eligibility category that provides coverage to non-elderly, non-pregnant individuals with family income below 133 percent Federal Poverty Level (FPL) who are not entitled to or enrolled in Medicare Part A, not enrolled in Medicare Part B, and not eligible under any other Medicaid eligibility category. The ACA required that most individuals covered under the new eligibility group be enrolled in Medicaid Alternative Benefit Plans (ABP). Medicaid Alternative Benefit Plans must provide a minimum set of standard health benefits known as Essential Health Benefits (EHB).

The New York State Department of Health will provide the Medicaid State Plan as the Alternative Benefit Plan to the new Medicaid eligible population group. This will allow for continuity of coverage for individuals currently enrolled, provide for equity of coverage for new enrollees coming into the program and assure the

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New York  ABP1
Alternative Benefit Plan

health care needs of the population are met by a cost effective benefit plan that complies with the EHB requirement. State Medicaid expenditures will decrease for State Fiscal Year 2013-2014 as a result of adopting the Alternative Benefit Plan. The State will receive enhanced federal financial participation for the new adult group eligibility category provided the benefits conform to the ABP requirements of the ACA. Federal financial participation will be 100 percent for newly eligible individuals and 75 percent for current enrollees.

The public is invited to review and comment on this proposed State Plan Amendment. Additional information concerning the Alternative Benefit Plan can be obtained by writing to: Department of Health, Division of Eligibility and Marketplace Integration, One Commerce Plaza, Suite 1200, Albany, NY 12237, Attention: Dawn Oliver

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state’s approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state’s approved Medicaid state plan that is not subject to 1937 requirements.

The state first chose the Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program as the benchmark plan and compared it to the Essential Health Benefits and to the Medicaid State Plan. The Medicaid State Plan covers all the benefits in the benchmark plan except chiropractic services. The state is proposing to substitute personal care services from the Medicaid State Plan for this benchmark covered benefit. In addition to EHBs, the ABP includes the 1937 covered benefits in the Medicaid State Plan.
Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Benefit

### Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.

- The state/territory offers benefits based on the approved state plan.
- The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
- The state/territory offers the benefits provided in the approved state plan.
- Benefits include all those provided in the approved state plan plus additional benefits.
- Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
- The state/territory offers only a partial list of benefits provided in the approved state plan.
- The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Medicaid State Plan section 3.1 A Categorically Needy

### Selection of Base Benchmark Plan

TN: 13-0060
New York

Approval Date: 06/05/2014
Effective Date: 01/01/2015
The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- C Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- C Any of the largest three state employee health benefit plans by enrollment.
- C Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- C Largest insured commercial non-Medicaid HMO.

Plan name: Standard Blue Cross Blue Shield Federal Employee

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

- The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
- The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

Other Information Related to Cost Sharing Requirements (optional):

Existing state plan cost-sharing rules apply to the Adult Group the same as applied to all other Medicaid populations.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
The state/territory proposes a "Benchmark-Equivalent" benefit package. **No**

### Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

| Standard Blue Cross/Blue Shield Federal Employee Preferred Provider Option |

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

<table>
<thead>
<tr>
<th>Secretary-Approved</th>
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The Alternative Benefit Plan will include all mandatory and optional benefits defined in the New York Medicaid State Plan under the categorically needy population designation (3.1A).

Utilization thresholds and authorization requirements which apply to the fee-for-service delivery system do not apply to managed care service delivery.
### Alternative Benefit Plan

#### Essential Health Benefit 1: Ambulatory patient services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician services</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Amount Limit:** No limitation
- **Scope Limit:** Services include acupuncture services provided by a licensed physician. Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
  
  Medicaid state plan attachment 3.1A, 5(a) physician services whether furnished in the office, the patient's home, a hospital or elsewhere. Includes services physician directed mental health and substance use disorder services.

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<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
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</thead>
<tbody>
<tr>
<td>Outpatient hospital services</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Amount Limit:** No limitation
- **Scope Limit:** Includes ambulatory surgical centers, free standing clinic, health center and renal dialysis services. Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
  
  Medicaid state plan attachment 3.1A, 2(a)(d)

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<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical services provided by licensed practitioner</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Amount Limit:** No limitation
- **Scope Limit:** Services provided by licensed practitioners within the scope of their practice as defined by state law. Includes Cognitive Rehabilitative Therapy (CRT) provided by licensed providers.
Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A, 6(a,b,d) includes: nurse, podiatrist, psychologist, social worker, nutritionist, physician assistant, nurse practitioner and other licensed medical service providers.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

no limitation if medically necessary

Duration Limit:

benefit year

Scope Limit:

Includes specialty clinic services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A, (9)

Clinic services provided to Medicaid recipients enrolled in managed care plans are exempt from the NYS Utilization Threshold program. Individuals in the new adult group will be enrolled in managed care plans. This population will not be subject to the service limits defined in the UT Program.

Medicaid enrollees who access their covered benefits via the Fee-For-Service delivery system are subject to service limits for non-exempt clinic services as defined in the NYS Medicaid Utilization Threshold (UT) Program. The UT Program places limits on the number of non-exempt clinic services a Medicaid member may receive in a benefit year. These service limits are established based on each member’s clinical information. This information includes diagnoses, procedures, prescription drugs, age and gender. As a result, most Medicaid members have clinically appropriate service limit levels and will not need additional services authorized through the Threshold Override Application (TOA) process. Medicaid enrollees may receive services in excess of the UT Program limits upon the request of the licensed provider for additional services and the submission of documentation supporting the need for continued medical care above the threshold limit. Non-exempt clinic services may be provided to an enrollee who has exceeded the threshold without a request for additional services submitted by the licensed provider (outside the TOA process) in the following instances: immediate/urgent need, services rendered in retroactive period, emergency care, member has temporary Medicaid, request from county for second opinion to determine if member can work, or a request for UT override is pending. These exemptions along with the TOA process ensures that no one receives less than the benchmark benefit or the Medicaid state plan benefit, whichever is greater.

Clinic services, by specialty code that are subject to the UT Program threshold (non-exempt) in the FFS delivery system are: 321, 901, 902, 903, 905, 909, 914 THRU 917, 919 THRU 921, 923 THRU 933, 935, 950 THRU 958, 965, 966, 999. For code definitions see: DATA DICTIONARY, NEW YORK STATE DEPARTMENT OF HEALTH Office of Health Insurance Programs, Provider Network Data System (PNSD), Version 6.7 revised (January 2014)

Clinic services exempt from the UT Program: pediatric general medicine and specialties, child teen health program (CTHP), school supportive health services program, dialysis, oncology, OPWDD clinic treatment and specialty programs, TB/Directly Observed Therapy, Prenatal Care.
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice Services</strong></td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization:</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>Services are palliative in nature, include supportive medical, social, emotional and spiritual services to terminally ill persons as well as emotional support for family members. Services may be delivered at home, nursing home or hospice residence.</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td>Medicaid state plan attachment 3.1A, (18)</td>
</tr>
<tr>
<td>Hospice services are provided to an individual who has been certified (diagnosed) by a physician as being terminally ill, with a life expectancy of approximately twelve months or less. Services include curative treatment for children under age 21. Medicaid Managed Care Enrollees receive coverage for hospice services through the Medicaid fee-for-service program.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal care services - provided in the home</strong></td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>In-home and community services prescribed in accordance with a plan of treatment, provided by a qualified person under supervision of a registered nurse. Attendant services and supports to assist in accomplishing (ADLs) and health related tasks.</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td>Medicaid state plan attachment 3.1A, (26)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other laboratory and x-ray services</strong></td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
</tbody>
</table>

**Scope Limit:**
Includes diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology services and magnetic resonance imaging (MRI) performed upon the order of a physician or qualified licensed provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the benchmark plan:

- Medicaid state plan attachment 3.1A (3)
- **18 NYCRR 505.17(c)**
- Certain radiology services require prior authorization.

### Benefit Provided:

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitation</td>
<td>No limitation</td>
</tr>
</tbody>
</table>

**Scope Limit:**
Services, drugs and supplies related to abortion when the life of the mother would be endangered if the fetus were carried to term or when pregnancy is a result of an act of rape or incest.

Other information regarding this benefit, including the specific name of the source plan if it is not the benchmark plan:

- Medicaid State Plan 3.1A (20) Covered services for pregnant women
## Essential Health Benefit 2: Emergency services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other medical services - emergency hospital</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- None

**Amount Limit:**
- No limitation

**Provider Qualifications:**
- Medicaid State Plan

**Scope Limit:**
- Procedures, treatments or services needed to evaluate or stabilize an emergency medical condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**
- Medicaid state plan attachment 3.1A 24(e)

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<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other medical services - emergency transportation</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- None

**Amount Limit:**
- No limitation

**Duration Limit:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Scope Limit:**
- Emergency ambulance transportation (inl. air ambulance) for the purpose of obtaining hospital services for a person suffering from a severe, life-threatening or potentially disabling condition which requires emergency services during transport.

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**
- Medicaid state plan attachment 3.1A 24(a)
### Essential Health Benefit 3: Hospitalization

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- No limitation

**Duration Limit:**
- None

**Scope Limit:**
- None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (1) inpatient hospital services other than inpatient services provided in institutions for mental disease.

### Organ transplant services - inpatient hospital

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ transplant services - inpatient hospital</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- Concurrent Authorization

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- No limitation

**Duration Limit:**
- None

**Scope Limit:**
- Organ transplant services include transplant of the pancreas, kidneys, heart, lung, small intestine, liver, blood or marrow cell, cornea, single or double lobar lung.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan 3.1E
Organ transplant must be performed in a hospital approved by the Commissioner of Health and the hospital must be a member of the Organ Procurement and Transplantation Network approved by HHS. Solid organ and cell transplant service covered in the New York Medicaid State Plan include the solid organ and cells covered in the BC/BS Federal Employee Standard Benefit Plan.

### Hospice Care - Inpatient

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care - Inpatient</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- Prior Authorization

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- No limitation

**Duration Limit:**
- No limitation
**Scope Limit:**

Services delivered in an inpatient setting that are palliative in nature, include supportive medical, social, emotional and spiritual services to terminally ill persons as well as emotional support for family members.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

<p>| Medicaid state plan attachment 3.1A, (18) |
| Hospice services are provided to an individual who has been certified (diagnosed) by a physician as being terminally ill, with a life expectancy of approximately twelve months or less. Services include curative treatment for children under age 21. |
| Medicaid Managed Care Enrollees receive coverage for hospice services through the Medicaid fee-for-service program. |</p>
<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician services - Obstetrical and Maternal</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td>Medicaid state plan attachment 3.1A 5(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital - Obstetrical and Maternal</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td>Medicaid state plan attachment 3.1A (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse-midwife services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
</tr>
<tr>
<td>No limitations</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
</tr>
<tr>
<td>Includes the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to healthy women. Includes newborn evaluation, resuscitation and</td>
<td></td>
</tr>
</tbody>
</table>
referral for infants.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (17)
Care may be provided on an inpatient or outpatient basis including in a birthing center or in the patient's home.
### Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services - MH and SUD</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Provider Qualifications:** Medicaid State Plan
- **Amount Limit:** No limitations
- **Duration Limit:** None
- **Scope Limit:** Medically supervised inpatient services to treat persons with mental illness and/or substance use disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (1)
Services provided to persons other than those residing in New York State certified psychiatric centers and institutions for mental diseases.

---

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care provided by licensed providers</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Provider Qualifications:** Medicaid State Plan
- **Amount Limit:** No limitations
- **Duration Limit:** None
- **Scope Limit:** Includes the medically necessary services of licensed; clinical psychologists, social workers, pharmacists, nurse practitioners and other providers of medically necessary services. Includes Cognitive Rehabilitative Therapy by licensed providers.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan 3.1A 6(d)
Services provided to persons other than those residing in New York State certified psychiatric centers and institutions for mental diseases.

---

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

- **Authorization:** None
- **Provider Qualifications:** Medicaid State Plan

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**TN:** 17-0068  
**NEW YORK**  
**Approval Date:** 03/16/2018  
**Effective Date:** 12/01/2017
Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitations</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Scope Limit:
Includes MH Continuing Day Treatment Programs, MH Continuing Treatment Programs, Substance Use Disorder Treatment Programs, Methadone Maintenance Treatment Programs, Developmental Disability Clinic Treatment and other specialty treatment programs.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (9) Clinic services listed above are claimed under the clinic category in the NY Medicaid State plan. Clinic services for developmental disability specialty, MMTP, alcohol/SUD treatment, mental health, are exempt from the NYS Utilization Threshold program. Physician services in the managed care delivery system are exempt from the UT program. Clinic services are provided to persons other than those residing in New York State certified psychiatric centers and institutions for mental diseases.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services - MH and SUD</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
</tbody>
</table>

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A, 5(a) physician services whether furnished in the office, the patient's home, a hospital or elsewhere for treatment of mental health and substance use disorders. Services provided to persons other than those residing in New York State certified psychiatric centers and institutions for mental diseases.
### Essential Health Benefit 6: Prescription drugs

**Benefit Provided:**
Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

**Prescription Drug Limits (Check all that apply):**
- [ ] Limit on days supply
- [ ] Limit on number of prescriptions
- [x] Limit on brand drugs
- [ ] Other coverage limits
- [ ] Preferred drug list

Authorization: [ ] Yes
Provider Qualifications: [ ] State licensed

Coverage that exceeds the minimum requirements or other:
Medicaid state plan 3.1A (12)
The State of New York's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.
### Essential Health Benefit 7: Rehabilitative and habilitative services and devices

**Benefit Provided:**
- Physical therapy - rehabilitative/habilitative

**Source:**
- Secretary-Approved Other

**Authorization:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- > of 20 PT visits; or 75 shared O/P therapy visits

**Duration Limit:**
- per benefit year

**Scope Limit:**
- Services provided by a physical therapist for the maximum reduction of physical disability and restoration to the patient's best functional level. Habilitative services are provided to the patient to acquire a skill and avert the loss of functions.

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**

**Medicaid state plan attachment 3.1A (11) (a) limitations and BC/BS Standard Optional limitations apply:**

- Any enrollee who reaches 75 outpatient visits across combined therapies without reaching 20 physical therapy visits in a benefit year may access additional physical therapy services up to 20 visits. Physical therapy provided in an inpatient setting (hospital, rehab facility or nursing home) or in the home care setting does not count toward the 20 physical therapy visits per year limitation.

- Any enrollee who reaches 20 physical therapy visits in a benefit year without reaching the outpatient visit maximum of 75 visits per year across all therapies may access additional physical therapy services up to the 75 PT/OT/ST outpatient visit maximum. Therapy services provided in the home care setting are counted as outpatient visits across combined PT/OT/ST services for purposes of applying the 75 visit per year limitation.

- The limit ensures that no one receives less than the benchmark benefit or the Medicaid state plan benefit, whichever is greater.

- There is no outpatient visit limit for physical therapy for persons with a developmental disability or persons with a traumatic brain injury.

- Includes Cognitive Rehabilitative Therapy services.

- Habilitative services are not provided as part of the home care benefit.

---

**Benefit Provided:**
- Occupational therapy - rehabilitative/habilitative

**Source:**
- Secretary-Approved Other

**Authorization:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- > of 20 OT visits; or 75 shared O/P therapy visits

**Duration Limit:**
- per benefit year

**Scope Limit:**
- Services provided by an occupational therapist for the maximum reduction of physical disability and
Alternative Benefit Plan

Restoration to the patient's best functional level. Habilitative services are provided to acquire a skill and avert the loss of functions.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (11) (b) limitations and BC/BS Standard Optional limitations apply:

Any enrollee who reaches 75 outpatient visits across combined therapies without reaching 20 occupational therapy visits in a benefit year may access additional occupational therapy services up to 20 visits. Occupational therapy provided in an inpatient setting (hospital, rehab facility or nursing home) or in the home care setting does not count toward the 20 physical therapy visits per year limitation.

Any enrollee who reaches 20 occupational therapy visits in a benefit year without reaching the outpatient visit maximum of 75 visits per year across all therapies may access additional occupational therapy services up to the 75 PT/OT/ST outpatient visit maximum. Therapy services provided in the home care setting are counted as outpatient visits across combined PT/OT/ST services for purposes of applying the 75 visit per year limitation.

The limit ensures that no one receives less than the benchmark benefit or the Medicaid state plan benefit, whichever is greater.

There is no outpatient visit limit for occupational therapy for persons with a developmental disability or persons with a traumatic brain injury.

Includes Cognitive Rehabilitative Therapy services.

Habilitative services are not provided as part of the home care benefit.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and Language Services - rehab/hab</td>
<td>Secretary-Approved Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; of 20 ST visits; or 75 shared O/P therapy visits</td>
<td>per benefit year</td>
</tr>
</tbody>
</table>

Scope Limit:

Services provided by a speech-language pathologist for the maximum reduction of physical disability and restoration to the best functional level. Habilitative services are provided to acquire a skill and avert the loss of functions.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (11) (c) limitations and BC/BS Standard Optional limitations apply:

Any enrollee who reaches 75 outpatient visits across combined therapies without reaching 20 speech therapy visits in a benefit year may access additional speech therapy services up to 20 visits. Speech therapy provided in an inpatient setting (hospital, rehab facility or nursing home) or in the home care setting does not count toward the 20 speech therapy visits per year limitation.

Any enrollee who reaches 20 speech therapy visits in a benefit year without reaching the outpatient visit maximum of 75 visits per year across all therapies may access additional speech therapy services up to the
Alternative Benefit Plan

75 PT/OT/ST outpatient visit maximum. Therapy services provided in the home care setting are counted as outpatient visits across combined PT/OT/ST services for purposes of applying the 75 visit per year limitation.

The limit ensures that no one receives less than the benchmark benefit or the Medicaid state plan benefit, whichever is greater.

There is no outpatient visit limit for speech therapy for persons with a developmental disability or persons with a traumatic brain injury. Includes Cognitive Rehabilitative Therapy services. Habilitative services are not provided as part of the home care benefit.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
</tbody>
</table>

Scope Limit:
Includes nursing services, physical therapy, occupational therapy, or speech pathology, audiology and health aides services supervised by a registered nurse or therapist.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Medicaid state plan attachment 3.1A 7(a)

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services - Supplies and Equipment</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
</tbody>
</table>

Scope Limit:
Medical necessary supplies, equipment and appliances, suitable for use in the home prescribed by a physician, consistent with 440.70. Includes durable medical equipment.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Medicaid state plan attachment 3.1A 7(c)
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source: State Plan 1905(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing aid services and products</strong></td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>None</td>
</tr>
<tr>
<td>Provider Qualifications:</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>No limitation</td>
</tr>
<tr>
<td>Duration Limit:</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td><em>Audiology services include audiometric exam and testing, hearing aid evaluation and prescription. Hearing aid services include selecting, fitting and dispensing hearing aids, batteries and repair.</em></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

**Medicaid state plan attachment 3.1A 13(d)**

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source: State Plan 1905(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Services</strong></td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>None</td>
</tr>
<tr>
<td>Provider Qualifications:</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>No limitations</td>
</tr>
<tr>
<td>Duration Limit:</td>
<td>No limitations</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td><em>Audiology services and hearing evaluations conducted by a licensed audiologist. Hearing tests are performed for diagnostic as well as rehabilitative purposes.</em></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

**Medicaid state plan attachment 3.1A 13(d)**
**Alternative Benefit Plan**

<table>
<thead>
<tr>
<th>Essential Health Benefit 8: Laboratory services</th>
<th>Collapse All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Provided:</strong> Laboratory services</td>
<td><strong>Source:</strong> State Plan 1905(a)</td>
</tr>
<tr>
<td>Authorization: Other</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: No limitation</td>
<td>Duration Limit: None</td>
</tr>
</tbody>
</table>

**Scope Limit:**
All laboratory examinations, which must be medically necessary and related to the specific needs, complaints, or symptoms of the patient, require written order of a physician or qualified practitioner.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Medicaid state plan attachment 3.1A 3
Utilization Thresholds do not apply to services otherwise subject to thresholds when provided as managed care services furnished by or through a managed care program qualified by the NYS Department of Health to persons enrolled in and receiving medical care from such program.

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Approval Date: 03/16/2018
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**Essential Health Benefit 9: Preventive and wellness services and chronic disease management**

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and licensed provider services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Benefit Provided:**
- Physician and licensed provider services

**Source:**
- State Plan 1905(a)
## Alternative Benefit Plan

| Essential Health Benefit 10: Pediatric services including oral and vision care |
|------------------|------------------|------------------|
| Benefit Provided: | Source:           |  |
| Medicaid State Plan EPSDT Benefits | State Plan 1905(a) |  |
| Authorization:    | Provider Qualifications: |  |
| None             | Medicaid State Plan |  |
| Amount Limit:    | Duration Limit:    |  |
| No limitation    | None              |  |
| Scope Limit:     |  |
| Early and periodic screening, diagnostic and treatment services for individuals under 21 years and treatment of conditions found. No limitation in scope of benefit. |  |

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid state plan attachment 3.1A (4) (b)
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Other Covered Benefits from Base Benchmark</th>
<th>Collapse All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Base Benefit Provided:</td>
<td>Source: Base Benchmark</td>
</tr>
</tbody>
</table>

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**NEW YORK**  
**Approval Date:** 03/16/2018  
**Effective Date:** 12/01/2017
## Alternative Benefit Plan

### Base Benchmark Benefits Not Covered due to Substitution or Duplication

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Benefit Source</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services</td>
<td>Base Benchmark Benefit that was Substituted:</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Outpatient Surgery &amp; diagnostics</td>
<td>Benefit Provided:</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Physician services</td>
<td>Base Benchmark Benefit that was Substituted:</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Routine immunizations</td>
<td>Benefit Provided:</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Podiatry services</td>
<td>Base Benchmark Benefit that was Substituted:</td>
<td><strong>Remove</strong></td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

- **Chiropractic services**
  - Personal care services will substitute for adult chiropractic services covered in the Standard BC/BS Federal Employee Benefit.
  - Personal care services are covered in the New York Medicaid state plan attachment 3.1A (26) EHB 1

- **Outpatient Surgery & diagnostics**
  - Outpatient surgery and related diagnostics is a duplication of outpatient hospital services covered in the New York Medicaid State Plan.

- **Physician services**
  - Physician services is a duplication of physician services covered in the New York Medicaid State Plan.

- **Routine immunizations**
  - Routine immunizations available at participating retail pharmacy is a duplication of prescription drug services covered under the New York Medicaid State Plan.

- **Podiatry services**
  - Podiatry services is a duplication of medical care provided by licensed practitioners -podiatrist, covered in the New York Medicaid State Plan.
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Provided: Hospice Services - ambulatory</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Hospice services is a duplication of Hospice Services covered in the New York Medicaid State Plan. Hospice Service may be delivered ambulatory or non-inpatient setting.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Provided: Acupuncture services</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Acupuncture services is a duplication of acupuncture services provided by a licensed physician covered in the New York Medicaid State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Provided: Medical emergency facility svc</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Medical emergency facility services is a duplication of other medical services - emergency hospital services covered in the New York Medicaid State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit provided: Medical emergency professional</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Medical emergency professional services is a duplication of physician services and medical care provided by licensed practitioners covered in the NYS Medicaid State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Provided: Prescription drug benefit</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Prescription drug benefit is a duplication of drugs prescribed by a physician or licensed provider covered in the New York Medicaid State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Provided: Well child care to age 22</td>
<td>Remove</td>
</tr>
</tbody>
</table>

---

**Effective Date:** 12/01/2017

**TN:** 17-0068

**NEW YORK**

**Approval Date:** 03/16/2018

**ABP5**
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Well child care to age 22, is a duplication of EPSDT services for persons < 21yrs and preventive services for persons age 21-22 covered in the New York State Plan
EHB 10 - Pediatric services
EHB 9 - Preventive and wellness services

Base Benchmark Benefit that was Substituted: Benefit Provided: Bright Futures preventive

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Bright futures preventive services are a duplication of preventive services covered in the New York Medicaid State Plan.
EHB 9 - Preventive and wellness services

Base Benchmark Benefit that was Substituted: Benefit provided: Routine physical exam

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine physical exams is duplication of routine physical exam as a preventive services which is covered in the New York Medicaid State Plan.
EHB 9 - Preventive services

Base Benchmark Benefit that was Substituted: Benefit Provided: Routine laboratory tests

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine laboratory tests is a duplication of laboratory services covered in the New York Medicaid State Plan.
EHB 8 - Laboratory services

Base Benchmark Benefit that was Substituted: Benefit Provided: Routine hearing screening

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine hearing screening services is a duplication of hearing services covered in the New York Medicaid State Plan.
EHB 7 - Rehabilitative and habilitative

Base Benchmark Benefit that was Substituted: Benefit Provided: Pediatric oral exam

Source: Base Benchmark
### Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

**Base Benchmark Benefit that was Substituted:**

**Benefit Provided:** Cognitive rehabilitative therapy

**Source:** Base Benchmark

Cognitive rehabilitative therapy is a duplication of physician services, services provided by licensed practitioners and services provided by a physical therapist, occupational therapist or speech therapist in the Medicaid State Plan. CRT encompasses an array of services provided by physicians and licensed practitioners with different specialties in varied medical settings. The NY Medicaid State Plan provides a greater benefit for therapy services due to no limitations on amount, duration and scope of CRT coverage under both medical and behavioral therapy.

- EHB 1
- EHB 5
- EHB 7

**Base Benchmark Benefit that was Substituted:**

**Benefit Provided:** Durable Medical Equipment

**Source:** Base Benchmark

Durable Medical Equipment is a duplication of home health services - supplies and equipment covered in the NYS Medicaid State Plan.

- EHB 7 - Rehabilitation and Habilitation services

**Base Benchmark Benefit that was Substituted:**

**Benefit Provided:** Hearing tests and hearing aids

**Source:** Base Benchmark

Hearing tests and hearing aids is a duplication of audiology and hearing aid services covered in the New York Medicaid State Plan.

- EHB 7 - Rehabilitation and Habilitation services

**Base Benchmark Benefit that was Substituted:**

**Benefit Provided:** Physician care delivery

**Source:** Base Benchmark

Physician care including delivery, pre and post-natal and postpartum care are a duplication physician services covered in the New York Medicaid State Plan.

- EHB 4 - Maternity and newborn care
<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Inpatient hospital maternity</th>
<th>Source: Base Benchmark</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital maternity and physician care is a duplication of inpatient hospital services and physician services covered in the New York Medicaid State Plan. Includes newborn examination and screening prior to discharge from hospital or birthing center.</td>
<td>EHB 4 - Maternity and newborn care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Inpatient hospital room/board</th>
<th>Source: Base Benchmark</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient room and board and other inpatient services is a duplication of inpatient hospital services covered in the New York Medicaid State Plan.</td>
<td>EHB 3 - Hospitalization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Diagnostic, screening preventive</th>
<th>Source: Base Benchmark</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic, screening and preventive services is a duplication of diagnostic, screening and preventive services covered in the New York Medicaid State Plan.</td>
<td>EHB 9 - Preventive and wellness services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Outpatient services</th>
<th>Source: Base Benchmark</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services including medical emergency care is a duplication of physician services, clinic services, outpatient hospital services covered in the New York Medicaid State Plan.</td>
<td>EHB 1 - Ambulatory Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Organ transplant- hospital</th>
<th>Source: Base Benchmark</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant inpatient hospital services are a duplication of organ transplant-inpatient hospital services covered in the New York Medicaid State Plan. The solid organs, blood and cells covered for transplant in the BC/BS FEBP are covered in the Medicaid State Plan.</td>
<td>EHB 3 - Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base Benchmark Benefit that was Substituted:</td>
<td>Benefit Provided: MH and SUD inpatient hospital</td>
<td>Source: Base Benchmark</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</td>
<td>Mental health and substance use disorder inpatient hospital services are a duplication of inpatient hospital services MH and SUD covered in the NYS Medicaid State Plan. EHB 5 - Mental Health and Substance Use Disorder Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Outpatient MH/SUD facility care</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</td>
<td>Outpatient MH/SUD facility care is a duplication of physician services, medical care provided by licensed practitioners and clinic services covered in the New York Medicaid State Plan. EHB 5 - Mental Health and Substance Use Disorder Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Inpatient professional MH/SUD</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</td>
<td>Inpatient professional MH/SUD care is a duplication of physician services and medical care provided by licensed practitioners covered in the New York Medicaid State Plan. EHB 5 - Mental Health and Substance Use Disorder Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Professional outpatient MH/SUD</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</td>
<td>Professional outpatient MH/SUD care is a duplication of physician services, medical care provided by licensed practitioners and clinic services covered in the New York Medicaid State Plan. EHB 5 - Mental Health and Substance Use Disorder Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Routine dental for children</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</td>
<td>Routine dental services for children is a duplication of EPSDT services covered in the New York Medicaid State Plan. EHB 10 - Pediatric Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Diagnostic tests</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
</table>

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ABP5
Effective Date: 12/01/2017
### Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

**Diagnostic tests including radiology and laboratory services**

- A duplication of other laboratory and x-ray services covered in the New York Medicaid State Plan.

**EHB 1 - Ambulatory Patient Services**

- **Base Benchmark Benefit that was Substituted:** Source: Base Benchmark

- **Benefit Provided:** Emergency transportation

  Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

  - Emergency transportation is a duplication of other medical services-emergency transportation, covered in the New York Medicaid state plan.
  
  **EHB 2 - Emergency services**

- **Base Benchmark Benefit that was Substituted:** Source: Base Benchmark

- **Benefit Provided:** Licensed provider services

  Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

  - Medical services provided by licensed providers is a duplication of medical care provided by licensed practitioners covered in the New York Medicaid State Plan.

  **EHB 1 - Ambulatory Care**

- **Base Benchmark Benefit that was Substituted:** Source: Base Benchmark

- **Benefit Provided:** IP professional care-maternity

  Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

  - Maternity services provided by inpatient professionals is a duplication of Nurse-midwife services covered in the New York Medicaid State Plan.

  **EHB 4 Maternity and Newborn Care**

- **Base Benchmark Benefit that was Substituted:** Source: Base Benchmark

- **Benefit:** Freestanding Ambulatory Facility Services

  Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

  - Freestanding Ambulatory Facility Services is a duplication of clinic services covered in the New York Medicaid State Plan.

  **EHB 1 - Ambulatory Care**

- **Base Benchmark Benefit that was Substituted:** Source: Base Benchmark

- **Benefit Provided:** Hospice Care - Inpatient

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### Alternative Benefit Plan

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

**Hospice Care-Inpatient** is a duplication of the Inpatient Hospice services covered in the New York Medicaid State Plan.

**EHB 3 - Hospitalization**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Abortion services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Abortion services is a duplication of abortion services covered in the New York State Plan. Abortion services, drugs and supplies related to abortion are covered in the New York State Plan when the life of the mother would be endangered if the fetus were carried to term or when pregnancy is a result of an act of rape or incest.

**EHB 1 - Ambulatory services**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit: Physical Therapy - rehab/habiliitative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Physical therapy services in the BC/BS FEBP is a duplication of services covered in the secretary approved physical therapy benefit in the New York State Plan.

**EHB 7 - Rehabilitative and Habilitative services**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit: Occupational therapy-rehab/habiliitative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Occupational therapy services in the BC/BS FEBP is a duplication of services covered in the secretary approved occupational therapy benefit in the New York State Plan.

**EHB 7 - Rehabilitative and Habilitative services**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit: Speech and Language therapy-rehab/hab</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

Speech and language therapy services in the BC/BS FEBP are a duplication of services covered in the secretary approved speech therapy benefit in the New York State Plan.

**EHB 7 - Rehabilitative and Habilitative services**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Benefit Provided: Home health care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care covered in the BC/BS FEBP is a duplication of home health services covered in the New York Medicaid State Plan. The BC/BS FEBP Home Health Care benefit covers home nursing care for two (2) hours per day when a registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and a physician orders the care. The BC/BS FEBP home nursing care benefit is limited to 50 visits per person, per calendar year. The New York State Plan Home Health Services benefit exceeds the BC/BS benefit in services covered and duration of care, as medically needed.

EHB 7 - Rehabilitative and Habilitative services
**Alternative Benefit Plan**

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Incentives</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Explain why the state/territory chose not to include this benefit: These features in the BC/BS FEHB plan are essentially monetary rewards and are not incentives that have a relationship to health/wellness.</td>
<td></td>
</tr>
<tr>
<td>Adult routine dental services</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Explain why the state/territory chose not to include this benefit: This is not an EHB for the new adult group as it is an excepted benefit.</td>
<td></td>
</tr>
<tr>
<td>Routine Vision Services</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Explain why the state/territory chose not to include this benefit: This is not an EHB for the new adult group as it is an excepted benefit.</td>
<td></td>
</tr>
<tr>
<td>Healthy Newborn visits and screening</td>
<td><strong>Remove</strong></td>
</tr>
<tr>
<td>Explain why the state/territory chose not to include this benefit: This is not an EHB for the new adult group as it is an excepted benefit claimed under the child's eligibility.</td>
<td><strong>Add</strong></td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

**Other 1937 Covered Benefits that are not Essential Health Benefits**

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency transportation</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization: Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Transportation to medically necessary services</td>
<td></td>
</tr>
<tr>
<td>Other: Medicaid State Plan 3.1A (24)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care Facility services</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization: Concurrent Authorization</td>
<td></td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Scope Limit: Intermediate Care Facility services comprehensive and individualized health care and rehabilitation services to individuals with intellectual disabilities (IID) to promote functional status and independence.</td>
<td></td>
</tr>
<tr>
<td>Other: Medicaid State Plan 3.1 A (15) (a)(b)</td>
<td>Including such services in a public institution (or district part thereof) for the developmentally disabled or persons with related conditions. Other than such services provided in an institution for mental diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Services</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization: Concurrent Authorization</td>
<td></td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td>Duration Limit: see other below</td>
</tr>
<tr>
<td>Scope Limit: Services which help meet both the medical and non-medical needs of people with a chronic illness or</td>
<td></td>
</tr>
</tbody>
</table>
disability who cannot care for themselves for long periods of time. Other than services provided in an institution for mental diseases.

Other:

Medicaid State Plan 3.1 A (4)(a)

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Services for Pregnant Women</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization: Other</td>
<td>Duration Limit: During pregnancy + 60 days postpartum</td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td></td>
</tr>
<tr>
<td>Scope Limit: Extended services to pregnant women includes all major categories of services as long as the services are determined to be medically necessary and related to pregnancy.</td>
<td></td>
</tr>
</tbody>
</table>

Other:

Medicaid State Plan 3.1A (20)

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Nursing services</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization: Concurrent Authorization</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td></td>
</tr>
<tr>
<td>Scope Limit: Medically necessary nursing services, may be intermittent, part-time or continuous and must be provided in the home under the direction of a physician.</td>
<td></td>
</tr>
</tbody>
</table>

Other:

Medicaid State Plan 3.1A (8)

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Clinic Services</td>
<td></td>
</tr>
<tr>
<td>Authorization: Other</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>Amount Limit: No limitations</td>
<td></td>
</tr>
<tr>
<td>Scope Limit:</td>
<td></td>
</tr>
</tbody>
</table>

TN: 17-0068
NEW YORK

Approval Date: 03/16/2018
Effective Date: 12/01/2017
Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitations</td>
<td>None</td>
</tr>
</tbody>
</table>

| Services provided as defined by the Rural Health Clinic Services Act of 1977 (Public Law 95-210). |

Other:

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Clinic (FQHC)</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitations</td>
<td>None</td>
</tr>
</tbody>
</table>

Covered Federally Qualified Health Center (FQHC) Services as defined by Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990.

Other:

Medicaid state plan attachment 3.1A, 2(c)
Includes both FQHCs receiving a grant under Section 330 of the Public Health Service (PHS) Act and FQHCs not grant funded under Section 330 of the PHS, known as FQHC (look-alike) clinics based on the recommendation of the Health Resources and Services Administration.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine adult dental services</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitations</td>
<td>None</td>
</tr>
</tbody>
</table>

Preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition.

Other:

Medicaid State plan 3.1A (10) Dental Services
Alternative Benefit Plan

Covered if included in the managed care contractor's benefit package or as a Medicaid FFS benefit. All orthodontia is covered as a Medicaid FFS benefit.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Services</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Amount Limit:**
- No limitations

**Duration Limit:**
- None

**Scope Limit:**
- The offering, arranging and furnishing of those health services which enable enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy. Fertility services are limited.

**Other:**
- Covered if included in the managed care contractor's benefit package or as a Medicaid FFS benefit. Fertility services are limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic/Orthotic devices, Orthopedic footwear</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
</tbody>
</table>

**Authorization:**
- Other

**Amount Limit:**
- No limitations

**Duration Limit:**
- None

**Scope Limit:**
- Prosthetic appliances or devices which replace or perform the function of any missing part of the body. Orthotic appliances or devices used to support a weak or deformed body part or to restrict or eliminate motion in a body part.

**Other:**
- Orthopedic footwear includes shoes, shoe modifications or additions used to correct, accommodate or prevent a physical deformity or range of motion malfunction.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
</tbody>
</table>

**Authorization:**
- Prior Authorization
**Alternative Benefit Plan**

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No limitation</td>
<td>None</td>
</tr>
</tbody>
</table>

**Scope Limit:**
An electronic device which enables high risk patients to secure help in the event of a physical, emotional or environmental emergency. Usually connected to the patient's phone, will signal a response center when help button is activated.

**Other:**
Medicaid State Plan 3.1A (7)(c)

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner services</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

**Authorization:**
Other

**Provider Qualifications:**
Medicaid State Plan

**Amount Limit:**
No limitation

**Duration Limit:**
None

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

**Authorization:**
Prior Authorization

**Provider Qualifications:**
Medicaid State Plan

**Amount Limit:**
Replacement of missing teeth or dentures

**Duration Limit:**
None

**Scope Limit:**
Removable replacement for missing teeth and surrounding tissues. Two types of dentures; complete and partial dentures. Services include replacement of dentures.

**Other:**
New York Medicaid State Plan 3.1A (12)(b)
**Alternative Benefit Plan**

**Other 1937 Benefit Provided:**

<table>
<thead>
<tr>
<th>Eyeglasses and corrective lens</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization: Other</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: One pair or glasses or corrective lenses</td>
<td>Duration Limit: every 24 months</td>
</tr>
<tr>
<td>Scope Limit: Frames bearing lenses worn in front of the eyes or lenses worn on the eye normally used for vision correction.</td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

New York Medicaid State Plan 3.1A (12)(d)
Prior approval required for artificial eyes, certain special lenses and eye services.

**Other 1937 Benefit Provided:**

<table>
<thead>
<tr>
<th>Optometrists' services</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization: Other</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: One examination including refraction</td>
<td>Duration Limit: every 24 months</td>
</tr>
<tr>
<td>Scope Limit: Licensed practitioners trained in the health of the eyes and related structures, as well as vision, visual systems, and vision information processing.</td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

New York Medicaid State Plan 3.1A (6)(b)

**Other 1937 Benefit Provided:**

<table>
<thead>
<tr>
<th>Directly Observed Therapy - rehabilitative</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization: Other</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit: No limitation</td>
<td>Duration Limit: none</td>
</tr>
<tr>
<td>Scope Limit: Services to treat, control, monitor and measure Tuberculosis and other communicable diseases.</td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

Medicaid State Plan 3.1A (13)(d)
## Alternative Benefit Plan

**Other 1937 Benefit Provided:**

**Health Home Services**

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Provider Qualifications:** Medicaid State Plan

**Authorization:** Concurrent Authorization

**Amount Limit:** No limitations

**Duration Limit:** No limitation

**Scope Limit:** An inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for adults with chronic conditions.

**Other:**

Medicaid State Plan 1945, 3.11 A (H)

---

**Other 1937 Benefit Provided:**

**Community First Choice - personal care services**

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Provider Qualifications:** Medicaid State Plan

**Authorization:** Prior Authorization

**Amount Limit:** No limitations

**Duration Limit:** No limitations

**Scope Limit:** Consumer controlled enhanced personal attendant services and supports that include; functional skills training, coaching and prompting the individual to accomplish the ADL, IADL and health-related skills.

**Other:**

Medicaid State Plan 1915(k), 3.1-A 3(d)(B), 3(d)(C)

---

**Other 1937 Benefit Provided:**

**Rehabilitative Residential services**

**Source:** Section 1937 Coverage Option Benchmark Benefit Package

**Provider Qualifications:** Medicaid State Plan

**Authorization:** Concurrent Authorization

**Amount Limit:** no limitation

**Duration Limit:** no limitation

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**Effective Date:** 12/01/2017

**Approval Date:** 03/16/2018

**TN:** 17-0068

**NEW YORK**

**ABP5**

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## Alternative Benefit Plan

### Scope Limit:

Interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the individual's mental disease.

### Other:

Medicaid State Plan 3.1 A (13)(d)

Rehabilitative residential services are provided to persons residing in community residences licensed by the NYS Office of Mental Health. Services provided to persons other than those residing in New York State certified psychiatric centers and institutions for mental diseases.
Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
### EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

- The state/territory assuresses that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

- The state/territory assuresses EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

  Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

  - Through an Alternative Benefit Plan.
  - Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

| There is no visit limit for rehabilitative or habilitative services for persons aged 21 or younger. Persons age 21 and younger may receive chiropractic services. |

### Prescription Drug Coverage Assurances

- The state/territory assuresses that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

- The state/territory assuresses that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

- The state/territory assuresses that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

- The state/territory assuresses that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

### Other Benefit Assurances

- The state/territory assuresses that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

- The state/territory assuresses that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

- The state/territory assuresses that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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V.20130807
Alternative Benefit Plan

Service Delivery Systems

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [ ] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The state has provided Medicaid recipients enrollment in managed care plans since 1997. Medicaid Managed Care enrollment statewide is three million households. Another 400,000 adults are enrolled in managed care through an 1115 waiver program. Family Health Plus. Over 90 percent of Family Health Plus enrollees will be eligible for Medicaid under the new eligibility levels and are already enrolled in managed care. The state anticipates that only 77,000 enrollees will be newly eligible statewide in the adult group. As such, there was no need for an implementation plan for member or provider outreach. The state has engaged stakeholders in all aspects of ACA implementation, including the Medicaid expansion and the Alternative Benefit Plan.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

- [ ] The managed care program is operating under (select one):
  - [x] Section 1915(a) voluntary managed care program.
  - [ ] Section 1915(b) managed care waiver.
  - [ ] Section 1932(a) mandatory managed care state plan amendment.
  - [x] Section 1115 demonstration.
Alternative Benefit Plan

Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: April 1, 2013

Describe program below:

The Section 1115 demonstration Partnership Plan and the F-SHRP transfer of authority advanced the statewide managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

☒ Traditional state-managed fee-for-service

☐ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Traditional fee-for-service payment model. Providers are reimbursed at established rates for covered medically necessary services provided to enrollees prior to enrollment in managed care. Persons determined eligible for coverage have ten (10) days to select a health plan prior to auto assignment to a health plan. Enrollees may access state certified fee-for-service providers for medically necessary covered services not included in the managed care benefit package or not covered by the enrollee's health plan. These services include: non-emergency transportation services, nursing home services, hospice services, routine adult dental services and certain mental health and substance use disorder services. Managed care plans do not impose treatment limitations on MH/SUD services that are more restrictive than limitations defined in 3.1 A of the New York Medicaid state plan. MH and SUD benefits in the managed care benefit package are aligned with the state plan.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

All New York Medicaid Managed Care health plans provide members with a Member Handbook. The handbook explains the services covered by the health plan and the non-plan covered services that the enrollee must access via the fee for service delivery system. The New York Medicaid Managed Care Model Member Handbook is used by all participating health plans as an enrollee resource tool. Language in the handbook explains how to access both health plan covered services and services covered in the state plan that are not covered by the MMC plan contract; "Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. [Insert Plan Name] will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service."

There are medical services managed care enrollees must access via the FFS delivery system these include residential health care facility service, emergency/non-Emergency Transportation and hospice. Certain mental health, substance use disorder and supportive services are not covered by health plans participating in the NYS Medicaid Managed Care program. Enrollees access these services via the FFS delivery system. This represents a full list to date, of behavioral health services not covered by the managed care benefit package: (recognizing some services listed serve children)

a) Chemical Dependence Services:
- Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics:
- Opioid Treatment Programs
- Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

TN: 15-0396
NEW YORK

Approval Date: 10/28/2015
ABP8
Effective Date: 07/01/2015
Alternative Benefit Plan

Medically Supervised Ambulatory Chemical Dependence Outpatient Rehabilitation Programs
Outpatient Chemical Dependence for Youth Programs
Chemical Dependence Ordered by the LDSS

b) Mental Health Services:
Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)
Day Treatment
Continuing Day Treatment
Day Treatment Programs Serving Children
Home and School Based Services Waiver for Seriously Emotionally Disturbed Children
Case Management - target population SPMI
Partial Hospitalization
Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)
Assertive Community Treatment - ACT
Personalized Recovery Orientated Services - PROS

c) Rehabilitation Services Provided to Residents of OMH Licensed Community Residences and Family Based Treatment Programs
d) OPWDD Services (Office of Persons with Developmental Disabilities)
   Long Term Article 16 Clinic Services
   Day Treatment
   Medicaid Service Coordination - MSC
   Home and Community Based Services Waiver (HCBS)
   Care at Home Program

e) Community First Choice Option (CFCO) services will be accessible to enrollees in both the managed care and the Fee For
   Service delivery systems. The Managed Care/Managed Long Term Care benefit plan currently available to enrollees in the
   managed care delivery systems include the following CFCO services:
   personal care
   home health care (provided by an aide)
   consumer directed personal assistance program
   transportation (must relate directly to a functional need specified in the person-centered service plan)
   PERS
   durable medical equipment (must relate directly to a functional need specified in the person-centered service plan)
   The following CFCO services will be accessible via the FFS delivery system until the state plan amendment is approved. At that
   time, the services listed below will be included in the managed care/managed long term care benefit. Although, the services may
   not retain the same title when included, (for example, home and community support services is covered under waivers currently but
   will be incorporated into personal care under CFCO to include supervision and cueing).
   community habilitation (services must be delivered in a non-certified setting)
   home and community support services (supervision and cueing related to personal care)
   home delivered and congregate meals (where substituted for paid attendant care; *home delivered meals are covered under
   MLTC but not MC)
   assistive technology (as specified in the person-centered service plan; must increase independence or substitute for human
   assistance)
   environmental modifications (must relate directly to a functional need specified in the person-centered service plan; $15,000/
   year limit)
   vehicle adaptation (must relate directly to a functional need specified in the person-centered service plan)
   moving assistance (limited to a one-time expenditure of $5,000)
   community transitional services (must be transitioning from institutional care to home and community based setting; limited to a
   one-time expenditure of $5,000)
   fiscal intermediaries

f) Other Non-Covered Services:
The Early Intervention Program
Preschool Supportive Health Services
School Supportive Health Services
School Based Health Centers

TN: 15-0060
NEW YORK

Approval Date: 10/28/2015
ABP8

Effective Date: 07/01/2015

Page 3 of 4
Alternative Benefit Plan

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130718

TN: 15-0060
NEW YORK

Approval Date: 10/28/2015
ABP8

Effective Date: 07/01/2015

Page 4 of 4
### Employer Sponsored Insurance and Payment of Premiums

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<td>Yes</td>
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The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

Medicaid will pay the cost of employer sponsored insurance if it is cost effective. The scope of the employer sponsored benefit package is provided by the applicant. The employer's health plan must meet certain standards for covered benefits and costs. The state assesses cost effectiveness by comparing the ESI premium to the average Medicaid managed care rate which can vary by sex, age and location in the state. Medicaid fee-for-service will reimburse providers for any medically necessary service covered in the ABP that is not covered by the employer sponsored plan. No employer contribution is required.

The state/territory otherwise provides for payment of premiums.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

Section 4.22 C of the New York Medicaid State Plan defines the state method for determining the cost effectiveness of employer sponsored health insurance. ESI enrollees may access fee-for-service providers for medically necessary services covered in the Medicaid state plan that are limited by their employer sponsored benefit package. ESI enrollees are not enrolled in the NYS Medicaid Managed Care Program. All ESI enrollees receive an program guide that explains how to access medically necessary services via the FFS delivery system.

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**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
### Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

### Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
<table>
<thead>
<tr>
<th>Payment Methodology</th>
<th>ABP11</th>
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<tbody>
<tr>
<td>Alternative Benefit Plans - Payment Methodologies</td>
<td></td>
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<tr>
<td>☑️ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.</td>
<td></td>
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**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130807
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement Systems are included:

   Yes [ ] No [ ]

2. [X] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included.

   Yes [X] No [ ]

3. [ ] All individuals eligible under the State's approved title XIX plan.

4. [X] Qualified Medicare beneficiaries provided by section 301 of PL.100-360 as amended by section §434 of PL.100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of PL. 100-360 as amended by section §434 of PL.100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups.

1. Qualified Medicare beneficiaries provided by section 301 of PL.100-360 as amended by section §434 of PL.100-647.

2. All Title XIX recipients covered under Part A or B of Title XVIII and eligible for Part A or B services covered by Medicaid.

TN #04-09 Approval Date June 5, 2004
Supersedes TN #87-47 Effective Date April 1, 2004
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

[Dual eligibles (Medicaid and Medicare eligible) who are not Qualified Medicare Beneficiaries: The MA program will pay on behalf of MA recipients who are not qualified Medicare beneficiaries the full amount of any deductible and coinsurance costs incurred under Part B of Title XVIII of the Social Security Act, provided that such costs were incurred for care, services or supplies included in the MA Program.]

TN #03-38
Supersedes TN #87-47

Attachment 3.2-A

New York
2

December 24, 2003
TN #03-38     Approval Date    December 24, 2003
July 1, 2003    Effective Date
STATE PLAN UNDER TITLE XIX OF THE
SOCIAL SECURITY ACT-ATTACHMENT4.11-A

STANDARDS FOR INSTITUTIONS AND SUPPLIERS OF SERVICES

Department of Health
Citation: 10 NYCRR, HEALTH, Volume A
Chapter II Administrative Rules and Regulations
Subchapter D Laboratories
Part
58 Clinical Laboratories and Blood Banks

Citation: 10 NYCRR, HEALTH, Volume A-1
Subchapter J Controlled Substances
Part
80 Rules and Regulations on Controlled Substances
Subchapter K Hospitals and Related Facilities
Part
81 Residential Health Care Facilities: Patient Abuse
82 Hospital Survey Planning and Review
83 Shared Health Facilities
85 Medical Assistance-Benefits
Subchapter L X-ray Technology and Chiropractic Use of X-ray
Part
89 Practice of X-ray Technology
Subchapter M Physician’s Assistance, Prohibited Discrimination in Hospital Staff Appointments and Privileges
Part
94 Physician’s Assistants and Specialist’s Assistants
Subchapter N Practice of Nursing Home Administration and Home Nursing and Health Services and Agencies
Part
96 Licensure and Practice of Nursing Home Administration

| TN #86-7 | Approval Date May 7, 1986 |
| Supersedes TN #74-14 #74-2 | Effective Date January 1, 1986 |
Subchapter P  Health Maintenance Organization
Part
98     Health Maintenance Organization

Department of Health
Citation:   10 NYCRR HEALTH, Volume C
Chapter V Medical Facilities
Subchapter A  Medical Facilities - Minimum Standards

Article 1 General

Part
400     All Facilities--General Requirements
401     All Facilities--Operating Certificates

Article 2 Hospitals

Part
405     Hospitals--Minimum Standards

Article 3 Residential Care Facilities

Part
410     Respite Demonstration Projects
411     Ombudsmen Access to Residential Health Care Facilities
412     Reporting Information for Inspections
413     Consumer Information System
414     General Minimum Standards

Article 4 Nursing Homes

Part
415     Organization and Administration
416     Patient Services

Article 5 Health-Related Facilities

Part
420     Organization and Administration
421     Resident Services

Article 6 Skilled Nursing and Health-Related Services; Non-Occupants

Part
425     General Provisions
426     Organization and Administration
427     Registrant Services

TN    #86-7
Supersedes TN #74-14 #74-2
Approval Date  May 7, 1986
Effective Date  January 1, 1986
Article 7 Home Health Agencies: Treatment Centers and Diagnostic Centers

Part 430 Certified Home Health Agencies
Part 431 Treatment Centers and Diagnostic Centers

Subchapter B Hospital Establishment

Part 600 General Provisions
Part 610 Special Requirements for Non-profit Corporations
Part 620 Incorporations and Transfers of Proprietary Businesses
Part 630 Special Requirements for Local Governmental Applicants
Part 640 Procedures for Approval of the Development of Comprehensive Health Services and the Establishment of Such Facilities
Part 650 Dissolution of Corporations
Part 660 Public Health Council Approval of Maintenance Programs
Part 670 Determination of Public Need for Medical Facility Establishment

Subchapter C State Hospital Code

Article 1 General Provisions

Part 700 General
Part 702 Environmental Health
Part 703 Ambulatory Services
Part 705 New Medical Technology and Health Services Demonstration Projects
Part 706 Specialist Diagnostic and Therapeutic Services
Part 707 Physician's Assistants and Specialist's Assistants
Part 708 Appropriateness Review
Part 709 Determination of Public Need for Medical Facility Construction

Article 2 Medical Facility Construction

Part 710 Approval of Medical Facility Construction
Part 711 General Standards for Construction
Part 712 Standards of Construction for New Hospitals
Part 713 Standards of Construction for New Nursing Homes
Part 714 Standards of Construction for New Health-Related Facilities
Part 715 Standards of Construction for New Diagnostic or Treatment Facilities
Part 716 Standards of Construction for New Rehabilitation Facilities

Attachment 4.11-A

New York
3

May 7, 1986
Supersedes TN #74-14 #74-2

Approval Date May 7, 1986
Effective Date January 1, 1986
New York

Article 3 Hospital Operation
   Part
   720 Maximum Standard

Article 4 Residential Health Care Facility Operation
   Part
   730 Organization and Administration
   731 Patient Services
   732 Penalties
   733 Consumer Information Services
   734 Ombudsman Access to Residential Health Care Facilities

Article 5 Health-Related Facility Operation
   Part
   740 Organization and Administration
   741 Resident Services
   742 Penalties

Article 6 Treatment Centers and Diagnostic Center Operation
   Part
   750 General Provisions
   751 Organization and Administration
   752 Medical Staff Organization
   753 Maternal, Child Health and Newborn Services
   754 Family Planning Services
   755 Free-Standing Ambulatory Surgery Centers

Article 7 Certified Home Health Agencies
   Part
   760 Establishment
   761 Certification
   762 Approval of Construction
   763 Organization and Administration
   764 Patient Services
   765 Approval and Licensure of Home Care Services Agencies
   766 Licensed Home Care Services Agency Organization and Administration
   767 Licensed Home Care Services Agency Patient Services
   770 Long Term Home Health Care Program
   771 Organization and Administration of Long Term Home Health Care Programs

TN #86-7
Supersedes TN #74-14 #74-2
Approval Date May 7, 1986
Effective Date January 1, 1986
Article 8  Residential Health Care Facility Services for Nonoccupants

Part

780  General Provision
781  Organization and Administration
782  Registrant Services

Chapter VI  Emergency Services

Part

800  General
Department of Mental Hygiene

Citation: 14 NYCRR, MENTAL HYGIENE, Volume A
Chapter 1 General

Part 4 Residential Care for Mentally Retarded Persons Pending Admission to State Schools
Part 8 Public Access to Records of Department of Mental Hygiene and the Facilities in the Department
Part 9 Procedure under Article 730 of the Criminal Procedure Law

Chapter II All Facilities
Subchapter A Admission and Transfer of Patients
Part 15 Admission and Retention of Patients
Part 16 Community Agreements Regarding Admission Procedures
Part 17 Transfer of Patients
Part 18 Procedure for Treatment and Hospitalization of Certain Mentally Ill Prisoners in Jails

Subchapter B Institutional Care and Treatment
Part 21 Communications and Visits
Part 22 Services of Legal Process, and Execution of Instruments by Patients
Part 24 Investigation and Reports of Incidents
Part 25 Work Activities of Patients
Part 27 Quality of Care and Treatment

Subchapter C Termination of Inpatient Care
Part 36 Discharge and Conditional Release of Patients
Part 37 Procedure When Patients Leave Without Notice to the Facility

Subchapter D Safety
Part 45 Firearms

Subchapter E Facility Planning and Review
Part 51 Prior Approval by the Commissioner
Part 52 Implementation of State Environmental Quality Review Act
Part 53 Prior Approval of the Commissioner – Project Limited to Facilities in the Community Residence Class

 TN #86-7 Approval Date May 7, 1986
 Supersedes TN #74-14 #74-2 Effective Date January 1, 1986
Chapter III  Department Facilities

Part 55   Facilities Established by the Commissioner
      56   Department Facilities and Services Districts

Chapter IV  Regulation and Quality Control
Subchapter A  General Provisions

Part 70   Classes of Operating Certificates
      71   Visitation and Inspection of Facilities
      72   Definitions Pertaining to this Chapter
      73   Operating Certificate Issuance and Limitation

Subchapter C  Construction of Facilities

Part 77   Standards for Physical Facilities of Hospitals for the Mentally Ill, Schools for the Retarded, and Alcohol Facilities
      78   Fire Protection Standards

Subchapter D  Operation of Facilities

Part 82   Operation of Hospitals for the Mentally Ill
      83   Operation of Psychiatric Inpatient Units of General Hospitals
      84   Operation of Alcoholism Facilities
      85   Operation of Outpatient Facilities for the Mentally Disabled

Chapter VII  Mental Hygiene Facilities Improvement Fund

Part 150   Minimum Standards for Design, Construction and Equipment

Chapter VIII  Drugs

Part 201   Pilot Clinic Programs for Treatment of Drug Addiction
      202   Special Facilities Certified by the Commissioner for Drug Addicts

TN  #86-7
Supersedes TN  #74-14 #74-2
Approval Date  May 7, 1986
Effective Date  January 1, 1986
Chapter X Alcoholism

Part
303 Public Access to Records
304 Designation of Emergency Care Services for Intoxicated Persons and Persons Incapacitated by Alcohol
305 Preventative Counseling Services for children of Alcoholics or Alcohol Abusers
306 Incidents at Facilities for Alcoholism and Alcohol Abuse
330 Program Standards for Medical Ambulatory Services for Alcoholism
368 Declaratory Rulings
369 Appeals and Hearings
395 Alcoholism Counselors

Department of Mental Hygiene
Citation: 14 NYCRR, MENTAL HYGIENE, Volume B
Chapter XIII Office of Mental Health
Part
540 Patients Committed to the Custody of the Commissioner Pursuant to CPL Article 730
541 Defendants Committed to the Custody of the Commissioner Pursuant to CPL Section 330.20
542 Safety Standards for Securing Firearms and Ammunition
561 Use of Space
575 Community Support Services for the Mentally Ill
583 Pre-admission Certification Committees for Residential Treatment Facilities for Children and Youth
584 Operation of Residential Treatment Facilities for Children and Youth
585 Operation of Outpatient Programs for the Mentally Ill
586 Operations of Community Residences

Chapter XIV Office of Mental Retardation and Developmental Disabilities
Part
676 Diagnostic and Research Clinics
679 Medicaid Assistance Payment for Ambulatory Services for the Developmentally Disabled
680 Specialty Hospital
681 Operating Standards for Intermediate Care Facilities
688 Personal Care Services for Developmentally Disabled Persons Residing in Foster Homes and Community Residences
690 Operating Standards for Day Treatment Programs for Persons who are Developmentally Disabled

Chapter XX Commission on Quality of Care
Part
700 Commission on Quality of Care for the Mentally Disabled

TN #86-7 Approval Date May 7, 1986
Supersedes TN #74-14 #74-2 Effective Date January 1, 1986
New York 9

Chapter XXV  Division of Substance Abuse Services

Part
1000  General
1010  Approval of Substance Abuse Services
1020  Requirements for the Operation of All Substance Abuse Programs
1030  Requirements for the Operation of Drug-Free Substance Abuse Programs
1040  Requirements for the Operation of Chemotherapy Substance Abuse Programs
1060  Public Access to Records
DEPARTMENT OF SOCIAL SERVICES
Citation: 18 NYCRR, SOCIAL SERVICES, VOLUME B
Chapter II Regulations of the Department of Social Services
Subchapter C Social Services
Article 2 Family and Children Services

Part 428 Standards for Uniform Case Records and Child Service Plans

Article 3 Child Care Agencies

Part 441 General
442 Institutions
443 Certified and Approved Foster Family Boarding Homes-Agency Procedure for Certification, Approval and Supervision
444 Requirements for Licensed, Certified and Approved Foster Family Boarding Homes
447 Agency Boarding Homes
448 Group Homes
449 Supervised Independent Living
451 Group Emergency Foster Care

Article 5 Operating Certificates - Children’s Facilities

Part 476 General
477 Issuance of Operating Certificates

Article 6 Certificates of Incorporation: Miscellaneous Corporate Matters

Part 481 General
482 Approval of Certificates of Incorporation
483 Miscellaneous
484 Development and Improvement of Community Facilities

TN #86-7 Approval Date May 7, 1986
Supersedes TN #74-14, #74-2 Effective Date January 1, 1986
UTILIZATION CONTROL IN INTERMEDIATE CARE FACILITIES

1. Utilization control in intermediate care facilities is provided through facility-based reviews.

2. Utilization control in intermediate care facilities for the mentally retarded is through review by NYS OMRDD, Division of Quality Assurance staff, as well as independent organizations under contract with NYS OMRDD.

MP/arb
MP-2-11
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

STATE OF NEW YORK

Summary of Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees:
COOPERATIVE AGREEMENT

BY AND BETWEEN

The State Department of Health, hereinafter referred to as “Health” and the State Department of Social Services, hereinafter referred to as “Social Services”.

WITNESSETH:

WHEREAS, On July 30, 1965, the “Social Security Amendments of 1965” were enacted into law as Public Law 89-97, which among its provisions included the enactment of Title XIX making additional funds available to the states for Medical Assistance provided to eligible individuals; and

WHEREAS, Title XIX makes provision for the submission of a “State plan” by a “single State agency”;

WHEREAS, Chapter 256 of the Laws of 1966, added a new Title 11 to Article 5 of the Social Services Law (sections 363, et seq.) promoting the State’s goal of making available to everyone regardless of race, age, national origin, or economic standing, uniform high quality medical care, makes provisions for a program of Medical Assistance for Needy Persons, hereinafter referred to as “Medical Assistance” and designated Social Services the “single State agency” for purposes of Title XIX; and

WHEREAS, such a State plan heretofore has been developed by Social Services pursuant to Title XIX and Title 11 and has been submitted to, and approved by, the Health Care Financing Administration (HCFA), the federal agency responsible for administration of Title XIX; and

WHEREAS, Title XIX makes provision for a state agency to be designated to establish and maintain standards for institutions in which recipients of Medical Assistance may receive care or services and permits certain functions and services to be performed under such Title for the “single State agency” by other state and local agencies; and

WHEREAS, Health is the State agency which licenses health institutions, health maintenance organizations and agencies, the primary health service agency, and the agency designed to determine whether providers under Title XVIII of the Social Security Act meet the standards for participation in such program; and

WHEREAS, Chapter 474 of the Laws of 1996 amended Title 11, by designating Health as the “single State agency” having overall responsibility for the Medical Assistance program under Title XIX of the Social Security Act and Title 11 of Article 5 of the Social Services Law; for maintaining the “State plan” for Medical Assistance and submitting amendments thereto to HCFA; and for taking such steps, not inconsistent with law, as may be necessary to obtain and retain approval of such plans by HCFA; and

Attachment 4.16-A

New York 1

Supersedes TN #89-43

Approval Date January 31, 1997

Effective Date October 1, 1996
WHEREAS, Title 11, as amended, also designates Health as the agency responsible for establishing and maintaining standards for hospital and related services and non-institutional care, reviewing and approving local social services medical plans, establishing a uniform system of reports relating to quality of medical care, reviewing the quality and availability of medical care and services furnished under local social services medical plans, and providing consultative services to providers of care under the plan; and

WHEREAS, Title 11, as amended, designates Social Services as the agency responsible for determining the eligibility for Medical Assistance of applicants therefore, and for auditing payments to providers of care, services and supplies under the Medical Assistance program; and

WHEREAS, Health and Social Services, pursuant to Title 11, as amended, are authorized to enter into such cooperative arrangements as shall be necessary to assure that the purposes and objectives of the Medical Assistance program are effectively accomplished, and

WHEREAS, the Commissioner of Health has the authority, pursuant to Title 11, as amended, to delegate responsibility under Title 11 to other state departments and agencies and to enter into memoranda of understanding as may be necessary to carry out the provisions of Title 11; and

WHEREAS, Health and Social Services have been cooperating in carrying out the directives of the Legislature in implementing the Federal requirements under Title XIX and in defining the respective functions and responsibilities of Social Services and Health under Title 11, as amended;

NOW, THEREFORE, in order to implement the Medical Assistance Program and the Federal requirements applicable thereto, and to define the respective functions and responsibilities of Social Services and Health under such program, to improve access to primary care for all recipients, to assure the delivery of high quality care, to provide comprehensive care for the health needs of all recipients and to improve the cost effectiveness of the Medical Assistance program, Social Services and Health agree as follows:

I. FEDERAL RELATIONS

A. Health shall be responsible for submitting amendments of the “State plan” to HCFA necessary to implement the Medical Assistance program and for conducting negotiations with respect thereto and appealing denials thereof, in consultation with and with the participation of Social Services, as may be necessary.

B. Health shall be responsible for submitting Medical Assistance-related demonstration and waiver applications to the federal Department of Health and Human Services (HHS) and/or HCFA. However, Health shall consult with Social Services in the development and revision of any such applications that may affect Social Services responsibilities under the Social Services Law or this Agreement. Social Services shall assist Health in developing, revising and securing approval of any applications initiated by Health where such applications affect Social Services’ responsibilities under the Social Services Law or this Agreement.
C. Health shall submit a summary of this Agreement to HCFA in accordance with HCFA requirements.

D. In the event of a deferral or disallowance of federal Medical Assistance funds associated with the activities of Health or any other State agency, the defense against said Federal action shall be the responsibility of Health. However, Health shall consult with Social Services, and such other State agencies as may be necessary or appropriate, in the development and implementation of such defense and with regard to any appeal, settlement or discontinuance of appeal of any deferral or disallowance related to Title XIX.

II. MEDICAL ASSISTANCE ELIGIBILITY

A1. Health shall be responsible for establishing and revising the standards and policies relating to persons’ eligibility for Medical Assistance and for requiring adherence to the standards and policies relating to persons’ eligibility for Medical-Assistance by the social services districts of the State.

A2. Social Services, as the single state agency under Title IV-A of the federal Social Security Act, shall, through the social services districts, be responsible for determining the eligibility of persons for Medical Assistance. Health shall be responsible for determining eligibility for Medical Assistance for residents of the Oxford Home and for individuals who are the fiscal responsibility of the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities.

A3. Social Services may involve other State agencies in the eligibility determination process through cooperative agreements with the approval of Health.

B1. Social Services shall have responsibility for maintenance, operation and future systems development of the Welfare Management System (WMS) and associated subsystems. This responsibility includes notification to, and coordination with, Health for all changes to this system. Reasonable accommodation will be afforded to Health to allow development of systems initiatives in consultation with Social Services to support the Medical Assistance Program.

B2. Health shall have responsibility for maintenance, operation and future systems development of the Electronic Medicaid Eligibility Verification System (EMEVIS). This responsibility includes coordination with Social Services for all systems changes. Reasonable accommodation will be provided to Social Services to allow development of systems initiatives to support operation and development of Social Services’ programs.

B3. Health shall have responsibility for maintenance, operation and future systems development of the Medicaid Management Information System (MMIS) and associated systems as defined by the federal General Systems Design (GSD). Social Services shall retain
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responsibility for the Provider Surveillance and Utilization Review System (SURS). Health shall be responsible for notification to and coordination with Social Services of any systems changes to MMIS. Social Services will consult with Health on any Provider SURS initiatives. Reasonable accommodations will be provided to Social Services to support operation and development of Social Services’ programs.

C1. Health shall maintain a system of Fair Hearings in accordance with federal requirements to hear the appeals of applicants for and recipients of Medical Assistance who are adversely affected by the actions of Health or social services districts.

C2. Under such Fair Hearing system, social services agencies, including local social services districts, shall continue to be responsible for issuing notices of agency action with respect to matters affecting recipient eligibility. Social Services shall continue to receive requests for fair hearings, shall conduct administrative hearings and shall recommend appropriate actions with respect thereto to Health which shall issue the final administrative decisions thereon. Health shall designate appropriate staff of Social Services to issue final administrative decisions on behalf of Health, and to review issued fair hearing decisions for the purpose of correcting any error found in such decisions, including the reopening of a previously closed fair hearing record for purposes of completing such record.

III. MEDICAL STANDARDS AND PROGRAM OVERSIGHT

A. Health shall be responsible for establishing and maintaining, in conformance with any standards established by HHS, health standards for medical providers, as may be licensed by the State of New York, from which recipients of Medical Assistance may receive medical care or health-related services.

B. Health and Social Services shall share the responsibility for requiring adherence by providers of medical care and health services to the regulations promulgated by Health concerning the standards of medical care and health-related services, as reflected below.

C. Health shall, pursuant to the Public Health Law, certify managed care plans, and in consultation with the responsible special needs agency, special needs plans, for participation in the Medical Assistance program.

D. Health shall periodically review the utilization, appropriateness, availability and quality of medical care and services furnished to recipients of Medical Assistance under the program and shall make such reports as required by law of the findings together with any recommendations in accordance with State law, the federal Social Security Act and regulations promulgated thereunder.

E. Health shall be responsible for the administration of the Drug Utilization Review Program. Health and Social Services shall share

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the responsibility for conducting medical and drug review activity to control inappropriate utilization identified in conformance with established regulations and policies and commonly accepted medical practice.

F1. Social Services shall be responsible for conducting audits of managed care providers and other providers of care, services and supplies enrolled in the Medical Assistance program including the responsibility for on-going fraud and abuse monitoring, investigation and referral. In this regard, Social Services shall consult with Health to ensure that such audits are conducted in accordance with Medical Assistance policy as established by Health. Social Services shall maintain a system to review and audit provider performance under the program, to recover inappropriate payments to providers and to assess provider sanctions for program violations, shall maintain a system of provider hearings to review contested audit findings, recoveries, penalties and provider sanctions, shall maintain a system for withholding payments to providers, and shall maintain a system for the final recovery of overpayments and penalties and for sanctioning and excluding enrolled providers for program violations.

F2. Social Services audit responsibility shall include but not be limited to fiscal audits of providers (including billing audits and audits of rates conducted under Section 368-c of the Social Services Law), audits relating to provider unacceptable practices, other audits which relate to the ability of a provider to continue to participate in the Medical Assistance Program and activities related to Medical Assistance recipient fraud. Such responsibility shall also include the administration of contracts related to Social Services audit and revenue maximization responsibilities.

G. Social Services shall continue to be responsible for the audit and review of claims paid under the Medical Assistance Program to individuals who are not enrolled as providers.

H. Social Services and Health shall have joint responsibility for the pre-payment review of claims submitted by providers for payment under the Medical Assistance Program. Such joint responsibility shall include the effectuation of edits on claims for payments pending resolution of the review in conformance with policies and standards of Health. Reasonable accommodation will be provided to Social Services to allow development of systems to support any such initiatives.

I. Social Services, as part of its audit and fraud control responsibility, shall be responsible for Medical Assistance third party operations and recoveries. Health shall be responsible for third party policy as it relates to Medical Assistance eligibility. Each agency shall consult and coordinate with the other to ensure an effective third party recovery program.
IV. PROGRAM MANAGEMENT AND ADMINISTRATION

A. Health shall be responsible for the supervision of the administration, management and overall operation of the Medical Assistance Program.

B. Health shall be responsible for the establishment of the Medical Assistance delivery network; and recruitment, selection and procurement of providers and managed care plans; provided, however, nothing herein shall prohibit social services districts or groups of districts from procuring providers or managed care plans with the approval of Health.

C. Social Services shall be responsible for conducting management assessment reviews and audits, and for performing Medical Assistance quality control review of social services districts.

D. Social Services shall assure that medical care and health-related services, under Medical Assistance, be made available in all social services districts to the extent required by law and the regulations of Health and, where Health has determined that sufficient capacity exists in the managed care entities serving a district, assure that recipients receive such care under the managed care program in accordance with the regulations of Health.

E. Health shall be responsible for enrolling medical care providers into the Medical Assistance program, instructing them with respect to participation requirements and assuring payment and shall provide for agreements with providers of services under the State plan, in accordance with applicable Federal requirements. Nothing herein shall preclude Health from delegating to Social Services the responsibility for making an initial determination with respect to provider enrollment applications for those groups or types of providers that Health deems appropriate and for instructing such providers with respect to participation requirements.

F. Either Social Services or Health may terminate a provider's enrollment under the Medical Assistance program upon advance notice to the provider. Any such termination instituted by Social Services shall be upon advance written notice to and approval by Health. Health and Social Services shall establish a mechanism to provide for the notification to each other of any such terminations.

G. Health, in consultation with Social Services, shall be responsible for the design, development and operation, either directly or by contract, of the information systems which are necessary to support provider enrollment and payment functions under the Medical Assistance program. Provided, however, that, prior to entering into any contracts with fiscal agents, or extending the current contract, Health shall ensure that such contracts make adequate provision for assuring proper integration of Social Services' responsibilities, including Medical Assistance eligibility determination, fiscal audits, fraud and abuse under this Agreement information systems shall be at a minimum be

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accessible by Social Services and shall permit Social Services, upon notification to Health, to initiate withholding of payments, recoveries, terminations of enrollment and sanctions, as they relate to Medicaid providers. Social Services and Health shall develop procedures for the input and retrieval of information by Social Services related to such system and for the development of reports required by Social Services in its audit and fraud control responsibilities. Social Services shall have the right to disseminate information obtained from such systems in the course of its responsibilities and consistent with federal and state confidentiality requirements.

H. Social Services shall be responsible for provider fraud control mechanisms including but not limited to “post and clear” and “card swipe”. Social Services shall consult with Health during the development of any new initiatives.

I. Social Services shall be responsible for the development, implementation and monitoring of the Social Services Medical Assistance audit plan. Social Services shall consult with Health in the development of such plan and shall periodically advise Health of the status of all initiatives contained in the plan. All recoveries received by Social Services shall be processed and deposited in a manner to be developed by Social Services and Health.

J. Social Services shall continue to be responsible for medical support enforcement activities pursuant to the provisions of Title IV-D of the Social Security Act.

K. Social Services shall continue to be responsible for interaction with local services districts regarding local district Medical Assistance fiscal activities. Such responsibility shall include the processing of administrative and program claims, interception of funds for local district escrow accounts, recoupment of intergovernmental transfer revenue, issuance of disproportionate share payments, and maintenance of local district cost allocation plans.

L. Health shall be responsible for interaction with other state agencies regarding Medical Assistance claiming and the processing of reimbursement requests. Health shall be responsible for the filing of the Medical Assistance Quarterly Expenditure Report.

M. Social Services shall be responsible for the administration of the existing training contract with the State University College at Buffalo. Health shall be responsible for all training functions under the contract which are related to Medical Assistance.

N. Social Services shall be responsible for all Medical Assistance disability determination functions, including establishment of disability policy and, where applicable, review of social service district procedures.

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**Attachment 4.16-A**

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TN   #96-45 Approval Date January 31, 1997
Supersedes TN   #95-49 Effective Date October 1, 1996
V. RATES AND FEES
A. Health shall establish fees, rates and payment methodologies for providers of medical care and health-related services and shall establish the range of acceptable rates of payment for managed care providers, under the Medical Assistance Program. Provided, however, that nothing herein shall be interpreted as affecting the authority of local social services districts or other state agencies to establish rates of payment where such authority existed prior to the date of this Agreement.
B. Methodologies and levels of payment for physician case management programs, for comprehensive health services programs with special purpose certificates of authority and for special needs plans or programs shall be developed by Health in consultation with the responsible special needs agency.

VI. REPORTS, FORMS AND PROCEDURES
A. Through cooperative efforts, Social Services and Health shall develop mutually satisfactory forms and procedures for carrying out their respective responsibilities under Title 11 of Article 5 of the Social Services Law and this Agreement. Such forms and procedures shall include those necessary for determining eligibility for Medical Assistance and claiming Federal reimbursement.
B. Health shall require such reports as are or may be necessary to comply with Federal requirements and Social Services shall do whatever may be necessary to assure that such requirements may be met.
C1. Health, in consultation with Social Services, shall determine the nature and extent of the information which should be collected from providers and shall design reports required to monitor the health care provided under the Medical Assistance program. Health shall determine the nature and extent of the information which should be collected from providers for the purpose of establishing rates of payment and shall design such reports as are necessary to establish rates of payment and acceptable ranges of payment, including the collection and reporting of encounter data from managed care programs and HMOS. Social Services shall have access to any such information needed to carry out its responsibilities under this Agreement.
C2. Social Services shall provide advice and assistance to Health in the determination of the nature and extent of information to be collected from and design of reports for social services districts affecting their program and fiscal responsibilities.
D. In order to effectively monitor the quality and appropriateness of the care provided, to identify patterns of under-utilization or aberrant care practices, to provide information necessary for plan quality assurance and improvement activities, and to streamline multiple reporting activities, Health in consultation with Social Services...
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Services, shall be responsible for the design and implementation of an encounter data system sufficient to meet the needs of the State agencies and social services districts having responsibility for the implementation of the Medical Assistance program. These responsibilities shall include: identification of key clinical and utilization variables, data collection, and maintenance and training and technical assistance to providers. Social Services shall have access to all such data and information.

E. Health shall be responsible for obtaining data relating to the quality and availability of medical care and health services furnished under the Medical Assistance program and shall have the responsibility for collection of encounter data for the managed care program. Social Services shall continue to collect and process encounter data from providers currently enrolled in the Medical Assistance program until such time as the universal encounter data set is established, new provider agreements are executed with the providers, or Health has assumed responsibility for enrolling providers into the Medical Assistance program. Social Services shall have access to all such data and information.

F. Health shall provide encounter data and payment reports to Social Services, at such times and in such manner as may be necessary, to enable Social Services to carry out its functions and its responsibilities to supervise the social services districts under the Medical Assistance program and to carry out its functions and responsibilities with respect to financial audits, fraud and abuse, and provider sanctions.

G. Until such time as Health establishes a formal process for the communication of Medical Assistance policy to social services districts, Health shall have access to existing methods within Social Services for such communications. Communications included under the terms of this paragraph include but are not limited to Administrative Directives, Local Commissioners Memoranda, and the General Information System. Health and Social Services shall cooperate in this regard such that there is no interruption in the flow of Medical Assistance communications to the social services districts. Health shall use best efforts to establish a Medical Assistance policy communications process as soon as practicable.

VI. GRIEVANCE PROCEEDINGS AND APPEALS - RECIPIENTS

A. As provided for hereinabove and consistent with relevant federal and State law with respect thereto, upon designation by Health, Social Services shall make provisions for hearing appeals by applicants for, or recipients of Medical Assistance with respect to their eligibility for Medical Assistance and any adverse agency action taken with respect thereof; holding fair hearings on such appeals when hearings are requested; recommending final decisions and determinations; issuing final administrative decisions on behalf of Health through staff designated by the Commissioner of Health; and taking such steps as may be necessary to enforce Health’s final determinations and decisions.

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Supersedes TN NEW
Approval Date January 31, 1997
Effective Date October 1, 1996
B. Health, as the single state agency, shall decide and issue final administrative decisions on appeals reviewed or heard by Social Services in accordance with the requirements of the Social Services Law and federal law and regulations, as applicable. Health shall designate appropriate individuals in Social Services to issue final administrative decisions on behalf of the Commissioner of Health and to review issued fair hearing decisions for the purpose of correcting any error found in such decisions, including the reopening of a previously closed fair hearing record for purposes of completing such record. Health delegates to Social Services the responsibility for deciding and issuing those decisions in which Medicaid eligibility is dependent upon or is affected by an individual’s eligibility for public assistance. Health also delegates to Social Services the authority to respond on its behalf to any correspondence, contacts or inquiries relating to medical assistance hearings which are directed to Social Services, to Health or to the Commissioner of Health.

C. Health, consistent with its responsibility under the Public Health Law, this Agreement and the federal requirements therefor, shall assure that recipients, who are enrollees in managed care plans under the Statewide managed care program, shall have access to grievance and appeal procedures regarding services by their respective managed care plans, as specified in section 4403(1)(g) of the Public Health Law, 10 NYCRR 98.14 and the federal laws and regulations governing such procedures.

VIII. MONITORING AND ENFORCEMENT OF AGREEMENT

Except as otherwise specified to the contrary herein, Health, in consultation with Social Services, shall establish and implement policies and procedures reasonably necessary to monitor and evaluate the effectiveness and efficiency of the activities performed under this Agreement and the Medical Assistance program, appropriate to its responsibilities under State law and in accordance with applicable requirements of federal law and regulation.

IX. ADMINISTRATIVE PROCEEDINGS – PROVIDERS

A. Consistent with its responsibilities hereunder, Social Services shall be responsible and have authority for determining the amount of any restitution or administrative penalty due from a managed care plan or other provider, resulting from receipt of overpayment, fraud, abuse, or an unacceptable practice, and other administrative penalties, including but not limited to suspension, disqualification or limitation of such provider’s participation in the program. The Commissioner of Social Services, or designees, shall be delegated to perform any and all of the functions and shall have the authority for all actions described in 18 NYCRR Parts 515, 516, 517, and 518 and for the conduct of administrative proceedings to review such actions as described in 18 NYCRR Part 519 including the authority to render a final administrative decision.
B. Notwithstanding the foregoing provisions hereof regarding Social Services’ responsibilities with respect to fraud and abuse, Health shall retain its jurisdiction with respect to licensure of hospitals, as defined under Article 28 of the Public Health Law, HMOs and home health agencies, and physicians, physician assistants and specialists’ assistants.

C. Health retains its authority regarding any providers’ violation of Article 33 of the Public Health Law. This will also pertain when the provider’s violations occur when providing services in the Medical Assistance program. For the purposes of effectuating penalties designed to deter violations of Article 33 of the Public Health Law, Social Services shall be responsible for monitoring compliance by Medical Assistance providers with orders issued pursuant to Public Health Law Article 33.

X. CIVIL PROCEEDINGS
A. Social Services shall have authority in those proceedings involving any provider’s violation of Article 33 of the Public Health Law for recovery of such sums of money obtained by a provider or other vendor as the result of fraud, abuse, or unacceptable practice in the Medical Assistance program and to perform such other acts as may be necessary to enforce other civil penalties provided for in law. Social Services shall have primary responsibility and authority for interacting with the Department of Law in the defense of those actions brought against Social Services as a result of a determination made relating to its audit functions and in any action brought seeking recovery of overpayments or penalties identified in an audit or review conducted by Social Services.

B. Health delegates to Social Services the responsibility and authority to defend state and federal litigation involving appeals of final administrative hearing decisions issued by Social Services staff designated by Health. This delegation shall be limited to cases where the primary issue is whether the decision was based on substantial evidence, or where the fair hearing process itself is challenged, either systematically or in individual cases. Health also delegates to Social Services the authority to approve the payment of attorney’s fees by Health in appropriate cases, in the course of settlement negotiations, or where directed by a court's decisions.

XI. CRIMINAL PROSECUTION
Social Services shall be responsible and shall have the authority for the preparation of cases involving fraud, abuse or unacceptable practice in the Medical Assistance program for referral to an appropriate prosecuting agency or agencies. Nothing herein shall be construed as precluding Health from consulting with or referring matters to such prosecuting agency or agencies.

XII. FEDERAL ADVANCES
A. Health will periodically obtain, in conformity with applicable Federal regulations and practices, advances against Federal funds

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provided for the conduct of the functions and activities herein prescribed and authorized under the Medical Assistance program. Such funds may be received by the State Comptroller and, upon allocation in accordance with applicable provisions of law, shall become available to Health and Social Services in anticipation of Federal reimbursement to which they may become entitled as a result of reasonable and necessary costs incurred in performing the functions authorized by this Agreement.

B. Health will submit estimates of anticipated costs and entitlement to Federal reimbursement as a result thereof for such periods in accordance with federal requirements. Such costs shall be limited to costs allowable for the functions and activities herein provided in accordance with records maintained by Health or submitted by Social Services, including, but not limited to, the names of employees, salaries paid, hours of performance and specification of such activities; provided, however that where Health or Social Services utilize services or materials in the execution of this Agreement for purposes which include purposes other than those encompassed by Title XIX, the cost of those services or materials shall be claimed for federal financial participation in accordance with one or more cost allocation plans which meet the requirements of OMB Circular A-87 and 45 CFR 95.507.

C. At such intervals as Health may reasonably require, Social Services will submit a report of its actual expenses in executing the functions and activities authorized under such Title XIX. Health will determine whether such expenditures were necessary for the performance of the functions authorized by this Agreement and will compare such expenditures and Social Services' entitlement to Federal funds, as a result thereof, to the advances received from Federal funds for the period. If Health's examination of such expenditures determines that any such expenditure was not necessary to the purposes of this Agreement, Health shall inform Social Services of such determination. Social Services will be given a reasonable length of time, but not less than thirty (30) days, to justify such expenditures. If Health thereafter finds that such expenses are not necessary to the performance of such purposes, Social Services' entitlement to Federal reimbursement shall be reduced by an amount so determined and subsequent Federal advances adjusted, by increase or reduction, to compensate for such expense and for any difference between entitlements reported for the prior period and the advance for that period.

XIII. STAFFING

A. As required by Civil Service Law and regulations, Social Services shall identify and assign to Health such staff, who are substantially engaged in functions related to the supervision of the State’s Medical Assistance program, in such numbers as may be required to perform the functions assigned to Health under this Agreement. Staff so identified and assigned shall have relevant background, knowledge, skills and abilities necessary to the performance and of such functions and must be acceptable to Health. Staff identified for assignment to Health will have the legally
prescribed time frames from their notification of assignment to Health to protest such assignment. Health and Social Services shall have joint responsibility for determining the disposition of any such protest.

B. On an ongoing basis, Social Services and Health shall determine the nature and extent of the staffing needs of each agency with respect to their roles and responsibilities under this Agreement and may develop such staff deployment and redeployment plans to provide for the permanent transfer of such staff as is deemed necessary to effectively perform their respective functions hereunder. Social Services and Health shall effect the permanent reassignment and redeployment of such staff as is deemed necessary to effectively perform their respective functions hereunder in accordance with applicable provisions of the Civil Services Law and related statutes.

XIV. MISCELLANEOUS

A. Social Services and Health shall observe and require the observance of the applicable requirements relating to confidentiality of records and information and each agrees not to allow examination of records or to disclose information, except as may be necessary for the purpose of obtaining medical care and health services, assuring the propriety of such care and service, or the proper discharge of responsibilities relating thereto, and except as provided by applicable State and Federal laws and regulations.

B. Social Services and Health shall observe and require the observance of the requirements of Title V of the Civil Rights Act of 1964.

XV. TERMS OF AGREEMENT

A. This Agreement shall be effective only to the extent that it is found by HCFA to be permitted under applicable Federal law and to the extent that Federal aid is not impaired thereby.

B. Social Services and Health shall designate specific personnel in each State agency responsible for continuous liaison activities, including regular meetings and summaries thereof provided to the signatories hereto, to evaluate policies that affect the Medical Assistance program.

C. This Agreement shall run from the date hereof for a period of one year, at which time Health and Social Services shall review the Agreement for any needed changes and jointly plan to incorporate any such changes in the Agreement. If no changes are deemed appropriate, this Agreement shall automatically be renewed upon the same terms for additional periods of one year unless amended in writing by mutual agreement of the parties.

D. To the extent permitted by law, either party may terminate this Agreement on 30 days advance notice in writing to the other party. If terminated, any funds paid to Health under the provisions of this Agreement which have not been expended or encumbered in
accordance with the provisions of this Agreement prior to the date on which the Agreement was terminated and property purchased with funds paid to Health under the provisions of this Agreement, shall be accounted for in accordance with standards established by Social Services governing disposition of such property and funds.

E. This Agreement may be amended from time to time; however, no such agreement shall be effective unless signed by the Commissioners of Health and Social Services and shall be effective only to the extent set forth in Paragraph A. above.

F. The Memorandum of Understanding entered into between the parties on August 4, 1987 is hereby terminated. Provided, however, such August 4, 1987 Memorandum shall guide the parties in resolving any unforeseen problems or issues arising hereunder and in resolving any ambiguities herein.

Dated at Albany, New York

[handwritten date: 9/30] , 1996

By: [Signed] ______________________
Barbara A. DeBuono
Commissioner

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

[handwritten date illegible] , 1996

By: [Signed] ______________________
Brian J. Wing
Acting Commissioner

TN #96-45
Supersedes TN NEW
Approval Date January 31, 1997
Effective Date October 1, 1996
Summary of Agreement between New York State Department of Social Services (DSS) and New York State Office of Mental Health (OMH) (within the New York State Department of Mental Hygiene) dated September 29, 1982 and superceding all previous Agreements. Such agreement serves also as a Provider Agreement between the two agencies.

This Agreement makes provision of coverage under Medical Assistance for the following:

- persons under care in a general acute care hospital while on release from an OMH facility
- persons placed in family care on conditional release from an OMH facility
- persons age 65 or older who are in an OMH facility
- persons age 21 or younger who are in an OMH facility or a private not-for-profit facility duly certified for such by the OMH
- persons found in a psychiatric section of a general acute care hospital duly certified by the OMH and the New York State Department of Health

New York State Department of Social Services is responsible for:

1. Furnishing public and/or medical assistance.
2. Established standards of eligibility.
3. Determining eligibility within appropriate time frames.
4. Authorizing public and/or medical assistance.
5. Making provision for appeals and fair hearings.
6. Developing, in cooperation with the OMH, a system of reports to be made periodically to DSS relating to necessary data in connection with medical assistance provided.
7. Observing and requiring confidentiality of all records pertaining to client care.
8. Issuing policy, rules and regulations pertaining to the Medicaid program and for interpretation of the State Plan as the Single State Agency.
9. Forwarding to the OMH, in a timely fashion, any communications relating to OMH’s performance or responsibilities as an authorized medical provider.
10. In cooperation with the OMH jointly plan for developing alternate methods of care for the mentally ill.
11. Periodically transferring Federal Funds to OMH under an advance system.
The New York State Office Mental Health is responsible for:

1. Establishing mental health standards for inpatient and outpatient services furnished by public and private facilities.

2. Requiring adherence by State institutions to such standards.

3. Making application to Social Services for public and/or medical assistance on behalf of patients.

4. The marshalling, exploration and verification of all income and resources of patients.

5. Prompt application to Social Security Administration for appointment of Representative Payee as indicated.

6. Notify Social Services within 30 days of any change affecting eligibility.

7. Maintaining records necessary to fully disclose the nature, amount and duration of services reimbursed by medical assistance.

8. Assuring that each OMH facility has in effect a utilization review plan including medical care evaluations as required by applicable statute and/or regulation.

9. Furnishing DSS with notices of adverse utilization review determinations made on behalf of their facility’s patients.

10. Billing DSS only for actual and necessary care rendered.

11. OMH agrees to comply with federally mandated disclosure requirements.

12. Conducting periodic medical reviews either directly or through contract of Medicaid clients need for or continued care in public or private hospital facilities under OMH’s licensure.

13. Participation in fair hearings as advisors or expert witnesses.
Summary of Agreement between New York State Department of Social Services (DSS) and the New York State Office of Mental Retardation and Developmental Disabilities (within the NYS Department of Mental Hygiene) (OMR/DD) dated April 19, 1993 and April 30, 1993.

The New York State Department of Social Services shall be responsible for:

1. Establishing or revising standards, policies and procedures for determining eligibility for Medical Assistance.

2. Maintaining, through training programs and prompt updating of procedural changes, ongoing responsibility for the eligibility determination process.

3. Determining eligibility within 30 days of receipt of all information necessary to complete such determination from OMR/DD.

4. Maintaining free access to all eligibility documentation gathered by OMR/DD and periodically auditing the documentation to assure the accuracy and completeness thereof, as the basis for eligibility determinations made by DSS; complete system eligibility information shall be maintained by DSS subject to system purges/limitation.

5. Providing fair hearings in accordance with applicable DSS and HHS regulations for Medical Assistance applicants or recipients served by OMR/DD operated or licensed facilities.

6. Submitting amendments to “State Plan” and submitting this agreement as required by federal rules and serving as liaison with respect to all State Plan amendments, issues of compliance, or any other federal inquiry.

7. Entering into written provider agreements for the provision of Medical Assistance to eligible individuals only with providers certified by the Department of Health as meeting applicable standards for the provision of such services under federal and State law, which agreements will be in the form established and approved by DSS and shall comply with federal survey and certification requirements; DSS shall have the right to refuse to enter into such agreements, cancel, or suspend such agreements, with any provider should it determine that such provider is not in compliance with such requirements or that the provider has failed to comply with any of the terms thereof.

8. Providing a printout of annual redetermination cases at least 90 days prior to the expiration of the current authorization period.

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September 13, 1993

Approval Date

April 30, 1993

Effective Date

Supersedes TN #85-11

TN #93-22
The New York State Office of Mental Retardation and Developmental Disabili ties shall be responsible for:

1. Making application for Medical Assistance benefits on behalf of potentially eligible clients, and on behalf of those on release from an OMR/DD facility to receive care in a medical facility, application to be made no later than 30 days after receipt of all information needed to support an eligibility determination by DSS.

2. Marshalling, exploring, developing and verifying all income, resources, third-party benefits, and other eligibility information in order that DSS may accurately determine eligibility.

3. Notifying Social Services immediately upon receiving knowledge of any change that affects eligibility for Medical Assistance.

4. Timely notifying Social Services of any newly certified providers, of those providers which are decertified, and of any changes in addresses, ownership program capacity or otherwise.

5. On request, participating in Fair Hearings as advisors and witnesses.

6. Certifying to DSS that all facilities operated or licensed by OMR/DD for which reimbursement is claimed meet applicable federal standards.

7. Supplying Social Services in a timely manner with any documentation requested hereunder.

8. Conducting utilization review activities, required for all medical care and services including:
   
a. development of forms, criteria, training and technical assistance; approval of UR plans; placement planning, level of care determinations; and assuring that the general federal requirements are met (42 CFR 456.1 – 456.23)

   b. In the case of ICF/DD/s assuring that, in addition to meeting general federal criteria, they meet requirements of 42 CFR 456.350 – 456.438 as to –
      (1) Certificate of need,  
      (2) Evaluation and pre-admission reviews,  
      (3) Plan of care,  
      (4) Written UR review plans,  
      (5) Continued stay review,  
      (6) Description of UR review function.

Supersedes TN #85-11

Approval Date September 13, 1993
Effective Date April 30, 1993
9. Assuring the Independent Professional Reviews (IPR's) are conducted on a regular basis; consulting with Social Services as to their conduct and the contracting therefor; and initiating corrective action for problems identified thereby.

10. Surveying all facilities and programs under its jurisdiction and periodically evaluating all services for the developmentally disabled delivered under the auspices of these facilities and programs, as pertains to Medical Assistance.

11. Establishing regulations and procedures for all facilities and services under its jurisdiction and consulting Social Services regarding same prior to promulgation or implementation thereof, as pertains to Medical Assistance.

12. To ensure high quality provision of services, providing consultative services through its regional offices (District/Borough Developmental Services Office) to all Medical Assistance services administered by OMRDD.

13. Where appropriate, OMR/DD shall seek recoveries of Medical Assistance and credit such recoveries to DSS.

14. Sharing appropriate training materials with DSS when those materials pertain to the delivery of Medicaid services, so that DSS input can be made.

15. Consistent with the delegation of authority accepted by this agreement, where applicable, OMR/DD will establish reimbursement rates, fees and schedules for residential and non-residential care services in consultation with DSS and with the approval of the State Division of the Budget.

TN  #93-22
Supersedes TN  #89-43

Approval Date  September 13, 1993
Effective Date  April 30, 1993
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Summary of Agreement between the New York State Department of Social Services (DSS) and the New York State Division of Alcoholism and Alcohol Abuse (within the Department of Mental Hygiene) (DAAA) being dated December 30, 1981.

This agreement relates to the provision of Medicaid benefits to such persons who are admitted for either inpatient or outpatient care and services in facilities that fall under jurisdiction of the Division of Alcoholism and Alcoholism Abuse.

The New York State Department of Social Services shall be responsible for:

1. Establishing standards and criteria of eligibility for Medical Assistance.
2. Authorizing public and/or Medical Assistance.
3. Furnishing public and/or Medical Assistance.
5. Observing and requiring the confidentiality of records according to applicable statutes and regulations.
6. Administering the Medicaid program and verifying the quality and appropriateness of care rendered and reimbursed under this agreement.
7. Reimbursing all allowable and direct and indirect expenditures incurred.

The Division of Alcoholism and Alcohol Abuse either directly or through contract with the Office of Mental Health is responsible for:

1. Developing standards and policy governing the provision of medical care and/or rehabilitation relating to alcoholism.
2. Requiring adherence to such standard in state operated and voluntary operated facilities and settings.
3. Making application to Social Services for public or medical assistance on behalf of its patients.
4. The marshalling, exploring and verification of all income and resources of patients.
5. Maintaining records and reports that disclose the amount and duration of care supplied under the Medicaid program including indirect service costs under the Agreement.
6. Conducting annual periodic medical reviews and quality assurance reviews.
7. Billing Social Services only for actual allowable days of care as services provided under Medicaid.
8. Maintaining with Social Services an accurate and updated list of all providers eligible under Title XIX.
9. Participating in fair hearings as advisor or expert witness.

TN #85-11 Approval Date July 17, 1985
Supersedes TN #74-2 Effective Date April 1, 1985
A. Summary of the Agreement between the New York State Department of Social Services on behalf of the Division of Medical Assistance (DMA) and the New York State Department of Health on behalf of the Center for Community Health (CCH) dated June 12, 1989.

**The New York State Department of Social Services shall:**

1. Provide local social services with CCH supplied lists and descriptions of current MCH primary and preventive health care programs for CSN (including Maternal and Child Health Block Grant funded programs) operating in the local social services district.

2. Disseminate CCH supplied brochures describing program services and eligibility requirements to local social services districts.

3. Ensure that the local social services districts refer individuals who may be eligible for medical, nutritional or dental services to the local MCH primary and preventive health care programs.

4. Authorize payment of Medical Assistance funds for care, services and supplies covered under the Medical Assistance Program and provided to Medicaid recipients by MMIS enrolled MCH primary and preventive health care and CSN providers.
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5. Coordinate and defend the deferral and disallowance of Medicaid funds associated with the activities of DMA and CCH.
6. Conduct periodic evaluations of local social services districts to ensure that protocols established in accordance with this Agreement are implemented effectively.

The New York State Department of Health shall:

1. Disseminate written information describing the Child/Teen Health Plan (C/THP) and other Medical Assistance services and eligibility requirements to local MCH primary and preventive health care programs and programs for CSN.
2. Provide local MCH primary and preventive health care programs and programs for CSN with DMA supplied brochures describing C/THP and other Medical Assistance services.
3. Ensure procedures are in place for referral of all persons who may be eligible for Medicaid benefits but whose eligibility has not been determined.
4. Ensure that MCH primary and preventive health care program providers receiving Medicaid reimbursement for primary ambulatory care services covered by the C/THP program and rendered to C/THP eligibles participate and report.
such services as Child/Teen Health Plan examinations.

5. Be responsible within limits of the appropriations for payment for care, services, and supplies provided to MCH primary and preventive health care programs and programs for CSN participants not fully eligible for Medical Assistance as found in 18 NYCRR Part 360.

6. Conduct periodic evaluations of local MCH primary and preventive health care programs and programs for CSN to ensure that the quality of care is accordance with DCH standards.

**Jointly the New York State Department of Social Services and the New York State Department of Health shall:**

1. Make training programs available to local health care program providers and local social services districts to enable them to coordinate efforts of eligibility determination and increasing access to services.

2. Provide to each other, upon request, available data on clients participating in MCH primary and preventive health care programs and programs for CSN and the Medical Assistance Program.
3. Explore and study the feasibility of conducting special outreach, referral and tracking efforts directed at Medical Assistance eligibles who are either unserved or underserved and may be eligible for MCH primary and preventive health care programs or programs for CSN.

4. Meet annually, and more often as needed, and be responsible for the coordination of planning for effective service delivery, and consideration of new initiatives, and the discussion of any issues or resolution of any problem which may arise under the terms of this Agreement.

5. Ensure that local social services districts and local MCH primary and preventive health care programs and programs for CSN participate as appropriate in these discussions and are informed of any policy changes that occur in accordance with the terms of this Agreement.

Terms of this Agreement:

1. No amendment of the terms of this Agreement shall be valid unless reduced to writing and signed by the necessary parties.
2. This Agreement may be terminated by any of the parties hereto upon 30 days written notice to the other party.

3. This Agreement shall be for a period of two years beginning on the day last appearing and shall automatically be renewed for successive periods of two years, unless there is written notice to the other party of its intention not to renew the Agreement at least 30 days before the end of the current period.
Summary of a revised Agreement, dated January 14, 1983 between the New York State Department of Social Services and the Office of Vocational Rehabilitation (OVR) within the New York State Department of Education relating to medical assistance benefits.

The agreement relates to the joint development of services for the non-blind handicapped and defines the reimbursement responsibilities for each agency when mutually serving the same client.

**New York State Department of Social Services is responsible for:**

1. Authorizing public and/or medical assistance.
2. Referring applicants/recipients to OVR when rehabilitation needs are indicated.
3. Being payor in the first instance for those whose prescribed services which part of a rehabilitation plan of care, are covered services by Title XIX.
4. Providing funds for care and maintenance to eligible persons served by both agencies.

**The Office of Vocational Rehabilitation is responsible for:**

1. The provision of vocational rehabilitation services to the non-blind physically and mentally handicapped persons.
2. To develop, restore and/or improve the work capacities of the vocationally handicapped.
3. OVR shall refer to DSS for public assistance, any OVR applicant/client who appears in need of such social services.

**OVR and DSS shall jointly be responsible for:**

1. Developing financial and service plans for any case receiving both public assistance and rehabilitation services.
2. Establishing a regular visitation schedule in order to maximize resources for mutually sharing clients.
3. Sharing of data and information that would change the eligibility of the mutually shared client for continuing prescribed care or services.
4. Designing training for agency staff and linkage routes for effectiveness and efficiency.
5. Observing client confidentiality rules.

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**TN #85-11**

**Supersedes TN #74-2**

**Approval Date** July 17, 1985

**Effective Date** April 1, 1985

There is a joint responsibility of the above parties, including local Social Services districts that upon request to any other third party insurers for necessary information, that such request is only made to determine whether any insurance or other benefits have been or should have been claimed and paid with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.
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Summary of Agreement between New York State Department of Social Services (DSS) and the New York State Education Department (SED) dated October 25, 1993 and October 12, 1993.

The New York State Department of Social Services shall be responsible for:

1) Establishing and revising standards, policies and procedures for administration of “School Supportive Health Services” (SSHS) in the Medical Assistance program.
2) Assuring the SED will be informed of all information required to meet any current and new mandates of the Medical Assistance program as they pertain to School Supportive Health Services Program (SSHSP).
3) Initiating amendments to the “State Plan” and submitting these to federal Department of Health and Human Services (HHS); and serving as liaison with respect to all State Plan Amendments, issues of compliance, or any other federal inquiry.
4) Entering into written provider agreements for the provision of Medical Assistance to eligible individuals only with providers meeting applicable standards for the provision of such services under federal and State law, which agreements will be in the form established and approved by DSS and shall comply with applicable federal requirements. DSS shall have the right to refuse to enter into such agreements with any provider should it determine that such provider is not in compliance with such requirements or that the provider has failed to comply with any of the terms thereof.
5) Reviewing and approving curriculum related to SED’s training of school districts for the SSHSP.

The State Education Department shall be responsible for:

1) Reviewing of school districts’ eligibility to become SSHS.
2) Providing school districts with training and information on participation in the Medical Assistance Program as SSHSP providers.
3) Establishing a system to assure that the school districts bill the Medical Assistance Program only for those types of services which are Medicaid reimbursable.
4) Monitoring the school districts’ provision of SSHS to children with or suspected of having disabilities in accordance with Part 200 of the Regulations of the New York State Commissioner of Education and Article 89 of State Education Law.

TN #92-42
Supersedes TN NEW
Approval Date June 2, 1995
Effective Date May 21, 1992
5) Obtaining written assurances from the school districts of their compliance with applicable rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Social Services as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department and assuring that the local school districts understand and agree that they shall be subject and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting a school district’s past, present and future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

6) Monitoring school districts’ compliance with:
   • documentation requirements of SSHS;
   • the obligation to provide SSHS by appropriately licensed or certified staff who meet Medicaid standards; and
   • other third party insurance requirements.

7) Obtaining assurances from each school district to supply DSS with any documentation requested hereunder in a timely manner.

8) Obtaining assurances from each school district that it will not seek Medicaid reimbursement for any service paid for with other federal funds.

9) Assuring that Federal Medicaid funds are properly matched with State funds.

10) Obtaining assurances from each school district that they will not bill Medicaid for services covered by other third party reimbursement.
Summary of Agreement between New York State Department of Social Services (DSS), State Education Department (SED), and the Office of Mental Retardation and Developmental Disabilities (OMRDD).

1. State Education Department will be responsible for:
   a. SED will reimburse school districts for the cost of education and related services provided to children who reside in an ICF/DD and attend a public school, a Board Cooperative Education Services ("BOCES") program, or a SED approved school not operated by an ICF/DD.
   b. SED will provide OMRDD with cost data for education and related services for each child residing in an ICF/DD who attend public schools, BOCES, or SED approved school, or SED approved schools operated by ICFs/DDs. Such cost data will be provided on a mutually agreeable time schedule in a format prescribed by OMRDD. SED understands that OMRDD will use this data to develop ICF/DD reimbursement rates which include these and other costs allowable under the Medicaid program.
   c. SED agrees to be responsible for and to pay to DSS any disallowance taken pursuant to federal and/or state law. SED will recoup such disallowance by allowing OMRDD to adjust the appropriate ICF/DD reimbursement rate to account for such disallowance.
   d. SED will continue to monitor the education programs provided to children residing in ICFs/DD.
   e. SED will direct school districts that they cannot access Medicaid reimbursement from the School Supportive Health Services Program ("SSHP") for any child residing in the ICF/DD. SED and DSS will implement procedures to assure that there will be no double billing or double payment for educational and related services provided by school districts to children residing in ICFs/DD.
   f. SED will transfer to DSS the amount of non-federal share of any and all funds associated with claims for Medicaid from non-state operated ICF/DDs made pursuant to this agreement. The amount of the transfer to DSS will be based upon a contribution by SED of 50% of the estimated cost for education and related services which are part of the ICF/DD rate calculation as determined pursuant to paragraph b above, and reconciled to actual costs based upon adjudicated claims as determined by DSS.
   g. SED will review for form the contracts between the ICFs/DD and the school districts for education and related services and ensure that OMRDD receives signed copies of all such contracts.
New York
9A

2. Office of Mental Retardation and Developmental Disabilities will be responsible for:
   a. After payment is made by DSS through MMIS for all education and related services, OMRDD will recoup from participating non-state operated ICFs/DD the cost of such services provided to children residing in an ICF/DD and receiving education and related services in a public school, BOCES or a SED approved private school not operated by the ICF/DD and any other education costs incurred by a school district responsible for the education of the child from the reimbursement rate (calculated in accordance with paragraph 1(b) above) of the ICF/DD and transfer such funds to SED on a mutually agreeable schedule.
   b. Upon payment by DSS, OMRDD will transfer to SED the Federal share for any and all Medicaid payments for education and related services provided to children who reside in state operated ICFs/DD and receive educational and related services in public schools, BOCES, or an SED approved private school not operated by a state operated ICF.
   c. OMRDD will not be responsible for the state share of any Medicaid payment nor be responsible for payment of any Medicaid disallowance, however, in the event of any disallowance, OMRDD agrees to recoup the amount of any disallowance from the ICFs/DD incurring such disallowance by an adjustment to the reimbursement rate calculated in accordance with paragraph 1(b) and in accordance with paragraph 1(c).

D. OMRDD will continue to monitor ICF/DD program plans to assure compliance with applicable state and federal ICF/DD requirements.

3. Department of Social Services will be responsible for:
   a. DSS will pay through the MMIS 100% of the cost of education and related services provided to children resident in non-state operated ICFs/DD, in accordance with reimbursement rates developed OMRDD utilizing data provided by SED in accordance with paragraph 1(b).
   b. DSS will pay the federal share of the cost of education and related services provided to children resident in state operated ICFs/DD, in accordance with reimbursement rates developed by OMRDD utilizing data provided by SED in accordance with paragraph 1(b).
   c. DSS shall consider the SED contribution made pursuant to paragraph 1(F) above to represent the full non-federal share contribution, and include all overburden obligations of counties pursuant to Social Services Law at Section 368-a.
d. DSS shall hold SED responsible for any and all state and local share obligations incurred for education and (related services rendered under this memorandum.

e. DSS shall recover from SED the amount of any disallowance associated with any Medicaid payments made to any ICF/DD pursuant to this agreement.

4. State Education and the Office of Mental Retardation and Developmental Disabilities will be responsible for:

a. Jointly maintain and share data on the location and number of school age persons who reside in ICFs/DD.

b. Jointly develop contracts between the ICF/DD and school districts, CRP programs and SED approved schools operated by ICFs/DD.

5. This memorandum shall continue in full force and effect until and unless it is terminated.

6. This memorandum may be amended only in writing and upon the mutual consent of the parties.

7. This memorandum shall be effective on July 1, 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and returned home:

   See Supplement to Attachment 4.17-A

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

   A son or daughter can establish that he or she has been providing care which permitted the individual to reside at home by submitting evidence that he or she made arrangements or actively participated in arranging for care, either directly or indirectly, full-time or part-time.

3. The State defines the terms below as follows:
   - estate: all real and personal property and other assets included within an individual's estate, and passing under the terms of a valid will or intestacy.
   - individual's home: the former principal place of residence owned by the permanently institutionalized individual or the deceased recipient.
   - equity interest in the home: an individual's right to the use of and share in the proceeds from the sale of the property, as demonstrated by the presence of his/her name on the title.
   - residing in the home for at least one or two years on a continuous basis: and evidence that the relative was in residence on a regular basis for the continuous one or two years.
   - lawfully residing: the fact of the son or daughter's presence in the home as evidenced by postal, motor vehicle or voting records or by the testimony of a neighbor or other party.
4. The State defines undue hardship as follows: Undue hardship must be determined on a case by case basis. It includes (a) loss of a family farm or other family owned and operated business which is an income-producing asset, and (b) other compelling cases.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

   See Supplement to Attachment 4.17-A

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness): Cost-effectiveness is determined by weighing the amount available for recovery against the expected cost of the recovery action. If finite resources are a factor, the amount of a given potential recovery less its cost must then be weighed against the potential net return of other recovery actions.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

   Collection Procedures: TEFRA liens are filed against the homesteads of permanently institutionalized individuals. Liens are also filed against the estates of recipients who were permanently institutionalized or 55 years of age or older upon death.

   Advance Notification: Language on the Application for Public Assistance, Medical Assistance, Food Stamps, and Services now explains that a recovery may be sought for MA paid from the sale of the home of the applicant (if permanently institutionalized) or from his/her estate. The notification will also be placed in a pamphlet to be distributed at the time of application.

   Waiver Applications: These are filed as are any other disputed claims against estates through the State’s Surrogate Court, which has jurisdiction over all matters related to estate settlements.

   Appeals: A living recipient’s appeal regarding a property lien or other recovery action may be made by a conference with the social services district and/or the standard fair hearing process.

   Time Frames: All actions against the assets of living recipients are subject to timely notification requirements (at minimum ten days). A decedent’s assets may not be distributed until at least six months after the appointment of an estate administrator.
1. **It will be presumed that an individual will not return home if:**
   (1) a person enters a skilled nursing or intermediate care facility;
   (2) a person is initially admitted to acute care and is then transferred to an alternative level of care, pending placement in a residential care facility (RHCF); or
   (3) a person without a community spouse remains in an acute care hospital for more than six calendar months.

The individual or his/her representative may submit medical statements providing evidence that s/he may reasonably be expected to return home, contrary to the presumption of permanent placement based on his/her residence in a medical institution. Should the argument that the placement is temporary be rejected by the social services district, the client or his/her representative may appeal the decision through the fair hearing process.

5. **Notification:**

Advance notification of estate recoveries is provided. Applicants are notified at the time of application that recoveries against their estates may be undertaken.

Recoveries from estates must be made in accordance with the procedures established under the Surrogate's Court Procedure Act (SCPA) with respect to claims against decedent’s estates, including recoveries against estates which the social services district waives based upon undue hardship.

When asserting a recovery against the estate of a deceased Medical Assistance (MA) recipient, the social services district must notify the estate’s representative in writing of the claim against the estate. This notice should be served on the estate’s fiduciary within seven months of the issuance of letters testamentary or letters of administration by the Surrogate Court. The social services district should send the notice to the estate’s fiduciary by personal delivery, or by certified mail, return receipt requested, pursuant to §1803 of the SCPA.

The notice sent by the social services district to the estate’s fiduciary should set forth the amount of the claim, and must explain that if the representative asserts that the estate recovery would work an undue hardship upon the estate, the social services district may consider waiving the adjustment or recovery. The notice should advise that undue hardship may exist when:

- the estate asset subject to recovery is the sole income-producing asset of the beneficiaries, such as a family farm or family business, and income produced by the asset is limited;
New York

- the estate asset subject to recovery is a home of modest value;

- there are other compelling circumstances.

The notice also should advise that undue hardship will not be found by the social services district where the hardship is the result of Medicaid or estate planning methods involving divestiture of assets, or where the only hardship that would result is the inability of any of the beneficiaries to maintain a pre-existing life-style.

**Waiving recoveries based on undue hardship:**

The estate fiduciary must give prompt written notice to the social services district of its rejection of the claim in part or in whole together with an explanation of the basis for the undue hardship. (See §1806 of the SCPA). Upon rejection of the claim by the fiduciary based upon undue hardship, if the social services district does not find a basis for the undue hardship, it may object to the claim rejection in an accounting proceeding or by petitioning the Surrogate Court to decide whether the claim should be paid.

In an accounting proceeding, the social services district may file an objection to the fiduciary’s account which rejects its claim based on undue hardship, and have the validity of the claim determined by the Surrogate on this basis. (See §1808 of the SCPA). The social services district must file the objection to the account within eight days of receiving the fiduciary’s notice of rejection based upon undue hardship. (See §1808 of the SCPA). If the fiduciary has any affirmative defenses to the social services district's objection to the account, which were not set forth in the rejection served on the district, the fiduciary must reply setting forth the affirmative defenses within five days of the social service's district's service of its objection to the account. (See §1808 of the SCPA). Additionally, a beneficiary, or any other person whose interest in the estate would be adversely affected by allowance of the district's claim may, within eight days of the social services district's filling of its objection to the account, reply to the district's objection by setting forth any affirmative defense not set forth in the fiduciary's account. (See §1808 of the SCPA).

Alternatively, upon receiving notice that the estate’s fiduciary has rejected the claim based upon undue hardship, if the social service district does not find adequate basis for waiving the recovery, it may petition the Surrogate Court within sixty days of the fiduciary’s rejection of the claim showing the facts and requesting that the fiduciary show cause why the claim should not be allowed. (See §1810 of the SCPA).
Where the fiduciary has not allowed the claim in whole, the social services district also may petition the Surrogate Court showing the facts of its claim and requesting that the fiduciary be ordered to show cause why the claim should not be allowed and paid, including in cases where it deems the claim rejected because the fiduciary has not allowed the claim within ninety days or has not served notice rejecting the claim within that period. (See §1809 of the SCPA). The fiduciary is then required to answer the petition, setting forth the basis for any undue hardship, within five days of being cited with the petition. (See §1809 of the SCPA).

Pursuant to §1809 of the SCPA, the estate fiduciary also may present a petition to the Surrogate Court showing the facts of a disputed claim, and requesting that the district be required to show cause why the claim should not be disallowed based upon undue hardship. The fiduciary also may petition the Surrogate Court pursuant to §1809 of the SCPA in cases where he or she is aware that a social services district may have a claim which the estate wishes to reject based upon undue hardship, but the social services district has failed to serve a notice of the claim. The social services district is then required to answer within eight days of being cited with the petition. The fiduciary then has five days from service of the answer by the social services district to serve and file a reply to the answer.

**Cost-effectiveness Standards and Procedures:**

The social services districts are authorized to make judgments as to the cost-effectiveness of recoveries based upon their knowledge of the amount of recovery from each type of recovery, and the costs of pursuing each type of recovery.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

<table>
<thead>
<tr>
<th>Service</th>
<th>Deduct. Coins.</th>
<th>Type Charge</th>
<th>Copay.</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)</td>
<td></td>
<td>X</td>
<td>$25 per recipient stay regardless of length of stay, payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost $50 or less. Therefore, the State will meet the requirements of 42 CFR 447.54(c)</td>
<td></td>
</tr>
</tbody>
</table>

TN #92-28 Supersedes TN #85-33 Approval Date January 25, 1994 Effective Date November 1, 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims in accordance with 42 CFR 447.54 (a)(3).

TN #92-28
Supersedes TN NEW
Approval Date January 25, 1994
Effective Date November 1, 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

<table>
<thead>
<tr>
<th>Service</th>
<th>Deduct.</th>
<th>Type Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital – including non-emergency or non- urgent medical services</td>
<td>X</td>
<td></td>
<td>$3</td>
</tr>
<tr>
<td>Diagnostic and Treatment Center (Free-standing clinics)</td>
<td>X</td>
<td></td>
<td>$3</td>
</tr>
<tr>
<td>X-Ray</td>
<td>X</td>
<td></td>
<td>$1 each procedure</td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
<td></td>
<td>$.50 each procedure</td>
</tr>
<tr>
<td>Medical/Sick Room Supplies</td>
<td>X</td>
<td></td>
<td>$1 each order</td>
</tr>
</tbody>
</table>

TN #92-28
Supersedes TN NEW

Attachment 4.18-A
OMB NO. : 0938-0193

New York
1b

January 25, 1994
November 1, 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the categorically needy for services:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>TYPE OF CHARGE</th>
<th>AMOUNT AND BASIS FOR DETERMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Brand-name drugs</td>
<td>X, X, X</td>
<td>$3.00</td>
</tr>
<tr>
<td>2. Generic drugs</td>
<td>X, X</td>
<td>$1.00</td>
</tr>
<tr>
<td>3. Non-prescription drugs</td>
<td>X, X</td>
<td>$0.50</td>
</tr>
<tr>
<td>4. Preferred brand name drugs and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent</td>
<td>X, X</td>
<td>$1.00</td>
</tr>
</tbody>
</table>

TN #09-52 Approval Date March 12, 2010
Supersedes TN #08-42 Effective Date October 1, 2009
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for categorically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient’s own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.
D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of $41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of $100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of $200 per Medicaid recipient will apply.
1. Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.

2. Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.

3. Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.

4. Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.

5. Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of “Family Planning Products.” Family planning items are also identified in the MMIS during claims processing.

Supplement 1 to Attachment 4.18-A

New York

1

TN __#92-28________ Approval Date  January 25, 1994

Supersedes TN _______ NEW______ Effective Date  November 1, 1993
6.) Services provided by an HMO to an enrollee are identified [via] by the Electronic Medicaid Eligibility Verification System (EMEVSS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded. Individuals enrolled in health maintenance organizations (HMO’s) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the-counter medication ordered by a recognized practitioner as listed on Attachment 4.18-A, Page 1c.

7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

8.) Additional exclusions from co-payment may be made pursuant to state statute.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)</td>
<td>X</td>
<td>$25 per recipient stay regardless of length of stay, payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost less than $50. Therefore, the State will meet the requirements of 42 CFR 447.54(c)</td>
</tr>
</tbody>
</table>

**TN #92-28**

Supersedes TN #85-33

Approval Date: January 25, 1994

Effective Date: November 1, 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deduct.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coins.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Services as follows:</td>
<td></td>
<td>The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims in accordance with 42 CFR 447.54 (a)(3)</td>
</tr>
</tbody>
</table>

TN #92-28
Supersedes TN NEW

Approval Date: January 25, 1994
Effective Date: November 1, 1993
The following charges are imposed on the medically needy for services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital - including non-emergency or non-urgent medical services</td>
<td>X</td>
<td>$3</td>
</tr>
<tr>
<td>Diagnostic and Treatment Center (Free-standing clinics)</td>
<td>X</td>
<td>$3</td>
</tr>
<tr>
<td>X-Ray</td>
<td>X</td>
<td>$1 each procedure</td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
<td>$.50 each procedure</td>
</tr>
<tr>
<td>Medical/Sick Room Supplies</td>
<td>X</td>
<td>$1 each order</td>
</tr>
</tbody>
</table>

TN #92-28
Supersedes TN NEW
Approval Date January 25, 1994
Effective Date November 1, 1993
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services other than those provided under Section 1916 of the Act:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>TYPE OF CHARGE</th>
<th>AMOUNT AND BASIS FOR DETERMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Brand-name drugs</td>
<td>DEDUCTIBLE</td>
<td>X</td>
</tr>
<tr>
<td>2. Generic drugs</td>
<td>COINSURANCE</td>
<td>X</td>
</tr>
<tr>
<td>3. Non-prescription drugs</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. Preferred brand name drugs and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMOUNT AND BASIS FOR DETERMINATION</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Deductible</td>
<td>X</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>X</td>
</tr>
<tr>
<td>Co-pay</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMOUNT AND BASIS FOR DETERMINATION</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Deductible</td>
<td>X</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>X</td>
</tr>
<tr>
<td>Co-pay</td>
<td>X</td>
</tr>
</tbody>
</table>

March 12, 2010

TN #09-52 Approval Date

October 1, 2009

Supersedes TN #08-42 Effective Date
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for Medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient’s own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of $41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of $100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of $200 per Medicaid recipient will apply.
1.) Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.

2.) Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.

3.) Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.

4.) Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.

5.) Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of “Family Planning Products.” Family planning items are also identified in the MMIS during claims processing.
6.) Services provided by an HMO to an enrollee are identified [via] by the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.

Individuals enrolled in health maintenance organizations (HMO’s) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the-counter medication ordered by a recognized practitioner.

7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

8.) Additional exclusions from co-payment may be made pursuant to state statute.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically need pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.*
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

C. State or local funds under other programs are used to pay for premiums:
   [ ] Yes    [ ] No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

TN #91-75
Supersedes TN NEW

Approval Date March 3, 1992
Effective Date October 1, 1991
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver or premium payment):

*Description provided on attachment.

TN #91-75 Supersedes TN NEW Approval Date March 3, 1992 Effective Date October 1, 1991
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes  [ ] No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.*
APPENDIX II
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW YORK
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE
10 N.Y.C.R.R. PART 86-1

*Mandated Federal Reference

TN #85-34 Approval Date July 23, 1987
Supersedes TN #81-36 Effective Date July 1, 2011
Preface

General Reimbursement Provisions

January 1, 1988 the New York State Department of Health implemented a new Medicaid reimbursement methodology for hospitals utilizing case based rates of payment. This was a departure from the per diem methodology whereby hospitals received the same dollar amount per inpatient day of care regardless of the services rendered. The new system is more reflective of the amount of services rendered to each patient and makes a lump sum payment to the hospital based in part on an average per case cost of a hospital's peer group and the actual services that a particular patient receives during the inpatient stay.

This major change in reimbursement policy led to a change in the way methodology and rate changes are implemented since a portion of the rate is now based on a group average price. To stabilize the group price and hospital rates, the Department of Health calculates two rate changes per year, January 1 and July 1. However, the Department still makes modifications to the Medicaid State Plan for inpatient hospital reimbursement on a quarterly basis to reflect changes in the rate calculation methodology. Generally, the State Plan amendments effective in the second and fourth quarter of each year and on other than the first day of the first and third quarter of each year are prospectively implemented in inpatient hospital rates on the next rate calculation date of July 1 or January 1, unless otherwise noted in the State Plan or unless the prospective adjustment would seriously impact a general hospital's financial stability. Initial rate adjustments related to such amendments will be increased or decreased to take into account the effective period prior to the rate cycle.

TN    #92-26     Approval Date    May 19, 1993
Supersedes TN    NEW     Effective Date    April 1, 1992
(Statutory authority: Public Health Law, 2803, 2807, 2807-a, 2807-c, 2808-c, 3612; L 1983, ch. 758, 7)

Sec.
Preface  General Reimbursement Provisions
86-1.1  (Reserved)
86-1.2  (Reserved)
86-1.3  Financial and statistical data required
86-1.4  Uniform system of accounting and reporting
86-1.5  Generally accepted accounting principles
86-1.6  Accountant's certification
86-1.7 Certification by operator, officer or official
86-1.8 Audits
86-1.9 Patient days
86-1.10 Effective period of reimbursement rates
86-1.11 Computation of basic rate
86-1.12 Volume adjustment (1983 to 1987 only)
86-1.13 Groupings
86-1.14 Ceilings on payments
86-1.15 Calculation of trend factor (1983 to 1987 only)
86-1.16 Adjustments to provisional rates based on errors
86-1.17 Revisions in certified rates
86-1.18 Rates for services
86-1.19 Rates for medical facilities without adequate cost experience
86-1.20 Less expensive alternatives
86-1.21 Allowable costs
86-1.22 Recoveries of expense
86-1.23 Depreciation
86-1.24 Interest
86-1.25 Research
86-1.26 Educational activities
86-1.27 Compensation of operators and relatives of operators
86-1.28 [Costs of]Related organizations
86-1.29 Return on investment
86-1.30 Capital cost reimbursement
86-1.31 Termination of service
86-1.32 Sales, leases and realty transactions
86-1.33 Hospital closure/conversion incentive programs
86-1.34 Pilot reimbursement projects
86-1.35 (Reserved)
86-1.36 [Financially distressed hospital pool] (Reserved)
86-1.37 Fund administration
86-1.38 Alternative reimbursement method for mergers or consolidations
86-1.39 (Reserved)
86-1.40 Alternative reimbursement method for medical facilities with extended phase-in periods
86-1.41 (Reserved)
86-1.42 Hospital-based physician reimbursement program
86-1.43 (Reserved)
86-1.44 (Reserved)
86-1.45 Federal financial participation
86-1.46 (Reserved)
86-1.47 (Reserved)

Supersedes TN 92-26  Effective Date July 1, 2011

TN 10-33-B  Approval Date October 28, 2011
[86-1.50] Definitions: case payment system
86-1.51 Payor rates of payment
86-1.52 Payment components
86-1.53 Blended rates of payment
86-1.54 Development of DRG case-based rates of payment per discharge
86-1.55 Development of outlier rates of payment
86-1.56 Alternate level of care payments
86-1.57 Exempt units and hospitals
86-1.58 Trend factor
86-1.59 Capital expense reimbursement for DRG case-based rates of payment
86-1.60 Billing provisions and limitations on changes in case mix
86-1.61 Adjustments to rates
86-1.62 Service intensity weights and average lengths of stay
86-1.63 Non-Medicare trimpoints
86-1.64 Volume adjustment and case mix adjustment for exempt hospitals and units other than designated AIDS centers
86-1.65 Bad debt and charity care pools
86-1.66 Financially distressed hospitals
86-1.67 Statewide Planning and Research Cooperative System (SPARCS)
86-1.68 Federal upper limit compliance
86-1.69 (Reserved)
86-1.70 Malpractice insurance
86-1.71 Hospital closure incentive program
86-1.72 New hospitals and hospitals on budgeted rates]

TN #10-33-B Approval Date October 28, 2011
Supersedes TN #88-6 Effective Date July 1, 2011
New York
Contents

Hospital Inpatient Reimbursement - Effective December 1, 2009

• Definitions
• Statewide base price
• Exclusion of outlier and transfer costs
• Service Intensity Weights (SIWs) and average length-of-stay (LOS)
• Wage Equalization Factor (WEF)
• Add-ons to the case payment rate per discharge
• Outlier and transfer cases rates of payment
• Alternate level of care payments (ALC)
• Exempt units and hospitals
• Trend factor
• Potentially Preventable Negative Outcomes (PPNOs); Potentially Preventable Complications (PPC)
• Potentially Preventable Hospital Readmissions
• Capital expense reimbursement
• Reimbursable assessment for Statewide Planning and Research Cooperative System (SPARCS)
• Federal upper limit compliance
• Adding or deleting hospital services or units
• New hospitals and hospitals on budgeted rates
• Swing bed reimbursement
• Mergers, acquisitions and consolidations, restructurings, and closures
• Administrative rate appeals
• Out-of-state providers
• Supplemental indigent care distributions
• Hospital physician billing
• Serious Adverse Events
• Payment Adjustment for Provider Preventable Conditions
• Graduate Medical Education – Medicaid Managed Care Reimbursement
• Disproportionate share limitations
• [Reimbursable Assessment on Hospital Inpatient Services]
• Government General Hospital Additional Disproportionate Share Payments
• Reimbursable Assessment on Hospital Inpatient Services
• Government general hospital indigent care adjustment
• Additional Inpatient Hospital Payments
• Medicaid disproportionate share payments
• Indigent Care Pool Reform – effective January 1, 2013
• Additional disproportionate share payments
• Reimbursement for language assistance services in hospital inpatient settings

TN #13-13
Approval Date January 28, 2014
Supersedes TN #10-33-B
Effective Date January 1, 2013
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:

**Part I - Methods and Standards for Establishing Payments - Inpatient Hospital Care**

a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment.

b) Supplemental Indigent Care Adjustments as calculated pursuant to Part 1 of this Attachment.

c) Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment.

d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.

e) Indigent Care Adjustments to hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.

f) Additional Disproportionate Share Payments to voluntary non-profit hospitals as calculated pursuant to Part 1 of this Attachment.

**Part II - Methods and Standards for Setting Payment Rates for Inpatient Services Provided by Hospitals Operated by the NYS Office of Mental Health**

g) Inpatient Reimbursement for services provided by hospitals operated by the New York State Office of Mental Health as calculated pursuant to Part 2 of this Attachment.

h) Disproportionate Share Adjustments as calculated pursuant to Part 2 of this Attachment.
New York
A (1)

Part III – Methods and Standards of Setting Payment Rates for Hospitals Licensed by the Office of Mental Health

k) Inpatient Reimbursement for services provided by hospitals licensed by the New York State Office of Mental Health as calculated pursuant to Part 3 of this Attachment. Pages 1-2(a) and 3-5

l) Disproportionate Share Adjustments as calculated pursuant to Part 3 of this Attachment. Pages 2(c) and 7

m) Hospital Inpatient Reimbursement for services in private psychiatric hospitals calculated pursuant to Part 3 of this Attachment. Pages 8-9

n) Hospital Inpatient Reimbursement for psychiatric services for individuals under 21 who are admitted to Residential Treatment Services for Youth programs as calculated pursuant to Part 3 of this Attachment. Pages 10-14

Part VII – Methods and Standards for Establishing Payment rates for Specialty Hospitals

o) Specialty Hospital Inpatient Reimbursement as calculated pursuant to Part 7 of this Attachment. Pages 7-20

p) Disproportionate Share Adjustments as calculated pursuant to Part 7 of this Attachment. Page 24
Across the Board 2% Payment Reduction

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

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

Part I - Methods and Standards for Establishing Payments - Inpatient Hospital Care

a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment.

b) Supplemental Indigent Care Adjustments as calculated pursuant to Part 1 of this Attachment.

c) Graduate Medical Education - Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment.

d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.

e) Indigent Care Adjustments to hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.

f) Additional Disproportionate Share Payments to voluntary non-profit hospitals as calculated pursuant to Part 1 of this Attachment.
New York
A(1)(b)

Across the Board 2% Payment Reduction - effective 4/1/13 - 3/31/14

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

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

Part I - Methods and Standards for Establishing Payments - Inpatient Hospital Care

a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment.

b) Indigent Care Pool Reform – as calculated pursuant to Part 1 of this Attachment.

c) Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment.

d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.

e) Government General Hospital Indigent Care Adjustment as calculated pursuant to Part 1 of this Attachment.
86-1.1 [Definitions.] Reserved

TN #88-6
Supersedes TN #85-34

Approval Date August 1, 1991
Effective Date January 1, 1988
New York

2

86-1.2 [Medical facility rates.] Reserved

TN #88-6
Supersedes TN #85-34

Approval Date August 1, 1991
Effective Date January 1, 1988
86-1.3 Financial and statistical data required. (a) Each medical facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (Medicare) shall use the same fiscal year for title XIX (Medicaid) and title B (children’s bureau programs) as is used for title XVIII. All medical facilities must report their operations from January 1, 1977 forward on a calendar-year basis.

(b) Financial and statistical reports required by the Subpart shall be submitted to the department and/or its agent no later than 120 days following the close of the period. Extensions of time for filing reports may be granted by the commissioner upon application received prior to the due date of the report only in those circumstances where the medical facility establishes, by documentary evidence, that the reports cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a medical facility fails to file the required financial and statistical reports on or before the due dates, or as the same may be extended pursuant to subdivisions (b) or (e) of this section, or fails to comply with the provisions of section 86-1.6 of this Subpart, the State Commissioner of Health shall reduce the current rate paid by governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which said required reports are filed.

(d) In the event that any information or data which a facility has submitted to the Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) If the financial and statistical reports required by this Subpart are determined by the department or its agent to be incomplete, inaccurate or incorrect, the facility will have 30 days from date or receipt of notification to provide the corrected or additional data. Failure to file the corrected or additional data that was previously required within [that period] 30 days, or within such period as extended by the Commissioner, will result in application of subdivision (c) of this section.

(f) Data required to be filed with the department pursuant to section 400.18(b) of this Title shall be submitted according to the specified format for at least 80 percent of all discharged patients within 60 days from the end of the month of patient billing and for at least 100 percent of all patients discharged during the hospital's twelve month fiscal reporting period within 120 days from the end of the hospital's fiscal year reporting period. Where the 80 percent criterion is not met for a given quarter, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.

TN #92-46 Approval Date November 4, 1993
Supersedes TN #92-06 Effective Date October 1, 1992
Where the 100 percent criterion is not met for the given twelve month fiscal period, the commissioner shall notify the facility and the facility shall, within 100 days from the end of the hospital’s fiscal year reporting period, meet the 100 percent criterion. If the 100 percent criterion is not then met, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates the delay in submission is beyond its control.
(g) [Data required to be filed with the department pursuant to section 400.18(c) of this Title shall be submitted according to the specified format for at least 95 percent of all discharged patients within 60 days from the end of the month of patient discharge. Where in each of two successive quarters this criterion is not met, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control. Such data shall be submitted according to the specified format for at least 95 percent of all patients discharged during the hospital's twelve-month fiscal reporting period within 120 days from the end of that fiscal reporting period. Where this criterion is not met for the given fiscal period, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.]

Reserved

(h) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which may include but are not limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey, a malpractice insurance survey, a graduate medical education survey, and a quarterly utilization survey must be provided by the medical facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility, prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in
rate in accordance with application of the provisions of subdivision (c) of this section, unless the medical facility can prove by documentary evidence that the data being requested is not available.

(i) General hospitals shall submit to the commissioner at least 120 days prior to the commencement of each revenue cap year, a schedule of anticipated capital-related inpatient expenses for the forthcoming year pursuant to the provisions of section 86-1.30 of this Subpart.

(j) General hospitals shall submit to the Commissioner of Health a report of hospital expenses incurred in providing services during the period covered by the reports required under this section for which payment was not received and is not anticipated. The report shall be completed in accordance with definitions of bad debt and charity care found in section 86-1.11 of this Subpart. The report shall identify as bad debts or charity care the cost of services provided to emergency inpatients, nonemergency inpatients, emergency ambulatory patients, clinic patients and referred or private ambulatory patients for which the hospital did not receive and does not anticipate payment.

(k) Medical facilities shall submit to the Commissioner of Health discrete financial and statistical data for medical/surgical services, maternity services, pediatric services, normal newborns, premature newborns, psychiatric services, intensive care services, coronary care unit and other intensive care-type inpatient hospital units, and statistical data for alternate level of care services.
New York
4(b)

(I) General hospitals with exempt psychiatric units shall submit hospital data regarding patients in such units as required by the Office of Mental Health.

(m) Each medical facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions of subdivision (c) of this section.
Section 86-1.4 Uniform system of accounting and reporting. (a) Medical facilities shall maintain their records in accordance with:

(1) section 405.23 of Article 2 of Subchapter A of Chapter V of this Title; and

(2) Article 8 of Subchapter A of Chapter V of this Title.

(b) Rate schedules shall not be certified by the Commissioner of Health unless medical facilities are in full compliance with reporting requirements of this Subpart and section 405.23 of this Title.

(c) For purposes of rate setting, medical facilities shall submit to the New York State Department of Health, or its authorized agent, a certified uniform financial report and a uniform statistical report in accordance with the policies and instructions as set forth in section 405.23(b) of Article 2 of Subchapter A of Chapter V of this Title.

(d) The institutional cost report and supplementary schedule form as adopted by the department shall be used to report financial and statistical data for 1981 in order to establish rates of payment for title 19 providers in 1983.

(e) Failure of a medical facility to file the reports required pursuant to this section will subject the medical facility to a rate reduction as set forth in section 86-1.3 of this Subpart.
Section 86-1.5  Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility, unless the reporting instructions authorize specific variation in such principles.
Section 86-1.6 Accountant’s certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.

(b) The requirements of subdivision (a) of this section shall apply to medical facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section. Certification of reports from these facilities will be required effective with report periods beginning on or after January 1, 1977.

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Section 86-1.7 Certification by operator, officer or official.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical report forms provided by the State Commissioner of Health.
Section 86-1.8 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the medical facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent that audited rate.

(b) Subsequent to the filing of fiscal and statistical reports, field audits shall be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (Medicare/Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved, or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit, the medical facility shall be afforded a closing conference. The medical facility may appear in person or by anyone authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the medical facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees, and such other material as the provider wishes to submit in its behalf, and forwarding all material documentation in support of the medical facility’s position.

(f) The medical facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit

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findings as adjusted in accordance with the determination of the bureau review shall be final, except that the medical facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the medical facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the medical facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the medical facility.

(2) The issues and documentation presented by the medical facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.
(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.

(4) The hearing shall be conducted in conformity with section 12-a of the Public Health law and the State Administrative Procedure Act.

(5) At the conclusion of the hearing the medical facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid, based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for
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the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.]

reserved.

(i) Notwithstanding the provisions of this section, the commissioner may promulgate rate revisions based on audits completed by another State agency. Unless otherwise indicated, such audits shall not be considered final and shall not prelude conduct of a complete audit by the State Department of Health or its agent.
Section 86-1.9 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one inpatient between the census taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the date of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother’s discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

(d) For reimbursement purposes, patient days for medical/surgical, pediatrics, and maternity shall be computed as follows:

(1) Medical-surgical patient days for facilities located in counties having an average population density of 100 or more persons per square mile shall be determined by using the higher of the minimum utilization factor of 85 percent of certified beds or actual patient days of care furnished by the facility. Medical-surgical patient days for facilities located in counties having an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 80 percent of certified beds or actual patient days of care furnished by the facility.

(2) Pediatric patient days shall be determined by using the higher of the minimum utilization factor of 70 percent of certified beds or actual patient days of care furnished by the facility.

(3) Maternity patient days for facilities located in areas having a plan approved by the commissioner for the regionalization of obstetrical service, and subsequent to January 1, 1978 for all facilities including those services in areas not having an approved plan shall be determined as follows:

(i) Maternity patient days for facilities in counties with an average population density of 100 or more persons per square mile shall be determined by using the lower of the minimum utilization factor of 75 percent of certified beds or, if the facility generated less than 1,500 live births, the difference between 1,500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility, or, if the facility generated more than 1,500 live births, the actual days of care furnished by the facility.

(ii) Maternity patient days for facilities in counties with an average population density of less than 100 persons per square mile shall be determined by using the lower of the minimum utilization factor of 60 percent of certified beds or, if the facility generated less than 500 live births, the
difference between 500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actually days of care furnished by the facility or if the facility generated more than 500 live births, the actual days of care furnished by the facility.

(iii) Maternity service patients for purpose of computations pursuant to subparagraphs (i) and (ii) of this paragraph shall include obstetrical and gynecological patients housed in the maternity unit.

(4) The provisions of paragraphs (1) and (2) of this subdivision shall be waived in total or in part by the Commissioner of Health in those cases where waiver has demonstrated to be a matter of public interest and necessity. Where a facility could reach its minimum utilization factor by reducing the certified bed capacity by more than five beds or one percent of its certified bed complement, whichever is greater, the commissioner may grant a waiver only if the facility decertifies the total number of beds necessary to reach the minimum utilization factor. Where the minimum bed utilization factor would be reached by certifying no greater than five beds or one percent of its certified bed complement, a waiver shall be granted and decertification of beds shall not be required.

(5) The provisions of paragraph (3) of this subdivision shall be waived by the Commissioner of Health in those cases wherein there is an approved regional plan and wherein the service in question, its capacity and operation are consistent with the approved regional plan. The provisions of paragraph (3) of this subdivision may be waived by the commissioner where it is a matter of public interest and necessity; if such a waiver is granted, maternity patient days shall be determined by using the higher of the applicable minimum utilization factor or live birth formula as set forth in paragraph (3) of this subdivision.

(6) The provision of paragraphs (1) – (3) of this subdivision shall be waived for rural hospitals as defined in this Title.

(7) No waiver pursuant to this subdivision shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of the request and justification for the waiver, and fulfillment of conditions to the waiver, where such conditions exist.

(e) For reimbursement purposes, patient days for open heart surgery, cardiac invasive diagnostic procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations or procedures:

(1) Patient days for any facility engaged in performing open heart surgery and carrying out less than 100 adult and/or 50 pediatric (less than age 21) operations during the reporting period shall be increased by an amount equal to the average length of stay for the adult and/or pediatric open heart surgery cases multiplied by the difference between 100 adult or 50 pediatric and

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the actual number of adult or pediatric open heart surgery operations carried out by the approved cardiac surgical center as referenced in Part 405 of this Title.

(2) Patient days for any facility engaged in performing adult or pediatric (less than 21) cardiac invasive diagnostic procedures and carrying out less than 200 adult and/or 100 pediatric procedures during the reporting period shall be increased by an amount equal to the average length of stay for the adult or pediatric procedures multiplied by the difference between 200 adult and/or 100 pediatric cardiac invasive diagnostic procedures and the actual number of procedures carried out by the approved cardiac diagnostic center as referenced in Part 405 of this Title.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants during a reporting period shall be increased by an amount equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity. No waiver shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of request and justification for the waiver.

(f) Patient days for all alternate level of care (ALC) services shall be reported separately. Patient days for alternate level of care services shall be utilized in the determination of minimum utilization standards as set forth in section 86-1.9(d) of this Subpart.

(g) For rate year 1985 hospitals located in an HSA region where the average daily medical/surgical occupancy is less than the appropriate minimum utilization factor set forth in paragraph (1) of subdivision (d) of this section and the hospital itself has an average daily medical/surgical occupancy of less than the appropriate minimum utilization factor set forth in paragraphs (1) and (4) of subdivision (d) of this section and the hospital provides alternate level of care services, the hospital's title XIX rate shall be reduced by the difference between its title XIX rate and the facility's allowable routine cost as determined pursuant to this Subpart and a statewide average of allowable ancillary costs for hospital-based skilled nursing or health related facilities, as appropriate to the level of care actually provided to the patient and as determined pursuant to Subpart 86-2 of this Title. Beds for which a facility has applied for decertification by January 1, 1986 and which are decertified by the commissioner shall not be counted in the calculation of occupancy rates for the purposes of this subdivision. The provisions of this subdivision shall be waived for hospitals which in 1985 meet the definition of rural hospital set forth in section 405.2(m) of this Title and which are not identified as unnecessary in the state and regional medical facilities plan established pursuant to section 710.13 of this Title.

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Section 86-1.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification of reimbursement rates by article IX-C corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.
Section 86-1.11  Computation of basic rate –

(b) Payment rates for the period January 1, 1983 through December 31, 1983 shall be established on a prospective basis. Such payments shall be computed on the basis of allowable historical inpatient expense based on the fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to January 1, 1983 and upon the data described below. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in subdivision (1) of this section and section 86-1.41 of this Subpart. Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law and other patients, so that the share borne by each program is based upon actual services received by that program’s beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(1) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) After July 1, 1984 the apportionment computed in this section will be revised to reflect 1982 charge data and patient day data received by the Commissioner pursuant to section 86-1.3 of this Subpart.

(3) In 1983, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of average cost. In 1984 and 1985, one-third and two-thirds, respectively, of malpractice costs will be apportioned on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility’s malpractice losses paid by that payor to its total paid malpractice losses for the current cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the national ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as

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a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(c) (1) To the allowable basic rate, computed in accordance with ceiling limitations and to the discrete alternate level of care rate if applicable, and prior to the addition of capital costs (depreciation, leases and interest), there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (e)-(g) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(2) reserved

(d) General hospital inpatient revenue cap. (1) An inpatient revenue cap for each general hospital for each of the rate years 1984 and 1985 shall be established as follows and shall include only the revenues set forth below. An initial inpatient revenue cap shall be calculated for each general hospital by first trending to each rate year the allowable historical inpatient operational expenses reimbursed in 1983. The initial allowable historical inpatient operational expenses to be trended shall reflect all closed appeals and audit adjustments pursuant to this Subpart. The trend factors used shall be developed in accordance with section 86-1.15 of this Subpart. The following revenues shall then be added to trended allowable historical inpatient operational expenses for each rate year:

   (i) capital related inpatient expenses determined in accordance with sections 86-1.29 and 86-1.30 of this Subpart;
   (ii) the allowances provided for in subdivisions (e)-(g) of this section, calculated for each rate year utilizing the sum of trended allowable historical inpatient operational expenses and capital related inpatient expenses; and
   (iii) any anticipated additional revenues generated by a general hospital’s charge schedule, developed in accordance with section 86-1.2 of this Subpart, for each respective rate year.

(2) The initial revenue caps for rate years 1984 and 1985 shall be adjusted to reflect the following:

   (i) case mix changes pursuant to the provisions of subdivision (s) of this section and volume changes;

   (ii) appeals filed and/or adjustments made pursuant to sections 86-1.16 and 86-1.17 of this Subpart; and

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(iii) any adjustments made in payments under title XVIII of the Federal Social Security Act (Medicare) pursuant to section 86-1.43 of this Subpart.

(3)(i) The commissioner shall require direct repayment or adjust a subsequent year’s inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that exceed a previous year’s inpatient revenue cap initially established or adjusted in accordance with this Subpart. A general hospital determined to have such excess revenues shall be subject to direct repayment or adjustment of a subsequent revenue cap when such excess is due to establishment of a charge schedule that is not in compliance with section 86-1.2(c) of this Subpart. Revenue received established as a result of the provisions of title XVIII of the Federal Social Security Act (Medicare) phase-in policies or from charges authorized under section 86-1.17(h) of this Subpart in excess of the revenue cap shall not be included in the adjustment.

(ii) A facility that maintains charge schedules less than the maximum set forth in section 86-1.2(c) of this Subpart such that it results in it receiving less than the maximum allowable charge paying rate shall not be compensated by other payors for the amount by which its charge revenues are less than the maximum amount allowed.

(4) That portion of the revenue cap that is related to utilization of inpatient services shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law, and those enrolled in organizations operating in accordance with the provisions of article 44 of the Public Health Law, so that the share borne by each program is based upon actual services received by that program’s beneficiaries. To accomplish this apportionment, for each ancillary department, the ratio of total department costs to total department charges will be applied to program beneficiary charges for the services of that ancillary department to develop an ancillary cost per day for beneficiaries of that program; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(i) Any adjustment in the overall revenue cap in accordance with this Subpart shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs.

(ii) After such adjustments, the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs, shall constitute guaranteed revenue to the general hospital.
(iii) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diem, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(e) reserved

(f) reserved

(g) Bad debt and charity care regional pools and allowances. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the three year period commencing January 1, 1983, and ending December 31, 1985. Such pools shall receive funds from hospitals pursuant to this subdivision and section 86-1.37 of this Subpart. For the rates established in 1983, the resources available for purposes of establishing the bad debt and charity care pools shall be calculated on the basis of two percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient operating costs after application of the trend factor plus the addition of capital costs. For the rates established in 1984 and 1985, the resources available for establishing these pools shall be calculated on the basis of three percent and four percent, respectively of total statewide general hospital reimbursable inpatient operating costs in the respective rate year after application of the trend factor plus the addition of capital costs.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (g)(8) of this section, a facility must meet the following criteria. Compliance with these criteria shall be subject to audit.

(i) The costs of bad debt and charity care must be determined according to the following definitions and must be reported in the appropriate sections of the facility’s Institutional Cost Report.
(a) Bad debt. Bad debts are the amounts which are considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from rendering services, and are collectable in money in the next operating cycle. Bad debts shall be determined in accordance with generally accepted accounting principles which recognize the direct charge-off method, the reserve method, or a combination of the direct charge-off method and the reserve method. Additionally, the debt must be related to a service which the facility has been authorized by the commissioner to provide. If an amount previously written off as a bad debt is recovered in a subsequent accounting period, the amount written off must be used to reduce the cost of bad debt for the period in which the collection is made.

(b) Charity care. Charity care is the reduction in charges made by the provider of services because the patient is indigent or medically indigent. Reductions in charge for employees which are accounted for as fringe benefits, such as hospitalization and personal health programs, are not considered charity care. Courtesy allowances, such as free or reduced-charge services provided to other than the indigent or medically indigent, are not considered charity care.

(ii) The facility must maintain reasonable collection efforts and procedures.

(a) The hospital must utilize commonly accepted business methods and practices to collect unpaid amounts from all classes of payors. Such methods may differ for inpatient and outpatient services. The hospital shall utilize good business judgment and practices in determining the amounts to be collected.

(b) The hospital must determine the patient’s ability to pay for the services rendered and document the method under which the determination was made.

(c) The hospital must generate and maintain written documentation of requests for payment for services provided.

(d) The hospital must take any subsequent actions as appropriate within good business practice such as subsequent billings, collection letters or telephone calls. These subsequent actions must be documented.

(e) The hospital may turn accounts over to a collection agency. Amounts turned over may be written off as a bad debt at the time of turnover. Amounts collected by the facility after write-off
constitute a recovery of bad debts in the period collected.

(f) The hospital shall not be required to pursue judgment claims before the account can be written off.

(g) A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1985. A finding of inconsistency may be waived upon demonstration by the facility that a policy change served to make bad debt determination policies consistent with the requirements of this subdivision.

(iii) The facility shall submit by October 1, 1983 and thereafter within 120 days from the beginning of a rate year, a report containing an opinion by its independent certified public accountant or independent licensed public accountant in a form approved by the commissioner after consultation with the New York State Society of Certified Public Accountants, as to whether the facility meets the criteria of this subdivision for eligibility for a distribution from the bad debt and charity pool. The commissioner may accept a report containing an opinion that the facility is in compliance with the criteria of this subdivision as establishing initial eligibility as of the first day of each rate year for distribution from the pool. Thereafter if the commissioner determines that the facility is not in compliance, such noncompliance shall be applicable for the entire rate year. The facility may appeal this noncompliance determination pursuant to the provisions of section 86-1.17(i) of this Subpart. If the facility chooses to appeal the commissioner's determination, the facility will continue to receive payments from its regional pools, if otherwise eligible, until a final determination has been made. If it is finally determined that the facility is not in compliance or if the facility chooses not to appeal the commissioner's determination that it is out of compliance, the facility shall repay to its regional pools all monies received from these pools for the period during which it was out of compliance. If a facility fails to repay such monies to its regional pools within a reasonable period of time, major third-party payors shall adjust the facility's rate as directed by the commissioner to reflect money owed to the pools and shall pay these monies to the pool administrator.

(2) For the purposes of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established in chapter 1016 of the Laws of 1969, as amended and all other
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public general hospitals having annual inpatient operating costs in excess of $25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) reserved
(4) reserved
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(g)(5) reserved
(g)(6) reserved
(g)(7) reserved

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Approval Date August 1, 1991
Effective Date January 1, 1988
Reserved

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Supersedes TN  #85-34

Approval Date  August 1, 1991
Effective Date  January 1, 1988
Reserved

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Effective Date January 1, 1988
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Approval Date  August 1, 1991
Effective Date  January 1, 1988
(8) reserved

(g)(9) reserved

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(m) Payment rates for the periods January 1, 1986 through December 31, 1986 and January 1, 1987 through December 31, 1987 shall be established on a prospective basis and shall be based on the reimbursable operating costs used in determining payments for services provided during 1985. Such costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in section 86-1.41 of this Subpart.

(1) Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the federal Social Security Act and article 43 of the New York State Insurance Law and other patients, so that the share assigned to each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem. This apportionment shall be based on 1984 data. Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) The costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the 1984 cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the statewide ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(3) reserved
(4) To the allowable basic rates, computed in accordance with ceiling limitations and prior to the addition of a factor for capital costs, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (p) and (q) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(5) Adjustments to rates shall be made to reflect case mix and volume changes and appeals filed and/or adjustments made pursuant to this Subpart.

(n)(1) reserved

(2) reserved

(3) reserved
(o) reserved

attachment 4.19-a

new york
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TN #88-6
Supersedes TN #87-5

Approval Date August 1, 1991
Effective Date January 1, 1988
Reserved

New York
34

Attachment 4.19-A

TN #88-6
Supersedes TN #87-5

Approval Date August 1, 1991
Effective Date January 1, 1988
(p) Regional pools in 1986 and 1987: bad debt and charity care. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the rate years 1986 and 1987. Such pools shall receive funds from hospitals pursuant to the provisions of this subdivision and section 86-1.37 of this Subpart. For the rates established in 1986 and 1987, the resources available for the purposes of establishing the bad debt and charity care pools shall be calculated on the basis of four and one-half percent of the total statewide calculated on the basis of four and one-half percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient costs after application of the trend factor excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal Social Security Act, and inpatient uncollectible amounts.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (q) of this section, a facility must meet in 1986 and 1987 the criteria specified in paragraphs (1) and (2) of subdivision (g) of this section with the following exception: a policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1987. Compliance with these criteria shall be subject to audit.

(2) For the purpose of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New...
York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of $25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) Hospital need shall be calculated pursuant to the provisions of paragraph (3) of subdivision (g) of this section.

(4) reserved

(p)(5) reserved
(r) reserved

(s) a case mix adjustment to general hospitals’ rates of payment and revenue caps shall be made in 1984 and 1985 and to general hospitals’ rates of payment in 1986 and 1987 according to the provisions of this subdivision.

(1) For 1984 and 1985, a hospital shall have its case mix changes from 1981 to the appropriate rate year calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department, and diagnosis related group (DRGs). (The SIWs are the relative cost weights established by the department for DRGs such that the SIW for any given DRG indicates how expensive the average patient is in those DRGs compared to the average patient in all DRGs). The operating cost per day SIWs shall be all-payor SIWs.
(2) **For 1986 and 1987**, a hospital shall have its case mix changes from the previous rate year to the appropriate rate year calculated on the basis of the non-Medicare patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.2 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department and diagnosis related groups (DRGs). The operating cost per day SIWs shall be non-Medicare payor SIWs.

(3) **[In 1984 and 1985, hospitals]** Hospitals whose case mix as measured according to the provisions of [paragraph] paragraphs (1) and (2) of this subdivision increased by an amount less than or equal to 1 percent but did not decrease by an amount greater than [or equal to] 2 percent shall not receive any adjustment. Hospitals whose case mix increased by more than 1 percent [or more] or decreased by more than 2 percent [or more] shall receive an adjustment to their operating rates of payment and revenue caps pursuant to the provisions of paragraph [(5)] (4) of this subdivision.

[(3) For 1986, a hospital shall have its case mix change from 1985 to 1986 calculated as follows:

(i) The department shall evaluate all hospitals' patient discharge data used as the basis upon which the hospital's case mix change is calculated for the percentage of patient records which, relevant to the data necessary to assign a patient to a diagnosis related group, are either inconsistent, incomplete, or not sufficiently specific.

(ii) A hospital having 10 percent or less of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the Department, and diagnosis related groups. The SIWs that shall be used shall be payor-specific.

(iii) A hospital having more than 10 percent of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights, and patient groupings which shall include major diagnostic categories and may include such factors as:

(a) presence of surgical procedures other than imaging procedures;

(b) sex; and]
(c) age.

The SIWs that shall be used shall be payor specific.

(4) In 1986, hospitals shall have their operating rates adjusted for only those payors whose case mix index calculated according to the provisions of paragraph (3) of this subdivision changes by 1 percent or more. Adjustment shall be made according to the provisions of paragraph (5) of this subdivision.

(5) The rates of payment and revenue caps of hospitals eligible for a case mix adjustment shall be adjusted as follows:

(i) [in no case shall the first 1 percent of change in case mix be reflected in an adjustment to hospital rates of payment and revenue caps, except as calculated for rate years 1984 and 1985 pursuant to paragraph (2) of this subdivision;]

(ii) for those hospitals receiving an adjustment pursuant to the provisions of paragraph (3) of this subdivision the operating cost per diems paid to hospitals shall be adjusted upward or downward in direct proportion to the percent of change in case mix, as measured according to the provisions of either paragraph (1) or (3) (2) of this subdivision, as appropriate, that exceeds [1 percent, except as provided in paragraph (2) of this subdivision] the corridors established in paragraph (3) of this subdivision and in accordance with subparagraph (iii) of this paragraph; and

[(iii) the commissioner shall not recognize the total upward case mix adjustment provided for in this subdivision if he finds that prior rate year adjustments have previously reimbursed a portion of all of such case mix associated cost increases. Such prior rate year adjustments shall include adjustments pursuant to section 86-1.12 of this Subpart which included an adjustment for case mix and that portion of any rate adjustment made pursuant to paragraphs (1), (3), (4) and/or (7) of section 86-1.17(a) of this Subpart which accounted for a change in case mix.]

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TN #87-5 Approval Date January 29, 1988
Supersedes TN #85-34 Effective Date January 1, 1987
86-1.12* Volume adjustment. Within six months following the rate period, a volume adjustment to the rate will be made for those hospitals which meet the following criteria and which are entitled pursuant to the following calculations:

(a) The adjustment will be available for all hospitals except those:

1. which closed during the rate year of the volume adjustment; and
2. with rates calculated based on budget.

(b) The rate will be adjusted according to the following rules:

1. The change in total certified days will be construed as the net change in total certified days attributable to a change in the facility's average length of stay from the base year to the rate year and a change in the facility's number of discharges from the base year to the rate year.

2. A change of less than one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in no rate adjustment.

3. Any change of less than five percent but greater than or equal to one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in an automatic rate adjustment, from which there shall be no administrative appeal.

(i) In calculating this automatic rate adjustment, it will be recognized that all of a facility's capital costs are fixed. Operating costs shall be considered fixed where there are decreases in volume as measured by discharges and/or average length of stay. Operating costs shall be considered variable where there are increases in volume as measured by discharges and/or average length of stay.

(ii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in average length of stay from the base year to the rate year shall be made incrementally according to the steps in the following table:

<table>
<thead>
<tr>
<th>Decrease in Patient Days</th>
<th>Increase in Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>(% Change)</td>
<td>Fixed Variable Percent</td>
</tr>
<tr>
<td>0 to 5</td>
<td>80/20</td>
</tr>
<tr>
<td>5+ to 7</td>
<td>75/25</td>
</tr>
<tr>
<td>7+ to 10</td>
<td>70/30</td>
</tr>
<tr>
<td>10+</td>
<td>65/35</td>
</tr>
</tbody>
</table>

(iii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in discharges from the base year to the rate year shall be made incrementally according to the steps in the following table:

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.
(4) A change greater than or equal to five percent in total certified days between the base year and the rate year, adjusted for leap years, will result in a further rate adjustment which will be in accordance with subparagraphs (3)(i)-(iii) of this subdivision.

(i) A facility having a change in total certified days of greater than or equal to five percent may ask the commissioner to review the reasons for the change in volume and to revise the target volume and/or fixed and variable percentage(s). The commissioner shall determine the cause for the change and its relation to the efficient costs of providing patient care services. Based upon this review, the commissioner may adjust the target volume and/or the fixed and variable percentage(s) cited in paragraph (3) of this subdivision upward and/or downward, independent of the facility’s request to allow the hospital to be reimbursed for the costs of efficient production of services for the change in volume.

(ii) Facilities having a change in total certified days of greater than or equal to five percent shall have the right to administratively appeal their rate adjustment pursuant to section 86-1.17 of Subpart, within 120 days of receipt of the initial notice of said adjustment.

(c) Similarly, when utilization in the base year or rate year is affected by labor strikes, lockouts, or by the establishment of a certified hospital-based ambulatory surgery service as defined in section 405.2(n) of this Title, a proportionate revision to the target volume will be determined.

(d) All payment adjustments resulting from the application of this provision shall be made within six months following the republication of rate referred to above.

(e) Volume adjustment for 1986 and 1987. Within six month following the rate period, a volume adjustment to the rate will be made in accordance with subdivisions (a) through (d) of this section based upon changes in utilization between 1985 as the base year and 1986 as the rate year, and 1986 as the base year and 1987 as the rate year, with the following exceptions:

(1) The volume adjustment shall take into consideration only changes in total certified days for other than beneficiaries of title XVIII of the Federal Social Security Act.

(2) The commissioner may provide for the volume adjustment in the rate year if the facility submits in writing a request for such an adjustment and the facility decertifies at a minimum the equivalent of the number of beds comprising one nursing unit.

(3) If a hospital has experienced a change of greater than five percent in total certified days between 1981 (base year) and 1985

<table>
<thead>
<tr>
<th>Decrease in Patient Discharges</th>
<th>Increase in Patient Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>(%) change</td>
<td>(%) change</td>
</tr>
<tr>
<td>Fixed Variable Percent</td>
<td>Fixed Variable Percent</td>
</tr>
<tr>
<td>0 to 6</td>
<td>60/40</td>
</tr>
<tr>
<td>6+</td>
<td>50/50</td>
</tr>
<tr>
<td>0 to 6</td>
<td>60/40</td>
</tr>
<tr>
<td>6+</td>
<td>50/50</td>
</tr>
</tbody>
</table>
(rate year), and did not meet, minimum medical/surgical utilization requirements of section 86-1.9 of this Subpart in 1985, and received a rate adjustment in accordance with this section, 86-1.12, for the 1985 rate year, the commissioner shall adjust such hospital's 1987 rate for changes in certified days from 1986 to 1987 and shall, in calculating such hospital's 1987 per diem inpatient rate, include those imputed medical/surgical days necessary to meet the minimum medical/surgical utilization requirements pursuant to section 86-1.9 unless such hospital submits in writing by December 31, 1987 a request to decertify the beds necessary to meet such minimum medical/surgical utilization requirements. In no event shall the volume adjustment computed in accordance with this paragraph result in a per diem rate greater than the hospital's actual rate year inpatient per diem costs.
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Section 86-1.13 Groupings. (a) For the purpose of establishing routine and ancillary cost ceilings (for other than specialty hospitals), peer groups of hospitals shall be developed taking into consideration, but not limited to, the following general criteria:

(1) case mix;
(2) service mix;
(3) patient mix;
(4) size of facility;
(5) teaching activity; and
(6) geographic location.

(b) Based on the variable listed in subdivision (a) of this section, the commissioner shall establish a group for each facility in which the facility is at the center of its group—called seed clustering. The size of each group may be variable and shall be determined using acceptable statistical parameters which define the degree of comparability within each group. For the purpose of grouping in accordance with seed clustering, hospitals will be stratified to separate facilities located in the Blue Cross/Blue Shield of Greater New York region from facilities in the rest of the State.

(c) In the event a hospital fails to submit the data required for inclusion in a group which is developed in accordance with subdivision (a) of this section, the commissioner, on the basis of available data, shall develop proxy measures for the required variables, and based on these measures shall construct a peer group. The proxy variables shall not have a financial impact on any facility except that which failed to submit the requisite data.
Section 86-1.14 Ceilings on payments. (a) Reimbursement rate ceilings will be established as specified in this section for comparable groups of medical facilities (except specialty hospitals) developed in accordance with section 86-1.13 of this Subpart. The ceilings shall be established after the application of a wage equalization factor and a power equalization factor but prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) Facilities with ancillary costs less than 75 percent or over 125 percent of the peer group weighted average shall have such costs raised or lowered to the specified limits. The peer group weighted ancillary average cost of the respective groups shall then be recomputed with these adjustments. The original ancillary costs of such facilities shall be subject to the ceilings.

(c)(1) In computing the allowable costs for inpatient routine services for hospitals, no amount shall be included that is in excess of 107.5 percent of the weighted average per diem cost, using total expected patient days developed from application of the length of stay standards, of routine inpatient services of all hospitals in the peer group. For the purposes of this calculation, the total expected patient days shall also include imputed days. For the purpose of this computation, routine inpatient services shall not include capital costs, or costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of 105 percent of the weighted average per discharge cost of ancillary services (including imputed discharges) of all hospitals in the peer group. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In determining a facility's disallowances, its routine and ancillary ceilings shall subsequently be adjusted to consider differences in a hospital's case mix complexity relative to its peers.

(2) For the purpose of establishing limits on allowable costs for interns and residents, supervising physicians and other individual physicians, no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the price index used for physician services as developed in section 86-1.15 of this Subpart. For the purpose of this computation, other costs excluded from peer group ceiling calculations as set forth in paragraph (1) of this subdivision, shall not be included.

(d) For the purposes of adjusting the allowable costs for inpatient routine services for other than specialty hospitals, a total length of stay standard for each hospital will be developed which shall take into consideration the following variables:

(1) patient mix characteristics;

(2) whether the hospital is a teaching or nonteaching institution;
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(3) the diagnostic mix of the hospital, including whether the hospital has a certified hospital-based ambulatory surgery service;

(4) presence or absence of surgery; and

(5) the geographic region the hospital is located in.

For the purpose of establishing standards a teaching hospital is one which has a special educational index greater than 100, as determined by the commissioner.

(e) For the purpose of establishing limits on allowable costs for a specialty hospital, a weighted average percentage change in operational cost per day from the prior year to the base year will be computed for facilities in that hospital’s region. In computing the allowable cost for specialty hospitals no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the aforementioned average percent change. For the purpose of this computation, costs excluded from peer group ceiling calculations, as set forth in subdivision (c) of this section shall not be included. In addition, reimbursement for specialty hospitals shall be limited to the movement in the application of the trend factor established under section 86-1.15 of this Subpart for 1984 and 1985 reimbursement periods. The allowances and pool distributions described in 86-1.11 shall be available to specialty hospitals pursuant to the conditions of that section.

* * *

(h) Limits on ceiling disallowances. (1) The total percentage of regional operational disallowances, excluding the minimum utilization disallowances, will be limited to the percentage of 1982 regional costs disallowed as a result of routine disallowances and one-half the length of stay disallowances, adjusted by a statewide adjustment factor, plus ancillary disallowances and the professional component limitation as set forth in subdivision (c) of this section. This maximum disallowance and the rate year disallowance subject to it will be adjusted to reflect appeals. Any excess disallowance in 1983 will result in proportionate relief to all hospitals subject to the disallowance within the affected region.

* * *
Calculation of trend factor. (a) The commissioner shall establish a trend factor for allowable operating cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

1. The elements of a medical facility’s costs shall be weighted based upon data for the following categories:
   - (i) salaries;
   - (ii) employee health and welfare expense;
   - (iii) nonpayroll administrative and general expense;
   - (iv) nonpayroll household and maintenance expense;
   - (v) nonpayroll dietary expense; and
   - (vi) nonpayroll professional care expense.

2. Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

3. Geographic differentials may be established where appropriate.

4. The cost indicators used in determining the projection factors shall be compared on a semiannual basis with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health. Based upon such review the commissioner may, in his discretion, either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

5. This subdivision has been superseded by section 2807-a(8) of the Public Health Law. The commissioner shall implement adjustments to the trend factor semiannually; provided, however, that adjustments, except for the final adjustment, in the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates of charge limits differing by more than one half of one percent from that which was previously determined.

(b) (1) The maximum increase in allowable charges shall be calculated by the use of the trend factors calculated in accordance with the methodology described in subdivision (a) of this section.

(2) The maximum allowable increase in gross inpatient charges shall be the product of allowable 1982 gross inpatient charges, the 1983 trend factor, and the ratio of 1981 inpatient costs to 1980 gross inpatient charges.

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.
(3) The provisions of this subdivision shall expire on December 31, 1983.

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Section 86-1.16  Adjustments to provisional rates based on errors.
Rate appeals pursuant to section 86-1.17(a)(1)-(2) of this Subpart, if not commenced within 120 days of receipt of the commissioner’s initial rate computation sheet, may be initiated at time of audit of the base year cost figures upon or prior to receipt of the notice of program reimbursement. Such rate appeals shall be recognized only to the extent that they are based upon mathematical or clerical errors in the cost and/or statistical data as originally submitted by the medical facility, or revisions initiated by a third-party fiscal intermediary or, in the case of a governmental facility, by the sponsor government, or mathematical or clerical errors made by the Department of Health. Such notice of appeal must be presented in writing prior to or at the exit conference for such audits.

TN #85-34
Supersedes TN #82-1
Approval Date July 23, 1987
Effective Date January 1, 1986
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Section 86-1.17 Revisions in certified rates

(a) The State Commissioner of Health shall consider only those applications for prospective revisions of certified rates and any established revenue cap in the current year which are in writing and are based on one or more of the following:

(1) reserved
(2) reserved
(3) reserved
(4) Documented increases in the overall operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the commissioner through the certificate of need (CON) process. The provisions of this paragraph shall be applicable with respect to appeals filed with payors, including article 43 corporations and intermediaries responsible as payors for titles XVIII and XIX Social Security Act programs. To receive consideration for the reimbursement of such
costs in the current rate year, a facility shall submit, at time of appeal or as requested by the commissioner, detailed staffing documentation, proposed budgets and financial data, anticipated unit costs and incremental costs for all directly and indirectly affected cost centers, initiated by the approved CON application involving any of the aforesaid activities pursuant to section 710.1 of this Title.

(i). reserved
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reserved

TN #89-6
Supersedes TN #85-34

Approval Date July 21, 1992
Effective Date January 1, 1989
(ii) If after the application of the programmatic and cost analyses, the commissioner determines that the budgeted incremental operating costs are more than 7.5 percent of the base year reimbursable operating costs for the rate(s) and rate year being appealed, a facility shall be reimbursed as follows:

(a) Net incremental costs, which are based on budgeted data, shall be determined by the commissioner after programmatic and cost analyses. Such analyses shall include, but not be limited to, a facility-wide review of cost centers directly and indirectly affected by the approved CON project. Such analyses shall result in a determination which limits budgeted costs as follows:

(1) Net increases in staffing shall be evaluated in accordance with the department peer group guidelines. For the purpose of establishing peer group staffing guidelines, at least the following general criteria shall be considered:

(i) number of certified beds;
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(ii) allocation statistics appropriate to each cost center or unit of service; and

(iii) number of full-time equivalents (FTE’s) per each cost center or unit of service.

Based on the groups established pursuant to the above, the commissioner shall develop staffing guidelines which shall be the average of staffing within a group for each cost center or unit of service. The guidelines developed through this process in conjunction with the programmatic review shall be used to evaluate the appealing facility’s requested FTE complement per cost center or unit of service.

(2) Nonsalary reimbursable operating costs shall be limited to the facility’s base year unit costs or, if these are not available, to group average unit costs, trended forward to the respective rate year by the trend factor established according to section [86-1.15] 86-1.58 of this Subpart, multiplied by the appropriate budgeted statistics.

(3) Energy costs shall be reimbursed in full if the facility can document that it has:

   (i) performed an energy audit pursuant to the guidelines of the State Energy Office in the “Energy Audit Report, EA-1 10-80 (revised as of October 1980), General
Instructions, Grant Programs for Schools and Hospitals and Buildings Owned by Units of Local Government and Public Care Institutions” and the accompanying Energy Audit Report, which are hereby incorporated by reference. Copies of the Energy Audit General Instructions and Report may be obtained from the New York State Energy Office, Empire State Plaza, Agency Building 2, 20th Floor, Albany, New York 12223. A copy is available for inspection and copying at the Records Access Office of the New York State Department of Health, Erastus Corning 2nd tower, Empire State Plaza, Albany, New York 12237, and at the New York State Department of State, 162 Washington Avenue, Albany, New York 12231; and (ii) adhered to Subchapter C, Chapter 2, Subtitle BB of Title 9 NYCRR (New York State Lighting Standards), as adopted by the New York State Energy Office on September 16, 1980, hereby incorporated by reference with respect to any new construction which is the subject of an appeal hereunder.
(4) If compliance with the above energy standards has not been documented, then energy costs shall be limited to the base year costs trended forward to the respective year by the trend factor established pursuant to section 86-1.15 of this Subpart, multiplied by the appropriate budgeted statistics.

(b) reserved

(c) reserved

(d) reserved

(e) reserved
(5) reserved

(6) reserved

(7) reserved

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TN #89-6
Supersedes TN #85-34

Approval Date July 21, 1992
Effective Date January 1, 1989
(c) An application by a medical facility for review of a certified rate is to be submitted on forms provided by the department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the department may request such additional documentation as determined necessary.

(1) The affirmation of revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a rate review officer on forms supplied by the department. The request shall contain a statement of the factual issues to be re-
solved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the rate review officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. No administrative appeal shall be available from this determination. The rate review officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting for the factual issues as determined by such officer. The hearing shall be held in conformity with the provisions of section 12-a of the Public Health Law and the State Administrative Procedure Act.

(3) The recommendation of the rate review officer shall be submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

(4) The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978 will not be required to be resubmitted subsequent to April 1, 1978.

(d) Reserved

(e) In reviewing appeals for revisions to certified rates, the commissioner may refuse to accept or consider an appeal from a medical facility:

(1) providing an unacceptable level of care as determined after review
(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law; or

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid. In such instances subdivision (d) of this section shall not be effective until the date the appeal is accepted by the commissioner.

(f) Any medical facility eligible for title XVIII (Medicare) certification providing services to patients insured under title XIX which is not, or ceases to be, a title XVIII provider of care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

(g) reserved

(h) reserved
(i) reserved

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TN #89-6
Supersedes TN #85-34
Approval Date July 21, 1992
Effective Date January 1, 1989
86-1.18 Rates for services. (a) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, separately identify all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner.

(b) Payment for newborns shall be made at one third of the mother’s rate.

(c) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, establish one all-inclusive prospective rate for inpatient hospital care to reflect the services provided by each facility possessing a valid operating certificate. In addition, the commissioner shall identify and certify all-inclusive prospective rates for emergency services, clinic services and for such other services as deemed appropriate.
Section 86-1.19 Rates for medical facilities without adequate cost experience. (a) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience, or when there is a new service for which there is a discrete rate and which is without adequate cost experience.

(b) The rates certified for such medical facilities or approved services as set forth in subdivision (a) of this section, shall be determined on the basis of generally applicable factors, including but not limited to the following:

(1) the usual and customary rates, for comparable services, in the geographic area;

(2) satisfactory cost projections;

(3) allowable actual expenditures; and

(4) an anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

* * *

(d) All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to section 86-1.8 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period, consistent with the provisions of this Subpart.
Section 86-1.20 Less expensive alternatives. Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could be reasonably anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service. In this respect, the chief executive officer of a medical facility will be required to submit to the State Department of Health as an attachment to the uniform financial report, effective with report periods beginning on or after January 1, 1977, an affidavit delineating the medical facility's practices of pursuing joint central services or less expensive alternatives. There must be a letter accompanying the affidavit, reflecting the health systems agency's acknowledgement that they have received such affidavit.
Section 86-1.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (Medicare) program.

(b) Allowable costs may not include costs for services that have not been approved by the commissioner.

(c) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (Medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(e) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(f) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(g) [Reserved]

(h) Allowable costs shall not include costs which principally afford diversion, entertainment or amusement to their owners, operators or employees.

(i) Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(j) Allowable costs shall not include the direct or indirect costs of advertising, public relations and promotion except in those instances where the advertising is specifically related to the operation of the facility and not for the purpose of attracting patients.

(k) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(l) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising and political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner pursuant to subdivision (f) of this section.

TN #85-34 Approval Date July 23, 1987
Supersedes TN #81-36 Effective Date January 1, 1986
(m) [Reserved]

(n) Allowable costs shall not include any element of cost, as determined by the commissioner, to have been created by the sale of a medical facility.
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Section 86-1.22 Recoveries of expense. Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

(a) drugs and supplies sold for use outside the medical facility;

(b) telephone and telegraph services for which a charge is made;

(c) discount on purchases;

(d) living quarters rented to employees;

(e) employee cafeterias;

(f) meals provided to special nurses or patients’ guests;

(g) operation of parking facilities for community convenience;

(h) lease of office and other space of concessionaries providing services not related to medical service;

(i) tuitions and other payments for educational service, room and board and other services not directly related to medical service.
86-1.23 Depreciation. (a) Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, 1983 edition, American Hospital Association, consistent with title XVIII provisions. This regulation is effective for depreciable assets purchased on or after January 1, 1978. Copies of this publication are available from the American Hospital Association, 840 North Lake Short Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the records access officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

(b) In the computation of rates effective January 1, 1975 for voluntary facilities, depreciation shall be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years’ digit method. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. Effective with the fiscal year starting on or after January 1, 1981 in instances where funding is required (that being the transfer of monies to the funded accounts), depreciation on major movable equipment shall be funded in the year revenue is received from the reimbursement of each expense and in the amount included in reimbursement for that year. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts [for six months or more] to be considered as valid funding transactions unless expended for the purposes for which it was funded.

(c) In the computation of rates effective January 1, 1975 for public facilities, depreciation is to be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years’ digits method.

(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight-line basis on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years’ digits method.
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(e) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan financed portion of the facilities, the State Commissioner of Health shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Subpart.
Section 86-1.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained. Financial need for capital indebtedness relating to a specified project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusted malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:

(i) for all medical facilities, investment income shall
(ii) any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

(iii) any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.

(d) Interest on current indebtedness shall be treated and reported as an operating, administrative expense.

(e) Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:

(1) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment; a note payable secured by the nonmovable equipment of a facility; a capital lease;

(2) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment;

(3) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to
the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptance demonstration to the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness; or

(4) incurred for the purpose of advance refunding of debt. [Losses] Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity day of the refunding debt.
(f) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility’s capital expense.

(g) Voluntary facilities shall report mortgage obligations, financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.
Section 86-1.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.
[Section 86-1.26 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.]
Section 86-1.27 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators, the commissioner may consider the quality of care provided to patients by the facility during the year in question.
Section 86-1.28 [Costs of related] Related organizations. (a) A related organization shall be defined as any entity which the medical facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association of material interest exists in an entity which supplies goods and/or services to the medical facility, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption. A special purpose organization shall be defined as an organization which is established to conduct certain of the facility's patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the organization’s activities, management and policies; or

(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by
the contributor or were otherwise required to be transferred to the facility or used as its
discretion or direction:

(ii) the facility has transformed some of its resources to a special purpose
organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a
dormitory) to a special purpose organization that is operating primarily for the benefit of the
facility.

(b) The costs of goods and/or services furnished to a medical facility by a
related organization are included in the computation of the basic rate at the lower of the cost to
the related organization or the market price of comparable goods and/or services available
in the medical facility's region within the course of normal business operations.

(c) If the medical facility has incurred any costs in connection with a related
organization, the final payment rate shall include the costs of such goods and/or services.
Section 86-1.29 Return on investment. (a) In computing the allowable costs of a proprietary medical facility, there shall be included an allowance of a reasonable return on the average equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner as reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider’s investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation for patient care activities.
Section 86-1.30  Capital cost reimbursement. The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29, 86-1.59 of this Subpart and be certified and audited as actually having been expended; provided, however, that:

(a) with respect to a facility for which a rate has been determined and certified by the Commissioner of Health prior to March 10, 1975, the Commissioner of Health may continue such method and computation of such rate or make such modifications and changes to lower such rate as in his judgement are necessary and proper and in the public interest; and

(b) with respect to a facility which has been established by the Public Health Council, and for which a rate has not been determined and certified by the Commissioner of Health prior to the effective date of this section, and a legally binding arms length lease was the basis for the establishment approval granted by the Public Health Council, the Commissioner of Health may determine and certify a rate on the basis of such lease. A lease with a related organization described in subdivision (a) of section 86-1.28 of this Subpart shall be deemed to be a non-arms length lease.

(c)(1) The provisions of this section shall not apply to any facility which, as of the effective date of this Subpart, is located in and operated from leased space pursuant to a lease:

(i) which was entered into and approved for reimbursement prior to March 10, 1975;
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(ii) which the commissioner finds to be bona fide, valid and noncancelable;
(iii) the terms of which the commissioner finds to be fair and reasonable; and
(iv) the payments, or portion thereof made pursuant to which, are found by the
commissioner to be the proper basis for reimbursement of capital cost paid to
such facility pursuant to article 28 of the Public Health Law prior to March 10,
1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of
this subdivision shall consist of a payment factor sufficient to reimburse the facility for
the total payments required under the base thereof to the extent approved by the
commissioner pursuant to paragraph (1) of this subdivision.

(d) In computation of rates for voluntary medical facilities which are rented from proprietary
interests, capital reimbursement shall be computed as if the facility were operated under
proprietary sponsorship, except where the realty was previously owned by the voluntary
medical facility, or where the proprietary interest has representation on the board of directors
of the voluntary medical facility.
(e) reserved
(f) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, under the hospital certificate of need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.
Section 86-1.31 Termination of service. The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or the withholding of such service and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-1.8(f) of this Subpart.
Section 86-1.32 Sales, leases and realty transactions.

(a) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner of Health, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29 and 86-1.30 of this Subpart.

(b) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations generally under section 86-1.30 of this Subpart, or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

(c) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment prior to October 23, 1992, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:

1 Included in rates of payment effective on and after October 23, 1993.
[(i)] (1) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;

[(ii)] (2) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and

[(iii)] (3) the leasing was based on economic and technical considerations.

[(iv)] (4) If all of these conditions are not met, the allowable rental cost shall not exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the equipment, such as interest, taxes, depreciation, insurance and maintenance costs.

[(v)] (5) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental for the cost of land is not includable in allowable costs.

(d) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment entered into on or after October 23, 1992 which meets any one of the four following condition, establishes the lease as a virtual purchase.

(1) The lease transfers title of the facilities or equipment to the lessee during the lease term.
(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee’s incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee’s incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(e) If a lease is established as a virtual purchase under subdivision (d) of this section, the rental charge is includable in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

(1) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchase.

\[\text{Included in rates of payment effective on and after October 23, 1993.}\]
(2) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital related costs in the year the asset is returned.

(3) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental an amount not in excess of the cost of ownership.

(4) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(5) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under subdivision (e) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.

(6) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.
(f) If a facility enters into a sale and leaseback agreement involving plant facilities or equipment on or after October 23, 1992, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:

(1) If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

(2) If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year.

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3 Included in rates of payment effective on and after October 23, 1993.

TN #93-46
Supersedes TN NEW
Approval Date May 7, 1996
Effective Date October 23, 1993
may not exceed the amount of costs of ownership for that year.

(3) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

(4) If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land is not includable in allowable costs.
Section 86-1.33 Hospital Closure/Conversion Incentive Programs.
(a) Hospital Closure Incentive Program. To reduce excess beds by encouraging the closure of hospitals, the Commissioner of Health may consider proposals by hospitals which mutually agree that one or more of the hospitals in the group shall close. The plan must be approved by the appropriate health systems agency prior to submission to the Commissioner of Health. The variable costs associated with the closed facility or facilities (which include personal costs) shall become part of the operating expenses of the remaining facilities in the group. The Commissioner of Health may consider a reasonable incentive structure for increased costs of the remaining facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(b) Hospital Conversion Incentive Program. (1) To encourage hospitals to reduce excess acute care beds by substantially reducing the certified capacity or by converting a substantial number of such beds to a level of care for which the commissioner has determined a need exists, the commissioner may consider proposals by one or more hospitals which provide for the substantial reduction of acute care beds. Each facility undergoing conversion of beds must submit an individual proposal. The proposal must be reviewed by the appropriate health systems agency prior to submission to the commissioner. The variable costs associated with any layoffs at the converting facility may become part of the operating expenses of the converting facility or the other facilities which are the subject of the proposal. The commissioner may consider a reasonable incentive structure for increased costs of the converting facility or the other facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(2) Paragraph (1) of this subdivision shall not apply in the case of a conversion caused by a determination under section 2806(6) of the Public Health Law, or where the commissioner finds that a conversion is entered into primarily to avoid the imposition of a utilization penalty.
Section 86-1.34 Pilot reimbursement projects. (a) The Commissioner of Health may waive the requirements of this Subpart to effect the development of additional knowledge and experience in different types of reimbursement mechanisms, contingent upon the approval of the United States Department of Health, Education and Welfare, and subject to the provisions of section 222(a) of the Social Security Act.

(b) Individual hospitals or groups of hospitals shall enter into such ventures with the understanding that the reimbursement received over the life of this pilot project shall be as defined in the experiment.
Section 86-1.35 [Reserved]
Section 86-1.36

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TN #89-6
Supersedes TN #85-34

Approval Date July 21, 1992
Effective Date January 1, 1989
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Supersedes TN #85-34

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Supersedes TN  #85-34

Approval Date    July 21, 1992
Effective Date   January 1, 1989
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Supersedes TN #85-34
Approval Date July 21, 1992
Effective Date January 1, 1989
Fund administration. (a) The commissioner or his designee shall create and administer the following pools of funds in each region defined in this section: a financially distressed hospital pool which will be funded by the allowances provided in section 86-1.11(g)(8) of the Subpart;

These pools shall be established for each of the following regions: Long Island (Nassau and Suffolk Counties); New York City (Richmond, Manhattan, Bronx, Queens, and Kings Counties); Northern Metropolitan (Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester Counties); Northeastern Blue Cross Region; Utica/Watertown Blue Cross Region; Syracuse Blue Cross Region; Rochester Blue Cross Region; Western Blue Cross Region. Hospitals not participating as of December 31, 1985 in the regional bad debt and charity care pools established pursuant to section 86-1.11 of this Subpart and no longer exempt from the provisions of section 2807-a of the Public Health Law shall be assigned to a region for purposes of calculating the bad debt charity care add-on percentage and making distributions from such pool pursuant to subdivision (p) of section 86-1.11 of this Subpart. Assignment to a region shall be based upon but not limited to the following factors:

(1) Numbers and types of hospitals within the region and
(2) Geographical proximity of the hospital requiring such assignment to a particular region.

(b) Monthly, each of the major third-party payors (Medicare, Medicaid and article 9C and article 44) will issue separate checks based upon the pool allowances to the pool administrator for each region, based on inpatient hospital claims with a service date on or after January 1, 1983 which were paid for the preceding monthly: one for the financially distressed hospital pool, and one for the bad debt/charity care pool.

(c) reserved

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category. For 1984 and 1985 the proxy for the “all other payor” category shall be similarly computed using the facility's 1983 and 1984 RCCAC logs, respectively. The facility shall pay to the pool administrator the regional allowances based upon these proxies on a monthly basis, by issuing three checks, one for each pool. Payments for January, February and March of 1983 must be submitted to the pool administrator on or before July 31, 1983. Payments for the months thereafter shall be submitted on or before the 20th day of the fourth month following the calendar month to which the payment applies. The January and February payments to be made to the pool administrator on or before May 20th and June 20th of each year shall be based upon the previous year's proxy. The methodology used to determine the proxy for the 1983, 1984 and 1985 payments received for the “all other payor” category shall not thereafter be adjusted to actual using cash receipts. However, on or about July 1, of each year when the previous year’s RCCAC data becomes available, facilities shall recalculate their annual liability for pool contributions for the previous year using this data. This recalculated amount shall also represent a new estimated liability for the current year. Facilities shall compare the newly calculated annual for the previous year to

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TN #87-48
Supersedes TN #-----
Approval Date November 21, 1988
Effective Date December 16, 1987
(d) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator, information for the “all other payor” category of the facility’s RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, television and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers’ Compensation, No-Fault, and other per diem payors not included in the “all other payor” category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due to the pools.

(e) If any hospital shall fail to timely file reports or submit checks in accordance with subdivision (d) of this section, then the distribution of any funds to such hospital will be withheld until such time as the reports and checks are appropriately submitted by such hospital. In addition, in the event that a hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital’s payments from all major third-party payors until such time as the required reports and checks are received by the pool administrator.

(f) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivision (g) of section 86-1.11 and 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from the major third-party payors will be made on or before March 14, 1983.

(g) During 1983 in the initial funding process of the pools, the immediate demand for funds from a particular pool may exceed the available funds in such pool. Also, because of a lag in distribution from some pools associated with the application process, some pools may have cash available beyond immediate distribution needs. In order to meet distribution needs as they arise, the commissioner or his designee, may, in 1983, allow borrowing from one pool to another within a region. In no event, however, will such borrowing be allowed.
by one pool from other pools in an amount in excess of projected amounts to be paid for the year by the major third-party payors to the borrowing pool, and in no event will borrowing be permitted if it will impair the ability of the lending pool to meet its distribution needs. All amounts borrowed shall be fully repaid during the first half of 1984.

(h) The major third-party payors shall provide the commissioner or his designee, at the time of check submission, with reports showing the paid claims by region, including, but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(i) The commissioner or his designee shall retain amounts in each regional pool, as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

(j) The commissioner is authorized to make contingent distributions from the financially distressed hospital pool upon filing of this regulation, to hospitals participating in the transitional reimbursement program as of December 31, 1982 and to such other hospitals as are found by the commissioner to be in serious financial jeopardy, in amounts necessary to stabilize and maintain operations, taking into account available pool funds. Distributions shall be contingent upon subsequent determinations by the commissioner of hospital participation in the financially distressed hospital pool pursuant to standards to be adopted by the State Hospital Review and Planning Council. After these determinations by the commissioner, any contingent amounts to which such hospitals are found by the commissioner to be unentitled shall be repaid by the hospitals to the pool.

(k) Fund administration in 1986 and 1987 regional pools. The commissioner or his designee shall establish and administer the pools created by the provisions of subdivision (p) and (q) of section 86-1.11 of this Subpart according to the criteria contained in this section applicable to the period January 1, 1985 through December 31, 1985, with the following exceptions for regional pools:

(1) Article 43 corporations and Medicaid shall each issue separate monthly checks to the regional bad debt and charity care pools and to the regional financially distressed facility pools.

(2) reserved
Reserved

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TN #88-6
Supersedes TN #87-5

Approval Date  August 1, 1991
Effective Date  January 1, 1988
(3) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator information from the “all other payor” category of the facility’s RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, televisions and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers’ Compensation, No-Fault, article 44 corporations, and other per diem payors not included in the “all other payor” category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due the pools.

(4) If any hospital shall fail to timely file reports or submit checks in accordance with paragraph (3) of this subdivision, the distribution of any funds to such hospital in accordance with the distribution schedule in subdivisions (p) and (q) of section 86-1.11 of this Subpart shall be withheld until such time as the reports and checks are submitted by such hospital. In addition, in the event that a hospital fails to timely submit the required reports and checks, the hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital’s payments from both major third-party payors until such time as the required reports and checks are received by the pool administrator.

(5) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivisions (p) and (q) of section 86-1.11 and section 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from both major third-party payors.

(6) Article 43 corporations and the New York State Department of Social Services shall provide the commissioner or his designee, at the time of the check submission, with reports showing the paid claims by region, including but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(7) The commissioner or his designee shall retain amounts in each regional pool as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

(1) reserved.
Section 86-1.38 Alternative reimbursement method for mergers or consolidations.
As used in this section, the term merger shall mean the combining of two or more medical facilities, licensed under article 28 of the Public Health law, where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. The provisions of this section shall apply only if facilities seek an alternative reimbursement mechanism to complete the merger. Otherwise, reimbursement for merged facilities will be consistent with all other provisions of this Subpart.

(a) Application for merger. A merger shall meet all of the following qualifying criteria and conditions:

(1) There is a demonstrated public need for the existing hospital service in whole or in part at the current site(s) of the applicant. The determination of public need shall be made pursuant to section 2802 of the Public Health Law and in accordance with Part 709 of this Title.

(2) The application must include a demonstration of overall financial savings that can be obtained within three years from the date of inception. This projection of savings should demonstrate reduction of overall costs for the separate entities, and reduction of gross reimbursement based on costs from third-party payors due primarily to reduction in beds or services.

(3) The medical facilities must demonstrate that adequate health care services are and will be provided; that conformity with the State Hospital Code is, and will be, maintained, and an approved plan of correction for any operational and structural deficiencies in accordance with State Hospital Code has been filed.

(b) In order to meet the requirements of paragraph (a)(2) of this section, the facility(s) must submit to the commissioner a plan of merger. This plan should include, but not be limited to:

(1) a description and composition of the proposed governing structure of the facilities submitting the applications;

(2) the development of a market analysis of the population being served;

(3) development of a functional consolidation of services, outlining:

(i) changes in the size and scope of the medical staff organization;

(ii) clinic and outpatient activities;

(iii) the integration of such areas as administration, operation of plant, laboratory, X-ray, therapies, for example;

(iv) redeployment of existing employees and future labor practices; and
(v) such other information as the commissioner may require

(4) financial plan which provides for:

(i) expected changes in revenues and expenditures due to the actions to be taken by the facilities. This shall be presented in the form of a projected budget for the merged entity and shall include compete budgeted uniform statistical and financial reports; and

(ii) projected changes in salaries, fringe and union benefits;

(5) a capital plan which outlines expected capital outlays necessary to effectuate the planned merger; and

(6) changes in the quality and volume of health services to be provided as a result of the planned merger.

(c) Operating and capital costs reimbursement. Reimbursement under the provisions of this section for mergers meeting the requirements of subdivision (a) of this section shall be determined as follows and shall be for a period not to exceed three years from the date of approval of formal corporate merger of the involved facilities. Following a review of the budgeted statistical and financial data submitted by the facilities, the commissioner shall develop a new group for the merged institution, excluding the projected costs and statistics of the merged institution. All applicable ceilings shall be calculated as required by this Subpart.

(1) Mergers with ceiling penalties. In the event that the merged institution incurs ceiling penalties, the commissioner may waive these penalties for the first full year of operation under the merger. In the second year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than one third of the amount waived in the first year, increased by the trend factor into the current rate period. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than two thirds of the amount waived in the first year, increased by the trend factor into the current rate period.

(2) Mergers without ceiling penalties. In the event that the merged institution incurs no ceiling penalties, rates during the first year of operation will be determined by taking the approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period. In the second year of operation, facility rates will be the initial approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period less two percent. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics increased by the appropriate trend factor into the current rate period less four percent.

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Supersedes TN #81-36
Approval Date July 23, 1987
Effective Date January 1, 1986
(3) Facilities reimbursed under this section will not be eligible for waiver of ceiling penalties in the fourth year of operation as a merged facility. In the fourth year, the facility's reimbursement rate will be based on budgeted costs for the immediate preceding year subject to the standard Part 86 methodology applicable in the fourth year. In all years subsequent to the fourth year, actual base year costs of the facility will be subjected to the standard Part 86 methodology applicable at the time.

(d) Capital Reimbursement. Capital costs associated with a closure of a facility as part of an approved plan under this section will be reimbursable to the new, merged entity subject to appropriate Federal waiver.

(e) Upon application to the commissioner, a volume adjustment as specified in section 86-1.12 of this Subpart may be implemented.

(f) Where a facility(s) covered under this Subpart demonstrates to the commissioner, subsequent to its initial participation in this Subpart, that a deviation from the original approved plan and budget will provide a more cost effective result, a new plan and budget that has been approved by the commissioner will be accepted and utilized in formulation of revised reimbursement rates for the remaining time of participation in the Subpart.

(g) Annual report. Each year a facility(s) covered under this Subpart must demonstrate to the commissioner the cost savings arising from the improved efficiencies and more effective delivery of care due to the merger, consolidation or closure of the facilities participating in the plan. This report should reflect the objectives outlined in the approved plan and be issued by the governing authority of the facilities participating.

(h) Termination of facility(s) participation. Reimbursement under this section shall terminate if:

   (1) the facility deviates from its plan of merger without written approval of the commissioner;

   (2) the facility fails to continue to meet the criteria delineated in this section; or

   (3) three years have passed from the date of certification of the rate established pursuant to this section.
86-1.39 [Workers’ compensation and not fault reimbursement rates.] Reserved
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Section 86-1.40  Alternative reimbursement method for medical facilities with extended phase-in periods. The current reimbursement system may not enable new or substantially changed facilities which require an extended start-up period to proceed in a financially viable manner and, therefore, the following alternative reimbursement method is established to insure that needed and qualifying medical facilities can develop.

(a) Facilities which apply for alternative reimbursement under this section must demonstrate that the following qualifying criteria have been met:

1. The commissioner is satisfied that adequate health care services are and will be provided by the facility.
2. There has been a finding by the commissioner that the projected expansion and phase-in of the medical facility is appropriate and in the public interest.
3. Pursuant to a plan of construction or expansion, approved by the commissioner, the facility will either be opening as a new facility or opening additional beds, commencing additional services, or projecting staffing increases.
4. The facility can demonstrate to the satisfaction of the commissioner that its staffing and operational costs will, by the end of its approved transition period, be within acceptable staffing guidelines and capable of operating under the standard reimbursement methodology.
5. The facility must demonstrate that it meets the criteria of a new facility or the criteria set forth in paragraph (4) of section 86-1.17 of this Subpart. A new facility is defined as one that has had no previous cost experience and no previous operating certificate.
6. There are such other related indications of substantial changes as the commissioner may specify.

(b) Facilities which apply for alternative reimbursement under this section will be required to submit, subject to the approval of the commissioner, the following information at least 60 days prior to the start of the alternative reimbursement period:

1. a market analysis of the population to be served;
2. an organization description of the hospital, including a description of the medical staff organization and composition of the governing body;
3. a detailed plan of the phase-in of routine and ancillary services, beds, staffing levels and expected utilization by major program area during the phase-in period in a manner prescribed by the commissioner;
4. a detailed transitional financial plan which reflects anticipated revenues, including annual tax levy support and expenditures during the phase-in period, including a facility

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Supersedes TN  #81-36 Effective Date January 1, 1986
budget which reflects planned services expansion as described in paragraph (b)(3) of this section. If requested by the commissioner, the facility shall provide a line item budget with respect to staffing and personnel, and such detail as prescribed by the commissioner for other than personal service items, including capital.

(c) A facility which meets the criteria and informational requirements in subdivisions (a) and (b) of this section, and has received the commissioner’s approval of its detailed transitional financial plan, shall have the operating and capital components of its rate established as follows:

(1) A reimbursement rate established under this section shall only be for a time period as approved in the facility’s submitted plan, but no greater than five years.

(2) The capital cost component of the rate for each year of the plan will be based on approved annual budgeted cost, divided by the approved targeted patient volume for the rate year and retrospectively adjusted to actual certified cost.

(3) The operating component of the rate will be determined based on an approved budget subject to the following limitations and adjustments:

   (i) Changes in personal service and nonpersonal service costs from the base period to the rate period shall be limited to the same factors for inflation which affect the hospital industry, except that costs associated with the phase-in of beds, programs and services which were not existent in a previous period will be allowed, subject to the review and approval of their incremental costs.

   (ii) For each year in transition, a peer group will be simulated for the facility. The simulation will be based on the facility’s approved budget and phase-in statistics for the facility. The operating component of the reimbursement rate will be subjected to a maximum of the peer group coiling increased by no greater than five percent times the remaining years of the transition period.

   (iii) If the facility’s volume is below the approved target volume, no adjustment shall be made.

   (iv) If the facility’s volume is above the approved targeted volume by five percent, the facility will be submitted to a volume adjustment to adjust their rate over the approved target for incremental costs.

   (v) The hospital will be expected to meet the length of stay standards specified in section 86-1.17 of this Subpart.

   (vi) The rates established under this section shall be prospective and be subject to adjustment and audit. A length of stay penalty, utilization penalty and volume adjustment
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may be implemented in the year succeeding the rate period in which the respective requirements are not met.

(d) Reimbursement under this section shall terminate if:

(1) the facility significantly deviates from its approved plan without the written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section;

(3) the facility requests to withdraw from this program with the understanding that participation in subsequent rate years is prohibited.

(e) The effective date of the reimbursement rate established pursuant to this section shall be the day on which Federal approval is effective.
86-1.41  [Hospital-based ambulatory surgery rates.]  Reserved
Section 86-1.42 Hospital-based Physician Reimbursement Program.

(a) Definitions. As used in this section:

1. Physician shall mean hospital-based supervisory and other salaried physicians, excluding interns and residents.

2. Fringe benefits shall mean fringe benefits required by law, plus health, welfare, retirement, and educational benefits given in lieu of direct compensation.

3. Total physician compensation shall mean the prospectively set base year compensation for physicians responsible for a service or department plus a fringe benefit allowance not to exceed 25 percent of the base year compensation, less any portion of that compensation which is for other than that service or department.

4. Total employee staff compensation shall mean the prospectively set base year compensation for nonphysician employees assigned to a service or department, plus a fringe benefits allowance, less any portion of that compensation which is for other than that service or department.

(b) Notwithstanding any other provision of this Subpart, allowable reimbursable costs for physicians responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine and pathology, nuclear medicine, electrocardiography and hospital cardiology services, exclusive of cardiac catheterization, shall be 104 percent of total physician and employee staff compensation for each of these services. Allowable reimbursable costs for physicians responsible for clinical laboratory services shall be 103 percent of total physician and employee staff compensation for such services. Reimbursement paid pursuant to this subdivision in excess of actual salaries, fringe benefits, and incentive payments, if any, shall be called professional development funds. These funds shall be distributed by the hospital among the clinical laboratory service and the aforementioned inpatient diagnostic and therapeutic services and departments. These funds shall be considered departmental funds and may be used to improve the clinical care of patients receiving services from the department, to enhance or supplement the department’s educational program, and for purchases of hospital patient care equipment. These funds shall be committed annually.

(c) Notwithstanding any other provision of this Subpart, hospitals shall be reimbursed for the cost of a single adjustment to total physician compensation for physicians who are responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine including all clinical laboratories and pathology, nuclear medicine, electrocardiography and hospital cardiology services exclusive of cardiac catheterization, provided that the overall compensation for such physicians in aggregate does not exceed the 80th percentile as reported in the American Association of Medical Colleges faculty compensation survey for the base year. This adjustment shall be in an amount sufficient to provide funds for overall compensation of such physicians in the aggregate equivalent to the 80th percentile as reported in the survey. The cost of such adjustment in excess of the

TN #85-34 Approval Date July 23, 1987
Supersedes TN #81-36 Effective Date January 1, 1986
limitation on allowable costs for such services as set forth in section 86-1.14(c) of this Subpart shall be excluded from the calculation of base period costs and shall be reimbursed.

(d) The provisions of this section shall apply only to those hospitals:

(1) which apply to the commissioner for participation in this program within six months of the effective date of this section;

(2) which have a written agreement with their physicians which specifies physician responsibility with regard to scope of service and education of all physicians on the prudent use of diagnostic services and which specifies productivity and utilization standards for all departments to reduce unit costs of services;

(3) which document a fixed prospective physician compensation arrangement set in advance of the rate year, which may include an incentive plan provided such plan does not exceed 15 percent of the aggregate prospective base compensation and provided such plan has been approved by the commissioner upon a showing by the hospital that incentive plan costs will be offset by equivalent productivity gains and cost savings; and

(4) which, following the first year of participation in the program, document annually an appreciable reduction in unit costs of services as a result of participation in the program.

(e) This section shall be contingent upon Federal financial participation.
86-1.43 [Medicare adjustment]  Reserved

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TN #88-6
Supersedes TN #85-34
Approval Date  August 1, 1991
Effective Date January 1, 1988
86-1.44 [Computation of rates of payment for licensed freestanding ambulatory surgery centers.] Reserved

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Section 86-1.45 Federal financial participation. The rates of payment made for inpatient hospital services rendered to title XIX recipients established in accordance with the methodology contained in this Subpart shall be contingent upon Federal financial participation (FFP) and approval.

TN #85-34
Supersedes TN NEW

Approval Date July 23, 1987
Effective Date January 1, 1986
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101(a)

86-1.46 Reserved

TN #88-6
Supersedes TN NEW

Approval Date August 1, 1991
Effective Date January 1, 1988
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86-1.48  Reserved 

TN #88-6  
Supersedes TN NEW  
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86-1.49  Reserved

TN #88-6
Supersedes TN NEW

Approval Date  August 1, 1991
Effective Date  January 1, 1988
Hospital Inpatient Reimbursement - Effective December 1, 2009

Definitions. As used in this Section, the following definitions shall apply:

1. Diagnosis related groups (DRGs) shall mean the 3M Corporation All-Patient-Refined (APR) classification system, which utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of a patient's condition and the associated risk of mortality, and reflects such factors as the patient's medical diagnosis, severity level, sex, age, and procedures performed.

   a. Effective January 1, 2013, Version 30 of the APR classification system will be used.

2. DRG case-based payment per discharge shall mean the payment to be received by a hospital for inpatient services rendered to each patient based on the DRG to which that patient has been assigned, as determined by multiplying the statewide base price by the applicable service intensity weight (SIW) and facility-specific wage equalization factor (WEF) and as further adjusted for teaching hospitals by the inclusion of reimbursement for direct and indirect graduate medical education (GME) costs and for all hospitals, the inclusion of non-comparable costs.

3. Service intensity weights (SIWs) are the cost weights established such that the SIW for any given DRG indicates the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs. Weights are developed using cost data from Medicaid fee-for-service, Medicaid managed care and commercial payors as reported to the Statewide Planning and Research Cooperative System (SPARCS).

4. Case mix index (CMI) shall mean the relative costliness of a hospital’s case mix relative to the case mix of all other hospitals as reflected in the weighted aggregate SIW for the hospital.

5. Reimbursable operating costs shall mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, adjusted for inflation between the base period used to determine the statewide base price and the rate period in accordance with trend factors determined pursuant to the applicable provisions of this Attachment, but excluding the following costs:

   a. ALC costs;
   b. Exempt unit costs;
   c. Transfer costs; and
   d. High-cost outlier costs.

TN #13-01 Approval Date August 9, 2013
Supersedes TN #12-04 Effective Date January 1, 2013
6. **Graduate medical education (GME).**

   a. **Direct GME costs** shall mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians trended to the rate year by the applicable provisions of this Attachment.

   b. **Indirect GME costs** shall mean an estimate of the costs associated with additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies result from the training of residents and fellows.

7. **High-cost outlier costs** for payment purposes shall mean 100 percent of the hospital’s charges converted to cost using the hospital’s most recent ratio of cost-to-charges that exceed the DRG specific high-cost thresholds calculated pursuant to Exclusion of Outlier and Transfer Costs of this Section.

8. **Alternate level of care (ALC) services** shall mean those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

9. **Exempt hospitals and units** shall mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of Exempt Units and Hospitals of this Section, rather than receiving per discharge case-based rates of payment.

10. **The wage equalization factor (WEF)** shall mean the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.

11. **Statewide Base price** shall mean the numeric value calculated pursuant to Statewide Base Price of this Section, which shall be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.

12. **Non-comparable adjustments** shall mean those base year costs that are passed through the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following shall be considered non-comparable adjustments:

    a. Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the Institutional Cost Report (ICR); and
b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and

c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act.

13. Transfers. For purposes of transfer per diem payments, a transfer patient shall mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or

b. is transferred to an out-of-state acute care facility; or

c. is a neonate who is being transferred to an exempt hospital for neonatal services.

14. Discharges, as used in this Section, shall mean those inpatients whose discharge from the facility occurred on or after December 1, 2009, and:

a. the patient is released from the facility to a nonacute care setting;  
b. the patient dies in the facility; or  
c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or  
d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

15. Arithmetic Inlier Length of Stay (ALOS) shall mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including the day of discharge. The ALOS shall be calculated for each DRG on a statewide basis.

16. General hospital, as used in this Section, shall mean a hospital engaged in providing medical or medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions or deformities.
17. **Charge converter** shall mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.

18. **IPRO** shall mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.
**Statewide base price.**

1. For periods on and after December 1, 2009, a statewide average cost per discharge shall be established in accordance with the following:

   a. Reimbursable Medicaid acute operating costs, excluding costs related to graduate medical education, alternate level of care, exempt units, patient transfers, high-cost outliers, and non-comparables, derived from the base period in paragraph (3);
   b. Adjust subparagraph (a) for case mix and wage neutrality factors derived from the base period in paragraph (3);
   c. Divide subparagraph (b) by Medicaid inpatient discharges from the base period in paragraph (3); and
   d. Adjust subparagraph (c) for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of this Attachment.

2. An adjustment will be made to the statewide average cost per discharge, calculated in accordance with subparagraph (1) of this section, to establish a “statewide base price” that generates the same level of total Medicaid payments for the reimbursement of operating costs as total Medicaid payments made for the reimbursement of operating costs during calendar year 2008 subsequent to the exclusion of prior period adjustments and the following reductions:

   a. One hundred fifty-four million five hundred thousand dollars; and
   b. Two hundred twenty-five million dollars.

No further reconciliation adjustment to the statewide base price to account for changes in volume or case mix will be implemented.

3. For periods on and after December 1, 2009, the “base period” shall be the 2005 calendar year except as noted in subparagraph (a) below and “operating costs” shall be those reported by each facility to the Department prior to July 1, 2009.

   a. For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period ended March 31, 2006.
   b. Discharges to be used for direct graduate medical education and non-comparable adjustments in accordance with the Definitions section should be 2007, provided, however, that discharges for non-comparables adjustments shall not include those patients that are transferred to a facility or unit that is exempt from the case-based system, except when the patient is a newborn transferred to an exempt hospital for neonatal service and thus classified as a transfer patient pursuant to this Section.
4. To establish the Transition II Pool, effective October 20, 2010, the statewide base price will be reduced such that the level of total Medicaid payments shall be decreased for the periods specified on the ‘Transition II Pool’ section by the corresponding Transition II fund amount.

5. For the period effective July 1, 2011 through March 31, 2012, the statewide base price will be reduced such that the level of total Medicaid payments are decreased by $24.2 million.

6. For the period May 1, 2012, through March 31, 2013, and for state fiscal year periods on and after April 1, 2013, the statewide base price shall be adjusted such that total Medicaid payments are decreased for each such period by $19,200,000.
Exclusion of outlier and transfer costs.

1. In calculating rates pursuant to this Section, high-cost outlier costs from hospitals with ancillary and routine charges schedules shall be excluded from the statewide base price and shall equal 100 percent of the excess costs above the high cost outlier threshold which shall be developed using acute Medicaid operating costs derived from the base period used to calculate the statewide base price. The Medicaid discharges to be applied to the high-cost outlier thresholds shall be those that occurred in the base period used to calculate the statewide base price.

2. In calculating rates pursuant to this Section, transfer case costs shall be excluded from the statewide base price by excluding the transfer discharges that occurred in the base period used to calculate the statewide base price, except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.
Service Intensity Weights (SIW) and average length-of-stay (LOS).

1. The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/ and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) below. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods on and after December 1, 2009 through December 31, 2010, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the Department by September 30, 2009.

3. For periods on and after January 1, 2011 through December 31, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the Department by June 30, 2010.

4. For periods on and after January 1, 2012 through December 31, 2012, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2007, 2008 and 2009 calendar years as submitted to the Department by September 30, 2011.

5. For periods on and after January 1, 2013 through [December 31, 2013]June 30, 2014, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2008, 2009 and 2010 calendar years as submitted to the Department by September 30, 2012.
Wage Equalization Factor (WEF).

1. The statewide base price per discharge shall be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment shall be used to adjust for the level of wage and fringe benefit costs for each hospital in accordance with the following:

   a. The WEF shall be based on each hospital’s occupational mix and wages for registered nurses, licensed practical nurses, surgical technologists, nursing aides, orderlies, attendants and medical assistants as reported and approved by the federal Medicare program, and the hospital’s proportion of salaries and fringe benefit costs to total operating costs as reported to the Institutional Cost Report (ICR). The WEF shall be computed as follows:

      I. For all occupations described in paragraph (a), a statewide average salary shall be calculated by dividing the statewide sum of hospitals’ total dollars paid by the statewide sum of hospitals’ hours paid; and

      II. For each hospital, an actual weighted average salary shall be calculated by dividing the total dollars paid for such occupations by the total hours paid for such occupations; and

      III. An initial WEF shall be calculated for each hospital by dividing the hospital-specific actual weighted average salary as calculated pursuant to subparagraph (ii) of this paragraph by the statewide average salary calculated pursuant to subparagraph (i) of this paragraph; and

      IV. The final WEF shall be calculated using the following formula:

         \[
         (1 / \left( \frac{\text{Labor Share}}{\text{Initial WEF}} \right) + \text{Non-Labor Share}) \]

         where “Labor Share” is calculated by dividing the hospital’s total salary cost plus the hospital’s total fringe benefits by the hospital’s total operating costs as reported in the ICR for the same calendar year used to calculate the statewide base price for the applicable rate period. The “Non-Labor Share” equals 1 less the “Labor Share” of costs.

   b. A hospital may submit updated occupational service data as approved by the federal Department of Health and Human Services prior to January 1 of a rate year for use in calculating the WEF in accordance with this Section.
c. For those hospitals that are in bankruptcy proceedings in the base year and that have subrogated their labor contracts, the Commissioner shall use the higher of the hospital-specific or regional average WEF. These regions will be consistent with those used in the development of exempt unit cost ceilings.
Add-ons to the case payment rate per discharge.

Rates of payment computed pursuant to this Attachment shall be further adjusted in accordance with the following:

1. A direct graduate medical education (GME) payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility's total reported inpatient Medicaid direct GME costs by its total reported Medicaid discharges as defined in the Statewide Base Price Section. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from the cost included in the statewide base price.

2. (a) An indirect GME payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

\[
(1 - \frac{1}{(1+1.03(((1+r) ^0.0405)-1))})
\]

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics of the hospital for the period ended June 30, 2005, as contained in the survey document submitted by the hospital to the Department as of June 30, 2009, and the staffed beds for the general hospital reported in the 2005 ICR and submitted to the Department no later than June 30, 2009, but excluding exempt unit beds and nursery bassinettes.

(b) Indirect GME costs are those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from computation of the statewide base price. The amount of such exclusion shall be determined by multiplying the total reported Medicaid costs less reported direct GME costs by the following formula:

\[
1.03(((1+r) ^0.0405)-1)
\]

where "r" equals the ratio of residents and fellows to beds as determined in accordance with subparagraph (a) of this paragraph.
3. A non-comparable payment per discharge shall be added to case payment rates after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility’s total reported Medicaid costs for qualifying non-comparable cost categories by its total reported Medicaid discharges as defined in the Statewide Base Price Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from the cost included in the computation of the statewide base price.
4. For the rate periods on and after December 1, 2009, additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made, in accordance with the following:

a. General hospitals eligible for distributions pursuant to this section shall be those nongovernmental hospitals with total Medicaid discharges equal to or greater than seventeen and one-half percent for 2007, and a total reduction in Medicaid inpatient revenue, as a result of the application of otherwise applicable rate-setting methodologies in effect for the period December 1, 2009 through March 31, 2010, in excess of 9.7%.

b. For the period December 1, 2009 through March 31, 2010, $33.5 million dollars shall be allocated to eligible hospitals such that no hospital’s reduction in Medicaid inpatient revenue, as a result of the hospital acute care rate methodology changes that are effective December 1, 2009, exceeds 9.7%. The allocation amount for each eligible hospital shall equal the amount of inpatient Medicaid revenue for that hospital that existed using the Medicaid reimbursement provisions in effect immediately prior to the revisions instituted on December 1, 2009, multiplied by that hospital’s percentage of reduced Medicaid revenue that is in excess of the threshold set forth in paragraph (a)(ii).

c. For periods on or after April 1, 2010, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital’s allocation of the funds distributed for the period December 1, 2009 through March 31, 2010, to the total funds distributed for that period applied to the appropriate funds available for the applicable periods below:

   i. for the period April 1, 2010 through March 31, 2011, $75 million;
   ii. for the period April 1, 2011 through March 31, 2012, $50 million; and
   iii. for the period April 1, 2012 through March 31, 2013, $25 million.

d. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added to the rates shall be established by dividing the total allocated funds in accordance with paragraph (b) and (c) by the hospital’s total reported Medicaid discharges in the applicable base period.

e. Each hospital receiving funds pursuant to this section shall, as a condition for eligibility for such funds, adopt a resolution of the Board of Directors of each such hospital setting forth its current financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such Board of Directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report fails to set forth adequate progress, as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions pursuant to this section and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section. The Commissioner shall be provided with copies of all such resolutions and reports.
New York
111(a)

5. **Transition II Pool.** For the rate periods on and after October 20, 2010 additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made in accordance with the following:

a. Hospitals eligible for distributions pursuant to this section shall be those governmental and nongovernmental general hospitals with:

   i. total Medicaid inpatient discharges equal to or greater than 17.5% for the 2007 period; and

   ii. total reduction in Medicaid inpatient revenue, as a result of the application of otherwise applicable rate-setting methodologies in effect for the period October 20, 2010 through March 31, 2011, in excess of 10.2%.

b. For the period October 20, 2010 through March 31, 2011, total funding equaling $37.5 million shall be allocated. The allocation amount for each eligible hospital shall equal the amount of inpatient Medicaid revenue for that hospital that existed using the Medicaid reimbursement provisions in effect immediately prior to the revisions instituted on December 1, 2009, multiplied by that hospital’s percentage of reduced Medicaid revenue that is in excess of the threshold set forth in paragraph (a)(ii).

c. For the periods on and after April 1, 2011, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital’s allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period applied to the appropriate funds for the applicable periods below:

   i. for the period April 1, 2011 through March 31, 2012, $75 million; and

   ii. for the period April 1, 2012 through March 31, 2013, $50 million; and

   iii. for the period April 1, 2013 through March 31, 2014, $25 million.

d. The distributions authorized pursuant to this section shall be made available through a commensurate reduction in the statewide base price for the October 20, 2010 through March 31, 2011, and each applicable period thereafter, as otherwise computed in accordance with the Statewide Base Price Section.
New York  
111(b)

e. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added on to the rates for the period October 20, 2010 through March 31, 2011 shall be established by dividing the total funds allocated in accordance with paragraph (b) by six months of the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment. For the periods on and after April 1, 2011 the amount per discharge to be added on to the rates shall be established by dividing the total funds allocated in accordance with paragraph (c) by the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment.

f. Hospitals receiving funds pursuant to this section that did not previously receive funds to facilitate improvements in hospital operations and finances beginning on December 1, 2009, shall, as a condition for eligibility for such funds, adopt and submit a restructuring plan that includes both an assessment of the hospital's current financial position and the plan to restructure and improve its financial operations. The plan must also provide for ongoing Board oversight of plan implementation, along with measurable objectives. Two years following receipt of funds, the Board of Directors must issue a report setting forth what progress has been made toward accomplishing the goals of the restructuring plan. The Commissioner shall be provided with copies of all such resolutions and reports. If such report fails to set forth adequate progress toward the goals of the hospital's restructuring plan as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section.

g. Unallocated funds awarded to hospitals deemed ineligible by the Commissioner, as a result of paragraph (f) of this section, shall be redistributed to all remaining eligible hospitals using the proportion of each eligible hospitals' allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period.
Outlier and transfer cases rates of payment.

1. **a.** High cost outlier rates of payment shall be calculated by reducing total billed patient charges, as approved by IPRO, to cost, as determined based on the hospital's ratio of cost to charges. Such calculation shall use the most recent data available as subsequently updated to reflect the data from the year in which the discharge occurred, and shall equal 100 percent of the excess costs above the high cost outlier threshold. High cost outlier thresholds shall be developed for each individual DRG and adjusted by hospital-specific wage equalization factors (WEF) and increased by the U.S. Consumer Price Index for all Urban consumers from the base period to the rate period used to determine the statewide base price and the rate period.

**b.** Cost outlier thresholds for each base APR-DRG will be calculated as follows:

- **i.** using the applicable base year Medicaid claims data, organize costs per claim with each base APR-DRG from least to greatest value.
- **ii.** divide the listing of claims from subparagraph (i) for each base APR-DRG into three quartiles;
- **iii.** the first quartile (Q1) is the set of data having the property that at least one-quarter of the observations are less than or equal to Q1 and that at least three-quarters of the data are greater than or equal to Q1;
- **iv.** the third quartile (Q3) is conversely identified;
- **v.** determine the inter-quartile range (IQR) by identifying the spread of the difference between Q1 and Q3 (\(IQR = Q3 - Q1\));
- **vi.** cost outlier thresholds are determined by applying the IQR as follows:

\[
(y) \times IQR + Q3
\]

where \((y)\) equals a predetermined standard multiplier. This multiplier is a factor of 5.5.

**c.** A non-public, not-for-profit general hospital which has not established an ancillary and routine charges schedule shall be eligible to receive high-cost outlier payments equal to the average of high-cost outlier payments received by comparable hospitals, as determined using the following criteria:

- **i.** downstate hospitals;
- **ii.** hospitals with a case mix greater than 1.75;
- **iii.** hospitals with Medicaid revenue greater than $30 million; and
- **iv.** hospitals with a proportion of outlier to inlier cases greater than 3.0 percent.
2. Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital shall be calculated on the basis of a per diem rate for each day of the patient’s stay in the transferring hospital, subject to the exceptions set forth in paragraphs (a), (b) and (c) of this paragraph. The total payment to the transferring facility shall not exceed the amount that would have been paid if the patient had been discharged. The per diem rate shall be determined by dividing the DRG case-based payment per discharge as defined in the Definitions Section by the arithmetic inlier length of stay (LOS) for that DRG, as defined in the Definitions Section, and multiplying by the transfer case’s actual length of stay and by the transfer adjustment factor of 120 percent. In transfer cases where the arithmetic inlier LOS for the DRG is equal to one, the transfer adjustment factor shall not be applied.

a. Transfers among more than two hospitals that are not part of a merged facility shall be reimbursed as follows:

i. the facility which discharges the patient shall receive the full DRG payment; and

ii. all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG.

b. A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.

c. Transfers among non-exempt hospitals or divisions that are part of a merged or consolidated facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.

d. Services provided to neonates discharged from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain shall be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.
Alternate level of care payments (ALC).

1. Hospitals shall be reimbursed for ALC days at the appropriate 1987 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D trended to the rate year.

   The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph shall be based on the combination of residential health care facilities as follows:

   a. The downstate group consisting of residential health care facilities located in the five boroughs of New York City and Nassau, Suffolk, Westchester and Rockland counties.

   b. The upstate group consisting of all other residential health care facilities in the State.

2. Hospitals that convert medical/surgical beds to residential health care beds shall be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.
Exempt units and hospitals.

1. *Physical medical rehabilitation inpatient services* shall qualify for reimbursement as an exempt unit/hospital pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:

   a. Such hospital or such unit qualified for exempt unit status for purposes of reimbursement under the federal Medicare prospective payment system as of December 31, 2001; or

   b. On or before July 1, 2009, the hospital submitted a written request to the Department for exempt status providing assurances acceptable to the Department that the hospital or unit within the hospital meets the exempt status for 2009 for periods prior to December 1, 2009.

   i. For periods on and after January 1, 2010, a hospital seeking exempt status for a hospital or a distinct unit within the hospital not previously recognized by the Department as exempt for reimbursement purposes shall submit a written request to the Department for such exempt status and shall provide assurances and supporting documentation acceptable to the Department that the hospital or unit meets qualifying exempt status criteria in effect at the time such written request is submitted. Approval by the Department of such exempt status shall, for reimbursement purposes, be effective on the January 1 following such approval, provided that the request for such exempt unit status was received at least 120 days prior to such date.

   ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility’s reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions this Attachment.

   iii. For days of service occurring on and after May 12, 2016, the rates of payment for inpatient services for physical medical rehabilitation will be revised to include costs for pediatric ventilator services that receive Certificate of Need (CON) approval.

   (1) A hospital that has been approved through the CON process to include pediatric ventilators within their physical medical rehabilitation unit will provide or report the following:

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**TN #16-0029**

Approval Date March 22, 2017

Supersedes TN #09-0034

Effective Date May 12, 2016
(a) Documentation of CON approval of the pediatric ventilator service within their physical medical rehabilitation unit.

(b) Discretely report the costs and statistics for these services on a hospital’s Institutional Cost Report.

(2) A hospital that has a full year experience of pediatric ventilator service costs (defined as audited costs) and statistics will have their physical medical rehabilitation rate, which includes pediatric ventilator service, calculated as follows:

(a) A separate rate will initially be calculated for the physical medical rehabilitation service, using data in 1(b)(ii), and for the pediatric ventilator service using the same base year data as utilized for the medical rehabilitation service (subject to the provisions in paragraph 3 below). Two separate rates will then be combined as detailed in 2(c) to develop one physical medical rehabilitation rate for payment.

(b) The method for calculating the pediatric ventilator service rate, prior to developing the combined rate, will be the same as utilized for the physical medical rehabilitation rate, as described in this section, with the exception that the pediatric ventilator services will not be held to the 110% ceiling of the regional average costs. The pediatric ventilator service rate will not be included in the physical medical rehabilitation services 110% ceiling regional average.

(c) A combined per day payment rate for medical rehabilitation services will be developed from the two separate rates as follows:

(i) The percentage of Medicaid days for each of the two services to the total Medicaid days for the two services is multiplied by each service’s per day payment.

(ii) The Medicaid days utilized for this proportional calculation are those as referenced in 1(b)(iii)(2)(a).

(iii) The results of multiplying the respective proportional percentage to each service’s respective per day rate are then added together to develop the physical medical rehabilitation rate to be paid for both the physical medical rehabilitation and pediatric ventilator service days.
(3) A hospital without an initial full year of pediatric ventilator service cost and statistics experience will have their physical medical rehabilitation rate, which includes the pediatric ventilator service, calculated as above in 1(b)(iii)(2). Except rather than data from 1(b)(iii)1(b) the costs and statistics used for the pediatric ventilator service will be based on budgeted CON approved costs. The budgeted costs will be subject to review and limitation based on a comparison to other hospitals and nursing homes providing the service.

(a) Budgeted base year costs will be replaced with actual audited costs at the time a full year of actual audited costs are available using data in 1(b)(iii)(1)(b).

(b) The pediatric ventilator service rate developed from actual audited costs will be subject to the same review and limitation based on a comparison to other hospitals and nursing homes providing the service that was initially completed for budgeted costs.

2. Chemical dependency rehabilitation inpatient services shall qualify for reimbursement pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:
a. The services provided in such hospital or unit are limited to chemical dependency rehabilitation care and do not include chemical dependency related inpatient detoxification and/or withdrawal services; or

b. Such hospital or unit is licensed to provide such services pursuant to both the Public Health Law and the Mental Hygiene Law and meets the applicable alcohol and/or substance abuse rehabilitation standards set forth in regulations:

i. Any such unit within a hospital must be in a designated area and consist of designated beds providing only chemical dependency rehabilitation inpatient services with adequate adjoining supporting spaces and assigned personnel qualified by training and/or by experience to provide such services and in accordance with any applicable criteria regarding the provision of such services issued by the New York State Office of Alcohol and Substance Abuse Services.

ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of this Attachment.

3. **Critical access hospitals.**

   a. Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals for periods on and after December 1, 2009, 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.

   b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, and held to a ceiling of 110% of the average of such costs for all such designated hospitals statewide. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

4. **Cancer hospitals.**

   a. Hospitals shall qualify for inpatient reimbursement as cancer hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as comprehensive cancer hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

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**TN #09-34**

**Approval Date** January 20, 2010

**Supersedes TN NEW**

**Effective Date** December 1, 2009
b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

5. **Specialty long term acute care hospital.**
   a. Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as specialty long term acute care hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

   b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

6. **Acute care children's hospitals.** Hospitals shall qualify for inpatient reimbursement as 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 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 reflecting reported Medicaid discharges of greater than 50 percent of total discharges.

   i. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

7. **Substance abuse detoxification inpatient services.** For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services:
   a. [(JMDC 20, DRGs 743 through 751)] effective December 1, 2008 through March 31, 2013.
   b. MDC 20, APR-DRGs 770 through 776 effective April 1, 2013. APR-DRGs are more fully described in the Definitions section and the Service Intensity Weights (SIW) and Average Length-of-Stay section of this Attachment.

[will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services.]
Medically managed detoxification services are for patients who are acutely ill from alcohol and or substance related addictions or dependence, including the need or risk for the need of medical management of severe withdrawal, and/or are at risk of acute physical or psychiatric co-morbid conditions. 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 per diem rates for inpatient detoxification, withdrawal, and observation services will be determined as follows:

a. The operating cost component of the per diem rates will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008, adjusted for inflation. The inflation factor will be calculated in accordance with the trend factor methodology described in this Attachment. The average operating cost per diem for the region in which the hospital is located will be calculated using costs incurred for patients requiring detoxification services. The operating cost component of the per diem rates will be transitioned to 2006 as follows:

1. For the period December 1, 2008 through March 31, 2009, 75% of the operating cost component will reflect the operating cost component of rates effective for December 31, 2007, adjusted for inflation, and 25% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

2. For April 1, 2009 through March 31, 2010, 37.5% of the operating cost component will reflect the December 31, 2007 operating cost component, adjusted for inflation, and 62.5% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
b. For purposes of establishing the average operating cost per diem by region for medically managed detoxification and medically supervised withdrawal services, the regions of the state are defined as follows:

1. New York City - Bronx, New York, Kings and Richmond Counties;
2. Long Island - Nassau and Suffolk Counties;
3. Northern Metropolitan - Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
5. Utica/Watertown - Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
6. Central - Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga, and Tompkins Counties;
7. Rochester - Monroe, Ontario, Livingston, Wayne and Yates Counties; and
8. Western - Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.

c. For each of the regions, the 2006 operating costs incurred by general hospitals in such region for providing care to inpatients requiring detoxification services, as defined by OASAS, and reported in the 2006 ICR submitted to the Department prior to 2008, are adjusted by a length of stay (LOS) factor. This LOS factor reflects the loss of revenue due to the reduction of payments for services over the 5th day of stay. The total adjusted operating costs for each region, divided by the total regional days, is the average operating cost per diem for the region.

d. The per diem rates for inpatients requiring medically managed detoxification services will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the first 5 days of service. However, such payments will be reduced by 50% for services provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.

e. Per diem rates for inpatients requiring medically supervised withdrawal services, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the period January 1, 2009 through December 31, 2009. For periods on and after January 1, 2010, the per diem rates for withdrawal services will reflect 75% of the average operating cost per diem for the region, adjusted for inflation, and will be reduced by 50% for care provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.
f. Per diem rates for inpatients placed in observation beds, as defined by OASAS, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, and will be paid for no more than 2 days of care. After 2 days of care the payments will reflect the patient’s diagnosis as requiring either detoxification or withdrawal services. The days of care in the observation beds will be included in the determination of days of care for either detoxification or withdrawal services. Furthermore, days of care provided in observation beds will, for reimbursement purposes, be fully reflected in the computation of the initial five days of care.

g. Capital cost reimbursement for the general hospitals which are certified by OASAS to provide substance abuse services will be based on the current reimbursement methodology for determining allowable capital for exempt unit per diem rates. Such capital cost will be added to the applicable operating cost component as a per diem amount to establish the per diem rate for each service.
New York 117(d)

8. *Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services, for patients admitted on and after October 20, 2010, will be reimbursed on a per diem basis as follows:*

   a. Reimbursement will use the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system.

   b. The operating component of the rate will be a statewide price, calculated utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs developed using the ratio of cost to charges approach to determine costs and a regression model to price out various components of the costs to determine cost significance in such components. The components include patient age, rural designation, comorbidities, length of stay, and presence of mental retardation. The costs of these components as developed in the regression model were excluded in developing the statewide price.

      i. The facility-specific old operating per diem rates were trended to 2010, and for each case, these rates were multiplied by the length of stay (LOS) to calculate the “old payment.”

      ii. Facility-specific 2005 Direct Graduate Medical Education (DGME) costs were divided by 2005 patient days to calculate DGME per diem rates. These rates were then trended to 2010.

      iii. The 2010 payment rate for Electroconvulsive Therapy (ECT) was established as $281 (based on the ECT rate in effect for Medicare psychiatric patients during the first half of 2010). This rate was then adjusted by each facility’s wage equalization factor (WEF).

      iv. For each case, the proper DGME payment (DGME rate multiplied by the LOS) and ECT payment (WEF-adjusted ECT rate times the number of ECT treatments) was subtracted from the “old payments” to derive the “old payments subject to risk adjustment.”

      v. For each case, a payment adjustment factor was derived based on the regression model, including the LOS adjustment factor as defined by the new payment methodology.

      vi. The sum of the old payments subject to risk adjustment from step iv ($502,341,057), was divided by the sum of payment adjustment factors from step v ($831,319), which resulted in the statewide per diem rate of $604.27 as of October 20, 2010.

The current statewide per diem rate of $642.66 reflects the effect of restoring transition funds back into the statewide price pursuant to the Transition Fund Pool section of this Attachment.
c. The non-operating component of the rate will reflect the 2010 budgeted capital costs per diem and the 2005 Medicaid fee-for-service Direct GME costs (DGME). Capital costs will be calculated in accordance with this section including an adjustment to reflect allowable capital costs as reflect in the applicable rate year’s Institutional Cost Report. DGME costs are the 2005 reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians. The DGME costs allocated to the psychiatric unit is divided by the total patient days spent in the psychiatric unit to derive the 2005 per diem cost of the DGME attributable to the psychiatric unit. This 2005 per diem psychiatric DGME cost is then inflated by 2.95% for 2006, 2.1% for 2007, and 0% thereafter to trend it to October 2010 payment levels.

d. The statewide price will be adjusted for each patient to reflect the following factors:

i. A facility-specific wage equalization factor (WEF), calculated in accordance with the Wage Equalization Factor (WEF) section of this Attachment, will reflect differences in labor costs between hospitals.

ii. A service intensity weight (SIW) associated with the case, calculated utilizing the grouper assigned APR-DRG, will be applied to the adjusted operating per diem. The SIWs for the APR-DRGs as noted in the Inpatient Psychiatric Services Service Intensity Weights (SIWs) table are different than those for the acute system. The SIWs reflect the cost weights assigned to each All Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. The SIWs are developed using two years of Medicaid fee-for-service cost data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years 2005 and 2006. Costs associated with statistical outliers will be excluded from the SIW calculation.
### Inpatient Psychiatric Services Service Intensity Weights (SIWs)

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<tr>
<th>APR-DRG Codes</th>
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TN #10-03     Approval Date September 13, 2011
Supersedes TN New Effective Date October 20, 2010
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Supersedes TN _____ New _________ Effective Date _______ October 20, 2010 ________
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### New York
117(i)

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iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. Accordingly, there are 27 rural facilities that provide inpatient psychiatric services.

iv. An age adjustment payment factor of [1.0872] 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

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TN    #18-0059 Approval Date November 28, 2018
Supersedes TN #14-0029 Effective Date July 01, 2018
v. A payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis.

vi. The payment methodology will include one comorbidity factor per stay and if more than one comorbidity is present during a patient’s stay, the comorbidity that reflects the highest payment factor will be used to adjust the per diem operating component.

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vii. A variable payment factor will be applied to the operating per diem for each day of the stay, with the factor for days 1 through 4 established at 1.2, the factor for days 5 through 11 established at 1.0, the factor for days 12 through 22 established at 0.96 and the factor for stays longer than 22 days established at 0.92.

viii. An annual adjustment for inflation will be applied as determined in accordance with the trend factor provisions of this Attachment.

TN #10-03 Approval Date September 13, 2011
Supersedes TN New Effective Date October 20, 2010
For dates of service beginning on or after July 1, 2014, an additional ten percent increase will be applied for hospitals located in an upstate region as defined in subdivision (l) of this section.

e. The first day of a patient's readmissions to the same hospital within 30 days of discharge will be treated as day four for purposes of the variable payment factor computed as aforementioned, with subsequent days treated in a conforming manner with the provisions.

f. Reimbursement for physician services will not be included in rates and such services may be billed on a fee-for-services basis pursuant to the Hospital Physician Billing Section in Attachment 4.19-B.

g. Reimbursement for electroconvulsive therapy will be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.

h. New inpatient psychiatric exempt hospitals or units established pursuant to Article 28 of the Public Health Law will be reimbursed at the statewide price plus budgeted capital and Direct GME. Budgeted capital will be adjusted as described in this section and will be adjusted to actual costs in future years. Direct GME will be adjusted to actual costs based upon the first twelve months reporting following the calendar year after the opening of the new unit.

i. The base period costs and statistics used for inpatient psychiatric per diem rate setting operating cost components including the weights assigned to diagnostic related groups (DRG) designated as psychiatric DRGs for per diem reimbursement, will be updated as soon as practical at which time the State will submit a state plan amendment for the implementation of rebasing. The payment factors for rural designation, age, certain defined comorbidities, and the presence of mental retardation may also be updated to reflect more current data.

j. For rate periods through December 31, 2014, reimbursement will include transition payments of $25 million on an annualized basis, which will be distributed as follows:

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Approval Date: April 15, 2015
Effective Date: July 1, 2014
i. Fifty percent of the payments will be allocated to facilities that experience a reduction in Medicaid operating revenue relative to payments prior to this new methodology in excess of threshold percentage set forth in this paragraph as a result of the implementation of rates set pursuant to this section. The payments will be allocated proportionally, calculated utilizing each eligible facility’s relative Medicaid operating revenue reduction in excess of the threshold, as determined by the Commissioner. The threshold percentage described in this paragraph will be 6.02%. Therefore, 50% of the $25 million will be allocated to hospitals such that they will not lose more than 6.02% of revenue from the existing payment to the new payments in year 1.

ii. Fifty percent of the payments will be allocated to facilities whose rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility’s calculated Medicaid costs by a threshold percentage in excess of 1.20%. The payments will be allocated proportionally, utilizing the degree by which each facility’s Medicaid operating revenue shortfall exceeds such threshold percentage. Therefore, with the utilization of 2006 data, 50% of the $25 million will be allocated to hospitals whose costs are above their revenues.

iii. In 2010-11, the $25 million investment will be allocated to a transition fund pool. In future years through December 31, 2014, the $25 million transition fund pool will be reduced, and the excess funds will be reinvested into the statewide base price as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Transition</th>
<th>Statewide Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/20/2010 – 12/31/2011</td>
<td>$25 million</td>
<td>$0</td>
</tr>
<tr>
<td>1/1/2012 – 12/31/2012</td>
<td>$17 million</td>
<td>$8 million</td>
</tr>
<tr>
<td>1/1/2013 – 12/31/2013</td>
<td>$8 million</td>
<td>$17 million</td>
</tr>
<tr>
<td>1/1/2014 – 12/31/2014</td>
<td>$0</td>
<td>$25 million</td>
</tr>
</tbody>
</table>

k. For the rate period October 20, 2010 through March 31, 2011, reimbursement will include transition payments totaling, in aggregate, $12 million and will be distributed to eligible hospitals as described below, provided, however, that if less than $12 million is distributed in such rate period then additional distributions of the $12 million will be made in subsequent rate periods as follows:

TN #10-03 Approval Date September 13, 2011
Supersedes TN New Effective Date October 20, 2010
New York 117(m)

i. Eligible hospitals will be those general hospitals which receive approval for certificate of need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health inpatient beds in response to the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined to have complied with Department of Health requests to adjust behavioral health service delivery in order to ensure access.

ii. Eligible hospitals will, as a condition of their receipt of the rate adjustments, submit to the Department of Health proposed budgets for the expenditure of the additional Medicaid payments for the purpose of providing inpatient behavioral health services to Medicaid eligible individuals. The budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to the rate adjustments being issued.

iii. Distributions will be made as add-ons to each eligible facility’s inpatient Medicaid rate and will be allocated proportionally, utilizing the proportion of each approved hospital budget to the total amount of all approved hospital budgets. Distributions will be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

For purposes of this section, the downstate region of New York State will consist of the following counties of: Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess; and the upstate region of New York State will consist of all other New York counties.
9. Hospitals or distinct units of hospitals that fail to maintain qualifying criteria for exempt status for reimbursement purposes, as set forth in this Attachment, shall continue to be reimbursed in accordance with such exempt status until the commencement of the next rate period, as determined by the Department.

10. Rates of payment for inpatient services described in paragraphs (1) and (2) above, which utilize regional averages for determining a cost ceiling shall utilize regions of the State set forth below, except that if the otherwise applicable region has less than five exempt hospitals or units in the service, facilities located in the nearest regions will be used to establish a minimum of five hospital or units for the purpose of determining ceilings. Such regions are as follows:

a. New York City, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;
b. Long Island, consisting of the counties of Nassau and Suffolk;
c. Northern Metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;
e. Utica / Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;
f. Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;
g. Rochester, consisting of the counties of Monroe, Ontario, Livingston, Wayne and Yates; and
h. Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

11. Capital cost components of per diem rates determined pursuant to this Section shall be computed on the basis of budgeted capital costs allocated to the exempt hospital or distinct unit of a hospital pursuant to the capital cost provisions of this Attachment divided by exempt hospital or unit patient days reconciled to actual total expense.
12. *New hospitals and new hospital units.* The operating cost component of rates of payment for new hospitals, or hospital units, without adequate cost experience [shall] will be computed based on either budgeted cost projections, subsequently reconciled to actual reported cost data, or the regional ceiling calculated in accordance with paragraph (10) of this section, whichever is lower. The capital cost component of such rates [shall] will be calculated in accordance with the capital cost provisions of this Attachment.

13. Effective July 1, 2018, hospitals that have been approved by the Office of Mental Health to operate distinct units to provide specialized inpatient psychiatric care to stabilize adults with co-morbid mental illness and intellectual developmental disability diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, will be reimbursed a flat per diem operating rate of $1,177.11, and the rate-setting methodology provided in paragraph 8 of this section will not apply to services furnished in such units. Capital costs will be reimbursed on a per diem basis for the cost of capital in accordance with paragraph 11 of this section. Specialized inpatient psychiatric units are a new approach to treating dually-diagnosed individuals. The units are physically distinct and have been approved by the State to provide such care and services based on a review of the unit’s physical plant specifications, enhanced staffing, and adherence to specialized clinical protocols, which demonstrate sufficient specialization in the assessment and treatment of adults with co-occurring intellectual or developmental disability, including autism spectrum disorder, and mental illness diagnoses, who exhibit destructive behaviors, or an acute safety risk or decrease in functioning.
Trend factor.
1. The trend factor terms used in this section will be used to develop rates of payments on or after December 1, 2009.
2. The Commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of this Attachment, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section for rate periods through March 31, 2000.
3. The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the Commissioner.
4. The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the Commissioner shall apply the 1995 trend factor methodology.
5. The Commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.
6. Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors of final trend factors used for the January 1, 1995 through December 31, 1995, rate period for purposes of projecting allowable operating costs to subsequent rate periods.
7. Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996, rate period for purposes of projecting allowable operating costs to subsequent rates periods.
8. Trend factors used to project reimbursable operating costs to rate periods commencing July, 1, 1999 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

9. For rate periods on and after April 1, 2000, the Commissioner shall establish trend factors for rates of payment for hospitals to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs calculated pursuant to this Attachment.
   a. 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.
   b. After the final U.S. Consumer Price Index (CPI) for all Urban Consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in subparagraph (a) and any difference will be included in the prospective trend factor for the current year.
   c. At the time adjustments are made to the trend factors in accordance with this section, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

10. The final 2006 trend factor shall be the U.S. CPI for all Urban Consumers, as published in the U.S. Department Labor Statistics, minus 0.25%.

11. The final 2007 trend factor shall equal 75% of the final trend factor determined in paragraph (b) above.

12. The applicable trend factor for the 2008 and 2009 calendar year periods shall be zero.

13. The applicable trend factor for the 2010 calendar year shall be zero for inpatient services provided by general hospitals on and after January 1, 2010.
14. Effective for services provided on and after April 1, 2011, the applicable trend factor for the 2011 calendar year period will be no greater than zero.

15. Effective for services provided on and after January 1, 2012, the applicable trend factor for the 2012 calendar year period will be no greater than zero.

16. The applicable trend factor for the 2013 calendar year will be no greater than zero for services provided on and after January 1, 2013.

17. The applicable trend factor for the 2014 calendar year period will be no greater than zero for services provided on and after January 1, 2014.

18. The applicable trend factor for the 2015 calendar year period will be no greater than zero for services provided on and after January 1, 2015 through March 31, 2015 and April 23, 2015 through December 31, 2015.

19. The applicable trend factor for the 2016 calendar year period will be no greater than zero for services provided on and after January 1, 2016.

20. The applicable trend factor for the 2017 calendar year period will be no greater than zero for services provided on and after January 1, 2017 through March 31, 2017[.] and April 1, 2017 through December 31, 2017.

21. The applicable trend factor for the 2018 calendar year period will be no greater than zero for services provided on and after January 1, 2018.

22. The applicable trend factor for the 2019 calendar year period will be no greater than zero for services provided on and after January 1, 2019 through March 31, 2019.
Potentially Preventable Negative Outcomes (PPNOs)

Potentially Preventable Complications (PPC)

For discharges occurring on and after July 1, 2011 through March 31, 2012 Medicaid rates of payment to hospitals that have higher than expected Medicaid payments related to potentially preventable complications, based on the criteria set forth in the Complication Criteria section, as determined by a risk adjusted comparison of the actual and expected Medicaid payments per case for each hospital as described by the Methodology section, will be reduced in accordance with the PPC Adjustment Factor section. Such rate adjustments for this period will result in an aggregate reduction in Medicaid payments of $31,257,000. For discharges occurring on and after April 1, 2013 through March 31, 2014, such rate adjustments will result in an aggregate reduction in Medicaid payments of $41,000,000. For discharges beginning April 1, 2014 through March 31, 2015, such rate adjustments will result in an aggregate reduction in Medicaid payments of $20,500,000.

Definitions. As used in this Section, the following definitions will apply:

1. **Potentially Preventable Complications** will mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under version 30 of the Potentially Preventable Complication grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs, effective for periods on and after July 1, 2011, are available on the following Department of Health website link: www.health.ny.gov/health_care/medicaid/quality/ppo/complications

2. **Hospital** will mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.

3. **Observed case** will mean all non-Medicare acute care cases.

4. **PPC Coefficient** will mean a dollar amount, the result of an indirect standardization, equal to the statewide average incremental Medicaid payment attributable to each of the 64 PPCs.

5. **Adjusted Admission APR-DRG** will be defined as the assigned hospital admission APR-DRG SOI for each observed case using version 30 of the APR-DRG grouper and results from 3M’s PPC grouping logic software. The software results identify each PPC per admission, which has been adjusted to reassign all secondary diagnosis, not identified as a PPC or the direct cause of a PPC, as present on admission.
Complication Criteria.

A complication is a condition that develops after admission to the hospital. Complications may or may not be preventable. For a complication to qualify as a PPC, the secondary diagnosis must meet the following criteria:

a. Shall not be redundant with the diagnosis that was the reason for hospital admission;

b. Shall not be an inevitable, natural, or expected consequence or manifestation of the reason for hospital admission;

c. Shall be expected to have a significant impact on short or long-term debility, mortality, patient suffering, or resource use; and

d. Shall have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on the resource use must not be significant for some patients but trivial for others.

Methodology.

1. The actual Medicaid payment will be computed as the aggregate Medicaid payment for each hospital observed case assigned using version 28 of the APR-DRG grouper. The discharge APR-DRG severity of illness (SOI) service intensity weight (SIW) is multiplied by the Medicaid statewide base price for the applicable rate period.

2. The expected Medicaid payment will be computed as the aggregate Medicaid payment for each adjusted admission APR-DRG. The expected Medicaid payment will equal the adjusted admission APR-DRG SIW multiplied by the Medicaid statewide base price for the applicable rate period. The expected Medicaid payment will then be reduced by the sum of the PPC coefficient for the particular observed case.

3. For each hospital, a hospital-specific coefficient will be computed and equal to the aggregate actual Medicaid payment minus the aggregate expected Medicaid payment of all observed cases, divided by the total number of observed cases. In the event the hospital-specific coefficient is less than zero, the hospital coefficient shall be set to zero.
PPC Adjustment Factor.

1. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, 2014, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.

2. The hospital-specific coefficient is multiplied by the total number of non-behavioral health Medicaid discharges to compute the PPC penalty. The PPC penalty is then multiplied by the hospital’s wage equalization factor (WEF) and, for teaching hospitals, the indirect graduate medical education (IME) factor.

3. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.

4. For each hospital, a PPC adjustment factor will be computed as the ratio of the hospital’s PPC penalty and the hospital’s total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this section.

Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.

Each hospital will be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. POA data was evaluated using 2009 Statewide Planning and Research Cooperative System (SPARCS) data. Two levels of POA quality will be established for each of the criteria, “red” and “grey” zones. The criteria and levels will be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: “red” will be greater than or equal to 7.5%, “grey” will be greater than or equal to 5%, but less than 7.5%.

2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: “red” will be greater than or equal to 10%, “grey” will be greater than or equal to 5%, but less than 10%.

3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: “red” will be greater than or equal to 96%, “grey” will be greater than or equal to 93%, but less than 96%.

4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: “red” will be less than or equal to 70%, “grey” will be greater than or equal to 70%, but less than 77%; and

TN  #14-0026  Approval Date  June 26, 2015
Supersedes TN  #13-0041  Effective Date  April 1, 2014
5. For surgical cases only, the percent of secondary diagnoses coded as present on admission: “red” will be greater than or equal to 40%, “grey” will be greater than or equal to 30%, but less than 40%.

6. Hospitals are determined to have unreliable POA data if any of the five criteria are in the “red” zone, or if two or more of the five criteria are in the “grey” zone.

7. An upstate and downstate average PPC [adjustment factor] penalty will be [applied to each hospital deemed to have unreliable] calculated by computing a weighted average of the hospital-specific coefficients of all hospitals with reliable POA data located in each designated region using the total number of non-behavioral health Medicaid discharges of such hospitals. For each hospital deemed to have unreliable POA data the upstate and downstate average PPC penalty will be multiplied by the hospital’s WEF, and, for teaching hospitals, the IME factor. The [upstate and downstate] PPC adjustment factor will be [calculated using a weighted average of all hospitals with reliable POA data located in each designated region] computed pursuant to the PPC Adjustment Factor section.

8. For purposes of this section, the downstate region of New York State will consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess. The upstate region of New York State will consist of all other New York counties.
Potentially Preventable Hospital Readmissions (PPR)

For discharges occurring on and after July 1, 2010 through March 31, 2012, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, will be reduced in accordance with the Payment Calculation Section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of $27.8 million for the period July 1, 2010 through March 31, 2011 and $12 million for the period April 1, 2011 through March 31, 2012. For discharges occurring on and after April 1, 2013 through March 31, 2014, rate adjustments will result in an aggregate reduction in Medicaid payments of $27.4 million and $13.7 million for the period April 1, 2014 through March 31, 2015.

Definitions. As used in this Section, the following definitions will apply:

1. Potentially Preventable Readmissions (PPR) will mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the PPR grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through March 31, 2011; version 28 for the period April 1, 2011 through March 31, 2012; [and] version 29 for the period April 1, 2013 through March 31, 2014; version 30 for the period April 1, 2014 through June 30, 2014; version 31 for the period July 1, 2014 through December 31, 2014; and version 32 for the period January 1, 2015 through March 31, 2015.

2. Hospital will mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.

3. Expected Potentially Preventable Readmissions, for the period July 1, 2010 through June 30, 2011, are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, 2012; and April 1, 2013 through March 31, [2014] 2015, the Expected Potentially Preventable Readmissions will be derived using 2009 SPARCS Medicaid data through an indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least one PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination will be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations will be the Expected PPRs.

4. Observed Rate of Readmission will mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.
5. **Expected Rate of Readmission** shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.

6. **Excess Rate of Readmission** shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.

7. **Behavioral Health**, for the period July 1, 2010 through June 30, 2011, shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, 2014, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.

8. **Average Hospital Specific Payment** shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

**Readmission Criteria.**

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
   a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
   b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
      i. the same or closely related condition or procedure as the prior discharge;
      ii. an infection or other complication of care;
      iii. a condition or procedure indicative of a failed surgical intervention; or
      iv. an acute decompensation of a coexisting chronic disease.
   c. The readmission is back to the same or to any other hospital.

2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:
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a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. For the period July 1, 2010 through June 30, 2011, the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link:

   www.health.ny.gov/health_care/medicaid/quality/ppo/outcomes

c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.

d. For readmissions occurring during the period up through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, the readmissions involve a discharge determined to be behavioral health related.

Methodology.


2. The expected rate of readmission shall be reduced by:

   (a) 24% for periods prior to September 30, 2010;
   (b) 38.5% for the period October 1, 2010 through December 31, 2010;
   (c) 33.3% for the period January 1, 2011 through June 30, 2011.
   (d) 11.4% for periods on and after July 1, 2011.

3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.

4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.
Payment Calculation.

1. An average hospital specific payment will be used to compute the total Medicaid operating payments, excluding behavioral health, associated with the risk adjusted excess readmissions in each hospital.

2. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.

3. For each hospital, a hospital specific readmission adjustment factor shall be computed as the ratio of the hospital’s total Medicaid operating payments for the applicable rate period associated with the risk adjusted excess readmissions identified in the Methodology Section and the hospital’s total Medicaid operating payments for the same rate period for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this Section.
4. Non-behavioral health related Medicaid operating payments to hospitals shall be reduced by applying the hospital specific readmission adjustment factor from this Section to the applicable case payment or per-diem payment amount for all non-behavioral health related Medicaid discharges for each hospital.
Capital Expense Reimbursement.

1. The allowable costs of fixed capital including but not limited to depreciation, rentals, interest on capital debt, and major movable equipment shall be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of this section.

2. General hospitals shall submit a budgeted schedule of anticipated inpatient capital-related expenses for the forthcoming year to the Commissioner at least 120 days prior to the beginning of the rate year.

3. The following principles shall apply to budgets for inpatient capital-related expenses:
   a. The basis for determining capital-related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.
   b. Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to the Hospitals section of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.
c. **The submitted budget may include the capital-related inpatient expense of all existing capital assets, as well as estimates of capital-related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year.**

d. **Any capital-related expense generated by a capital expenditure acquired or placed in use during a rate year shall be carried forward to the subsequent rate year, provided all required approvals have been obtained. In instances where such approvals have been obtained or where approval is not required and such assets are acquired or placed in use during a rate year, the budget may include estimates for capital-related expenses relating to these assets.**

4. **Allocation of budgeted capital costs.** In each rate year budgeted capital costs shall be allocated to exempt units and hospitals (including certified substance abuse detoxification services) and DRG case payment rates based on reported capital statistics for the year two years prior to the rate year.
5. **Payment for budgeted allocated capital costs.**

   a. Capital per diems for exempt units and hospitals shall be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense.

   b. Capital payments for APR-DRG case rates shall be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense.

   c. Capital payments for transferred patients shall be the determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. **Depreciation.**

   a. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

   b. In the computation of rates for voluntary facilities, depreciation shall be included on a straight line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method, or accelerated under a double declining balance, or sum-of-the-years’ digit method. Depreciation shall be funded unless the Commissioner determines, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall
occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded. Failure to meet the funding requirements will result in a reduction amount reimbursed for depreciation equal to the unfunded amount.

c. In the computation of rates for public facilities, depreciation is to be included on a straight-line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight-line method, or accelerated under a double declining balance or sum-of-the-years’ digits method.

d. Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan-financed portion of the facilities, the Commissioner shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Attachment.
7. Interest

a. Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

b. To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, be at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made, and exclude costs and fees incurred as a result of an interest rate swap agreement. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner has been obtained. Financial need for capital indebtedness relating to a special project shall exist when all available restricted funds designated for capital acquisitions of that type have been considered for equity purposes.

c. Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusteeed malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:

i. for all medical facilities, investment income shall first be used to reduce operating interest expense for that year;

ii. any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and
iii. any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.

d. Interest on current indebtedness shall be treated and reported as an operating, administrative expense.

e. Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the Commissioner, incurred for authorized purposes, and the principal of the debt is the lesser of the approval of the Commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:

i. evidenced by a mortgage note or bond and secured by a mortgage on the land, building or non-movable equipment; a note payable secured by the non-movable equipment of a facility; a capital lease;

ii. incurred for the purpose of financing the acquisition, construction or renovation of land, building or non-movable equipment;

iii. found by the Commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration to the Commissioner that such refinancing will result in a debt service savings over the life of the indebtedness; or

iv. incurred for the purpose of advance refunding of debt. Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity date of the refunding debt.

f. Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.
g. Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

8. Sales, leases and realty transactions.

a. If a medical facility is sold, leased, or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner, the capital cost component for such rate shall be determined in accordance with the provisions of this Section.

b. If a medical facility is sold, leased, or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the Commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This paragraph shall not be construed as limiting the powers and rights of the Commissioner to change rate computations generally or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this paragraph shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

c. An arms length lease purchase agreement with a non-related lessor involving plant facilities or equipment which meets any one of the four following conditions, establishes the lease is a virtual purchase.

i. The lease transfers a title of the facilities or equipment to the lessee during the lease term.

ii. The lease contains a bargain purchase option.

iii. The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

iv. The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee’s incremental borrowing rate, unless the interest rate implicit in the lease is known and is
less than the lessee’s incremental borrowing rate, in which case the interest rate implicit in the lease is used.

d. If a lease is established as a virtual purchase under paragraph (c), the rental charge may be included in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

i. The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

ii. If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

iii. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

iv. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

v. If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under this paragraph, must be used in calculating the limitation on adjustments for the purpose of determining any gain or less upon disposal of an asset.

vi. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.
e. If a facility enters into a sale and leaseback agreement involving plant facilities or equipment, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:

i. If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

ii. If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

iii. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

iv. If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land may not be included in allowable costs.
Reimbursable Assessment for Statewide Planning and Research Cooperative System (SPARCS).

The Commissioner will inform each such hospital of its actual fee to support the statewide planning and research cooperative system and each hospital will submit such fee on a quarterly basis to be received by the Commissioner no later than the 15th of February, May, August and November of each year. Failure to submit such fees in accordance with this schedule will result in a [one]two-percent reduction in the affected hospital's rate beginning on the first day following the due date and continuing until the last day of the calendar month in which said fees are submitted.
Federal upper limit compliance.

1. In the event the State cannot provide assurances satisfactory to the Secretary of the Department of Health and Human Services related to a comparison of rates of payment for general hospital inpatient services to beneficiaries of the Title XIX program in the aggregate to maximum reimbursement payments provided in Federal law and regulation for purposes of securing Federal financial participation in such payments, such rates of payments shall be adjusted proportionally as necessary to meet Federal requirements for securing Federal financial participation.
Adding or deleting hospital services or units.

1. Notification of the elimination of a general hospital inpatient service or identifiable unit of such a service in instances in which the costs of such service are reflected in the rate calculated pursuant to this Section shall be submitted in writing by the facility to the Department within 60 days of the elimination of such service or unit. If a rate is modified by the Department as a result of such service or unit elimination, such rate shall be effective as of the date of the elimination of the service or unit.

2. Notification of the establishment of a new hospital or of a new exempt unit of an existing hospital shall be submitted in writing by the facility to the Department within 60 days of the establishment of such new hospital or such new unit. Thereafter the Department shall establish inpatient rates for such new hospital or such new exempt unit in accordance with the provisions of this Attachment. Such rates shall be effective the first day of the month following 30 days after such a notification or the date of the approved certificate of need (CON) certification, whichever is later.
New hospitals and hospitals on budgeted rates.

1. New hospitals. Payments to new hospitals without adequate cost experience for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Attachment except as follows:
   a. Rates of payment shall be computed on the basis of 100 percent of the statewide base price multiplied by the service intensity weight for each DRG as determined and set forth with the provisions of this Attachment.
   b. The WEF used to adjust the statewide base price shall be equal to 1.0 until adequate data becomes available.
   c. The non-comparable operating costs of new facilities as defined by the Definitions Section and direct graduate medical education costs shall consist of the hospital’s budgeted operating costs for these services.

2. Hospitals on Budgeted Rates. Payments to hospitals without adequate cost experience whose rates are based on budgeted cost projections for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Subpart except as follows:
   a. Reimbursement for the costs of graduate medical education and non-comparable services shall be calculated pursuant to the provisions of paragraph(1)(c) above.
   b. The WEF used shall be calculated for the facility based on available historical data.
Swing bed reimbursement.

1. Definitions.
   a. For purposes of this Section, a swing bed program operated by a rural hospital that has an approval from the Centers for Medicare and Medicaid Services (CMS) to provide post-hospital skilled nursing facility (SNF) care, shall mean beds used interchangeably as either general hospital or nursing home beds with reimbursement based on the specific type of care provided so that use of beds in this manner provides small hospitals with greater flexibility in meeting fluctuating demands for inpatient general hospital and nursing home care.
   b. Rate shall mean the aggregate governmental payment made to eligible facilities per patient day as defined in Attachment 4.19-D for the care of patients receiving care pursuant to Title XIX of the federal Social Security Act (Medicaid).

2. Rates of payment.
   Payments to eligible hospitals for patient days resulting from usage of swing beds in caring for patients for whom it has been determined that inpatient hospital care is not medically necessary, but that skilled nursing or health related care is required, shall be determined as follows:
   a. The operating component of the rate shall consist of the following:
      i. a direct component which shall be equivalent to the 1988 statewide average direct case mix neutral cost per day for hospital-based residential health care facilities, after application of the Regional Direct Input Price Adjustment Factor (RDIPAF) as determined pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A;
      ii. an indirect component which shall be equivalent to the 1988 statewide average indirect cost per day for hospital-based residential health care facilities, after application of the RDIPAF pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A; and
      iii. a non-comparable component which shall be equivalent to the 1988 statewide average non-comparable cost per day for hospital-based residential health care facilities, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A.
b. For general hospitals with more than 49 beds, the maximum number of days for which the operating component of the rate as defined in this Attachment shall be paid shall be equivalent to fifteen (15) percent of a hospital’s total annual patient days for acute, exempt unit, and alternate level of care services, excluding swing bed days.

c. The operating component of the rate as defined in this Attachment shall be paid for the first sixty (60) days per year during which a patient is receiving care as a participant in the swing bed program. Any patient stay in excess of sixty (60) days per year shall be reimbursed at the prevailing average rate paid for the care of Alternate Level of Care (ALC) patients pursuant to the Alternate Level of Care Payments provisions of this Attachment. The sixty-day period shall begin the first day on which the patient receives care as a participant in the swing bed program.

d. A capital cost per diem shall be paid on the basis of budgeted capital costs allocated to the swing bed program, pursuant to the capital cost provisions of this Attachment, divided by patient days associated with the swing bed program, reconciled to actual total capital expense.
Mergers, acquisitions, consolidations, restructurings and closures.

1. Rates of Payment. [As used in this Section, t]he terms merger, acquisition, and consolidation, for the purpose of calculating a combined reimbursement rate, [shall]will mean the combining of two or more general hospitals where such combination is a full asset merger or a full asset acquisition (hereinafter referred to as full asset merger) and is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department’s Certificate of Need process.

Payments for hospitals subject to a full asset merger, acquisition or consolidation for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the full asset merger transaction is effected and [shall]will be computed in accordance with this Section except as follows:

a. The WEF used to adjust the statewide base price [shall]will be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the full asset merger, acquisition or consolidation.

b. The direct GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the full asset merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation [shall]will be based on the total residents and beds of all such hospitals subject to the full asset merger, acquisition, or consolidation.

d. The non-comparable payment per discharge added to the case payment rates [shall]will be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the full asset merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

e. Rates calculated for exempt units where the hospitals merging provide the same exempt service will not be merged until such time that the base used for the exempt service is updated. At the time of the base rate update, combined costs and utilization will be used to develop the exempt service rate. Until that time, each hospital will continue to be reimbursed their facility specific exempt unit rate based on the method approved for the exempt service.
1. A. Temporary rate change for full asset mergers and acquisitions.

a. For the period April 1, 2012 through August 31, 2016, the Commissioner may grant approval of a temporary change to rates calculated pursuant to this Section for hospitals that complete a merger, acquisition or consolidation provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate change. The temporary rate change shall be in effect for no longer than such time as base year costs are updated for the development of these temporary rates or such time as statewide base year costs are updated for the development of rates, whichever is earlier, and shall consist of the various operating rate components of the surviving entity. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Attachment. The Commissioner may establish, as a condition of receiving such a temporary rate change, benchmarks and goals to be achieved as a result of the ongoing consolidation efforts and may also require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital’s temporary rate change prior to the end of the specified timeframe.

b. The Commissioner shall withdraw approval of a temporary rate change for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.

c. For the period beginning September 1, 2016 and thereafter, the Commissioner may grant approval of a temporary change to the non-capital components of acute rates calculated pursuant to this Section for hospitals that have undergone a full asset merger:

i. The acute operating rate of all hospitals merged which represents the highest payment will be paid to all hospitals in the merged entity. The acute rates used in the development of the payment calculation to determine the highest payment will be based on all operating components of a hospital’s acute rate and not determined on an individual operating acute rate component basis.
ii. Facilities seeking a rate change under this section will submit an appeal and demonstrate that the additional resources provided by a temporary rate change will achieve one or more of the following:

(1) protect or enhance access to care;

(2) protect or enhance quality of care; or

(3) improve the cost effectiveness of the delivery of health care services.

iii. The temporary rate change issued pursuant to this section will be effective as of the date the full asset merger transaction is effected and will be in effect for three years. At the expiration of the temporary rate change period, the facility will be reimbursed in accordance with the otherwise applicable rate-setting methodology as stated in this section and will be effective the first day of the month following the expiration of the three year period.

iv. During the temporary rate change period each provider will continue to be reimbursed their facility specific acute capital rate payment.

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2. Temporary rate adjustment for Vital Access Provider (VAP) Programs

a. A temporary rate adjustment will be provided to eligible hospital 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 hospital providers, the [annual] amount of the temporary rate adjustment, and the duration of [the] each rate adjustment period [shall] will be listed in the table which follows. The total [annual] adjustment amount for each period shown will be paid quarterly during each period in equal installments [with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider.] The [quarterly] temporary 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.
b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

| Hospitals: |
|-----------------|-----------------|-----------------|
| **Provider Name** | **Gross Medicaid Rate Adjustment** | **Rate Period Effective** |
| Beth Israel Medical Center | $15,000,000 | 11/01/2014 – 03/31/2015 |
| | $33,200,000 | 04/01/2015 – 03/31/2016 |
| | $33,200,000 | 04/01/2016 – 03/31/2017 |
| Brookdale University Hospital and Medical Center | $14,000,000 | 02/01/2014 – 03/31/2014 |
| Brooklyn Hospital Center | $5,000,000 | 02/01/2014 – 03/31/2014 |
| | $5,000,000 | 04/01/2014 – 03/31/2015 |
| Canton Potsdam Hospital/EJ Noble | $2,000,000 | 01/01/2014 – 03/31/2014 |
| | $400,000 | 04/01/2014 – 03/31/2015 |
| Catskill Regional Medical Center | $889,105 | 01/01/2014 – 03/31/2014 |
| | $1,040,305 | 04/01/2014 – 03/31/2015 |
| | $1,164,505 | 04/01/2015 – 03/31/2016 |
| Champlain Valley Physicians Hospital Medical Center | $1,450,852 | 05/01/2017 – 03/31/2018 |
| | $981,422 | 04/01/2018 – 03/31/2019 |
| | $660,708 | 04/01/2019 – 03/31/2020 |
| Eastern Niagara Hospital | $1,425,000 | 07/01/2018 – 03/31/2019 |
| | $1,575,000 | 04/01/2019 – 03/31/2020 |
| Healthalliance Mary's Ave Campus Benedictine Hospital | $2,500,000 | 02/01/2014 – 03/31/2014 |
| Interfaith Medical Center | $12,900,000 | 11/01/2013 – 03/31/2014 |
| | $11,110,190 | 07/01/2018 – 03/31/2019 |
| | $13,505,285 | 04/01/2019 – 03/31/2020 |
| | $13,384,525 | 04/01/2020 – 03/31/2021 |
| Jamaica Hospital Medical Center | $8,365,000 | 07/01/2018 – 03/31/2019 |
| Kingsbrook Jewish Medical Center | $1,480,000 | 11/01/2013 – 12/31/2013 |
| | $2,320,000 | 01/01/2014 – 03/31/2014 |
| Kings County Hospital Center | $1,000,000 | 01/01/2014 – 03/31/2014 |

*Denotes this provider is a Critical Access Hospital (CAH).
### Hospitals Continued:

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## New York
### 136(b.2)

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<td></td>
</tr>
<tr>
<td>Hospital]</td>
<td>$1,773,128</td>
<td>04/01/2015 - 03/31/2016</td>
</tr>
<tr>
<td></td>
<td>$1,710,279</td>
<td>04/01/2016 - 03/31/2017</td>
</tr>
<tr>
<td></td>
<td>$ 301,744</td>
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</tr>
<tr>
<td></td>
<td>$  618,290</td>
<td>04/01/2018 - 03/31/2019</td>
</tr>
<tr>
<td></td>
<td>$  590,069</td>
<td>04/01/2019 – 03/31/2020</td>
</tr>
<tr>
<td></td>
<td>$  289,897</td>
<td>04/01/2020 – 03/31/2021</td>
</tr>
</tbody>
</table>

---

**Attachment 4.19-A**

**August 6, 2018**

**Approval Date**

**April 12, 2018**

**Effective Date**

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**Supersedes TN #18-0003**

**TN #18-0038**
## Hospitals (Continued):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Joseph’s Hospital Health Center-Syracuse</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>$1,287,472</td>
<td>04/01/2018 – 03/31/2019</td>
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<tr>
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<td>$  245,297</td>
<td>04/01/2019 – 06/30/2019</td>
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<tr>
<td>United Health Services, Inc. [Binghamton]</td>
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<td></td>
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<tr>
<td></td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>$3,196,083</td>
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</tr>
<tr>
<td></td>
<td>$ 452,987</td>
<td>01/01/2018 – 03/31/2018</td>
</tr>
<tr>
<td></td>
<td>$1,811,948</td>
<td>04/01/2018 – 03/31/2019</td>
</tr>
<tr>
<td></td>
<td>$1,811,948</td>
<td>04/01/2019 – 03/31/2020</td>
</tr>
<tr>
<td></td>
<td>$1,358,965</td>
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</tr>
</tbody>
</table>
### Hospitals (Continued):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate</th>
<th>Rate Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lewis County General Hospital</strong>*</td>
<td>$65,564</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$262,257</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$262,257</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td><strong>Lincoln Medical Center</strong></td>
<td>$963,687</td>
<td>04/01/2012 – 03/31/2013</td>
</tr>
<tr>
<td></td>
<td>$963,687</td>
<td>04/01/2013 – 03/31/2014</td>
</tr>
<tr>
<td><strong>Little Falls Hospital</strong>*</td>
<td>$21,672</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$86,688</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$86,688</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td><strong>Maimonides Medical Center</strong></td>
<td>$2,500,000</td>
<td>11/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td><strong>Montefiore Medical Center</strong></td>
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<td>11/01/2013 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$750,000</td>
<td>10/01/2016 – 03/31/2017</td>
</tr>
<tr>
<td></td>
<td>$454,545</td>
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</tr>
<tr>
<td></td>
<td>$454,546</td>
<td>04/01/2018 – 03/31/2019</td>
</tr>
<tr>
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<td>$340,909</td>
<td>04/01/2019 – 09/30/2019</td>
</tr>
<tr>
<td><strong>New York Methodist Hospital</strong></td>
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<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$3,201,500</td>
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<tr>
<td></td>
<td>$3,118,500</td>
<td>04/01/2015 – 03/31/2016</td>
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<tr>
<td><strong>Niagara Falls Memorial Medical Center</strong></td>
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<tr>
<td></td>
<td>$171,238</td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>$501,862</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$260,345</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td><strong>Nassau University Medical Center</strong></td>
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<td>04/01/2012 – 03/31/2013</td>
</tr>
<tr>
<td></td>
<td>$6,500,000</td>
<td>04/01/2013 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$7,000,000</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td><strong>Richmond University Medical Center</strong></td>
<td>$8,897,955</td>
<td>01/01/2013 – 03/31/2013</td>
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<tr>
<td></td>
<td>$2,355,167</td>
<td>04/01/2013 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$1,634,311</td>
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</tr>
<tr>
<td></td>
<td>$9,966,329</td>
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</tr>
<tr>
<td></td>
<td>$9,869,000</td>
<td>04/01/2019 – 03/31/2020</td>
</tr>
<tr>
<td></td>
<td>$9,711,500</td>
<td>04/01/2020 – 03/31/2021</td>
</tr>
</tbody>
</table>

*Denotes this provider is a Critical Access Hospital (CAH)
## Hospitals (Continued):

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Gross Medicaid Rate</th>
<th>Provider Name</th>
<th>Period</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Barnabas Hospital</td>
<td>$ 2,588,278</td>
<td></td>
<td>01/01/2013 – 03/31/2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 1,876,759</td>
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<td>04/01/2013 – 03/31/2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 1,322,597</td>
<td></td>
<td>04/01/2014 – 03/31/2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 2,500,000</td>
<td></td>
<td>01/01/2017 – 03/31/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10,000,000</td>
<td></td>
<td>04/01/2017 – 03/31/2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10,000,000</td>
<td></td>
<td>04/01/2018 – 03/31/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 7,500,000</td>
<td></td>
<td>04/01/2019 – 12/31/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$12,000,000</td>
<td></td>
<td>07/01/2018 – 03/31/2019</td>
<td></td>
</tr>
<tr>
<td>St. John's Riverside-St. John's Division</td>
<td>$1,800,000</td>
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<tr>
<td></td>
<td>$ 700,000</td>
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<td>04/01/2019 – 03/31/2020</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 500,000</td>
<td></td>
<td>04/01/2020 – 03/31/2021</td>
<td></td>
</tr>
<tr>
<td>Soldiers &amp; Sailors Memorial Hospital</td>
<td>$ 19,625</td>
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<td>02/01/2014 – 03/31/2014</td>
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<tr>
<td></td>
<td>$117,252</td>
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<td>04/01/2014 – 03/31/2015</td>
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<tr>
<td></td>
<td>$134,923</td>
<td></td>
<td>04/01/2015 – 03/31/2016</td>
<td></td>
</tr>
<tr>
<td>South Nassau Communities Hospital</td>
<td>$3,000,000</td>
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<td>11/01/2014 – 03/31/2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000,000</td>
<td></td>
<td>04/01/2015 – 03/31/2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$4,000,000</td>
<td></td>
<td>07/01/2018 – 03/31/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$4,000,000</td>
<td></td>
<td>04/01/2019 – 03/31/2020</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$4,000,000</td>
<td></td>
<td>04/01/2020 – 03/31/2021</td>
<td></td>
</tr>
<tr>
<td>Strong Memorial Hospital</td>
<td>$4,163,227</td>
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<td>$4,594,780</td>
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<td>04/01/2019 – 03/31/2020</td>
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</tr>
<tr>
<td></td>
<td>$4,370,030</td>
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<td>04/01/2020 – 03/31/2021</td>
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<tr>
<td>Wyckoff Heights Medical Center</td>
<td>$1,321,800</td>
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<td>01/01/2014 – 03/31/2014</td>
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</tr>
<tr>
<td></td>
<td>$1,314,158</td>
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<td>04/01/2014 – 03/31/2015</td>
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<tr>
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<td>$1,344,505</td>
<td></td>
<td>04/01/2015 – 03/31/2016</td>
<td></td>
</tr>
</tbody>
</table>
Administrative rate appeals

1. Administrative rate appeals of rates of payment issued pursuant to this Attachment must be submitted to the Department in writing within 120 days of the date such rates are issued by the Department to the facility. Such rate appeals must set forth in detail the basis for such appeal and be accompanied by any relevant documentation. Thereafter the Department shall respond to such rate appeals in writing and shall either affirm the original rates, revise such rates or request additional information. A failure to respond to the Department’s request for additional information within 30 days shall be deemed to constitute the withdrawal, with prejudice, of the facility’s rate appeal, provided, however, that the Department may extend that time period upon a request by the facility and for good cause shown. Upon its receipt of the requested additional information the Department shall issue a written determination of such rate appeal.

2. The Department’s written determination of a facility’s rate appeal shall be deemed final unless the facility submits a written request for further consideration of the rate appeal within 30 days of the date the Department issued such written determination, provided, however, that if such written determination advises the facility that its rate appeal is being denied on the ground that the appeal constitutes a challenge to the rate-setting methodology set forth in this Attachment, such denial shall be deemed to be the Department’s final administrative determination with regard to such appeal and there shall be no further administrative review available. The Department shall otherwise respond in writing to such further appeal and either affirm or revise its original rate appeal determination and this response by the Department shall be deemed its final administrative determination with regard to such rate appeal.

3. Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to the audit provisions of this Attachment.

4. The Department shall consider only those rate appeals that reflect one or more of the following bases.
   a. Mathematical or clerical errors in the financial and/or statistical data originally submitted by the medical facility, including information reported to the New York State Statewide Planning and Research Cooperate System (SPARCS), or mathematical or clerical errors made by the Department. Revised data submitted by a facility must meet the same certification requirements as the original data and the Department may require verification of revised SPARCS data by an independent review agent at the cost of the facility; and
b. Any errors regarding a medical facility's capital cost reimbursement.

[5. The Department may refuse to accept or consider a rate appeal from a facility that:

a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or

b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or

c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or

d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.

6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.]

c. i. Beginning on and after January 1, 2014, direct graduate medical education (DGME) and indirect graduate medical education (IME) costs, as defined under the Definitions Section of this Attachment for Graduate Medical Education, for hospitals where the teaching status has changed from non-teaching to teaching.

ii. Rate appeals and rate adjustments for new teaching hospitals.

1. Eligible for reimbursement.

   a. New teaching hospital (from non-teaching to teaching status)

   b. New residency programs which are started by the new teaching hospital during the 5-year ramp-up period as defined in subparagraph 4(c)(ii)(3)(d).

2. Not Eligible for reimbursement.
a. New teaching program in an already existing teaching hospital.
b. Residency programs transferred to the new teaching hospital from an existing teaching hospital.
c. Affiliated existing teaching hospital training additional residents ‘based at’ the new teaching hospital. Affiliated hospital will not receive a rate adjustment.

3. Appeal requirements.
   a. A hospital is required to submit a written request to the Department of Health (Department) for additional reimbursement due to the new teaching status.
   b. An initial rate adjustment will be calculated for Program Year 1 (PGY 1) provided the Department has received the appeal request and all supporting documentation required 30 days prior to the start of the first teaching program. If an appeal is received subsequent to the start of PGY 1, the rate adjustment will be calculated based on the ramp-up period that the provider is in at the time of the appeal request.
   c. Ramp-up schedules 1 and 2 are determined based on the Department’s receipt of the appeal request pursuant to subparagraph 4(c)(ii)(3)(b). Ramp-up appeal requests will only be accepted during the hospital’s determined schedule. The appropriate schedule will be noted in the Department’s response to the appeal request. A chart of the potential appeal schedules has been provided below:

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Appeal Deadline</th>
<th>Effective Date of Rate Adj.</th>
<th>Rate Year / Resident counts</th>
<th>Ramp-Up Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30 days prior to July 1st</td>
<td>July 1st</td>
<td>Program</td>
<td>Initial Year</td>
</tr>
<tr>
<td>2</td>
<td>30 days prior to Jan 1st</td>
<td>Jan 1st</td>
<td>January - Calendar Year</td>
<td>Schedule 1</td>
</tr>
<tr>
<td></td>
<td>After Jan 1st but 30 days prior to July 1st</td>
<td>July 1st</td>
<td>July - PGY residents</td>
<td>Schedule 2</td>
</tr>
<tr>
<td>3</td>
<td>30 days prior to Jan 1st</td>
<td>Jan 1st</td>
<td>January - Calendar Year</td>
<td>Schedule 1</td>
</tr>
<tr>
<td></td>
<td>After Jan 1st but 30 days prior to July 1st</td>
<td>July 1st</td>
<td>July - PGY residents</td>
<td>Schedule 2</td>
</tr>
<tr>
<td>4</td>
<td>30 days prior to Jan 1st</td>
<td>Jan 1st</td>
<td>January - Calendar Year</td>
<td>Schedule 1</td>
</tr>
<tr>
<td></td>
<td>After Jan 1st but 30 days prior to July 1st</td>
<td>July 1st</td>
<td>July - PGY residents</td>
<td>Schedule 2</td>
</tr>
<tr>
<td>Final</td>
<td>30 days prior to Jan 1st</td>
<td>Jan 1st</td>
<td>January - Calendar Year</td>
<td>Schedule 1</td>
</tr>
<tr>
<td></td>
<td>After Jan 1st but 30 days prior to July 1st</td>
<td>July 1st</td>
<td>July - PGY residents</td>
<td>Schedule 2</td>
</tr>
</tbody>
</table>
New York 138.2

d. Hospitals have 5 years to establish new programs. This time period is viewed as a ‘ramp-up’ period and year 1 of the program is defined as the first approved program year that the hospital received teaching status. Appeals for new teaching costs will only be accepted during this ramp-up period.

e. The hospital will provide the following data:

i. Documentation from the accrediting organization demonstrating the maximum number of approved positions eligible for the associated programs.

ii. Documentation from the new teaching hospital demonstrating the projected filled slots for the associated programs for the upcoming PGY. Documentation must include the resident name, residency program, program year, start date, and expected graduation date.

iii. Documentation from the new teaching hospital demonstrating the actual filled slots for the associated programs from the prior PGY if applicable. This includes resident name, residency program, program year, start date, and expected graduation date.

iv. Completion of the Department’s New Teaching Hospital - Form (A) found on the APR-DRG website below:

https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/

v. Budgeted DGME costs must be included in the New Teaching Hospital Form (A) and must reflect calendar year based on the effective date of the rate adjustment. Budgeted DGME Costs must be discretely reported consistent with the standard cost centers provided for interns and residents, and supervising physicians within the annual institutional cost report.

4. Additional reimbursement will be received based on:

a. The initial effective date for a rate increase due to an appeal will be in accordance with subparagraph 4 (c)(ii)(3)(b). This provides for reimbursement effective July 1st.

b. Subsequent appeals after the initial effective date will be accepted during the ramp-up period and in accordance with subparagraph 4(c)(ii)(3)(c).

c. A Direct Graduate Medical Education (DGME) payment per discharge will be added to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment.

TN #14-0009 ___________ Approval Date October 5, 2017
Supersedes TN NEW ________ Effective Date January 1, 2014
i. For new teaching hospitals budgeted DGME costs will be submitted by the hospital and used until the first full year of actual DGME costs are available in a provider's Institutional Cost Report (ICR). The first full year of actual DGME costs for this purpose will be the first full year after the last ramp-up year. DGME budgeted costs can be submitted by a hospital for a rate revision each year during the ramp-up period.

   1. If an appeal is not submitted with updated budgeted DGME costs, the budgeted DGME costs currently in the rate will continue.

ii. The DGME budgeted costs will be allocated between inpatient and outpatient services, however, there is no rate increase in the outpatient services for new teaching hospitals. Appeals for an initial rate adjustment are required to report the percentage of costs allocated to Inpatient and Outpatient services in section 6 of the New Teaching Hospital - (Form A). Once a full year of program costs have been included in an ICR submitted to the Department during the ramp up period, the total inpatient DGME traceback percentages for that year will be utilized for the remainder of the ramp-up period.

iii. At the time the Department updates the base year utilized for the DGME add-ons to the rate, if the provider is still in their ramp-up period, the new teaching costs will remain on budgeted costs.

iv. The DGME add-on to the rate will be calculated by dividing the total inpatient DGME budgeted costs by the total reported Medicaid discharges as defined in paragraph 3 (b of the Statewide base price section.

d. An Indirect Medical Education (IME) payment will be added to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment.

i. An IME percentage will be calculated for new teaching hospitals as follows and applied to the adjusted statewide base price to determine the per case add-on payment.

   1. For IME rate adjustments, effective July 1st for program year, the IME Payment percentage will be calculated based on the formula \[1.03\times((1+(r))^{0.405})-1]\] where “r” equals the ratio of residents for the upcoming PGY, as provided with the appeal, to inpatient acute staff beds as reported in the base period defined in paragraph 3 of the statewide base price section.

   2. For IME rate adjustments, effective January 1st for calendar year, the IME Payment percentage will be calculated based on the formula \[1.03\times((1+(r))^{0.405})-1]\] where “r” equals the ratio of calendar year residents as defined in paragraph 3 of this section to
inpatient acute staff beds as reported in the base period defined in paragraph 3 of the Statewide base price section.

3. Calendar year residents are calculated as follows:
   
   i. Upcoming PGY Resident counts as provided in paragraph 4(c)(ii)(3)(e)(ii) are multiplied by six months
   
   ii. Prior PGY Resident counts as provided in 4(c)(ii)(3)(e)(iii) are multiplied by six months
   
   iii. The calendar year residents equal the sum of i and ii divided by twelve months.

   ii. IME residents will be calculated each ramp-up year until the final year ramp-up.

5. The Department may refuse to accept or consider a rate appeal from a facility that:
   
   a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
   
   b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or
   
   c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
   
   d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.

6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.

TN #14-0009 ___________ Approval Date October 5, 2017
Supersedes TN NEW_________ Effective Date January 1, 2014
Out-of-state providers.

1. For discharges occurring on and after December 1, 2009, rates of payment for inpatient hospital services provided by out-of-state providers in accordance with the prior approval requirements shall be as follows:

   a. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals 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;

   b. For rates effective beginning March 5, 2014, the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall also apply with regard to services provided by out-of-state providers located in cities where the city’s population census is 500,000 or greater based on the U.S. Department of Commerce, United States Census Bureau. This population test will be updated when the acute inpatient rates are updated to a new cost base and will remain constant while the cost base is in effect. For implementing the census population test, the latest census data that is available at that time will be used;

   c. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the upstate region of New York State shall apply with regard to all other out-of-state providers;

   d. high cost outlier rates of payment shall be calculated in accordance with the Outlier and Transfer Cases Rates of Payment section of this Attachment, with the exception of the wage equalization factor (WEF) being based upon the weighted average of the upstate or downstate region; and

   e. the weighted average of the capital component of the inpatient rates in effect for similar services for hospitals located in New York State shall apply with regard to services provided by out-of-state providers.

2. Notwithstanding any inconsistent provision of this Section, in the event the Department determines that an out-of-state provider is providing services that are not available within New York State, the Department may negotiate payment rates and conditions with such provider; provided however, such payments shall not exceed the provider’s usual and customary charges for such services.

3. For purposes of this Section, 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.

TN #14-20
Supersedes TN #10-33-B
Approval Date June 19, 2014
Effective Date March 13, 2014
Supplemental indigent care distributions.

The methodology described in this section sunsets on December 31, 2012. The new methodology effective January 1, 2013 is described in the Indigent Care Pool Reform section of this Attachment.

1. From funds in the pool for each year, except as otherwise provided for in this section, $27 million shall be reserved on an annual basis for the periods January 1, 2000 through May 1, 2009, to be distributed to each hospital based on each hospital’s proportional annual reduction to their projected distribution from the New York State Health Care Reform Act Profession Education Pool, relative to the statewide annual reduction to said pool, as authorized by State law, up to the hospital specific disproportionate share (DSH) payment limits.

2. Effective May 1, 2009 through December 31, 2009:
   
a. Each hospital eligible for supplemental indigent care distributions in 2008 shall receive 90% of its 2008 annual award amount as Medicaid DSH payment.

b. $307 million shall be distributed to facilities designated by the Department as teaching hospitals as of December 31, 2008, to compensate such facilities for Medicaid and self-pay losses. The payment amounts apply consistently to all teaching hospitals, and are reasonably related to costs, based on Medicare GME payments as a proxy, and are pursuant to the following schedule of payments:

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 28, 2014</td>
<td>$307 million</td>
</tr>
</tbody>
</table>

Supersedes TN #09-34

Effective Date January 1, 2013
## Calendar Year 2009

### New York Hospital

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBANY MEDICAL CENTER HOSPITAL</td>
<td>$7,207,099</td>
</tr>
<tr>
<td>ST PETERS HOSPITAL</td>
<td>$1,001,662</td>
</tr>
<tr>
<td>ALBANY MEDICAL CENTER SOUTH CLINICAL CAMPUS</td>
<td>$3,880</td>
</tr>
<tr>
<td>UNITED HEALTH SERVICES, INC</td>
<td>$1,140,730</td>
</tr>
<tr>
<td>OLEAN GENERAL HOSPITAL</td>
<td>$24,817</td>
</tr>
<tr>
<td>ERIE COUNTY MEDICAL CENTER</td>
<td>$597,922</td>
</tr>
<tr>
<td>MERCY HOSPITAL OF BUFFALO</td>
<td>$319,739</td>
</tr>
<tr>
<td>ROSWELL PARK MEMORIAL INSTITUTE</td>
<td>$1,652,987</td>
</tr>
<tr>
<td>KALEIDA HEALTH</td>
<td>$4,938,527</td>
</tr>
<tr>
<td>HIGHLAND HOSPITAL OF ROCHESTER</td>
<td>$2,845,852</td>
</tr>
<tr>
<td>ROCHESTER GENERAL HOSPITAL</td>
<td>$3,553,825</td>
</tr>
<tr>
<td>STRONG MEMORIAL HOSPITAL</td>
<td>$11,695,895</td>
</tr>
<tr>
<td>THE UNITY HOSPITAL OF ROCHESTER</td>
<td>$572,019</td>
</tr>
<tr>
<td>GLEN COVE HOSPITAL</td>
<td>$471,540</td>
</tr>
<tr>
<td>WINTHROP UNIVERSITY HOSPITAL</td>
<td>$6,071,885</td>
</tr>
<tr>
<td>SOUTH NASSAU COMMUNITIES HOSPITAL</td>
<td>$530,429</td>
</tr>
<tr>
<td>NASSAU UNIVERSITY MEDICAL CENTER</td>
<td>$1,783,090</td>
</tr>
<tr>
<td>NORTH SHORE UNIVERSITY HOSPITAL</td>
<td>$13,118,952</td>
</tr>
<tr>
<td>ST FRANCIS HOSPITAL OF ROSLYN</td>
<td>$425,667</td>
</tr>
<tr>
<td>ST ELIZABETH MEDICAL CENTER</td>
<td>$7,889</td>
</tr>
<tr>
<td>FAXTON- ST LUKE’S HEALTHCARE</td>
<td>$23,436</td>
</tr>
<tr>
<td>COMMUNITY-GENERAL HOSPITAL OF GREATER SYRACUSE</td>
<td>$196,351</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER</td>
<td>$6,987,635</td>
</tr>
<tr>
<td>CROUSE HOSPITAL</td>
<td>$958,865</td>
</tr>
<tr>
<td>MARY IMOGENE BASSETT HOSPITAL</td>
<td>$472,619</td>
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<tr>
<td>ELLIS HOSPITAL</td>
<td>$960,657</td>
</tr>
<tr>
<td>ST CHARLES HOSPITAL</td>
<td>$249,445</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL AT STONY BROOK</td>
<td>$13,197,922</td>
</tr>
<tr>
<td>HUNTINGTON HOSPITAL</td>
<td>$64,200</td>
</tr>
<tr>
<td>GOOD SAMARITAN HOSPITAL OF WEST ISLIP</td>
<td>$589,318</td>
</tr>
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</table>

### Uninsured Distribution to Teaching Hospitals

#### January 20, 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Amount</th>
</tr>
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<tbody>
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<td>GOOD SAMARITAN HOSPITAL OF WEST ISLIP</td>
<td>$589,318</td>
</tr>
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#### Approval Date: January 20, 2010

#### Effective Date: December 1, 2009
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Amount</th>
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<tbody>
<tr>
<td>BENEDICTINE HOSPITAL</td>
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<td>KINGSTON HOSPITAL</td>
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</tr>
<tr>
<td>JACOBI MEDICAL CENTER</td>
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<tr>
<td>MONTEFIORE HOSPITAL &amp; MEDICAL CENTER</td>
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</tr>
<tr>
<td>LINCOLN MEDICAL &amp; MENTAL HEALTH CENTER</td>
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<tr>
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<tr>
<td>BROOKLYN HOSPITAL</td>
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<tr>
<td>CONEY ISLAND HOSPITAL</td>
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<td>LONG ISLAND COLLEGE HOSPITAL</td>
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<td>BETH ISRAEL MEDICAL CENTER</td>
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<tr>
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<tr>
<td>MANHATTAN EYE EAR AND THROAT</td>
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<tr>
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<td>NY EYE AND EAR INFIRmary</td>
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<td>ST LUKES - ROOSEVELT HOSPITAL CENTER</td>
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<td>S VMC ST VINCENTS-MANHATTAN</td>
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<tr>
<td>GOLDWATER MEMORIAL HOSPITAL</td>
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<td>COLER MEMORIAL HOSPITAL</td>
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</tr>
<tr>
<td>NYU HOSPITALS CENTER</td>
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TN #09-34
Supersedes TN NEW

Approval Date: January 20, 2010
Effective Date: December 1, 2009
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW YORK PRESBYTERIAN HOSPITAL</td>
<td>$27,337,202</td>
</tr>
<tr>
<td>ELMHURST HOSPITAL</td>
<td>$2,226,463</td>
</tr>
<tr>
<td>JAMAICA HOSPITAL</td>
<td>$1,185,404</td>
</tr>
<tr>
<td>LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER</td>
<td>$18,206,316</td>
</tr>
<tr>
<td>QUEENS HOSPITAL CENTER</td>
<td>$554,077</td>
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<tr>
<td>NY MED CTR OF QUEENS</td>
<td>$3,178,354</td>
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<tr>
<td>FOREST HILLS HOSPITAL</td>
<td>$1,334,742</td>
</tr>
<tr>
<td>STATEN ISLAND UNIVERSITY HOSPITAL</td>
<td>$5,084,762</td>
</tr>
<tr>
<td>RICHMOND UNIVERSITY MEDICAL CENTER</td>
<td>$2,274,908</td>
</tr>
</tbody>
</table>

c. Effective May 1, 2009 through December 31, 2009, $16 million shall be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.

d. Effective December 1, 2009, $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital’s 2007 annual cost report, based on each hospital’s decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

TN #13-13 Supersedes TN #09-34
Approval Date January 28, 2014
Effective Date January 1, 2013
3. For annual periods beginning on and after January 1, 2010 through December 31, 2012:
   a. From regional allotments specified below, $269.5 million shall be distributed to non-major public teaching hospitals on a regional basis to cover each eligible facility’s proportional regional share of 2007 uncompensated care, as defined in the disproportionate share payment calculation provisions of this Attachment and offset by disproportionate share payments received by each facility during calendar year 2010 in accordance with the disproportionate share payment calculations provisions of this Attachment.

<table>
<thead>
<tr>
<th>Region</th>
<th>Revised Regional Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Island</td>
<td>$ 31,171,915</td>
</tr>
<tr>
<td>New York City</td>
<td>$ 181,778,400</td>
</tr>
<tr>
<td>Northern Metropolitan</td>
<td>$ 14,526,351</td>
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<tr>
<td>Northeast</td>
<td>$ 8,130,067</td>
</tr>
<tr>
<td>Utica/Watertown</td>
<td>$ 502,271</td>
</tr>
<tr>
<td>Central</td>
<td>$ 10,052,989</td>
</tr>
<tr>
<td>Rochester</td>
<td>$ 16,615,910</td>
</tr>
<tr>
<td>Western</td>
<td>$ 6,722,096</td>
</tr>
<tr>
<td>Statewide</td>
<td>$269,500,000</td>
</tr>
</tbody>
</table>

   b. $25 million shall be distributed to non-major public hospitals having eligible for payments based upon each facility’s proportion of uninsured losses as determined according to the methodology in the High Need Indigent Care Adjustment Pool of this Attachment.

   c. $16 million shall continue to be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.

   d. $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital’s 2007 annual cost report, based on each hospital’s decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.
(I) High Need Indigent Care Adjustment Pool. Funds will be deposited as authorized and used for the purpose of making Medicaid disproportionate share payments within the limits established on an annualized basis pursuant to disproportionate share limitations, except as otherwise provided for in this section, for the period January 1, 2000 through December 31, 2012, in accordance with the following:

(1) From the funds in the pool each year:

(i) Each eligible rural hospital will receive a payment of $140,000 on an annualized basis for the period January 1, 2000 through September 30, 2009. Effective on and after October 1, 2009 through December 31, 2012, each eligible rural hospital will receive a payment of $126,000 on an annualized basis, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this clause exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit will be provided as a nondisproportionate share payment in the form of a grant directly from this pool without federal financial participation;

(ii) Each such hospital will also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Percentage Coverage of Uncompensated Care Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td>60.0%</td>
</tr>
<tr>
<td>10-17</td>
<td>52.5%</td>
</tr>
<tr>
<td>18-25</td>
<td>45.0%</td>
</tr>
<tr>
<td>26-33</td>
<td>37.5%</td>
</tr>
<tr>
<td>34-41</td>
<td>30.0%</td>
</tr>
<tr>
<td>42-49</td>
<td>22.5%</td>
</tr>
<tr>
<td>50-57</td>
<td>15.0%</td>
</tr>
<tr>
<td>58+</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

(iii) “Eligible rural hospital”, as used in paragraph (1), will mean a general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, or a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital which has a service area which has an average population of less than two hundred persons per square mile measured as population density by zip code.
The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin or zip code as applicable for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the 1997 rate year, as reported to the commissioner by October 1, 1998. Population density shall be determined utilizing United States census bureau data for 1997.

(iv) “Eligible rural hospital weight”, as used in paragraph (1), shall mean the result of adding, for each eligible rural hospital:

(a) The eligible rural hospital’s targeted need, as defined in subparagraph (ii) of this section, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and

(b) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.

(2) From the funds in the pool each year, except as otherwise provided for in this section, $36 million on an annualized basis for the periods January 1, 2000 through September 30, 2009, and for the periods on and after October 1, 2009 through December 31, 2012, $32.4 million on an annualized basis, of the funds not distributed in accordance with paragraph (1), shall be distributed in accordance with the formula set forth in paragraph (12) of the Medicaid disproportionate share payments section of this Attachment.

(3) From the funds in the pool each year, any funds not distributed in accordance with paragraphs (1) or (2), shall be distributed in accordance with the formula set forth in subparagraph (d) of paragraph (10) of the Medicaid disproportionate share payments section.
For annual periods beginning January 1, 2009 through December 31, 2012, disproportionate share hospital (DSH) payments shall be reduced to 90 percent of the amount otherwise payable. In addition, DSH payments to each general hospital will be distributed in accordance with the following:

(a) $13.93 million will be distributed to major government hospitals and will be allocated proportionally, based on each facility’s relative uncompensated care need as determined in accordance with (c);

(b) $70.77 million will be distributed to general hospitals other than major government general hospitals and will be allocated proportionally, based on each facility’s relative uncompensated care need as determined in accordance with (c);

(c) each facility’s relative uncompensated care need amount will be determined by multiplying inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory units of services, by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January 1, 2010 through December 31, 2012, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July 1 of the prior year; and:

by multiplying outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department services and ambulatory surgery services, but excluding referred ambulatory services units of service, by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology, however, for those services for which APG rates are not available the applicable Medicaid outpatient rate shall be the rate in effect for the calendar year two years prior to the distribution year.

For distributions on and after January 1, 2010 through December 31, 2012, each facility’s uncompensated need amount will be reduced by the sum of all payment amounts collected from such patients. The total uncompensated care need for each facility will then be adjusted by application of the existing nominal need scale.
(d) (i) Continuing annually for periods on and after January 1, 2009 through December 31, 2012, no general hospital will receive DSH payment distributions that exceed the costs incurred by such hospital during the distribution period for providing inpatient and outpatient hospital services to Medicaid eligible patients or, uninsured patients. Such costs will be net of monies received from non-DSH related Medicaid payments and collections from uninsured patients.

(ii) DSH payment reductions will first be made from the public general hospital indigent care adjustment payments pursuant to this Attachment, and then from payments from this section.

(e) Distributions to voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by the final payment amounts paid to eligible voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Additional Inpatient Hospitals Payments Section for the period commencing July 1, 2010, and annually thereafter through December 31, 2012.

(f) In addition to reductions noted in paragraph (e), distributions to voluntary sector general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by $69.4M for the period commencing July 1, 2010 through December 31, 2010 and by $73.2M annually for rate periods commencing January 1, 2011 [and thereafter] through December 31, 2012 excluding distributions made in accordance with subparagraphs (b), (c), and (d) of paragraph (3) of the Supplemental Indigent Care Distributions Section.
Hospital physician billing.

1. With the exception of hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act, for discharges occurring on and after February 1, 2010, hospitals may bill for physician services in accordance with the applicable Medicaid physician fee schedule in addition to billing the applicable DRG.
Serious Adverse Events.
Effective October 1, 2008, through June 30, 2011, the New York State Medicaid program shall deny reimbursement or reduce payment for the higher DRG arising from the following three serious adverse events, defined as avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients: foreign object left in patient after surgery, air embolism, and blood incompatibility. On and after November 1, 2009, hospitals will be required to bill all claims associated with one of the remaining ten (10) serious adverse events using the following procedures:

a. For those cases where a serious adverse event occurs and the hospital elects to receive no payment for the admission (i.e., it is expected that Medicaid will deny the entire payment based on the type of event), the hospital will notify Medicaid of this case by submitting a claim using a new rate code 2590 (non-reimbursable with serious adverse events), along with the requisite billing information submitted with a claim.

Department of Health will identify claims billed with rate code 2590 and instruct the Island Peer Review Organization (IPRO), the New York State Medicaid review agent, to request the medical record for the admission and conduct a case review.

b. For those cases where a serious adverse event occurs and the hospital anticipates at least partial payment for the admission, the hospital will follow a two-step process for billing the admission:

i. The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.
ii. Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:

- 2591 (DRG with serious adverse events), or
- 2592 (Per Diem with serious adverse events)

The adjusted claim will then pend to the Department and will be forwarded to Island Peer Review Organization (IPRO) for further review. IPRO will review the medical record for the case to determine appropriate payment. Once IPRO has completed its review of the medical record, a preliminary notification indicating their findings will be issued. Hospitals will be required to respond to this preliminary finding within thirty days indicating whether it agrees or disagrees with the finding. If the provider disagrees with this preliminary finding, they may appeal by submitting additional rationale and supporting documentation to the IPRO. IPRO will then re-review the case taking into account the provider’s rationale and supporting documentation. A final determination will be made at the conclusion of this process.

The thirteen serious adverse events are as follows:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure on a patient
4. Foreign object inadvertently left in patient after surgery
5. Medication error
6. Air embolism
7. Blood incompatibility
8. Patient disability from electric shock
(9) Patient disability from use of contaminated drugs
(10) Patient disability from wrong function of a device
(11) Incidents whereby a line designated for oxygen intended for patient is wrong item or contaminated
(12) Patient disability from burns
(13) Patient disability from use of restraints or bedrails

Hospitals receiving payment under New York State Medicaid shall be required to provide information, through Present on Admission (POA) indicators, on each admission. These POA indicators shall designate which procedures or complications were present on admission, and which occurred during or as a result of hospital care. This provision applies to all Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.
**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.

**Health Care-Acquired Conditions**
The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A) of this State plan.

- _X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

**Other Provider-Preventable Conditions**
The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19(A) 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.

- _X_ Additional Other Provider-Preventable Conditions identified below: [Not applicable.]

Effective July 1, 2011, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

PPCs are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

For APR-DRG cases, the APR-DRG payable shall exclude the diagnoses not present on admission for any HCAC. For per diem payments, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC.
For per diem payments, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC. Claims containing a diagnosis not present on admission will be subsequently reviewed by clinical review staff to determine if the diagnosis contributed to a longer length of stay. If the clinical review can reasonably isolate that portion of the actual length of stay that is directly related to the diagnosis not present on admission, payment will be denied for the directly related length of stay.

No payment shall be made for inpatient services for OPPCs. OPPCs are the three Medicare National Coverage Determinations:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Surgical or other invasive procedure performed on the wrong body part; and
3. Surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment will be limited to the extent that the following apply:

1. The identified PPCs would otherwise result in an increase in payment.
2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPCs.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.
Graduate Medical Education - Medicaid Managed Care Reimbursement
Teaching hospitals shall receive direct reimbursement from the State Medicaid Agency for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care or Family Health Plus plans.
GME payments for DRG based services shall include the following:

a. A direct graduate medical education (GME) payment per discharge calculated for each teaching hospital by dividing the facility's total reported acute care Medicaid direct GME costs by its total Medicaid acute care discharges in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

b. An indirect GME payment per discharge calculated for each teaching hospital by applying the actual applicable Service Intensity Weight for the discharge, Wage Equalization Factor Adjustment, and indirect teaching cost percentage described in this Attachment to the statewide base price. Each of these variables will be for the applicable rate year in which the discharge occurs.

GME payments for exempt unit or hospital services shall include a direct GME and an indirect GME component calculated as follows:

a. A direct GME payment per discharge for each exempt unit or hospital by dividing the facility's applicable exempt unit or hospital Medicaid direct GME costs by the total Medicaid discharges for that exempt unit or hospital in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the average operating cost per diem for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.
b. An indirect GME payment per discharge for each exempt unit or hospital by applying the indirect teaching cost percentage calculated in accordance with this Attachment to the hospital’s operating cost per diem calculated in accordance with the provisions of this Attachment excluding the costs of direct GME calculated in (a) above, converted to a per diem basis, and trended forward to the rate period in accordance with the provisions of each applicable exempt unit or hospital’s average length of stay based on the latest available data reported on the Institutional Cost Report for the reporting period two years prior to the rate year.
Disproportionate Share Hospital (DSH) State Plan Rate Years

The State Plan Rate Year for Disproportionate Share Hospital payments made to general acute care and specialty hospitals in this Attachment and facility specific DSH caps shall be defined as running from January 1 through December 31 of the current calendar year and each subsequent calendar year thereafter.
Disproportionate share limitations.

1. Disproportionate share payment distributions made to general hospitals pursuant to this Attachment shall be limited in accordance with the provisions of this Section. The latest available annual cost report submitted by a hospital prior to the disproportionate share distribution period shall be used to determine eligibility pursuant to paragraph (2) and for projected limits pursuant to paragraph (5). Annual cost reports having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals, annual cost reports having an end date in the subsequent annual disproportionate share distribution period, shall be used to reconcile limits pursuant to paragraph (6).

2. General hospitals must meet the following conditions to receive disproportionate share distributions:
   a. The hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for obstetric services under a state plan. This requirement doesn't apply to a hospital if their inpatients are predominantly under 18 years old or if the hospital does not offer nonemergency obstetric services to the general population as of December 22, 1987. If the hospital is a rural hospital, an obstetrician is any physician with staff privileges to perform nonemergency obstetric procedures.
   b. The hospital must have a Medicaid inpatient utilization rate of at least one percent.

3. No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in paragraph (1) for furnishing inpatient and ambulatory hospital services to individuals who are eligible for medical assistance benefits pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as “Medicaid cost”) or to individuals who have no health insurance or other source of third party coverage (hereinafter referred to as “self-pay cost”), reduced by medical assistance payments made pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as “Medicaid revenue”), other than disproportionate share payments, and payments by uninsured patients. For purposes of this Section, payments to a general hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.

4. In order to ensure the continued flow of disproportionate share payments to hospitals, the Commissioner shall make projections of each hospital’s disproportionate share limitation based on the most current data available from the hospital’s annual cost reports. The

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TN ___ #09-34 _______ Approval Date January 20, 2010
Supersedes TN ___ NEW _______ Effective Date December 1, 2009
Commissioner shall use annual cost reports in accordance with the provisions of paragraph (5) to estimate Medicaid and self-pay costs in the projection methodology for a particular rate year. This shall be referred to as the “projection methodology”. Subsequent to the receipt of a hospital's annual cost report having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals whose annual cost reports have an end date within the subsequent annual period, each hospital's disproportionate share limitation shall be reconciled to the actual rate year data. This shall be referred to as the "reconciliation methodology".

5. **Projection methodology.** Each hospital's projected disproportionate share limitation for each rate year shall be the sum of its inpatient and outpatient Medicaid and uninsured gains/(losses) as calculated using reported base year data and statistics from the year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year. For the two thousand eleven calendar year, maximum disproportionate share payment distributions shall be determined initially based on each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, and shall subsequently be revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool. For calendar years on or after January 1, 2012, inpatient and outpatient Medicaid and uninsured gains/(losses) based on data for the most recent calendar year available [2 years] prior to the DSH payment year submitted by hospitals as prescribed by the Commissioner shall be used to determine maximum disproportionate share payments. All such initial determinations shall subsequently be revised to reflect actual calendar year inpatient and outpatient Medicaid and uninsured gains/(losses) applicable to the DSH payment year.

6. **Reconciliation methodology.** The Commissioner shall revise the projected limitation based on actual audited and certified data reported to the Commissioner for such calendar year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 USC §1396r-4. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department.

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outpatient Medicaid and self-pay gains/(losses) during the cost reporting year. The disproportionate share limitation schedule shall be accompanied by a certification by the hospital's independent public accountant which provides the Commissioner sufficient assurance as to the accuracy of the information contained in such schedule.

i. The final limit shall be calculated by excluding inpatient and outpatient Medicaid revenue impacts resulting from prospective adjustments to rates for periods prior to the implementation of the federal hospital specific disproportionate share payment limits from the inpatient and outpatient Medicaid and self-pay gains/(losses) reported on the disproportionate share payment limitation schedule.

a. Failure of a hospital to submit the information required by this Section in a form acceptable to the Commissioner shall result in the immediate withholding of subsequent disproportionate share distributions. Such withholding shall continue until the hospital complies with the reporting requirements of this section.
Government General Hospital Additional Disproportionate Share Payments

Government general hospital disproportionate share payments will be made to increase reimbursement to hospitals operated by the State of New York, the State University of New York. To be eligible, hospitals must be operating at the time the payments are made. The payments are subject to the payment limits established in this Attachment of this plan.

1. Government general hospitals operated by the State of New York or the State University of New York shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007 and April 1, 2007 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, for the state fiscal years beginning April 1, 2011 through March 31, 2013, for the state fiscal years beginning April 1, 2013 through March 31, 2016 and for the state fiscal years beginning April 1, 2016 through March 31, 2019, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.
Such payments shall continue to be established for periods beginning on April 1, 2007, through March 31, 2008, based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2007. For periods beginning April 1, 2008, through March 31, 2009, such payments shall be based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.
2. Government general hospitals operated by a county, which does not include a city with a population of over one million, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, for the state fiscal years beginning April 1, 2011 through March 31, 2013, [and] for the state fiscal years beginning April 1, 2013 through March 31, 2016 and for the state fiscal years beginning April 1, 2016 through March 31, 2019, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002, after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.
Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to up to 100% of actual reported data for 2007, for state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.
Government general hospitals operated by a county, which does not include city of over one million, or beginning April 1, 1997, government general hospitals located in the county of Erie, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, subject to the limits established in accordance with disproportionate share limitations. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006. Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to up to 100% or actual reported data for 2007 and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.
Government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million, shall receive 120 million dollars in additional disproportionate share payments effective January 1, 1997 and 120 million dollars in additional disproportionate share payments during each state fiscal year commencing April 1, 2000 and thereafter until March 31, 2003, $120 million during the state fiscal year April 1, 2005 through March 31, 2006, $120 million during the state fiscal year beginning April 1, 2006 through March 31, 2007, $120 million beginning April 1, 2007 through March 31, 2008, $120 million during the state fiscal year beginning April 1, 2008 through March 31, 2009, $420 million [annually] for the state fiscal year[s] beginning April 1, 2009 through March 31, 2010[1], $420 million for the state fiscal year beginning April 1, 2010 through March 31, 2011, and $120 million for the state fiscal year beginning April 1, 2011 through March 31, 2012 and annually thereafter, subject to the maximum payment amounts permitted under sections 1923(f) and 1923(g) of the federal Social Security Act after application of all other disproportionate share hospital payments[, $120 million annually for the state fiscal year beginning April 1, 2011, and annually thereafter]. Such facilities will also receive payments equivalent to any undistributed disproportionate share payment amount, after all other statewide disproportionate share payments, pursuant to the states’ allotment under 1923(f) and (g) of the federal Social Security Act. Such payments will be made to each qualified individual hospital based on the relative share of each such hospital’s medical assistance and uninsured patient losses for 1997 after considering all other medical assistance payments to such government general hospitals based on 1994 reconciled data as further reconciled to actual reported 1997 reconciled data, for any payments made in 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 or 1998 reconciled data, for payments made during the state fiscal year beginning April 1, 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 or 1999 data, for payments made during the state fiscal year ending March 31, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 or 2000 data, for payments made during the state fiscal year beginning April 1, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 or 2001 data, for payments made during the state fiscal year beginning April 1, 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 or 2002 data, for payments made during the state fiscal year beginning April 1, 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported data as further reconciled to actual reported 2001 or 2002 data, for payments made for the state fiscal year beginning April 1, 2005 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2005 or 2006 data, and for payments made for the state fiscal year beginning April 1, 2006, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2006 or 2007 data.
Such payments shall continue to be established for the state fiscal year beginning on April 1, 2007 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2007 or 2008 data, for the state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2008 or 2009 data. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Beginning April 1, 2000 government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million are authorized to receive additional disproportionate share payments as projected or reconciled pursuant to this Attachment governing disproportionate share payments to hospitals, based on the relative share of each such non-state operated government general hospital of projected or reconciled medical assistance and uninsured patient losses after payment of all other medical assistance, including disproportionate share payments to such government general hospitals. For the period April 1, 2000 through March 31, 2001, an additional payment of $103 million is authorized. Effective April 1, 2001 through March 31, 2002, additional payments of $113 million are authorized. For the state fiscal years beginning April 1, 2002 and ending March 31, 2009, and each state fiscal year thereafter, additional annual payments of $210 million are authorized. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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TN #10-20-B

Approval Date July 29, 2011

Supersedes TN #09-34

Effective Date April 1, 2010
For state fiscal years beginning April 1, 2003 and ending March 31, 2005, the Department of Health is authorized to pay government general hospitals, operated by the State of New York or by the State University of New York additional payments for inpatient hospital services as medical assistance payments for patients eligible for federal financial participation under Title XIX of the federal social security act pursuant to the federal laws and regulations governing disproportionate share payments to hospitals 175 percent of each such government general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such government general hospital, based initially on reported 2000 reconciled data. Such payments for the periods ending March 31, 2004 and March 31, 2005, shall be further reconciled to actual reported 2003 and 2004 data respectively, provided, however, that such payments for all eligible hospitals shall be reduced to the extent such payments would result in the exceeding of the State's disproportionate share allotment limit, as determined in accordance with federal statute and regulations, provided, however, that such reduction shall be based on each such hospital's proportionate share of the sum of all such payments that would be made without regard to such allotment limit. Such payments may be added to rates of payment or made as aggregate payments to an eligible government general hospital.
Reimbursable Assessment on Hospital Inpatient Services

Effective January 1, 2006, and thereafter, an assessment on net patient services revenue for hospital inpatient services rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.
Government General Hospital Indigent Care Adjustment.

For rate periods commencing January 1, 1997 [and thereafter,] through December 31, 2012 each eligible government general hospital [shall] will receive an annual amount equal to the amount allocated to such government general hospitals as determined pursuant to this Attachment for the period January 1, 1996 through December 31, 1996. The adjustment may be made to rates of payment or as aggregate payments to an eligible government general hospital and is contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

For calendar years effective January 1, 2013, and for each calendar year thereafter, eligible major government general hospitals will receive in aggregate $412,000,000 proportionately allocated based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available audited annual data as of January 1 of the distribution year prepared in accordance with federal DSH Auditing and Reporting regulations 42 CFR Parts 447 and 455 and submitted annually to the Department of Health as required by the Commissioner of Health. Eligible major government hospitals are defined as all State operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation, and all other public general hospitals having annual inpatient operating costs in excess of $25 million dollars. Medicaid and uninsured losses will be calculated in accordance with federal DSH Auditing and Reporting regulations 42 CFR Parts 447 and 455. Payments will be calculated on an annual basis and distributed in four quarterly installments.
Additional Inpatient Governmental Hospital Payments

For the period beginning state fiscal year April 1, [2016] 2017 and ending [December 31, 2016] March 31, 2018, the State will provide a supplemental payment for all inpatient services provided by eligible government general hospitals located in a city with a population over one million and not operated by the State of New York or the State University of New York. The amount of the supplemental payment will be [$337,471,812] $421,376,757 and paid semi-annually in September and March. It will be distributed to hospitals proportionately using each hospital’s proportionate share of total Medicaid days reported for the base year two years prior to the rate year. Such payments, aggregated with other medical assistance payments will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective periods.

TN ___ #17-0043_ Approval Date September 20, 2017

Supersedes TN ___ #16-0035_ Effective Date April 1, 2017
Additional Inpatient Governmental Hospital Payments (Continued)

For the state fiscal year beginning April 1, 2016 and ending March 31, 2017, the State will provide an additional supplemental payment for all inpatient services provided by eligible government general hospitals. To be eligible, hospitals must (1) be a government 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. Also, all medical assistance payments when aggregated with both the supplemental payment and the additional supplemental payment will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government hospitals for this period.

The amount of the supplemental payment will be [$132,540,359] the difference between the amount of $393,987,995 and the previous supplemental payment amount of $337,471,812 within the same year. Medical assistance payments will be made for all inpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act [initially] and calculated using each such hospital's proportionate share of total Medicaid days of all eligible hospitals reported for the [period from January 1, 2015 to December 31, 2015] base period two years prior to the rate year.

TN #16-0035-A
Supersedes TN #15-0022-B
Approval Date June 8, 2017
Effective Date April 1, 2016
Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of $235,500,000 for the period July 1, 2010 through March 31, 2011; $314,000,000 for the period April 1, 2011 through March 31, 2012; $281,778,852 for the period April 1, 2012 through March 31, 2013; $298,860,732 for the period April 1, 2013 through March 31, 2014; and $226,443,721 for the period April 1, 2014 through March 31, 2015; and $264,916,150 for the period April 1, 2015 through March 31, 2016; and $271,204,805 for the period of April 1, 2016 through March 31, 2017; and $319,459,509 for the period of April 1, 2017 through March 31, 2018 subject to the requirements of 42 CFR 447.272 (upper payment limit). Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

(a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services 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 such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such 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;

(c) No payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).

(i) did not receive an Indigent Care Pool (ICP) payment;
(ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
(iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.

(d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.
Medicaid disproportionate share payments.

1. For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.

2. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

3. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to government general hospital inpatient services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.

4. Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in this section. This paragraph sunsets on December 31, 2012.

5. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.

6. Major government general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other government general hospitals having annual inpatient operating costs in excess of $25 million. This paragraph sunsets on December 31, 2012.

7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals. This paragraph sunsets on December 31, 2012.

8. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payment made
directly to the government general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The costs of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

9. In order to be eligible for distributions, a general hospital’s targeted need must exceed one-half of one percent. This paragraph sunsets December 31, 2012.

10. For rate years commencing January 1, 1991 and prior to January 1, 1997, each eligible major government general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.

   a. Statewide resources shall mean the sum of the result of multiplying a statewide average 5.48% by each general hospital’s (including major government general hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds.

11. For rate periods commencing January 1, 1997 through December 31, [2014] 2012, each eligible major government general hospital shall receive an amount equal to the amount allocated to such major government general hospital for the period January 1, 1996 through December 31, 1996.

12. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (11) of this section and funds are reserved for distribution as high need adjustments in accordance with paragraph (13) of this section and shall be distributed to eligible hospitals, excluding major government general hospitals, on the basis of targeted need share.

   a. Need calculations shall be based on need data for the year two years prior to the rate year.
b. For the rate periods commencing January 1, 1991 and prior to January 1, 1997, the scale specified in this section, and for rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, the scale specified in subparagraph (d) of this section shall be utilized to calculate individual hospital’s nominal payment amounts on the basis of the percentage relationship between their need for the year two years prior to the rate year and their patient service revenues for the year two years prior to the rate year.

c. The scale utilized for development of each hospital’s nominal payment amount shall be as follows:

<table>
<thead>
<tr>
<th>Targeted Need Percentage</th>
<th>Percentage of Reimbursement Attributable to the Portion of Targeted Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1%</td>
<td>35%</td>
</tr>
<tr>
<td>1 - 2%</td>
<td>50%</td>
</tr>
<tr>
<td>2 - 3%</td>
<td>65%</td>
</tr>
<tr>
<td>3 - 4%</td>
<td>85%</td>
</tr>
<tr>
<td>4 - 5%</td>
<td>90%</td>
</tr>
<tr>
<td>5+%</td>
<td>95%</td>
</tr>
</tbody>
</table>

d. The scale utilized for development of each eligible government general hospital’s nominal payment amount shall be as follows:

TN #13-13

Supersedes TN #09-34

Approval Date January 28, 2014

Effective Date January 1, 2013
New York 161(c)

<table>
<thead>
<tr>
<th>Targeted Need Percentage</th>
<th>Percentage of Reimbursement Attributable to the Portion of Targeted Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 0.5%</td>
<td>60%</td>
</tr>
<tr>
<td>0.5+ - 2%</td>
<td>65%</td>
</tr>
<tr>
<td>2+ - 3%</td>
<td>70%</td>
</tr>
<tr>
<td>3+ - 4%</td>
<td>75%</td>
</tr>
<tr>
<td>4+ - 5%</td>
<td>80%</td>
</tr>
<tr>
<td>5+ - 6%</td>
<td>85%</td>
</tr>
<tr>
<td>6+ - 7%</td>
<td>90%</td>
</tr>
<tr>
<td>7+ - 8%</td>
<td>95%</td>
</tr>
<tr>
<td>8+%</td>
<td>100%</td>
</tr>
</tbody>
</table>

13. Payments described in paragraph 2 of the High Need Indigent Care Pool subdivision shall be distributed as high need adjustments to general hospitals, excluding major government general hospitals, with nominal payment amount in excess of 4 percent of reported costs as follows: each general hospital’s share shall be based on such hospital’s aggregate share of nominal payment amount above 4 percent of reported costs compared to the total aggregate nominal payment amount above 4 percent of reported costs of all eligible hospitals. This paragraph sunsets on December 31, 2012.

TN #13-13 Approval Date January 28, 2014
Supersedes TN #10-26 Effective Date January 1, 2013
Indigent Care Pool Reform - effective January 1, 2013

The provisions of this section will be effective for the period January 1, 2013 through December 31, 2015.

(a) Indigent Care Pool Reform Methodology. Each hospital’s uncompensated care nominal need will be calculated in accordance with the following:

1. Inpatient Uncompensated Care. Inpatient units of service for uninsured (self-pay and charity) patients, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the calendar year two years prior to the distribution year for each inpatient service area which has a distinct reimbursement rate, excluding hospital-based residential health care facility (RHCF) and hospice units of service, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

Medicaid inpatient rates for acute and psychiatric services will be the statewide base price adjusted for hospital-specific factors including an average case mix adjustment plus all rate add-ons except the public goods surcharge. Medicaid inpatient rates for all other inpatient services will be the per diem rate, excluding the public goods surcharge add-on. Units of service for acute care services will be uninsured patient discharges; units of service for all other inpatient services will be uninsured patient days, not including alternate level of care (ALC) days.

2. Outpatient Uncompensated Care. Outpatient units of service for those uninsured (self-pay and charity) patients reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year, excluding referred ambulatory services and home health units of service, will be multiplied by the average paid Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate in effect for January 1 of the distribution year will be utilized. The outpatient rates used are exclusive of the public goods surcharge.

Units of service for ambulatory surgery services will be uninsured procedures, not including those which result in inpatient admissions; units of service for all other outpatient services will be uninsured visits, not including those which result in inpatient admissions.
3. **Adjusted Inpatient Uncompensated Care.** The inpatient uncompensated care will be summed and adjusted by an inpatient statewide cost adjustment factor calculated as the statewide aggregate sum of the inpatient uninsured units multiplied by the step-down cost per unit for each applicable inpatient service, excluding hospital-based RHCF and hospice services, divided by the statewide aggregate sum of the inpatient uncompensated care.

Allowable step-down costs include the direct and indirect costs from the ICR for the calendar year two years prior to the distribution year. The direct costs are reported for each of the hospital’s inpatient service areas on Exhibit 11, and adjusted for reclasses, adjustments to expenses, and post step-down adjustments as reported on Exhibits 12, 14, and 15 respectively. Indirect routine and ancillary costs for each inpatient service area are allocated to such based on the cost allocation statistics reported on Exhibits 19 and 20 of the ICR. The resulting direct and indirect allowable step-down costs are adjusted for transfers and converted to a per unit amount for each inpatient service, excluding hospital-based residential health care facility (RHCF) and hospice services, by dividing such costs by the total units for the service as reported in Exhibit 32 of the ICR for the calendar year two years prior to the distribution year.

4. **Adjusted Outpatient Uncompensated Care.** The outpatient uncompensated care will be summed and adjusted by an outpatient statewide cost adjustment factor calculated as the statewide aggregate sum of the outpatient uninsured units of service multiplied by the step-down cost per unit for each applicable outpatient service, excluding referred ambulatory and home health services, divided by the statewide aggregate sum of the outpatient uncompensated care.

Allowable step-down costs include the direct and indirect costs from the ICR for the calendar year two years prior to the distribution year. The direct costs are reported for each of the hospital’s outpatient service areas on Exhibit 11, and adjusted for reclasses, adjustments to expenses, and post step-down adjustments as reported on Exhibits 12, 14, and 15 respectively. Indirect routine and ancillary costs for each outpatient service area are allocated to such based on the cost allocation statistics reported on Exhibits 19 and 20 of the ICR. The resulting direct and indirect allowable step-down costs are adjusted for transfers and converted to a per unit amount for each outpatient service, excluding referred ambulatory and home health services, by dividing such costs by the total units for the service as reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year.
5. **Total Net Adjusted Uncompensated Care.** The adjusted inpatient and outpatient uncompensated care will be summed and reduced by the sum of all uncompensated care collections (cash payments) collected from inpatient and outpatient uninsured patients as reported in Exhibits 32 and 33 of the ICR for the calendar year two years prior to the distribution year to determine total net adjusted uncompensated care.

6. **Nominal Need Factor.** A nominal need factor will be calculated as the sum of:
   a. 0.40; and
   b. the Medicaid inpatient utilization rate multiplied by 0.60.

   The Medicaid inpatient utilization rate will be calculated as the sum of Medicaid fee-for-service and Medicaid managed care discharges divided by the total inpatient discharges for the applicable inpatient services. The inpatient discharges used in this calculation will be from Exhibit 32 of the ICR for the cost reporting year two years prior to the distribution year.

7. **Uncompensated Care Nominal Need.** The total net adjusted uncompensated care will be multiplied by the nominal need factor to determine uncompensated care nominal need used to proportionally allocate the available indigent care pool funding described in paragraph (b) of the following Indigent Care Pool section.
(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts, which will be paid in twelve, approximately equal lump sum, monthly installments:

1. Major Government General Hospital Pool Distributions. $139.4 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital’s relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section.

Major government general hospitals are defined as all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation, and all other government general hospitals having annual inpatient operating costs in excess of $25 million. Hospitals eligible for distributions from this pool will be all such major government general hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

2. Voluntary General Hospital Pool Distributions. $994.9 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospital’s relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section.

Voluntary general hospitals are defined as all voluntary non-profit, private proprietary, and government general hospitals other than major government general hospitals. Hospitals eligible for distributions from this pool will be all such voluntary hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.
3. **Transition Pool.** A three-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform Methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2015 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments.

a. **Distribution Amount.** A hospital’s distribution will be determined by means of a comparison between their allocation as calculated in accordance with the Indigent Care Reform Methodology described in section (a)(1) through (a)(7), the Floor Amount in 3(c) below, and the Ceiling Amount in 3(d) below. If the Indigent Care Reform Methodology allocation is:
   i. less than or equal to the Floor Amount, the hospital will receive the Floor Amount.
   ii. greater than or equal to the Ceiling Amount, the hospital will receive the Ceiling Amount.
   iii. greater than the Floor Amount but less than the Ceiling Amount, the hospital will receive the Indigent Care Reform Methodology allocation payment.

b. **Separate uniform Floor percentages and uniform Ceiling percentages are calculated for each of the major governmental and voluntary pools.**

c. **The Floor Amount** For each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Floor Percentage for its respective pool. The Floor percentage is:
   i. 97.5% for 2013
   ii. 95.0% for 2014
   iii. 92.5% for 2015

d. **The Ceiling Amount** for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Ceiling Percentage for its respective pool. The ceiling percentage is calculated using an iterative process to obtain the unique percentage value such that:
   i. The total payments to all providers in each pool equals the amount of the respective pool in subdivision (b)(1) or (b)(2) and
   ii. The individual hospital payments will comply with the requirements described in paragraphs 3(a) through (c) above

e. **For 2014 and 2015,** these amounts will be further adjusted to carve out amounts used to fund the Financial Assistance Compliance Pool payments in paragraph 6.

An example of this methodology follows:

| TN #13-13 | Approval Date January 28, 2014 |
| Supersedes TN NEW | Effective Date January 1, 2013 |
### Sample Transition Period DSH Pool Payment Calculations

#### CY 2014

<table>
<thead>
<tr>
<th>Indigent Care Pool Payment Before Transition Period</th>
<th>Three Year Historical Average of Pool Payments</th>
<th>Tentative Transition Pool Carve-out (2014-2015)</th>
<th>Allocation Before Adjustment as % of Three Year Avg</th>
<th>Tentative Transition Period Payment as % of Three Year Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name</td>
<td>Floor Amount</td>
<td>Ceiling Amount</td>
<td>Tentative Transition Period Payment</td>
<td>Actual Transition Period Payment</td>
</tr>
<tr>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d)</td>
<td>(e)</td>
</tr>
<tr>
<td>Hospital A</td>
<td>$25,000,000</td>
<td>$18,000,000</td>
<td>$17,100,000</td>
<td>$19,782,000</td>
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<td>Hospital B</td>
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<td>$11,400,000</td>
<td>$13,188,000</td>
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<td>Hospital C</td>
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<td>$18,620,000</td>
<td>$21,540,400</td>
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<td>Hospital D</td>
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<td>Hospital E</td>
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<td>Hospital F</td>
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<td>$25,277,000</td>
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<td>Hospital G</td>
<td>$4,400,000</td>
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<td>$3,500,000</td>
<td>$5,934,600</td>
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<td>Statewide Totals</td>
<td>$139,400,000</td>
<td>$139,400,000</td>
<td>$132,430,000</td>
<td>$153,200,600</td>
</tr>
</tbody>
</table>

#### Percentages:

1. The unadjusted amount that would otherwise be paid to each hospital under the new DSH pool allocation methodology beginning 1/1/2013
2. The actual average amount paid to each hospital under the prior DSH pool allocation methodology in CYs 2010 - 2012
3. The amount for each hospital in (c) multiplied by the Floor Percentage in (i)
4. The amount for each hospital in (c) multiplied by the Ceiling Percentage in (ii)
5. For each individual hospital, if the Indigent Care Pool Actual Transition Period Payment is:
   1. < the Floor Amount, the Transition Period Payment is the Floor Amount
   2. > the Ceiling Amount, the Transition Period Payment is the Ceiling Amount
   3. Otherwise, it is the amount in (b) calculated using the new DSH pool allocation methodology effective 1/1/2013.

Using the formula: =IF(Bn<Dn,Dn,IF(Bn>En,En,Bn))

#### Financial Assistance Compliance Pool Carve-out for 2014 & 2015:

The carve-out will be calculated by taking each hospital's share of the $139.4M allocation and applying that percentage to the $3.2M in compliance pool funds.

#### This same process would apply to the Voluntary Allocations of $994.9M
4. **Voluntary UPL Payment Reductions.** The distributions in this section will be reduced by the final payment amounts paid to the eligible voluntary general hospitals, excluding government general hospitals, made in accordance with the Additional Inpatient Hospitals Payments section.

5. **DSH Payment Limits.** The distributions in this section are subject to the provisions of the Disproportionate share limitations section.

6. **Financial Assistance Compliance Pool.** For calendar years 2014 and 2015, an amount equivalent to one percent of total DSH funds will be segregated into the Financial Assistance Compliance Pool (FACP) and allocated to all hospitals which prior to December 31, 2015 demonstrate substantial compliance with §2807-k(5-d)(b)(iv) of the Public Health Law (New York State Financial Aid Law) as in effect on January 1, 2013. There will be separate pool amounts for major governmental and voluntary hospitals. The amounts are $3.2 million for major governmental hospitals and $23.2 million for voluntary hospitals.

The DSH funds in the FACP will be proportionately allocated to all compliant hospitals using the Indigent Care Reform Methodology described in subparagraph (3)(a) of this section. Compliance will be on a pass/fail basis. When a hospital is deemed compliant, one hundred percent of its share of the FACP funds will be released; there will be no partial payment for partial compliance. Any unallocated funds resulting from hospitals being non-compliant will be proportionally reallocated to compliant hospitals in each respective group based on their relative share of the distributions calculated in subparagraph (3)(a).
Additional disproportionate share payments.

Beginning April 10, 1997 and for annual periods beginning April 1, 1998 through December 31, 2011, additional disproportionate share payments shall be paid to voluntary non-profit general hospitals. Such payments shall be limited to [not exceed] each such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other medical assistance payments received, including disproportionate share hospital (DSH) payments made to such general hospitals and payments from and on behalf of such uninsured patients with the limitations based initially on reported data from the base year two years prior to the payment year and further reconciled to actual reported data from such payment year [and shall also not exceed the amount of state aid for which the hospital or its successor would have been eligible pursuant to the Funding for Substance Abuse Services and the Local Unified Services Sections of the Mental Hygiene Law (as described below) for fiscal year 1996-97, the Base Year. Such additional disproportionate share payments will be calculated by aggregating net approved operating costs for such mental health and/or alcoholism or substance abuse programs in each hospital. Net operating costs are defined as operating costs offset by revenues, other income, federal aid and fees. The payments may be made as quarterly aggregate payments to an eligible hospital]. Such payments shall not exceed the limit specified on the Disproportionate Share limitations section of this attachment.

[Payments beginning April 1, 1998 and thereafter will be related to the hospital's willingness to continue to provide services previously funded by state aid grants. The Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), in consultation with county directors of community services, will annually designate to the Department of Health those general hospitals eligible for the additional disproportionate share payment, and the amount thereof. If a hospital does not continue to provide substantially the same level of program and/or services as in the Base Year, the local governmental unit can recommend to the Commissioner of OMH and/or the Commissioner of OASAS that the provider not be designated to receive disproportionate share payments for mental health and/or substance abuse and alcoholism services in the future. In addition, if a hospital reduces its deficit from that of the Base Year, either as a result of increased program revenues, or as a result of program or service cutbacks, or as a result of lower costs, the local governmental unit can recommend to OMH and/or OASAS that the additional disproportionate share payment be reduced commensurate with the decrease in the deficit.

Services funded under the Local and Unified Services Section of the Mental Hygiene Law include mental health services. Alcoholism services funded under the Local and Unified Services section of the Mental Hygiene Law include health and alcoholism treatment services. Substance abuse services funded under Funding for Substance Abuse Services Section of the Mental Hygiene Law include health and substance abuse services.]

Payments to voluntary general hospitals providing mental health services for the period April 1, 2010 – December 31, 2010 and January 1, 2011 – December 31, 2011. The payment amounts apply consistently to voluntary general hospitals providing mental health services, and are reasonably related to costs, and are pursuant to the following schedule:

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Supersedes</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#10-04</td>
<td>September 29, 2011</td>
<td>#09-34</td>
<td>April 1, 2010</td>
</tr>
<tr>
<td>Hospital</td>
<td>April 1, 2010 - December 31, 2010</td>
<td>January 1, 2011 - December 31, 2011</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Bassett Healthcare</td>
<td>943,686</td>
<td>1,248,400</td>
<td></td>
</tr>
<tr>
<td>Benedictine Hospital</td>
<td>62,163</td>
<td>4,160</td>
<td></td>
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<tr>
<td>Beth Israel Medical Center</td>
<td>1,212,066</td>
<td>1,604,850</td>
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<tr>
<td>Bronx-Lebanon Hospital Center</td>
<td>740,049</td>
<td>696,611</td>
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<td>Brookdale Hospital Medical Center</td>
<td>1,083,018</td>
<td>1,422,646</td>
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<tr>
<td>Carthage Area Hospital</td>
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<td>Clifton Springs Hospital</td>
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<tr>
<td>Cortland Memorial Hospital</td>
<td>83,631</td>
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<tr>
<td>Ellis Hospital</td>
<td>675,282</td>
<td>637,756</td>
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<td>Episcopal Health Services, Inc</td>
<td>606,489</td>
<td>774,063</td>
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<td>Flushing Hospital and Medical Center</td>
<td>123,372</td>
<td>82,248</td>
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<td>Glens Falls Hospital</td>
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<td>607,170</td>
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<td>Good Samaritan Hospital Reg Med Ctr</td>
<td>169,419</td>
<td>123,085</td>
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<tr>
<td>Interfaith Medical Center</td>
<td>1,256,433</td>
<td>1,029,351</td>
<td></td>
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<tr>
<td>Kaleida Health</td>
<td>227,604</td>
<td>151,738</td>
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<tr>
<td>Kingsbrook Jewish Medical</td>
<td>197,184</td>
<td>253,051</td>
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<tr>
<td>Long Island Jewish Medical Center</td>
<td>624,630</td>
<td>813,626</td>
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<tr>
<td>Maimonides Medical Center</td>
<td>2,061,948</td>
<td>2,053,498</td>
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<td>Mercy Medical Center</td>
<td>86,421</td>
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<tr>
<td>Mount Sinai Hospital</td>
<td>1,381,293</td>
<td>1,187,020</td>
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<td>Mount Vernon Hospital</td>
<td>106,260</td>
<td>137,117</td>
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<tr>
<td>New York Presbyterian Hospital</td>
<td>1,893,480</td>
<td>2,233,985</td>
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<tr>
<td>Niagara Falls Comm MH Center</td>
<td>385,965</td>
<td>506,400</td>
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<td>North Shore Univ Hospital</td>
<td>586,014</td>
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<td>Olean General Hospital</td>
<td>91,296</td>
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<td>Orange Regional Medical Center</td>
<td>54,924</td>
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<tr>
<td>Oswego Hospital Mental Health Div</td>
<td>260,232</td>
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<td>Our Lady of Lourdes Memorial Hospital</td>
<td>34,002</td>
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<tr>
<td>Phelps Memorial Hospital Center</td>
<td>221,226</td>
<td>284,774</td>
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<td>Putnam Hospital Center</td>
<td>97,749</td>
<td>129,255</td>
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<td>Richmond University Medical Center</td>
<td>989,730</td>
<td>828,765</td>
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<td>Rochester General Hospital</td>
<td>64,731</td>
<td>85,594</td>
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<td>Samaritan Medical Center</td>
<td>154,836</td>
<td>103,724</td>
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<td>Sound Shore Med Ctr of Westchester</td>
<td>54,861</td>
<td>42,307</td>
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<tr>
<td>South Nassau Com Hospital</td>
<td>170,037</td>
<td>113,375</td>
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<tr>
<td>St Barnabas Hospital</td>
<td>610,992</td>
<td>798,468</td>
<td></td>
</tr>
<tr>
<td>St Joseph's Hospital Health Center</td>
<td>1,221,312</td>
<td>1,567,059</td>
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<tr>
<td>St Joseph's Medical Center</td>
<td>313,698</td>
<td>2,842,434</td>
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<td>St Luke's-Roosevelt Hospital Center</td>
<td>919,176</td>
<td>1,215,464</td>
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<tr>
<td>St Vincent's Catholic MC of NY</td>
<td>1,908,708</td>
<td>0</td>
<td></td>
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<tr>
<td>Strong Memorial Hospital</td>
<td>1,848,738</td>
<td>2,417,142</td>
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<tr>
<td>The Unity Hospital of Rochester</td>
<td>1,186,143</td>
<td>1,524,260</td>
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<tr>
<td>United Health Services Hospital</td>
<td>1,015,446</td>
<td>1,338,748</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>26,462,568</strong></td>
<td><strong>29,290,399</strong></td>
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**TN**  #10-04  **Approval Date**  September 29, 2011  
**Supersedes**  #09-34  **Effective Date**  April 1, 2010
New York
164

Payments to voluntary general hospitals providing alcohol and substance abuse services for the period April 1, 2010 – December 31, 2010 and January 1, 2011 – December 31, 2011. The payment amounts apply consistently to voluntary general hospitals providing alcohol and substance abuse services, and are reasonably related to costs, and are pursuant to the following schedule:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>April 1, 2010 - December 31, 2010</th>
<th>January 1, 2011 - December 31, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 15,469,267</td>
<td>$ 18,308,116</td>
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<tr>
<td></td>
<td>OASAS DSH Distributions to the Voluntary Hospitals</td>
<td>OASAS DSH Distributions to the Voluntary Hospitals</td>
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<tr>
<td>Beth Israel Medical Center</td>
<td>9,243,739</td>
<td>12,334,244</td>
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<tr>
<td>Interfaith Medical Center</td>
<td>144,173</td>
<td>96,115</td>
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<tr>
<td>Montefiore Hospital &amp; Medical Center</td>
<td>1,162,710</td>
<td>1,085,387</td>
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<tr>
<td>Mount Sinai Hospital</td>
<td>384,500</td>
<td>256,333</td>
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<tr>
<td>New York Presbyterian Hospital</td>
<td>335,471</td>
<td>447,294</td>
</tr>
<tr>
<td>Richmond University Medical Center</td>
<td>1,403,298</td>
<td>1,871,064</td>
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<tr>
<td>St Luke’s - Roosevelt Hospital Center</td>
<td>897,294</td>
<td>1,196,392</td>
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<tr>
<td>St Vincent’s Hospital &amp; Medical Ctr of NY</td>
<td>1,507,819</td>
<td>500,937</td>
</tr>
<tr>
<td>Staten Island University Hospital</td>
<td>390,263</td>
<td>520,350</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>15,469,267</strong></td>
<td><strong>18,308,116</strong></td>
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</tbody>
</table>

TN #10-04 Approval Date September 29, 2011
Supersedes #09-34 Effective Date April 1, 2010
Reimbursement for language assistance services in hospital inpatient settings:

Effective for hospital inpatient services provided on and after September 1, 2012, a Medicaid rate of payment for language interpretation services provided to patients with limited English proficiency (LEP) and communication services provided for patients who are deaf and hard of hearing will be established as follows:

(1) Payment will be established on a per unit basis, with the unit of payment based on the number of minutes of language assistance services provided.

(2) A maximum of two billable units of language assistance services will be allowable per patient per day with the billable units defined as follows:

i) 1st billable unit – for encounters providing one to 22 minutes of language assistance service.

ii) 2nd billable unit – for encounters providing additional minutes (23+) beyond the initial 22 minutes of language assistance services during the given patient day.

(3) The rate of payment will be established at $11.00 per unit of language assistance services, with a maximum payment per inpatient day of care of $22.00. Such payment will be available on an “as provided only” basis via a separate and discretely billed rate, and will supplement the applicable DRG or exempt unit per diem payment for the given inpatient stay to account for the additional costs of inpatient services involving language assistance services.

(4) To be reimbursable, the language assistance services must be provided by an independent third party, a dedicated hospital employee or a third party vendor (e.g., telephonic interpretation service) whose sole function is to provide interpretation services for individuals with LEP and communication services for patients who are deaf and hard of hearing.
Attachment A
Deleted Pages:

Pages 103, 104(a), 105, 106(a), 107, 108, 108(a), 109, 109(a), 110, 110(a), 111, 111(a), 112, 112(a), 112(b), 112(c), 112(d), 112(e), 112(f)(1), 112(f)(2), 112(g), 112(h), 113, 113(a), 113(b), 113(b)(1), 113(b)(2), 113(b)(2)(i), 113(b)(2)(ii), 113(b)(3), 113(c), 114, 114(a), 114(b), 115, 116, 117, 117(a), 117(a)(1), 117(b), 117(c), 117(d), 117(e), 118, 118(a), 119, 120, 120(a), 121, 121(a), 122, 123, 124, 125, 126, 127, 127(a), 128, 129, 130, 131, 131(a), 131(b), 131(c), 131(c)(1), 131(d), 131(e), 131(f), 131(g), 131(h), 132, 132(a), 133, 134, 134(a), 135, 136, 136(a), 136(b), 136(b)(1), 136(b)(2), 136(b)(3), 136(c), 136(c)(1), 136(d), 136(e), 137, 137(a), 138, 139, 139(a), 140, 141, 141(a), 142, 142(a), 143, 143(a), 144, 144(a), 144(b), 144(b)(1), 144(c), 144(d), 144(e), 145, 145(a), 145(b), 145(c), 145(d), 146, 146(a), 146(a)(1), 147, 148, 148(a), 148(b), 149, 149(a), 149(a)(i), 149(a)(ii), 149(a)(i), 149(a)(2), 149(b), 149(c), 149(d), 149(e), 150, 150(a), 151, 151(a), 152, 152(a), 153, 153(a), 153(b), 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 165(a), 165(b), 165(c), 165(d), 165(e), 165(f), 165(g), 165(h), 165(i), 165(j), 165(k), 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 175(a), 175(b), 175(c), 175(d), 175(d)(1), 175(d)(2), 175(d)(3), 175(d)(4), 175(d)(5), 175(d)(6), 175(d)(7), 175(d)(8), 175(d)(9), 175(d)(10), 175(d)(11), 175(d)(12), 175(d)(13), 175(d)(14), 175(d)(15), 175(d)(16), 175(d)(17), 175(d)(18), 175(d)(19), 175(d)(20), 175(d)(21), 175(d)(22), 175(d)(23), 175(d)(24), 175(d)(25), 175(d)(26), 175(d)(27), 175(d)(28), 175(d)(29), 175(d)(30), 175(d)(31), 175(d)(32), 175(d)(33), 175(d)(34), 175(d)(35), 175(d)(36), 175(d)(37), 175(d)(38), 175(d)(39), 175(d)(40), 175(d)(41), 175(d)(42), 175(d)(43), 175(d)(44), 175(d)(45), 175(d)(46), 175(d)(47), 175(d)(48), 175(d)(49), 175(d)(50), 175(e), 176, 176(a), 176(b), 176(c), 176(c)(1), 176(d), 176(e), 176(f), 176(g), 176(h), 176(i), 176(j), 176(k), 176(l), 176(m), 176(n), 176(o), 176(p), 176(q), 176(r), 176(s), 176(t), 176(u), 176(v), 176(w), 176(x), 176(x)(1), 176(x)(2), 176(x)(3), 176(x)(4), 176(x)(5), 176(x)(6), 176(x)(7), 176(x)(8), 176(x)(9), 176(x)(10), 176(x)(11), 176(x)(12), 176(x)(13), 176(x)(14), 176(x)(15), 176(x)(16), 176(x)(17), 176(x)(18), 176(x)(19), 176(x)(20), 176(x)(21), 176(x)(22), 176(x)(23), 176(x)(24), 176(x)(25), 177, 177(a), 178, 179, 179(a), 180, 180(a), 180(b), 180(c), 180(d), 180(e), 180(f), 180(g), 180(g)(1), 180(h), 180(i), 181, 181(a), 181(b), 182, 182(a), 183, 183(a), 184, 184(a), 185, 185(a), 185(b), 186, 187, 188, 188(a), 188(a)(1), 188(b), 188(b)(A), 188(b)(B), 188(b)(C), 188(b)(D), 188(b)(E), 188(b)(1), 188(b)(2), 188(b)(3), 188(b)(4), 189, 189(a), 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 210(a), 210(b), 211, 211(a), 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 222(a), 223, 224, 225, 226, 226(a), 226(b), 227, 228, 229, 230, 230(a), 230(b), 230(c), 230(d), 231, 231(a), 232, 232(a), 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 246(a), 246(b), 246(c), 246(d), 246(e), 246(f), 247, 248, 248(a), 248(a)(1), 248(b), 248(b)(1), 249(a), 249, 249(a)(1), 249(a)(2), 249(a)(3), 249(b), 249(c), 249(d), 249(d)(1), 249(e), 250, 251, 252, 253, 253(a)

Note: The State does not have a Page 233
Attachment B
New Pages:

### New York

#### ITEM PROXY

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
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</thead>
<tbody>
<tr>
<td><strong>Labor</strong></td>
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</tr>
<tr>
<td>Executive, Administrative and Managerial Personnel</td>
<td>ECI-Civilian-Compensation-Executive, Administrative and Managerial 1/</td>
</tr>
<tr>
<td>Professional and Technical Personnel</td>
<td>ECI-Civilian-Compensation-Professional and Technical 1/</td>
</tr>
</tbody>
</table>
| All Other Personnel | 1. ECI-Civilian-Compensation-Service Occupation 41.1% 1/  
2. ECI-Civilian-Compensation-Clerical 45.0% 1/  
3. ECI-Civilian-Compensation-Blue Collar 8.9% 1/  
4. ECI-Compensation-Private Industry-Workers-Union-Service Producing Industries 5.0% 1/ |
| **Regional Adjustment Factor** | Average hourly earnings industry composite-New York and U.S. – 50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C., U.S. – 50% |
| **Administrative and General** | |
| Telephone | Telephone rate index |
| Postage | Consumer Price Index (CPI-W) |
| Insurance- malpractice and umbrella | Malpractice survey |
| Insurance-General liability and property | General Liability insurance rates |
| Insurance Automobile | Automobile insurance (ECI) |
| Insurance-Other | Insurance Composite |

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TN #98-06  
Supersedes TN #95-06  
Approval Date April 6, 2000  
Effective Date January 1, 1998
ITEM | PROXY
--- | ---
Legal Fees | ECI-Compensation-Private Industry Workers- Professional Specialty & Technical 1/
Accounting Fees | ECI-Compensation-Private Industry Workers- Executive, Administrative and Managerial 1/
Office Supplies | 1. Office Supplies & Accessories (PPI) – 40%
 | 2. Office Machines NEC – 12.5% (PPI)
 | 3. Writing and Printing Papers – 20% (PPI)
 | 4. Pens, Pencils and Marking Devices – 12.5% (PPI)
 | 5. Classified Advertising – 7.5% (PPI)
 | 6. Periodicals, Circulation – 7.5% (PPI)
Management Consulting Fees | Average hourly earnings – Management and Public Relation Services 2/
 | a. ECI Private Industry Workers – Compensation – Executive, Administrative and Managerial 3/
 | b. ECI – Private Industry Workers – Wages and Salaries – Executive, Administrative and Managerial 3/
Data Processing | Average Hourly Earnings – Computer and Data Processing Services 2/
 | a. ECI- Private Industry Workers – Compensation-Professional Specialty and Technical 3/
 | b. ECI-Private Industry Workers-Wages and Salaries-Professional Specialty and Technical 3/
Interest Expense – Working Capital | Predominant prime time
Real Estate Taxes | 1. NYC tax rates
 | 2. Upstate overall tax rates
Dietary | 1. All Foods (PPI) – 40%
 | 2a. Food at Home, U.S. City average (CPI) or
 | 2b. Food at Home, NY-NENJ (CPI) – 40%
 | 3. Cups and Liquid – Tight Containers (PPI) – 3%
 | 4. Tableware, Serving Pieces, and Nonelectric Kitchenware (CPI) – 7%
 | 5a. Food Away From Home, (CPI) U.S. City average or
 | 5b. Food Away From Home, NY-NENJ (CPI) – 10%
### Operation and Maintenance of Plant

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance &amp; Repairs</td>
<td>Maintenance &amp; Repairs (CPI)</td>
</tr>
<tr>
<td>• #2 Fuel Oil</td>
<td>Price, Tank Car Reseller, NYC &amp; Albany</td>
</tr>
<tr>
<td>• #6 Fuel Oil</td>
<td>Price, Tank Car Reseller, NYC &amp; Albany</td>
</tr>
<tr>
<td>• Natural gas</td>
<td>NYSFPS data for Brooklyn Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric &amp; Gas, Orange &amp; Rockland, Rochester Gas &amp; Electric</td>
</tr>
<tr>
<td>• Purchased Steam</td>
<td>NYSDOH Price Index for Con-Ed purchased steam</td>
</tr>
<tr>
<td>• Electric Power</td>
<td>NYSFPS price index for Con-Ed, L.I. Lighting, Orange &amp; Rockland, Central Hudson, NYS Electric &amp; Gas, Niagara Mohawk, Rochester Gas &amp; Electric</td>
</tr>
<tr>
<td>• Water and Sewer</td>
<td>Water and Sewerage Maintenance (CPI)</td>
</tr>
<tr>
<td>• Waste Disposal</td>
<td>Refuse Collection (CPI)</td>
</tr>
<tr>
<td>• Laundry and Linen</td>
<td>Laundry and Dry Cleaning Other than Coin Operator (CPI)</td>
</tr>
<tr>
<td>• Housekeeping</td>
<td>1. Soap and Synthetic Detergents – 40% (PPI)</td>
</tr>
<tr>
<td></td>
<td>2. Unsupported Plastic Film and Sheeting – 30% (PPI)</td>
</tr>
<tr>
<td></td>
<td>3. Sanitary Papers and Health Products – 30% (PPI)</td>
</tr>
<tr>
<td>• Security</td>
<td>ECI-Private Industry Worker- Compensation-Service Occupation</td>
</tr>
</tbody>
</table>

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**TN #98-06**

**Approval Date** April 6, 2000

**Supersedes TN #95-06**

**Effective Date** January 1, 1998
### New York

#### Part I Appendix I Attachment 4.19-A

<table>
<thead>
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<th>ITEM PROXY</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
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<td><strong>Professional Services</strong></td>
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</tr>
<tr>
<td>• Maintenance &amp; Repairs</td>
<td>Equipment/ECI-Private Industry Workers-Compensation-Service Industry 1/</td>
</tr>
<tr>
<td>• Drugs</td>
<td></td>
</tr>
<tr>
<td>1. Preparations, Ethical (Prescription) (PPI) – 72.0%</td>
<td></td>
</tr>
<tr>
<td>2. Preparation, Prop. (Over the Counter) (PPI) – 5.0%</td>
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</tr>
<tr>
<td>3. Prescription Drugs (CPI) – 23.0%</td>
<td></td>
</tr>
<tr>
<td>• Medical Supplies</td>
<td></td>
</tr>
<tr>
<td>1. Medical Instruments and Apparatus – 45% (PPI)</td>
<td></td>
</tr>
<tr>
<td>2. Surgical Appliances and Supplies – 55% (PPI)</td>
<td></td>
</tr>
<tr>
<td>• Non-Medical Supplies</td>
<td></td>
</tr>
<tr>
<td>1. Office Supplies &amp; Accessories (PPI) – 40%</td>
<td></td>
</tr>
<tr>
<td>2. Office Machines NEC – 12.5% (PPI)</td>
<td></td>
</tr>
<tr>
<td>3. Writing and Printing Papers – 20% (PPI)</td>
<td></td>
</tr>
<tr>
<td>4. Pens, Pencils and Marking Devices – 12.5% (PPI)</td>
<td></td>
</tr>
<tr>
<td>5. Classified Advertising – 7.5% (PPI)</td>
<td></td>
</tr>
<tr>
<td>6. Periodicals, Circulation – 7.5% (PPI)</td>
<td></td>
</tr>
<tr>
<td>• Physicians Fees</td>
<td>Physicians’ Services (CPI) 4/</td>
</tr>
<tr>
<td>• Other Medical Professional</td>
<td>ECI-Compensation-Civilian-Professional Specialty and Technical 1/</td>
</tr>
<tr>
<td>• X-Ray Film</td>
<td>Change in manufacturer’s list prices</td>
</tr>
<tr>
<td>• Reagents</td>
<td>Reagents (PPI)</td>
</tr>
<tr>
<td>• Travel and Conference</td>
<td>Private Transportation (CPI)</td>
</tr>
<tr>
<td>• Employment Agency Fees- Nursing</td>
<td>ECI-Private Industry Workers-Compensation-Professional Specialty and Technical 1/</td>
</tr>
<tr>
<td>• Employment Fees</td>
<td>ECI- Civilian - Compensation – Clerical 1/</td>
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</tbody>
</table>

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**TN #98-06**  
**Supersedes TN #95-06**  
**Approval Date** April 6, 2000  
**Effective Date** January 1, 1998
Appendix II

TN #89-46
Supersedes TN ___NEW_____

Approval Date September 8, 1992
Effective Date November 13, 1989
Part I Appendix II Attachment 4.19-A

New York

PHASE I HOSPITALS

Albany Medical Center
Auburn Memorial
Beth Israel Medical Center
Bronx-Lebanon
City Hospital at Elmhurst
Community Hospital Western Suffolk
Cortland Memorial
Ellis Hospital
Erie County Medical Center
Long Beach Memorial
Maimonides
Mercy Hospital, Rockville
Metropolitan Hospital
Nassau County Medical Center
Niagara Falls Memorial
St. Joseph’s, Yonkers
St. Luke’s Roosevelt
St. Vincent’s, NYC
St. Vincent’s, Richmond
Southside Hospital
State University- Upstate
Strong Memorial
Summit Park
SUNY Stony Brook
United Health Services
Westchester County MC
Women’s Christian
Woodhull

TN #89-46
Supersedes TN NEW
Approval Date September 8, 1992
Effective Date November 13, 1989
New York

PHASE II HOSPITALS

Bayley Seton Hospital
Buffalo General Hospital
Cabrini Medical Center
Central General Hospital
Champlain Valley Hospital
Clifton Springs Hospital
Coney Island Hospital
Eastern Long Island Hospital
Franklin General Hospital
Genesee Hospital
Glens Falls Hospital
Good Samaritan Hospital of Suffern
Harlem Hospital
Mary Imogene Bassett
Montefiore Medical Center
North Central Bronx Hospital
Presbyterian Hospital
Queens Hospital
Samaritan Hospital
Saratoga Hospital
St. Barnabas Hospital
St. Francis Hospital
St. James Mercy Hospital
St. Mary's Hospital
St. Vincent's Hospital- Westchester

TN #89-46 Approval Date September 8, 1992
Supersedes TN NEW Effective Date November 13, 1989
METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR INPATIENT SERVICES PROVIDED BY HOSPITALS OPERATED BY THE NEW YORK STATE OFFICE OF MENTAL HEALTH

In accordance with the Mental Hygiene Law, the office of Mental Health (OMH) establishes Medicaid inpatient rates of reimbursement, subject to the approval of the Director of the State Division of the Budget, for the psychiatric hospitals it operates. Statewide average payment rates shall be established for each of the rate categories outlined below under section I. The rates shall be established on a prospective basis in advance of the payment year.

I. [GENERAL] RATE CATEGORIES
   [A separate rate is established for each of the following categories:]

   [1] A. Adult Services
   This rate category includes all inpatient units located at OMH Medicare and Medicaid certified Psychiatric Centers with the exception of Forensic Psychiatric Centers and discrete specialized units for children and youth for which separate rate categories are established.

   [2] B. Children’s Services
   This rate category applies to those separate and distinct Children’s Units operated by the OMH. The Children’s Units provide psychiatric care and treatment exclusively to children and/or adolescents. These Children’s Units are located both within OMH Medicare and Medicaid certified psychiatric centers as well as in separately accredited Children’s Psychiatric Centers certified only under the Medicaid Program.

   This rate category applies to those separate and distinct inpatient facilities that provide services to clients involved with the criminal justice system. These facilities provide a highly secure treatment environment for patients who are too dangerous to be treated in State civil psychiatric centers.

   [Medicaid inpatient rates for each category are established prospectively on a statewide basis by averaging together each of the per diem rate components outlined below for all Medicaid certified facilities.]

II. BASE YEAR [OPERATING] PER DIEM
   [The operating per diem of the inpatient Medicaid rates is developed by averaging together the following:] Allowable base year costs shall be determined as follows:
A. [For] Medicare Certified Psychiatric Centers (including Forensic Psychiatric Centers)
[the Medicare (Title XVIII) per diem payment rates resulting from the final
settlement of OMHs Medicare cost reports covering the fiscal year ended March 31,
1998.]

1. Inpatient routine and ancillary per diem cost shall be obtained from the
Medicare final settled cost reports for the fiscal year ended March 31, 2002.
Medicare final settlements are issued by OMH's Medicare Fiscal Intermediary
following their review and audit of the Medicare cost reports submitted by OMH
for each of the Medicare participating providers it operates. [For purposes
of Medicare reimbursement OMH Psychiatric Hospitals are treated as PPS exempt
providers with payment rates developed in accordance with 42 CFR section
413.40.]

2. Allowable inpatient cost shall be inclusive of capital cost and shall be
determined without consideration of the Medicare facility-specific target
rate limits or the Medicare national 75th percentile caps under 42 CFR § 413.40.
3. Allowable cost shall include the professional services of hospital-based
physicians. The allowable cost of physicians services shall be determined subject
to the Medicare reasonable compensation equivalent (RCE) limits under 42 CFR §
415.70. For purposes of applying this limitation the most recently issued RCE
limits shall be trended to the applicable rate year based upon the increase in the
Consumer Price Index for All Urban Consumers (CPI-U).

B. [For] Children’s Psychiatric Centers

Since the Children’s Psychiatric Centers are not Medicare participating providers
Medicare final settlements are not processed for these providers. As such, the [base
inpatient per diem] allowable inpatient cost for these facilities shall be determined
[based on their average inpatient cost per day for the base year. The base year to be
utilized shall be the same fiscal year as that used for the Medicare participating
psychiatric centers as outlined under paragraph II.A. above.

The inpatient cost per day for the Children’s Psychiatric Centers shall be
determined] in accordance with the cost reporting and cost-finding methods developed
by the Hospital industry as adopted by the Medicare (Title XVIII) and Medicaid (Title
XIX) Programs. In determining those items of cost that shall be determined to be
allowable, Medicaid (Title XIX) laws, rules and regulations shall be applied in accordance
with paragraph III.A. below.
New York

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[C. Exclusion of Capital Cost
In developing the statewide average base year operating per diem for each rate category, capital costs shall be eliminated from the amounts included in the per diems described above under the paragraphs II.A. and II.B. For purposes of this section capital costs shall be determined in accordance with the Medicare (Title XVIII) principles of reimbursement and accordingly will include depreciation on capital assets and interest expense on indebtedness incurred to construct or purchase capital assets.]

III. ADJUSTMENTS FOR MEDICAID PURPOSES
In determining the allowable base year operating per diem outlined under paragraph II above adjustments shall be made to reflect the following:

A. Differences in Medicare vs. Medicaid Covered Services
The final Medicare inpatient payment rates as referenced under paragraph II.A. above shall be adjusted to exclude the costs of any services included therein which have been determined to be non-reimbursable under the Medicaid Program [(i.e. patient education programs).] In addition the costs associated with any services covered under New York State's Medicaid Program but not reimbursable under the Medicare program (e.g. dental services) shall be added [to the final Medicare payment rates] to determine Medicaid allowable costs.

B. Other Allowable Costs
The base year per diem operating component developed in accordance with paragraph II above shall be adjusted to include other costs allowed under the Medicare principles of reimbursement but not claimed in the individual facility Medicare cost reports for the base year as referenced under paragraph II. A. above. This adjustment shall include costs related to services which have historically been included in the calculation of the OMH statewide inpatient Medicaid payment rates and found to be reimbursable by the Health Care Financing Administration.]

IV. TREND FACTOR
A trend factor shall be utilized in order to project the base year operating per diems as developed under paragraph II above to the applicable rate year. This trend factor will be developed by compounding the applicable increases in the Medicare RPL (rehabilitation, psychiatric and long-term care) market basket index/es for each year] between the base year and the rate year. In calculating the current year's rates the OMH shall utilize estimates in instances where the actual increase in the RPL market basket has
not yet been determined for any particular years between the base year and the rate year. Once the actual increases in the RPL have been determined the OMH will include an adjustment in the subsequent year's rate to compensate for any difference between the estimated and actual increases in the RPL market basket. For purposes of this section the Medicare RPL market basket index is that published by the Federal [Health Care Financing Administration (HCFA)] Centers for Medicare and Medicaid Services (CMS) [pursuant to 42 CFR section 413.40 for hospitals and units of hospitals which are exempt from the Medicare Inpatient Prospective Payment System (PPS)] for determining Medicare reimbursement to psychiatric hospitals under the inpatient psychiatric facilities prospective payment system (IPFs PPS).

V. ACCREDITATION ADJUSTMENT

A per diem adjustment shall be incorporated in the inpatient Medicaid rates for OMH facilities to account for additional costs incurred subsequent to the base year used to develop the operating per diem pursuant to paragraph II above in order to meet minimum Medicaid and Medicare facility accreditation requirements. In addition, this adjustment may include additional accreditation costs expected to be incurred during the year for which the payment rates are being computed. For purposes of determining expected accreditation costs to be incurred during the rate year the Governor's Executive Budget submission to the legislature shall be utilized.

[VI. CAPITAL-RELATED COSTS

The inpatient Medicaid payment rates for OMH facilities shall include an allowance for depreciation and interest expenses on buildings and equipment. Depreciation expense shall be computed utilizing the straight line method. Useful lives of depreciable assets shall be applied based upon the guidelines promulgated by the American Hospital Association.

The capital component of the rates shall be computed on a current basis. Accordingly the rates will reflect a projection of capital costs and patient days applicable to the rate year. A per diem adjustment shall be included in subsequent years rates to reflect any differences between projected and actual costs and patient days used in the calculation of the rate year capital per diem.]

VII. VOLUME ADJUSTMENT

A per diem adjustment will be incorporated in the inpatient Medicaid rates for OMH facilities to account for

TN #05-51
Supersedes TN #00-22
Approval Date June 1, 2006
Effective Date July 1, 2005
significant changes in costs due to significant changes in the number of patient days. The adjustment will be made only if the change in total inpatient days between the base year and the rate year exceeds two percent (2%). In calculating the rate adjustment, it will be recognized that all the facility’s capital costs are fixed. Operating costs will be considered eighty percent (80%) fixed and twenty percent (20%) variable. Under this formula if days increase more than two percent (2%), the rate for the applicable rate category will be reduced to allow only twenty percent (20%) of the operating per diem for the additional days. Alternatively, if days decrease over two percent (2%), the rate for the applicable rate category will be increased to allow eighty percent (80%) of the operating per diem for the lost days to be spread over the actual days for the rate period.

An estimated volume adjustment will be calculated and included in the rate calculation. The estimated volume adjustment will be calculated based upon the projected patient days for the upcoming rate year vs. the actual patient days for the base year used to calculate the rates. Following the close of the rate year a comparison would be made between the projected days used in calculating the estimated volume adjustment and the actual days incurred for the rate year. The volume adjustment will then be recalculated to reflect the actual days for the rate year. The difference, in any, between the estimated volume adjustment and the final actual volume adjustment will be included as a retroactive adjustment in the rate for the following year.

VIII. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

If it is determined by a utilization review committee that a Medicaid recipient no longer requires psychiatric hospital services but must remain in the hospital because a medically necessary skilled nursing facility or intermediate care facility bed is not available in the community (“alternate care day”) and it is determined that the statewide rate of occupancy...
of operational beds at OMH hospitals is less than 80%, the hospital will be reimbursed at the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate. Operational beds are defined as the projected census for the upcoming year for the Office of Mental Health psychiatric hospital system as derived from the Executive Budget. In determining whether the statewide occupancy rates meets the 80% requirement, for purposes of determining the applicable reimbursement rate, alternate care days will not be counted as occupied beds.
IX. DISPROPORTIONATE SHARE ADJUSTMENT

The Medicaid payment rates for OMH facilities will be adjusted in accordance with Sections 1902 (a)(13)(A) and 1923 of the Social Security Act to account for the situation of OMH facilities which serve a disproportionate number of low income patients with special needs. The adjustment will be made if either the Medicaid inpatient utilization rate for OMH hospitals is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or if the low income utilization rate for OMH hospitals exceeds 25 percent.

The Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days in a cost reporting period divided by the total number of hospitals inpatient days in that same period.

The low income utilization rate is defined as the sum (expressed as a percentage) of the fraction calculated as follows:

- Total Medicaid patient revenues paid to the hospital, plus the amount of cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and
- The total amount of the hospital’s charge for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period less the portion of cash subsidies reasonably attributable to inpatient hospital services, divided by the total amount of the hospital’s charges for inpatient service in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO’s, Medicare and Blue Cross.
Those OMH hospitals that qualify as a disproportionate share hospital will receive a payment adjustment to [fully] reimburse the hospital for the unreimbursed costs incurred in providing services to individuals who are either eligible for medical assistance or who have no health insurance or other source of third party coverage for the services provided. The OMH hospitals, in aggregate, will be paid DSH equal to 100% of the federal mental health facility DSH allotment.

For OMH hospitals, the State Plan rate year shall be defined as running from April 1 of a calendar year through March 31 of the subsequent calendar year. The four-digit State Plan rate year will be the year that contains the end date of period. For example, State Plan rate year 2011 will be the period from April 1, 2010 through March 31, 2011.

Due to State’s reliance on Section 1923(e) of the Social Security Act, OMH hospitals will be deemed disproportionate share hospitals without regard to the requirements of Section 1923(d)(1) of the Social Security Act.

X. DISPROPORTIONATE SHARE LIMITATIONS

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, [2]1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient days shall not be eligible to receive disproportionate share distributions.

[Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OMH facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor’s certification that the hospital’s applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating that all distributions in excess of the 100 percent limit will be used for health services.]
No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to [t]Title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act, other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patients made by the State [of] or a unit of local government within the State shall not be considered a source of third party payment.

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

Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has been compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceeded the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payments are due the facility, such additional payments will be made.

If it is determined that disproportionate share payments to a particular OMH facility exceeded the facility-specific calculation, such excess amounts will be recouped and reallocated to OMH facilities proportionally based on each facility’s remaining unreimbursed Medicaid and uninsured costs. If after such reallocation there remain additional unallocated amounts, such amounts will be allocated to governmental facilities, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million, whose disproportionate share payments were less than their respective facility-specific calculations, in accordance with the Disproportionate Share Limitations section of this Attachment. Such payments will be made to each such individual hospital based on the relative share of each hospital’s actual medical assistance and uninsured patient costs for that DSH state plan rate year (SPRY). The federal share of any remaining unallocated excess amounts above shall be promptly refunded to the federal government.

For any federal mental health facility DSH allotment that remains unused by OMH, the excess reallocated to those other non-state governmental facilities will occur in the same four-digit State Plan rate year.

XI. TRANSFER OF OWNERSHIP

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

The State’s methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share adjustment described in section IX. However, the calculations of hospitals’ bad debt and charity care costs which are partially covered by the disproportionate share adjustment described in section IX, does not include costs of services to any person for whom an additional disproportionate share payment has been made under this section.

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

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

TN #11-0016-B Approval Date 07/26/2018
Supersedes TN #96-0040-B Effective Date 01/01/2011
[A “disproportionate share hospital” for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low income person without expectation of payment from the person due to the patient’s inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a “disproportionate share hospital” (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid eligible patients on a non-emergency basis.

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

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

TN #11-0016-B Approval Date 07/26/2018
Supersedes TN #96-0040-B Effective Date 01/01/2011
METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR HOSPITALS LICENSED BY THE OFFICE OF MENTAL HEALTH

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

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

1. OPERATING COSTS

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

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

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

TN #92-15
Supersedes TN #91-15
Approval Date June 29, 1992
Effective Date May 28, 1992
In determining allowable operating costs for any base year there is applied a limitation, which is derived from the fiscal year one year prior to the base year, increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. Both the base year and the limitation are subject to an administration cost screen. The administration cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e. the same cost year the limitation is derived from), and is the group average cost plus ten percent. Separate administration cost screens are calculated for hospitals greater than 100 beds (group one), and hospitals less than 100 beds (group two). The allowable costs are the lesser of the base year operating costs or the limitation. The allowable operating costs are then increased for inflation to the rate year by the Medicare inflation factor described above, except that the 1996 Medicaid rates will not include an inflation factor for 1996 effective July 1, 1996, and the 2010 Medicaid rates will not include an inflation factor for 2010 effective January 1, 2010, and the 2014 Medicaid rates will not include an inflation factor for 2014 effective January 1, 2014. Such inflation factor shall be as determined by the Federal Government each year prior to the effective date of the payment rates calculated herein.

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

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

[1]2. CAPITAL COSTS
[To] [a]Allowable capital cost will be added to allowable operating costs [are added allowable capital costs]. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures subject to the Office of Mental Health’s certificate of need procedures must be reviewed and approved by the Office of Mental Health.

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

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

TN #14-0014 Approval Date March 16, 2015
Supersedes TN #12-0027 Effective Date January 1, 2014
3. **REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE**

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

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

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**TN #92-15**

**Approval Date** June 29, 1992

**Supersedes TN #91-15**

**Effective Date** May 28, 1992
[4. Additional Disproportionate Share Payment]

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

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

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

Due to State’s reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for hospitals licensed by the Office of Mental health does not include a disproportionate share adjustment.
[A “disproportionate share hospital” for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient’s inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a “disproportionate share hospital” (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

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

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

Medicaid rates for Residential Treatment Facilities for Children and Youth (“RTFs”) are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 93 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

Effective July 1, 2011 through June 30, 2012, the rate of payment shall be that which was in effect June 30, 2011.

Effective July 1, 2012 through June 30, 2013, the rate of payment shall be that which was in effect June 30, 2011.

Effective [September 1, 2012] July 1, 2015, such rate of payment will be lowered to reflect the removal of pharmaceutical costs, except as provided for in Section 1, below.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the Office of Mental Health, and will exclude eligible pharmaceuticals which will be reimbursed using the Fee-for-Service Program through the Medicaid formulary administered by the New York State Department of Health. The Fee-for-Service Program will be utilized for the purchase of eligible pharmaceuticals commencing on the date the child is determined to be Medicaid eligible. [Notwithstanding this program change, for those children who are deemed eligible for Medicaid subsequent to admission, and the eligibility is retroactive to date of admission, and who have received clinically documented necessary medications during the entire first 90 days of their stay, the pharmacy will bill the Medicaid formulary for the medications provided to the child beginning on day 91 of the stay.] The cost of medications provided to the [Medicaid eligible] child before the determination of Medicaid eligibility [during the first 90 days of stay] will be the responsibility of the RTF, and considered an allowable cost in the development of the provider’s reimbursement rate for inpatient stays. In determining the allowability of costs, the Office of Mental Health reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

(i) Clinical Care. This category of costs includes salaries and fringe benefits for clinical staff.

(ii) Other than Clinical Care. This category of costs includes the costs associated with administration, maintenance and child support.

Allowable per diem operating costs in the category of clinical care are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. Clinical services such as dental services, purchased on a contractual basis will be considered allowable and not subject to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.
Allowable per diem operating costs in the category of other than clinical care are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the clinical and other than clinical categories are computed as follows. For RTFs located in the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50[%] percent of the average per diem cost for all RTFs in this geographic area and 50[%] percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent. For RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties the standard is: the sum of 50[%] percent of the average per diem cost for all RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 50[%] percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent.
Allowable operating costs as determined in the preceding paragraphs will be increased annually by the Medicare inflation factor for hospitals and units excluded from the prospective payment system except for the rate periods effective July 1, 1995 through June 30, 1996, July 1, 2009 through June 30, 2010, July 1, 2013 through June 30, 2014 and July 1, 2014 through [June 30, 2015] December 31, 2014, where no inflation factor will be used to trend costs. Effective January 1, 2015, allowable operating costs will be trended by the Medicare inflation factor.

2. **CAPITAL COSTS**

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

**Transfer of Ownership**

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

3. **APPEALS**

The Commissioner may consider 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 service, programs, or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Other rate revisions may be based on additional staffing required to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

TN #15-0018 Approval Date June 28, 2017
Supersedes TN #14-0017 Effective Date January 1, 2015
4. RESIDENTIAL TREATMENT FACILITIES WITH INADEQUATE COST EXPERIENCE

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

Financial reports, reflecting actual cost and statistical information, in a form prescribed by the Commissioner, shall be required within one hundred twenty days following the first six month period during which the Residential Treatment Facility has operated at an average utilization of at least ninety percent or one
New York
4(b)

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

<table>
<thead>
<tr>
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<th></th>
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<td>$15.00</td>
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<td>$11.80</td>
<td>$12.50</td>
<td>$12.50</td>
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</table>

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 nursing facility providers. If a facility does not submit a survey, the minimum wage add-on will be calculated based on the facility’s Consolidated Fiscal Report (CFR) wage data from two years prior to the period being calculated. If a facility fails to submit both the attested survey and the CFR cost report, the facility’s minimum wage add-on will not be calculated.

i. Minimum wage cost development based on survey data collected.
   a. Survey data will be collected for facility specific wage data.
   b. Facilities will report by wage bands, the total count of FTEs and total hours paid to all employees (contracted and non-contracted staff) earning less than the statutory minimum wage applicable for each region.
   c. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
   d. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the facility has reported total hours paid. To this result, the facility’s average fringe benefit percentage is applied and added to the costs.

ii. Minimum wage cost development based on the CFR cost report data.
   a. The average hourly wages of employees where the reported average hourly wage is below the regional statutory minimum wage are identified.
   b. The total payroll hours of the employees identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.
   c. The facility’s fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
   d. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.
3. The facility specific cost amount will be adjusted by a factor calculated by dividing the facility's average dollar per hour under minimum wage by the regional average. The resulting amount will be divided by patient days to arrive at a rate per diem add on, which will be applied to only Medicaid days for purposes of Medicaid reimbursement.

4. In subsequent years until the minimum wage is completely implemented statewide, the Department will survey facilities utilizing the methodology employed in year one. If a facility fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the personnel wage data reported on the Facility's latest available CFR cost report. If a facility fails to submit both the survey and the CFR cost report, its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the nursing home rate, the minimum wage add-on will be excluded from the rate.

5. **Minimum Wage Reconciliation** - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the reconciliation survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the reconciliation survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider’s minimum wage add-on for the calendar year covered by the survey will be recouped.

   a. **Total annual minimum wage funding paid to the provider** (as determined from the minimum wage add-on to claims paid for services rendered in the prior calendar year) for the Medicaid share of the minimum wage law increase requirement. (This information will be supplied by the Department of Health.) Medicaid’s share is the percentage of minimum wage costs that are attributable to Medicaid services based on the proportion of Medicaid services to a provider’s total services.

   b. **Medicaid’s share of the total amount the provider was obligated to pay to bring salaries up to the minimum wage for the calendar year.** (This information will be completed by the provider.)

   c. **Minimum wage funds to be recouped or additional funds to be received by the provider.** (This information will be completed by the provider.) This will be the difference between the amount paid to the provider for the Medicaid share of the minimum wage law increase requirement and the corresponding amount the provider determined it was actually obligated to pay.

   d. **The State agency will review providers’ submissions for accuracy and reasonableness, following which it will process associated payments and recoupments via retroactive per unit rate adjustments as quickly as practical thereafter.**

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

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**TN #17-0010**  
**Supersedes TN NEW**  
**Approval Date January 12, 2018**  
**Effective Date January 1, 2017**
year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened, unless the Commissioner determines that the facility has not achieved the status of a stable, ongoing operation with reliable cost information, in which case the budget based rate will be continued, adjusted as necessary, for updated budget projections as appropriate.

5. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

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

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

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

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

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

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

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TN #11-0016-B Approval Date 07/26/2018
Supersedes TN #96-0040-B Effective Date 01/01/2011
[A “disproportionate share hospital” for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient’s inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a “disproportionate share hospital” (except hospitals serving an in-patient population predominantly composed of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

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

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a “high DSH” facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as “high-DSH”, payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a “high-DSH” facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years’ data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.]
OASAS establishes all inclusive program specific per diem rates on a prospective basis. Rates are established on the basis of certified cost reports which are submitted at least one year prior to the first day of the rate year which is the calendar year. For example, rates for the 1994 calendar year rate year were based upon 1992 calendar year data. A rolling base year is utilized, i.e. each year, rates are re-calculated using a new base year.

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

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

The program specific per diem rate is then calculated by dividing the sum of allowable trended adjusted operating costs and allowable capital costs by the higher of actual patient days (in the base year) or 90% of possible base year days for inpatient rehabilitation programs; for primary care (detoxification) programs, the higher of actual base year patient days or 85% or possible base year days is used. Possible days for each program is calculated by multiplying the certified bed capacity by the number of days in the base year, i.e. either 365 or 366. Rates which are based upon actual certified costs data are provisional pending audit. There is a process for a provider to appeal a provisional rate.
For new providers with inadequate cost experience, rates are calculated on the basis of a program specific 12 month budgeted cost report. As with actual cost based rates, allowable operating and capital costs are determined in accordance with HIM-15 and GAAP. Unlike actual cost based programs, operating costs will be limited to 115% of the statewide average for similar programs. The sum of allowable adjusted operating costs and allowable capital costs is then divided by the higher of budgeted days or 90%/85% of possible days to arrive at a budgeted per diem. Budgeted base rates are adjusted to actual rates upon receipt of actual certified cost reports. Program specific provisional rate are then established retroactively to the effective date of the budgeted rate.
New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Inpatient Psychiatric Services for Individuals under 21

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

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

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

Residential Rehabilitation Services for Youth

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

Definitions.

1. “Eligible residential rehabilitation services for youth provider” shall mean a residential rehabilitation services for youth provider that has been certified by the Office to provide services pursuant to Part 817.

2. “Allowable costs” shall mean those costs incurred by an eligible residential rehabilitation services for youth provider which are eligible for Medicaid payments. To be allowable, costs must be reasonable and necessary for efficient provision of chemical dependence services, related to patient care, recurring, and approved by the commissioner.

TN #05-54  Approval Date June 1, 2006
Supersedes TN NEW  Effective Date January 1, 2006
(3) “Patient day” shall mean the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hours on two successive days. A patient day is counted on the day of admission but not on the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(4) “Allowable days” shall mean the total of patient days provided by an eligible residential rehabilitation services for youth provider.

(5) “Fee Period” shall be the calendar year.

(6) “Base year” shall mean the period from which fiscal and patient data are utilized to calculate rates of payment for the fee period.

(7) “Fee Cycle” shall mean either one fee period or more than one consecutive fee periods. Such fee or fees shall be derived from a common base year.

(8) “New eligible residential rehabilitation service for youth provider” shall mean an eligible RRSY provider for which relevant historical chemical dependence service costs are not available.

(9) “Service operating fee” shall mean fees calculated as payment in full for operating expenses as required by Part 817. Such fee shall not include the capital add-on.

(10) “Capital add-on” shall mean a provider-specific cost based per diem to address allowable and approved real property, equipment and start-up costs not included in the service operating fee.

Calculation of service operating fees.

Service operating fees for RRSY shall be developed by the office using a cost model based on the requirements of Part 817. The cost model shall contain personal service and non-personal service costs. The cost model shall recognize cost differentials between the upstate and downstate regions of the state and also cost differentials between providers with differing service capacities. The service operating fees shall be deemed to be inclusive of all service delivery operating costs and shall be considered payment in full to the residential rehabilitation services for youth provider for all non-capital costs related to delivery of services provided pursuant to Part 817.
(1) For purposes of this section, the upstate and downstate geographic regions are defined as follows:
   (i) The downstate region includes New York City and the counties of Nassau, Suffolk, Westchester, Rockland and Putnam. New York City includes the counties of New York, Bronx, Kings, Queens and Richmond.
   (ii) The upstate region includes all other counties in New York State.

(2) Within each geographic region, four service operating fees shall be developed based on differing service capacities. The applicable fee for a given RRSY facility shall be determined based on the region in which the facility is located and the RRSY provider’s statewide certified RRSY capacity.

(3) The service operating fees for each fee cycle shall be developed using base year patient and fiscal data. The base year fee calculation shall then be trended, using the Congressional Budget Office’s Consumer Price Index for all Urban Consumers, to the first day of the fee cycle. The personal service component of the service operating fees shall be calculated by the office using the staffing requirements of Part 817 in conjunction with the applicable U.S. Department of Labor’s Employment and wage Estimates, as adapted by the office to coincide with the staffing position titles of Part 817 and the geographic regions defined above. The fringe benefits, non-personal service and administrative components of the service operating fees shall be calculated by the office using fringe benefit, non-personal service and administrative fiscal data for providers operating RRSY.

(4) The initial base year shall be 2002. The first day of the initial fee cycle shall be 1/1/2005. The service operating fees, effective 1/1/2005, shall be:

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<th>Fee Level</th>
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Prior to implementation these fees will be trended to first day of the fee period of implementation in accordance with number (5) below.

(5) Each year a trend factor based on the Congressional Budget Office’s Consumer Price Index for all Urban Consumers shall be applied to all components of the service operating fee. The trend factor shall not apply to the capital add-on to the service operating fee.
(6) With the approval of CMS, the service operating fees may be updated to adjust for programmatic changes or service operating cost variations not addressable by the annual trend factor. The process of updating service operating fees may include one or more of the following:

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

Capital add-on.

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

(1) The Office shall use, as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services’ Centers for Medicare and Medicare Services.

(2) Where HIM-15 is silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

Allowable capital costs may include:

(1) the costs of owning or leasing real property;

(2) the costs of owning or leasing moveable equipment and personal property; and

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

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

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

New eligible RRSY providers.

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

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

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

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

(4) Upon submission of the financial reports the commissioner may adjust retroactively the eligible RRSY provider’s existing capital add-on to more accurately reflect the reported operating costs and program utilization, based on patient days of the eligible RRSY provider.
METHODS AND STANDARDS FOR SETTING PAYMENT RATES
FINGER LAKES AREA HOSPITALS

TN #87-10
Supersedes TN

Approval Date March 15, 1988
Effective Date January 1, 1987
BACKGROUND

The Finger Lakes Hospital Experimental Payment Program (FLHEP) was implemented as of January 1, 1981 as a Medicare and Medicaid demonstration system under the authority of sections 402 and/or 222 of the Social Security Amendments of 1967 and 1972, respectively. This program continued until December, 1986. From January 1, 1987 to December 31, 1994, the Finger Lakes Area Hospitals’ Corporation (FLAHC) had received approval from the Federal Health Care Financing Administration (HCFA) for a waiver of Medicare reimbursement principles, to permit the continuation of the Finger Lakes Hospital Experimental Payment Program system under the authority of section 1886(c) of the Social Security Act, as amended. Section 1886(c) requires that the State hospital reimbursement control system for which a Medicare waiver is granted also apply to Medicaid revenues and expenses. Hence, in 1987, FLHEP was continued as a cost control system under section 1886(c) (known as FLHEP-2) rather than as a demonstration system. FLHEP was also continued for the 1988-1990 periods as FLHEP-3, and for the 1991-1993 periods (as FLHEP-4). FLHEP will continue as a cost control system under section 1886(c) for the period January 1, 1994 through June 30, 1996 as FLHEP-4E and for the period July 1, 1996 through December 31, 1996 as FLHEP-4EE. For 1995 and 1996, FLAHC member hospitals will no longer be covered under a waiver of section 1886(c) of the Social Security Act. Beginning in 1995 member hospitals will be reimbursed for Medicare patients in the same manner as other hospitals in New York State. Medicaid and Blue Cross continue to be participating payers in the FLHEP system. The hospitals participating in this program are F.F. Thompson, Geneva General, Myers Community, Newark-Wayne Community and Soldiers and Sailors.

SYSTEM OVERVIEW

For the period January 1, 1996 through December 31, 1996 all FLHEP hospitals will continue to participate in a total revenue system, with the revenue allocated among Medicare and non-Medicare payers using standard Medicare apportionment techniques. Inpatient reimbursement for all major third-party payers (Medicaid, Blue Cross) will be through a DRG-based case payment methodology similar to the case payment methodology followed by New York State for its non-Medicare inpatients. The case payment rates for the participating hospitals will be based on their historical payment base (1987 costs trended forward and adjusted). The design of FLHEP-4E and FLHEP-4EE includes continuation of the demonstration for the use of a severity measure that was started under the FLHEP-3 contract. Medicaid funds will be used to fund inpatient services only. The severity study will be funded from a statewide pool in which there is no federal financial participation.

TN ____ #96-02 ____ Approval Date _______ August 3, 1999 _______
Supersedes TN ____ #95-02 ____ Effective Date _______ January 1, 1996 _______
This plan covers the third year extension of the FLHEP-4 contract which runs through December 31, 1996. Extending this agreement will continue all existing FLHEP programs while providing the Finger Lakes Corporation sufficient time to transition to a modified reimbursement system.

The FLHEP-4E and 4 contracts, like the previous FLHEP contracts, are based on the concept of regional cooperation in the planning and delivery of services in the most cost effective manner possible. To that end, the participating hospitals shall engage in cooperative community service planning to ensure that changes in services or facilities continue to conform to this concept of cost effective delivery and organization of care in the area.

To calculate the rates, FLHEP-2 1987 hospital costs are aggregated and allocated to each member hospital using the following percentages:

- FF Thompson Hospital: 22.8119%
- Geneva General Hospital: 32.1315%
- Myers Community Hospital: 11.1376%
- Newark-Wayne Community Hospital: 24.4871%
- Soldiers and Sailors Memorial Hospital: 9.4318%

This cost, also known as the gross aggregate dollar amount, is the basis for the FLHEP-4E and 4EE rate calculations. The following amounts are subtracted from each hospital's gross aggregate dollar amount: The cost of actual 1987 capital, physician coverage, and the amount included for medical education. The 1987 reimbursable operating costs are increased by a factor of .5% to provide funding for advances in medical technology, and by the 1987 through 1996 trend factor to reflect inflation, and then apportioned to inpatient and outpatient services, acute units, Medicare, and non-Medicare, using 1987 FLHEP-2 final settlement data.

The trend factors are calculated, using the Panel of Health Economists’ methodology, for various groups of hospitals depending on their geographic location (upstate, downstate), urban or rural setting, and size (as measured by the number of patient days during a calendar year). This methodology is detailed in section 86-1.58 of attachment 4.19-A, Part I of the Plan. The FLHEP hospitals fall into three categories:

1. Upstate urban, less than 30,000 patient days
2. Upstate urban, greater than 30,000 patient days
3. Upstate rural, less than 15,000 patient days
The values of the trend factors for 1996 for these three categories are provided below:

<table>
<thead>
<tr>
<th>Category</th>
<th>1996 (Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.80</td>
</tr>
<tr>
<td>2</td>
<td>2.81</td>
</tr>
<tr>
<td>3</td>
<td>2.80</td>
</tr>
</tbody>
</table>

The initial trend factors are calculated using the latest data available; these values are subject to change as more current data become available. Consequently, the interim trend factors are adjusted up or down and these revised trend factors are then used to make prospective payment rate adjustments.

The inpatient acute, non-exempt, non-Medicare portion of each hospital's 1996 reimbursable operating costs are converted to an inpatient case payment rate for each hospital which is uniform for all of the non-Medicare payers. Each hospital's 1996 hospital specific case payment rate is blended with a group rate calculated in accordance with the State specified methodology, as detailed in section 86-1.53 of Attachment 4.19A, Part I of the Plan except that rural hospitals have the option of choosing a rate which is entirely the hospital specific rate. Each hospital's blended 1996 case payment rate will consist of two components. Forty five percent of the rate will be hospital specific case payment rate and the remaining 55% will be the group average case payment rate. Hospitals will be grouped under the methodology described in section 86-1.54 of attachment 4.19A, Part I of the Plan.

Each hospital also receives an add-on for pass-through costs which reflect (1) the hospital's actual cost for capital; (2) the 1979 physician coverage costs trended forward in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan and adjusted for changes in physician billing practice; and (3) the amount included in the regional aggregate dollar amount in 1987 for Medical Education trended in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan.

Each hospital is paid for each inpatient discharge, which is not an outlier or exempt as defined below, on or after January 1, 1996 the hospital's blended non-Medicare case payment rate, adjusted by the Service Intensity Weight related to the discharge, plus the medical education, the physician coverage and the capital add-ons.
The hospitals shall be paid for Exempt Unit Services by the payers on the same methodology and cost base as such units are paid in other hospitals in New York State. This methodology is detailed in section 86-1.57 of Attachment 4.19-A, Part I of the Plan.

Alternate Level of Care ("ALC") reimbursement is paid according to the New York State reimbursement methodology described in section 86-156 of Attachment 4.19-A, Part I of the Plan. The rate will be paid at the regional average nursing home per diem rate.

Hospitals transferring patients are paid a per diem rate which is calculated under the methodology detailed in section 86-1.54 of attachment 4.19-A, Part I of the Plan.

Outliers shall be paid in accordance to section 86-1.55 of Attachment 4.19-A, Part I of the Plan.

Future funding of expansion of services or facilities which require State Certificate of Need (CON) approval will occur through an adjustment determined according to State procedure and consistent with methodology described in section 86-1.61 of Attachment 4.19-A, Part I to the adjusted gross aggregate dollar amount for incremental non-volume related operating costs and adjustment to the capital add-ons when such projects are approved and implemented.

The payers participating in the contract have agreed to pay, on final settlement, their respective shares of the amount, if any, needed to assure that the hospitals receive their actual capital, and trended 1987 medical education costs and physician coverage costs.

The Health Department will certify the rates under the FLHEP-4E and 4EE Agreement for Medicaid as the rates for each hospital, contingent upon approval by HCFA of the Title XIX State Plan Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

Each hospital is required to purchase or provide through a state pool excess physician malpractice insurance pursuant to New York Law. There is no federal financial participation for these malpractice costs.
For each year of the FLHEP-4E and 4EE contract the case payment rates are adjusted to include changes to the hospitals’ adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of a trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the SysteMetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty which is detailed in section 86-1.61 and 86-1.75 of Attachment 4.19A, Part I of the Plan. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurement of severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The Finger Lakes area hospitals are currently being paid on the basis of the DRG assigned to each patient. The disease staging (Q scale) software program produces two outputs on severity; one written DRG and another relating to overall severity. The severity measure will be used as an offset to the case mix penalty which is applied if the criteria stipulated in section 86-175 of attachment 4.19A, Part I of the Plan are met.

The offset shall only be applied if the severity increase is positive, and the offset shall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). The methodology used to calculate this severity increase is described in the following paragraph.

Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year, T(b) and T(r) respectively. Calculate the average DRG weight for these cases, W(b) and W(r). The average severity in the base year is then T(b)/W(b)=S(b) and the average severity in the rate year is T(r)/W(r)=S(r). Then the percentage increase in severity is

\[100 \times (S(r)/S(b) - 1)\].

TN   #96-02
Supersedes TN   #95-02
Approval Date  August 3, 1999
Effective Date January 1, 1996
If this increase in severity is positive, then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P (as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P – Q, but not to less than zero.

An example of the severity offsets calculation is illustrated in Attachment A. This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.
Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

For each year of the FLHEP-4 contract after 1991, the case payment rates are adjusted to include changes to the hospitals’ adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

The term of the FLHEP-4 Agreement is January 1, 1991 through December 31, 1993. The term of the FLHEP-4E Agreement will be January 1 through December 31, 1994.
Severity Adjustment Measurement System

The Medicare program, New York State and other states and payors, have been using the Diagnosis Related Groups (DRGs) for payment purposes. While the DRGs are reasonably homogeneous in regard to resource use, they are far from ideal, and they may not take adequate account of the severity of illness of patients. A number of adjustments have been included in payment systems to partly remedy this problem. For example, the indirect medical education adjustment in the Medicare Prospective Payment System, and the disproportionate share adjustment, are added partly to deal with this problem. A better way to deal with the problem may be to measure severity of illness within the DRG and adjust for it directly. The purpose of the severity study that is being undertaken by FLAHC is to incorporate a severity measure to obtain a better understanding of the operation of the health care system, e.g., are patients who are travelling to obtain services in urban hospitals doing so because they are more severely ill or for some other reason?

This study will be funded through hospital payments made to a Statewide Pool for which there is no federal financial participation. Medicaid moneys will be sued to pay for inpatient hospital services.

The purpose of this demonstration is to develop a payment
system which incorporates a measure of the severity of illness of the patient into the
determination of the appropriate payment rate, to show that it is feasible to implement such a
system in a group of rural hospitals, and to carry out some research on the variation in severity
over time, across payor classes, across hospitals, and between cases treated in the area and
cases treated outside of the area.

After considerable discussion, review of the literature, and presentations from several of
the severity system vendors, Disease Staging (Q-scale), which is distributed by SysteMetrics,
was chosen to support the development of the severity adjustment payment system. The
FLAHC hospitals are currently being paid on the basis of the DRG assigned to each patient. The
Disease Staging software program produces two outputs on severity level—one within the DRG
and one overall—which could be useful in refining the DRGs in a payment demonstration. After
discussions with the Office of Health Systems Management, it was decided that the severity
measure would not be used to adjust payment rates directly, but would be used as an offset to
the case mix limit that is applied if the case mix of the hospital and the State as a whole
increase above certain thresholds. The case mix limit for 1989 and subsequent years is to be
offset by an increase in case mix severity within the hospitals participating in the
demonstration.
Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the SysteMetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty applied under the FLHEP contract. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurement of severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The offset shall only be applied if the severity increase is positive, and the offset shall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). There are two ways in which the increase in severity can be calculated:

1. Calculate the average within DRG severity for the base year (1987) and for the rate year (1989 or a subsequent year). This is the weighted average severity per case, with the...
weighing being the DRG weight for the case.

\[
\text{SUM} \left( \frac{s(i) \times w(i)}{\text{SUM} (w(i))} \right) = S
\]

Where \( s(i) \) is the DRG severity of case \( i \), \( w(i) \) is the DRG weight of case \( i \), and the sum is taken over all non-Medicare cases \( i \).

Let \( S(b) \) be the severity in the base year, and \( S(r) \) be the severity in the rate year. Then the percentage increase in severity is \( 100 \times \left( \frac{S(r)}{S(b)} - 1 \right) \).

2. Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year, \( T(b) \) and \( T(r) \) respectively. Calculate the average DRG weight for these cases, \( W(b) \) and \( W(r) \). The average severity in the base year is then \( T(b)/W(b)=S(b) \) and the average severity in the rate year is \( T(r)/W(r)=S(r) \). Then the percentage increase in severity is:

\[
100 \times \left( \frac{S(r)}{S(b)} - 1 \right)
\]

Method 2 is the more precise, therefore it is the one that should be offset against the case mix penalty.
If this increase in severity is positive then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P (as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P – Q, but not to less than zero.

This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.

Future analyses are planned to determine how severity changes over time within individual hospitals, how stable the measures of severity are, whether the patients who are migrating to urban providers are doing so because they are more severely ill, and other studies that will enable the hospitals to obtain a better understanding of the needs of their patients. For example, a study may be performed to determine whether patients are being admitted to a hospital at an appropriate point in the course of their illness. Admission at too early a stage when treatment could equally well be performed on an ambulatory basis could indicate inappropriate resource use, while admission at too late a stage may result in higher resource use because the patients are more severely ill than they would be if they had been admitted at an earlier stage. The hospitals may also start to use the severity system to augment their utilization review function within the hospital.
The following are the major components of the trend factor methodology as adopted by the Panel of Health Economists.

**Projection Methodologies**

**Salaries.** In order to quantify the salary price movement component of the trend factor, four national salary proxies are used, adjusted by a Regional Adjustment Factor (RAF). The four salary proxies are the Collective Bargaining Agreements (Nonmanufacturing), Employment Cost Index – Private Industry Workers, Employment Cost Index – Managers and Administrators, and Employment Cost Index – Professional and Technical Workers. There four proxies are weighted to produce a composite salary price movement. (Separate weightings are used for teaching and non-teaching hospitals and the Health and Hospitals Corporation.) In calculating the initial trend factors for a given year, a projection methodology for salary price movements is used. The projections are based on the compounding of quarterly increases in the salary proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

**Fringe Benefits.** The trend factor methodology uses a Total Compensation Factor (TCF) that measures the relationship between increases in total compensation (i.e. salaries and fringe benefits) and increases in salaries. This factor is then applied to the composite salary price movement to yield a total compensation price movement, hence reflecting the fringe benefits. Two national proxies are used to determine the total compensation factor: Employment Cost Index – Total Compensation – Private Industry workers, divided by Employment Cost Index – Wages and Salaries – Private Industry Workers. In calculating the initial trend factors for a given year, the TCF is projected based on the latest four quarters data on these two proxies. For the final trend factor calculation, actual data are used.

**Labor.** The labor portion of the trend factor refers to the combined salary and fringe benefits components. Hence, the labor price movement is the salary price movement, adjusted by the Total Compensation Factor (TCF) and by the Regional Adjustment Factor (RAF).

**Non-labor.** A number of different proxies are used to measure price movements in non-labor related expenses incurred by hospitals. In calculating the initial trend factors, an estimate of the non-labor component of the trend factor is made by using the projected Gross National Product Implicit Price Deflator as published by the American Statistical Association and National Bureau of Economic Research, Business Outlook Survey. The final trend factor calculations are made using the actual changes in the non-labor proxies.
Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share payment described in sections 86-1.65, 86-1.74 and 86-1.84 of Part I. However, the calculations of hospital's bad debt and charity care experience used to determine the disproportionate share payments made under sections 86-1.65, 86-1.74 and 86-1.84 of Part I does not include the costs of services to any person for whom an additional disproportionate share payment has been made under this section.

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

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient’s eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person’s eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person’s current valid official benefits card or a copy of an eligibility verification confirmation received from the Department’s Electronic Medicaid Eligibility Verification System (EMEV5), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.
A “disproportionate share hospital” for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient’s inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a “disproportionate share hospital” (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

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

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

The FLHEP-4E and 4EE contracts specify that any increase in severity, on an individual hospital basis, will be offset against the creep component in the case mix penalty.

Suppose that the case mix penalty for a given FLAHC hospital for 1992 was 2%. Once the severity data for 1992 has been analyzed, the increase in severity from 1987 to 1992 will be used to reduce this case mix penalty. Three different examples are described below to illustrate the three situations which can arise in the relationship between the case mix penalty and the change in severity.

1. Suppose that the severity of illness of the discharges from the hospital increases by 0.5% from 1987 to 1992. Then the case mix penalty will be reduced by the 0.5% to 1.5%:

   \[ 2.0\% - 0.5\% = 1.5\% \]

2. Suppose the severity of illness increases by 3% from 1987 to 1992. Then the case mix penalty will be reduced to 0%, since the increase in severity is far greater than the case mix penalty.

   \[ 2.0\% - 3.0\% = -1.0\% \]

   Since this is negative the case mix penalty is set at zero.

3. Suppose the severity change from 1987 to 1992 is negative. Then there is no adjustment to the case mix penalty.

   \[ 2.0\% - 0\% = 2.0\% \]
New York

TITLE XIX (MEDICAID) STATE PLAN AMENDMENT

This State Plan amendment is contingent upon an approved contract among the HEP participating hospitals, the Rochester Area Hospitals' Corporation (RAHC), and the contracting payors.

Effective January 1, 1988, Medicaid hospital inpatient reimbursement for all HEP-III participating hospitals will be through a DRG-based case payment methodology similar to the case payment methodology for the rest of the State. However, the Medicaid case payment rates for the HEP-III participating hospitals will be based on their 1987 HEP-E payment bases (which were the original 1978 HEP cost bases trended forward and adjusted). The 1987 total payment base for each hospital is allocated to non-Medicare patients using 1987 utilization data and then trended to 1988 by an inflation factor. The non-Medicare inpatient acute portion of each hospital's 1988 payment base is then converted to an inpatient Medicaid case payment rate for each DRG. There is a blending of the hospital specific case payment rate and a group pricing component, in proportions identical to those followed by hospitals in the rest of the State. Medicaid Alternate Level of Care (ALC) patients will be reimbursed at the regional nursing home per diem rate, according to the same methodology as under the State's overall system.

Whereas, in most respects, the Medicaid inpatient reimbursement methodology in the proposed HEP-III system is the same as that for the rest of the hospitals in the State, there are unique features of the system. The chief of these is the development (in 1988) and implementation (in 1989 and 1990) of a completely new system to provide financial incentives for quality patient care which may be able to be used in the future on a wider scale if its feasibility is demonstrated among the HEP-III hospitals. The quality assurance system will use the MEDISGRPS severity classification system and develop standards against which each hospital's inpatient care will be assessed. The hospital will face financial incentives (within limitations) to assure that these standards are met.

The HEP-III hospitals will also continue to pool capital costs, medical education and physician coverage costs (through the concept of levelling).

TN #88-9

Supersedes TN #----

Approval Date March 30, 1990
Effective Date January 1, 1988
New York
1

Reserved

[Methods and Standards for Establishing Payment Rates

Out of State Services

I. Inpatient Hospital Care

New York reimburses out of state hospitals at the facility's Medicaid rate established by the State in which the institution is located; or when no such rate exists, at the lowest of the following charges:

1. the Medicare rate set for the hospital; or
2. the hospital’s customary charge for public beneficiaries; or
3. the maximum New York State Title XIX rate for similar inpatient care.

Reimbursement for those days where recipients are awaiting placement to an alternate level of care (ALC) while they are inpatients at out of state hospitals will be at the facility’s approved Medicaid ALC rate.

II. Additional Disproportionate Share Payment

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

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State’s Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household’s regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.]
[Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 9426. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

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

Rates for specialty hospital services delivered on and after July 1, 2011 will be determined in accordance with the following described methodology.

(a) “Specialty hospital” as used in this Part of this Attachment is the program and site for which OPWDD has issued an operating certificate to operate as a specialty hospital for persons with developmental disabilities. “Provider” as used in this Part of this Attachment is the corporation or other organization operating a specialty hospital.

(b) **Unit of service** - The unit of service will be a day.

(c) **Rates** will be as follows:

<table>
<thead>
<tr>
<th>Rate period</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01/2011-12/31/2014</td>
<td>$895.16</td>
</tr>
<tr>
<td>01/01/2015-03/31/2015</td>
<td>$898.93</td>
</tr>
<tr>
<td>On and after 04/01/2015</td>
<td>$910.94</td>
</tr>
</tbody>
</table>

(d) **Rate appeals** - A provider may appeal for an adjustment to its rate that would result in an annual increase of $5,000 or more in the provider’s allowable costs and that is needed because of bed vacancies. A bed vacancy appeal may be requested when the occupancy rate of the specialty hospital is less than 100 percent. The appeal request must be made within one year of the close of the rate period in which the bed vacancies occurred or within six months of the notification to the provider of the rate amount, whichever is later. OPWDD will only grant the appeal if the provider has demonstrated that the vacancies were unavoidable. No amount granted on appeal will result in Medicaid payments exceeding the provider’s specialty hospital costs of providing Medicaid services for the rate period.

**TN #11-0086 Approval Date __February 18, 2016__**

**Supersedes TN #88-0014 Effective Date __July 1, 2011__**
(e) Additional Disproportionate Share Payment - Specialty Hospital

Disproportionate share hospital payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with section 1923(f) of the Social Security Act and cannot exceed the facility specific disproportionate share hospital payment limits at section 1923(g) of the Social Security Act.

Effective October 1, 2014, the State will make disproportionate share hospital (DSH) payments to privately operated specialty hospitals certified by the New York State Office for People With Developmental Disabilities (OPWDD). The annual total aggregate amount of the payment will be $10,000. Currently Terence Cardinal Cooke Health Care Center is the only privately operated specialty hospital certified by the New York State Office for People with Developmental Disabilities (OPWDD). Should additional hospitals qualify for this DSH payment, the total aggregate amount of payment will be distributed proportionately based on each hospital’s relative percentage of Medicaid days to total Medicaid days of all hospitals eligible for a payment under this provision.

February 18, 2016

TN #11-0086 Approval Date
Supersedes TN #00-0049 Effective Date

July 1, 2011
(b) Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under Medicaid, shall not be allowable for reimbursement.

(c) If a facility’s real property assets are sold or leased, or subject to any other transaction which results in a net decrease in the real property cost to the provider, the real property cost portion of a facility’s rate shall be prorated accordingly. For the purpose of this section, real property assets refer to buildings, building improvements and fixed equipment. Real property costs are the costs directly related to real property assets.

(ix) A facility’s annual rental payments for real property may be considered an allowable cost subject to the following conditions:

(a) The lease is reviewed by and acceptable to Office of Mental Retardation and Developmental Disabilities and any other State agency which must by law or regulation review and approve reimbursement rates.

(b) The lease agreement must be considered ‘an arm’s-length transaction’ not involving either an affiliate controlling person, immediate family or principal stockholder.

(c) The arm’s-length transaction requirement may be waived by the commissioner upon application for those corporations holding title to the specialty hospital’s physical plant, created pursuant to the Not-for-Profit Corporation Law with the approval of the commissioner.

(d) For the purposes of this section, affiliate means:

(1) With respect to a partnership, each partner thereof.

(2) With respect to a corporation, each office, director, principal stockholder and controlling person thereof.
With respect to a natural person, each member of said person's immediate family or each partnership and each partner of such person or each corporation in which said person or any affiliate of said person is an officer, director, principal stockholder or controlling person.

For the purposes of this section, controlling person of any corporation, partnership, or other entity means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the direction of the management policies of said corporation, partnership or other entity. Neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a facility, shall by reason of his or her official position be deemed a controlling person of any corporation, partnership or other entity. Nor shall any person who serves as an executive director, officer, administrator, principal employee or other employee of any corporation, partnership or other entity or as a member of a board of directors or trustees of any corporation be deemed to be a controlling person of such corporation, partnership or other entity solely as a result of such position or his or her official actions in such position.

For the purposes of this section, immediate family means brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent or child of such person whether such relationship arises by reason of birth, marriage or adoption.

For the purposes of this section, principal stockholder of a corporation means any person who beneficially owns, holds or has the power to vote, 10 percent or more of any class of securities issued by said corporation.

The rental amount is comparable to similar leases for properties with similar functions in the same geographical area.
(j) If the above criteria are not met, reimbursement for lease costs will be determined in accordance with section (d)(8)(x) and (xii).

(j) Lease options to renew shall not be exercised without review and approval of the parties listed in section (d)(8)(ix)(a). Such review and decision shall occur whenever possible more than 30 days before the last date the option may be exercised, the date of which the facility has notified OMRDD in accordance with section (d)(8)(ix)(k).

(k) Request for approval of lease renewals shall be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease renewal option.

(x) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life of buildings, fixed equipment and/or capital improvements. For the purposes of this section:

(a) Unless an exception is made by the commissioner, the useful life shall be the higher of the reported useful life or those from the Estimated Useful Lives of Depreciable Hospital Assets (1983 edition), published by the American Hospital Association and available by writing the American Hospital Association, 840 Lake Shore Drive, Chicago, IL 60611. On an exception basis, a useful life that is based upon historical experience as shown by documentary evidence and approved by OMRDD may be allowed.

(b) The depreciation method used shall be the straight-line method.

(c) In the event that the historical cost of the facility cannot be adequately determined by the commissioner, an appraisal value shall be the basis for depreciation. The appraisal shall produce a value approximating the cost of reproducing substantially identical assets of like type, quality and quantity at a price level in a reasonably competitive market as of the date of acquisition. Such appraisal shall be conducted by an appraiser approved by OMRDD and pursuant to a method approved by OMRDD and the cost of the appraisal is also allowable.
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(xi) Costs related to moveable equipment, furniture and fixtures may be considered an allowable cost subject to the following:

(a) Depreciation based upon historical cost of moveable equipment, furniture and fixtures is considered an allowable cost. The useful life shall be the higher of the reported useful life, or those from the Estimate Useful Lives of Depreciable Hospital Assets (1983 edition), published by the American Hospital Association and available by writing to the American Hospital Association, 840 Lake Shore Drive, Chicago, IL 60611. On an exception basis, a useful life that is based upon historical experiences as shown by documentary evidence and approved by OMRDD may be allowed.

(b) The facility shall use the straight-line, double-declining balance or sum-of-the-year's digits depreciation method. The depreciation method utilized must remain consistent throughout the useful life of an asset.

(c) Lease payments may be an allowable cost if the payments are made under a lease which is an arm's-length transaction as described in section (d)(8)(ix)(b).

(d) Any personal property and equipment transactions shall be through a multiple bid process and entered into at a fair market value price.

(e) If lease payments are not made pursuant to an arm's-length agreement, allowable costs will include allowable depreciation, the associated interest expense, if any, and other related expenses, including but not limited to maintenance costs.

(xii) Interest cost may be considered an allowable cost subject to the following:

(a) Interest for capital indebtedness, where the capital indebtedness does not exceed the current Office of Mental Retardation and Developmental Disabilities approved value of the property, will be considered allowable.

(b) An interest rate shall not be in excess of the amount a prudent borrower would pay at the time the loan was incurred.
The loan agreement must be entered into between parties not related through control, ownership, affiliation, or personal relationship as defined in section (d)(8)(ix)(d), unless this provision is waived by the commissioner. Such waiver shall be based on, but not limited to, a demonstration of need for the program and cost savings resulting from the transaction.

Interest income generated from the facility's revenues for the operation of the facility shall be used to offset interest expense incurred during the same reporting period. Notwithstanding the foregoing, a facility is not required to use the following to offset interest expense: income earned on qualified pension funds, income from gifts or grants which is donor-restricted, or income earned on secure investments pursuant to section (d) (10).

Interest on working capital indebtedness in accordance with standards contained herein will be considered allowable. In the event that a loan is not in accordance with the standards listed above, the approval of the commissioner is required.

Costs of related organizations, other than costs incurred pursuant to a lease, rent or purchase of real property, may be considered an allowable cost subject to the following:

A “related organization” means any entity of which the provider is in control or which the provider is controlled by (subject to the limitations in section (d)(8)(ix)(e), either directly or indirectly, or where a common ownership or financial interest exists in an entity which supplies goods and/or services to the facility.

The costs of goods and/or services furnished to a facility, within the course of normal business operations, by a related organization are allowable at the cost to the related organization, or the market price of comparable goods and/or services available in the facility's region, whichever is lower.]
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 Approval Date December 31, 1974
Supersedes TN --- Effective Date January 1, 1974
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.

b) Statewide Patient Centered Medical Home and the Adirondack Medical Home Multipayor Program for physicians, hospital based clinics and diagnostic and treatment centers.

c) E-prescription financial incentive payments to dentists, podiatrists, optometrists, nurse midwives, and nurse practitioners.

d) Reimbursement for dental services, podiatrists, optometrists, chiropractic services, nurse midwives, nurse practitioners, and clinical psychologists.

e) Methadone Maintenance Treatment Program (MMTP) services.

f) Outpatient reimbursement for Acute Care Children’s Hospitals.

g) Ordered Ambulatory Services.

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.

i) Additional funding for Freestanding Clinics licensed under Article 28 of the State Public Health Law providing services to persons with developmental disabilities.

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.
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k) 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. Pages 1(f)-1(p);

l) Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis. Page 2

m) AIDS/HIV Adult Day Health Care Services provided by a freestanding clinic. Pages 2-2(a)

n) 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. Pages 2(b)-2(b)(ii)

o) Workforce Recruitment and Retention payment for freestanding clinics. Pages 2(c)(vii)-2(c)(viii)

p) Products of Ambulatory Care reimbursement for Hospital Based Clinics and Freestanding Clinics. Pages 2(d)-2(e)

q) 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. Page 3-3(h)(12)

r) 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. Page 3(i)

s) Office of Mental Health Outpatient Programs licensed under 14 NYCRR Parts 579 and 585; including Clinic, Day and Continuing Treatment Programs. Pages 3(i)-3(k)

t) 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. Pages 3(L)-3(M)
u) Laboratory services. 

v) Home health services provided by Certified Home health Agencies (CHHA), including services to patients diagnosed with AIDS. Pages 4-4(a)(i)(2); 4(a)(ii)-4(b)

w) Personal Emergency Response Services (PERS). 

x) Services provided to Medically Fragile Children. 

y) Home Telehealth Services provided by CHAAs including those that provide AIDS home care services. Pages 4(a)(i)(4) – 4(a)(i)(5)

z) Assisted Living Programs. 

aa) Prescribed Drugs; E-Prescription Financial Incentive program to retail pharmacies; Pharmacy Medication Therapy; immunization reimbursement for pharmacists; and Non-prescription drugs. Pages 4(d)-5

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. Pages 5-5(a)(i)

cc) Physical Therapy. 

dd) Occupational Therapy. 

ee) Eyeglasses and Other Visual Services. 

ff) Hearing Aid Supplies and Services. 

gg) Prosthetic and Orthotic Appliances. 

hh) Comprehensive Psychiatric Emergency programs. 

ii) Durable Medical Equipment. 

jj) Medical/Surgical Supplies.
kk) Enterel Formula.  

ll) Transportation.  

mm) Out of State Services for fee based providers.  

nn) HMO’s and Prepaid Health Plans.  

oo) Personal Care Services.  

pp) Adult Day Health Care services including services provided to patients with HIV/AIDS.  

gg) Intensive Day Treatment Program certified by the Office of Mental Health pursuant to 14 NYCRR Part 581.  
r) Office of Mental Health Clinic, Day and Continuing Treatment program services in facilities certified under Article 31 of the State Mental Hygiene Law.  

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.  

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.  

uu) Preferred Physician and Children’s Program.  

vv) Medicaid Obstetrical and Maternal Services (MOMS).  

ww) Child Teen Health Program.
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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 Multipayer 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)
i) Ambulatory Patient Group (APG) reimbursement for hospital outpatient departments, emergency departments, and ambulatory surgery services.  Page 1(f)-1(p)

j) Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.  Page 2

k) Services to AIDS/HIV positive patients provided in Hospital Outpatient Departments and Freestanding clinics.  Pages 2(b)

l) Laboratory services.  Page 4

m) Home health services provided by Certified Home Health Agencies (CHHA), including services to patients diagnosed with AIDS.  Pages 4-4(a)(i)(2); 4(a)(ii)-4(b)


o) Services provided to Medically Fragile Children.  Page 4(a)(i)(3)

p) Home Telehealth Services provided by CHAAs including those that provide AIDS home care services.  Pages 4(a)(i)(4) – 4(a)(i)(5)

g) 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) Comprehensive Psychiatric Emergency programs.  Page 5(b)

x) Durable Medical Equipment.  Page 6
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y) Medical/Surgical Supplies.

z) Enteral Formula.

aa) Transportation.

bb) Out of State Services for fee based providers.

c) Personal Care Services.

d) 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.

e) Preferred Physician and Children’s Program.

ff) Medicaid Obstetrical and Maternal Services (MOMS).

gg) Child Teen Health Program.


ii) Emergency services for illegal aliens.

jj) Primary Care Case Management.

kk) Program of All-Inclusive Care for the Elderly (PACE).

ll) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).

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Supersedes TN NEW
2% Across The Board Rate Reduction - Early Intervention Services

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

Effective on and after February 1, 2013, payments for Early Intervention services will be exempt from the 2% Across the Board payment reduction.
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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, 2013 through March 31, 2015.
(1) For dates of service on and after April 1, 2013 and ending on March 31, 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.

b) Statewide Patient Centered Medical Home and the Adirondack Medical Home Multipayor Program for physicians, hospital based clinics and freestanding clinics.

c) E-prescription financial incentive payments to physicians, dentists, podiatrists, optometrists, nurse midwives, and nurse practitioners.

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.

e) Methadone Maintenance Treatment Program (MMTP) services.

[f] Outpatient reimbursement for Acute Care Children’s Hospitals.

[g] Ordered Ambulatory Services.

[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.

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.
g) Methadone Maintenance Treatment Program (MMTP) services.  

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.

i) Ambulatory Patient Group (APG) reimbursement for hospital outpatient departments, emergency departments, and ambulatory surgery services.

j) Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.

k) Services to AIDS/HIV positive patients provided in Hospital Outpatient Departments and Freestanding clinics.

l) Laboratory services.

m) Home health services provided by Certified Home Health Agencies (CHHAs), including services to patients diagnosed with AIDS.

n) Personal Emergency Response Services (PERS).

o) Services provided to Medically Fragile Children.

p) Home Telehealth Services provided by CH[A]HAs including those that provide AIDS home care services.

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.

r) Physical Therapy, except for those services provided in an office based setting.

s) Occupational Therapy, except for those services provided in an office based setting.

t) Eyeglasses and Other Visual Services.

u) Hearing Aid Supplies and Services.

v) Prosthetic and Orthotic Appliances.

w) Durable Medical Equipment.

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.
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. Pages 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.
Physician Services

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

For primary care and specialty physicians meeting the eligibility and practice criteria of and enrolled in the HIV Enhanced Fees for Physicians (HIV-EFP) program, and the Preferred Physicians and Children’s program (PPAC), fees for visits are based on the Products of Ambulatory Care (PAC) structure: fees are based on recipient diagnosis, service location and visit categories which reflect the average amount of physician time and resources for that level of visit. The PAC fee structure incorporates a regional adjustment for upstate and downstate physicians. Reimbursement for the initial and subsequent prenatal care and postpartum visit for MOMS is based on the Products of Ambulatory Care (PAC) rate structure. Reimbursement for delivery only services and total obstetrical services for physicians enrolled in MOMS is fixed at 90% of the fees paid by private insurers. Ancillary services and procedures performed during a visit must be claimed in accordance with the regular Medicaid fee schedule described in the first paragraph above. HIV-EFP, PPAC and MOMS fees were developed by the Department of Health and approved by the Division of the Budget. For services provided on and after June 1, 2003, a single fee, regionally adjusted (upstate and downstate) and based on program specific average cost per visit shall be established for the HIV-EFP and PPAC programs, respectively, and shall be paid for each visit. Visits for these programs shall be categorized according to the evaluation and management codes within the CPT-4 coding structure.

Effective September 1, 2012, reimbursement will be provided to physicians for breastfeeding health education and counseling services. Physicians 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.

Effective January 1, 2018 reimbursement will be provided to outpatient clinics of general hospitals (outpatient clinic) and diagnostic and treatment centers (D&T&C) for primary care practitioners who provide home visit primary care services to a patient who is unable to leave his or her residence to receive services at the outpatient clinic or D&T&C without unreasonable difficulty due to circumstances, including but not limited to, clinical impairment.

1. The patient must have a pre-existing clinical relationship with the outpatient clinic or D&T&C, or with the health care professional providing the service.

2. The primary care practitioner must be employed by either the outpatient clinic or D&T&C and acting at the direction of that provider.

3. These services are provided by a primary care practitioner which includes the following: physician, physician assistant, nurse practitioner or licensed midwife.

4. Primary care services are defined as services ordinarily provided to patients on-site at the outpatient clinic or D&T&C and cannot be home care services as stated in Chapter 3602, subdivisions 1 and 2. [https://codes.findlaw.com/ny/public-health-law/pbh-sect-3602.html](https://codes.findlaw.com/ny/public-health-law/pbh-sect-3602.html)
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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.
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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.
(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.
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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**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Fee Code</th>
<th>Volume</th>
<th>Medicaid Payments</th>
<th>ACR</th>
<th>ACR Medicaid Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Facility</td>
<td>9</td>
<td>$98.33</td>
<td>$37.56</td>
<td>$338.02</td>
</tr>
<tr>
<td>99201</td>
<td>Non-Facility</td>
<td>29</td>
<td>$659.46</td>
<td>$48.16</td>
<td>$1,396.50</td>
</tr>
<tr>
<td>99202</td>
<td>Facility</td>
<td>67</td>
<td>$1,451.31</td>
<td>$72.65</td>
<td>$4,867.86</td>
</tr>
<tr>
<td>99202</td>
<td>Non-Facility</td>
<td>68</td>
<td>$2,533.87</td>
<td>$83.34</td>
<td>$5,667.20</td>
</tr>
<tr>
<td>99203</td>
<td>Facility</td>
<td>255</td>
<td>$8,491.44</td>
<td>$110.72</td>
<td>$28,234.48</td>
</tr>
<tr>
<td>99203</td>
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<td>154</td>
<td>$8,590.88</td>
<td>$123.25</td>
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<td>99205</td>
<td>Non-Facility</td>
<td>38</td>
<td>$3,805.95</td>
<td>$237.02</td>
<td>$9,006.72</td>
</tr>
</tbody>
</table>

**Total Fees** $48,509.88 $132,658.13

Average percentage of Commercial Payments to Medicaid Payments 273%

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

<table>
<thead>
<tr>
<th>CPT</th>
<th>Fee Code</th>
<th>Medicaid Volume</th>
<th>Medicaid Payments</th>
<th>Average Medicaid Payment</th>
<th>Comm % of Medicaid</th>
<th>Calculated ACR Proxy</th>
<th>Calculated Payment Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>59514</td>
<td>Facility</td>
<td>2</td>
<td>$1,791.02</td>
<td>$895.51</td>
<td>273%</td>
<td>$2,448.92</td>
<td>$4,897.83</td>
</tr>
<tr>
<td>59840</td>
<td>Facility</td>
<td>8</td>
<td>$1,840.00</td>
<td>$230.00</td>
<td>273%</td>
<td>$628.97</td>
<td>$5,031.78</td>
</tr>
<tr>
<td>27600</td>
<td>Facility</td>
<td>2</td>
<td>$202.40</td>
<td>$101.20</td>
<td>273%</td>
<td>$276.75</td>
<td>$553.50</td>
</tr>
<tr>
<td>92014</td>
<td>Non-Facility</td>
<td>118</td>
<td>$6,537.35</td>
<td>$55.40</td>
<td>273%</td>
<td>$151.50</td>
<td>$17,877.44</td>
</tr>
<tr>
<td>51728</td>
<td>Non-Facility</td>
<td>10</td>
<td>$1,509.94</td>
<td>$150.99</td>
<td>273%</td>
<td>$412.92</td>
<td>$4,129.18</td>
</tr>
</tbody>
</table>

**Totals** $11,880.71 $32,489.73

Supplemental Payment $20,609.02

---

TN #11-07-A Approval Date **February 25, 2013**

Supersedes TN **NEW** Effective Date **April 1, 2011**
(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

1.5

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 (FQHCs) 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.
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.

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.

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.

Attachment 4.19-B

New York

1.6

(e)

(f)

(g)

Supersedes TN NEW

April 1, 2011

February 25, 2013
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

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Total Fees $48,509.88 ACR Medicaid $132,658.13
Average percentage of Commercial Payments to Medicaid Payments 273%

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

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<tr>
<th>CPT</th>
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Totals $11,880.71 Payment Ceiling $32,489.73
Supplemental Payment $20,609.02
(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.
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

Approval Date  November 18, 2015

Supersedes TN  #11-0007-C

Effective Date  July 1, 2015
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.

Approval Date: February 25, 2013
Effective Date: April 1, 2011
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  #13-04  Supersedes TN  NEW  Approval Date  May 30, 2013
Effective Date  January 1, 2013
(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.
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)
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.

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**TN #13-04**

**Approval Date** May 30, 2013

**Supersedes TN NEW**

**Effective Date** January 1, 2013
Crosswalk of Vaccine Product Codes to Administration Codes

<table>
<thead>
<tr>
<th>Vaccine Code</th>
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TN #13-04
Supersedes TN NEW

Approval Date: May 30, 2013
Effective Date: January 1, 2013
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

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.

Supersedes TN NEW

TN #13-04

Approval Date May 30, 2013

Effective Date January 1, 2013
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:


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

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

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TN #13-04
Supersedes TN NEW

Approval Date May 30, 2013
Effective Date January 1, 2013
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 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 physicians’ and/or nurse practitioners’ practices 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 providers 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 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.
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.
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.

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
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 (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 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”.

Attachment 4.19-B
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 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 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.]
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
Supersedes TN #95-25

Approval Date December 28, 2012
Effective Date September 1, 2012
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:


Supersedes TN # 18-0052 Approval Date __02/07/2019__

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

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.
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:


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.
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.
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.
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.
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.
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.
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, 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, 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 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, 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       #17-0034   Approval Date          September 25, 2017
Supersedes TN #15-0028   Effective Date    April 1, 2017
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 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 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.

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 be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period shall 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 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 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 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 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 be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall 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.

August 6, 2012
TN #11-66 ______ Approval Date ______
April 1, 2011
Supersedes TN NEW ______ Effective Date ______
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.
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.
New York
1(c)

[medicals 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 Approval Date September 9, 2011
Supersedes TN #06-45 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 Approval Date September 9, 2011
Supersedes TN #05-21 Effective Date April 1, 2008
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 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 Clinics 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 Clinics 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 Clinics for visits with evaluation and management codes identified by the Department as "primary care."

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

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.

Approval Date 06/14/2018

Supersedes TN #NEW

Effective Date 01/01/2017
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...
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.
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 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 Clinics 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 Clinics 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 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
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.
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.

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
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”.

TN #09-56-C
Supersedes TN NEW
Approval Date July 19, 2010
Effective Date December 1, 2009
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.
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.”
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.
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.

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.
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”.

TN #09-56-D Approval Date July 19, 2010
Supersedes TN NEW Effective Date December 1, 2009
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.
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.
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, 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
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.
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.
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, 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.
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. 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  Click on “Contacts.”

3M APG Crosswalk, version 3.13; updated as of [01/ 01/ 18 and 04/ 01/ 18] 07/01/18 and 10/01/18:
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:

APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 01/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/  Click on “2018”

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

APG Investments by Rate Period; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm  Click on “Investments by Rate Period.”

APG Relative Weights; updated as of [01/01/18] 07/01/18:

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

TN #18-0056 Approval Date December 14, 2018
Supersedes TN #18-0005 Effective Date July 01, 2018
Carve-outs; updated as of 10/01/12:

Coding Improvement Factors (CIF); updated as of 07/01/12:
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 Click on “If Stand Alone, Do Not Pay APGs.”

If Stand Alone, Do Not Pay Procedures; updated as of 01/01/18:
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 [01/01/15] 07/01/18:

Never Pay APGs; updated as of 07/01/17:

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

No-Blend APGs; updated as of 04/01/10:
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 Click on “No Blend Procedures.”
New York
1(e)(2.2)

No Capital Add-on APGs; updated as of 07/01/13:
Click on “No Capital Add-on APGs.”

No Capital Add-on Procedures; updated as of [04/01/12 and 07/01/12] 07/01/17:
Click on “No Capital Add-on Procedures.”

Non-50% Discounting APG List; updated as of [04/01/16] 07/01/17:
Click on “Non-50% Discounting APG List.”

Rate Codes Carved Out of APGs; updated as of 01/01/15:
Click on “Rate Codes Carved Out of APGs for Article 28 facilities.”

Rate Codes Subsumed by APGs; updated as of 10/01/12:
Click on “Rate Codes Subsumed by APGs - Hospital Article 28.”

Statewide Base Rate APGs; updated as of 01/01/14:
Click on “Statewide Base Rate APGs.”

Packaged Ancillaries in APGs; updated as of 01/01/12:
Click on “Packaged Ancillaries in APGs.”

TN    #17-0055    Approval Date 11/01/2018
Supersedes TN    #16-0043    Effective Date 07/01/2017
## Hospital-Based APG Base Rate Table

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

*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.

(2) 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)
# Freestanding Diagnostic and Treatment Center APG Base Rate Table

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Region</th>
<th>Rate Start Date</th>
<th>Base Rate Effective 09/1/2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Clinic</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$212.07</td>
</tr>
<tr>
<td>General Clinic</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$174.74</td>
</tr>
<tr>
<td>General Clinic MR/DD/TBI</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$254.48</td>
</tr>
<tr>
<td>General Clinic MR/DD/TBI</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$209.69</td>
</tr>
<tr>
<td>Dental School</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$268.35</td>
</tr>
<tr>
<td>Dental School</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$223.22</td>
</tr>
<tr>
<td>Renal</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$235.70</td>
</tr>
<tr>
<td>Renal</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$196.06</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$ 88.69</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$ 86.39</td>
</tr>
</tbody>
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TN #09-66 Approval Date February 6, 2013
Supersedes TN #09-62 Effective Date December 1, 2009
New York
1(e)(5)

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

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Region</th>
<th>Rate Start Date</th>
<th>Base Rate as of 10/01/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Clinic</td>
<td>Downstate</td>
<td>10/1/10</td>
<td>$181.16</td>
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<tr>
<td>Mental Health Clinic</td>
<td>Upstate</td>
<td>10/1/10</td>
<td>$139.25</td>
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</tbody>
</table>

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/
## New York 1(e)(6)

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Region</th>
<th>Rate Start</th>
<th>Base Rate Start</th>
<th>Base Rate End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Dependence Outpatient Clinic</td>
<td>Downstate</td>
<td>10/1/10</td>
<td>$201.55</td>
<td>$181.72</td>
</tr>
<tr>
<td>Chemical Dependence Outpatient Clinic</td>
<td>Upstate</td>
<td>10/1/10</td>
<td>$154.92</td>
<td>$146.57</td>
</tr>
<tr>
<td>Opioid Treatment Program (Clinic)</td>
<td>Downstate</td>
<td>1/3/11</td>
<td>$180.99</td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program (Clinic)</td>
<td>Upstate</td>
<td>1/3/11</td>
<td>$157.14</td>
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</tr>
<tr>
<td>Outpatient Rehabilitation Clinic</td>
<td>Downstate</td>
<td>1/1/11</td>
<td>$151.20</td>
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<tr>
<td>Outpatient Rehabilitation Clinic</td>
<td>Upstate</td>
<td>1/1/11</td>
<td>$116.23</td>
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</tbody>
</table>

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](https://www.oasas.ny.gov/admin/hcf/FFS/RegionAPGBaseRate.cfm)

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**TN 10-0041**

Approval Date: Aug 25, 2016

Supersedes TN 10-0017

Effective Date: Jan 1, 2016
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, 2016
Supersedes TN   #09-0065-A Effective Date October 1, 2015
**Associated Ancillaries** shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**APG Software** shall mean the New York State-specific version of the APG computer software developed and published by Health Information Systems, Inc. (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.

**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 - Hospital Outpatient 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 - Hospital Outpatient section.

**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.

**TN____#15-0019__________** Approval Date _February 17, 2016_

**Supersedes TN ___#09-0065-A___** Effective Date _October 1, 2015_
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.
“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, [9th] 10th 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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**TN** #15-0019 ________________  **Approval Date** __February 17, 2016______

Supersedes TN __#09-0065-A__  **Effective Date** __October 1, 2015______
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 a list of the uniform packaging APGs for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient 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. The sixteen 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; [and]
14. Chemical Dependence Outpatient Clinic - Downstate.
15. Outpatient Rehabilitation Clinic - Upstate; and
16. Outpatient rehabilitation Clinic - 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 date of service.


"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.]
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 [six] seven 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.

TN #18-0056 Approval Date December 14, 2018

Supersedes TN #17-0055 Effective Date July 01, 2018
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.
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.
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) For 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) 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 computed in accordance with this [Subpart]Attachment;

(5) For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment.

(6) For 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.
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/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 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.

Attachment 4.19-B

New York
1(k)
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.
New York
1(l)

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

\[
\frac{(51,000,000 + 25,000,000)}{(8.1610 \times 1.05 \times 50,000)} = 177.38 \text{ (Base Rate)}
\]

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.

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[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]

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 Approval Date February 6, 2013
Supersedes TN #09-62 Effective Date December 1, 2009
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.
[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.]
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.
[The following APGs shall not be eligible for reimbursement through the APG system:

065  RESPIRATORY THERAPY
066  PULMONARY REHABILITATION
094  CARDIAC REHABILITATION
117  HOME INFUSION
118  NUTRITION THERAPY
190  ARTIFICIAL FERTILIZATION
311  FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
312  FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
313  HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
314  HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
319  ACTIVITY THERAPY
320  CASE MANAGEMENT - MENTAL HEALTH OR SUBSTANCE ABUSE
371  ORTHODONTICS
427  BIOFEEDBACK AND OTHER TRAINING
430  CLASS I CHEMOTHERAPY DRUGS
431  CLASS II CHEMOTHERAPY DRUGS
432  CLASS III CHEMOTHERAPY DRUGS
433  CLASS IV CHEMOTHERAPY DRUGS
434  CLASS V CHEMOTHERAPY DRUGS
450  OBSERVATION
452  DIABETES SUPPLIES
453  MOTORIZED WHEELCHAIR
454  TPN FORMULAE
456  MOTORIZED WHEELCHAIR ACCESSORIES
492  DIRECT ADMISSION FOR OBSERVATION INDICATOR
500  DIRECT ADMISSION FOR OBSERVATION - OBSTETRICAL
501  DIRECT ADMISSION FOR OBSERVATION - OTHER DIAGNOSES
999  UNASSIGNED]
[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 EXTREMITIES
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]
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.
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.
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.
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:**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.O. Fox Memorial Hospital</td>
<td>$3,031,209</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$2,529,235</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$1,705,835</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Clifton-Fine Hospital</td>
<td>$1,225,000</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td>Cortland Memorial Hospital</td>
<td>$577,633</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$1,114,173</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$496,666</td>
<td>04/01/2015 – 03/31/2016</td>
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**TN** #13-0070  
Supersedes **TN** #11-0026-A  
**Approval Date** October 13, 2016  
**Effective Date** January 01, 2014
### Hospital-Based Outpatient Services (Continued):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
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<tbody>
<tr>
<td>Delaware Valley Hospital, Inc.</td>
<td>$221,650</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$164,400</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$66,200</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Ellenville Regional Hospital</td>
<td>$219,780</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$224,176</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$699,788</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Oswego Hospital</td>
<td>$300,000</td>
<td>01/01/2013 – 03/31/2013</td>
</tr>
<tr>
<td></td>
<td>$750,000</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$500,000</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td>River Hospital</td>
<td>$1,444,695</td>
<td>02/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td>Schuyler Hospital</td>
<td>$216,113</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$215,574</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$225,143</td>
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</tr>
</tbody>
</table>
Hospital-Based Outpatient Services - Critical Access Hospitals (CAHs):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carthage Area Hospital</td>
<td>$325,000</td>
<td>11/01/2014 - 03/31/2015</td>
</tr>
<tr>
<td>Catskill Regional Medical Center - Hermann Division</td>
<td>$275,000 $240,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Clifton-Fine Hospital</td>
<td>$350,000 $325,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Community Memorial Hospital</td>
<td>$240,000</td>
<td>11/01/2014 - 03/31/2015</td>
</tr>
<tr>
<td>Cuba Memorial Hospital</td>
<td>$315,000 $445,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Delaware Valley Hospital, Inc.</td>
<td>$246,000 $240,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Elizabethtown Community Hospital</td>
<td>$410,000 $240,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Ellenville Regional Hospital</td>
<td>$384,800 $240,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Gouverneur Hospital, Inc.</td>
<td>$300,000 $240,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Lewis County General Hospital</td>
<td>$370,000 $325,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Little Falls Hospital</td>
<td>$342,000 $240,000</td>
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</tr>
<tr>
<td>Margaretville Memorial Hospital</td>
<td>$128,600 $325,000</td>
<td>02/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td>Moses Ludington Hospital</td>
<td>$359,800 $325,000</td>
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TN  #14-0040  Approval Date  October 27, 2016
Supersedes TN  #14-0013  Effective Date  November 01, 2014
**Hospital-Based Outpatient Services - Critical Access Hospitals (CAHs) (continued):**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Revenue</th>
<th>Period</th>
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<tr>
<td>O'Connor Hospital</td>
<td>$363,800</td>
<td>02/01/2014 – 03/31/2014</td>
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<tr>
<td></td>
<td>$240,000</td>
<td>11/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td>River Hospital</td>
<td>$482,000</td>
<td>02/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$445,000</td>
<td>11/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td>Schuyler Hospital</td>
<td>$453,000</td>
<td>02/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$240,000</td>
<td>11/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td>Soldiers &amp; Sailors Memorial Hospital</td>
<td>$220,000</td>
<td>02/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$325,000</td>
<td>11/01/2014 – 03/31/2015</td>
</tr>
</tbody>
</table>

**Attachment 4.19-B**

New York
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**TN #14-0040**

**Approval Date** October 27, 2016

**Supersedes TN NEW**

**Effective Date** November 01, 2016
New York 1(r)

RESERVED

TN #13-0002

Approval Date June 12, 2018

Supersedes TN New

Effective Date January 1, 2018
RESERVED
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.
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 Approval Date  December 11, 2017
Supersedes TN  #07-06 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.

TN  #17-0006  Approval Date  December 11, 2017
Supersedes TN  #11-11  Effective Date  September 1, 2017
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.

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#11-21</td>
<td>August 31, 2012</td>
<td>April 1, 2011</td>
</tr>
<tr>
<td>Supersedes TN #08-29</td>
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</tr>
</tbody>
</table>
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.
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%.

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New York
2(b)

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%.

December 22, 2011

TN #09-23-A Approval Date December 22, 2011
Supersedes TN #07-06 Effective Date April 1, 2009
Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law [A]s 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, 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.
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.
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.

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 be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period shall 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 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 be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall 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 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 be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

TN #17-0034                  Approval Date September 25, 2017
Supersedes TN #15-0044      Effective Date April 1, 2017
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.
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.
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.
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 treatment 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.
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.
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.
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.
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.

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.

<table>
<thead>
<tr>
<th>% of eligible BD&amp;CC visits to total visits</th>
<th>% of nominal financial loss coverage</th>
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<tbody>
<tr>
<td>up to 15%</td>
<td>50%</td>
</tr>
<tr>
<td>15 - 30%</td>
<td>75%</td>
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<tr>
<td>30% +</td>
<td>100%</td>
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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.
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
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.
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 January 1, 2015, the Department of Health shall reimburse FQHC/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 FQHC/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.
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.
Minimum Wage – Article 28 FQHCs

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 FQHC rate as an alternative payment method (APM) rate.

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<tbody>
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<td>$13.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
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<td>$12.00</td>
<td>$13.50</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Nassau, Suffolk, &amp; Westchester counties</td>
<td>$10.00</td>
<td>$11.00</td>
<td>$12.00</td>
<td>$13.00</td>
<td>$14.00</td>
<td>$15.00</td>
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<tr>
<td>Remainder of the State</td>
<td>$9.70</td>
<td>$10.40</td>
<td>$11.10</td>
<td>$11.80</td>
<td>$12.50</td>
<td>$12.50</td>
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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). An Article 28 FQHC’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 FQHC specific wage data.
      2. Article 28 FQHCs 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 FQHCs 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 FQHC has reported total hours paid. To this result, the Article 28 FQHC’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.

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.
ii. Medicaid’s share of the total amount the Article 28 FQHC 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 FQHC.)

iii. Minimum wage funds to be recouped or additional funds to be received by the Article 28 FQHC. (This information will be completed by the provider.) This will be the difference between the amount paid to the Article 28 FQHC for the Medicaid share of the minimum wage law increase requirement and the corresponding amount the Article 28 FQHCs determined it was actually obligated to pay.

iv. The State agency will review Article 28 FQHCs’ 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 FQHC rate, since this APM rate will be an increase to the PPS FQHC rate.

h. For the purpose of comparing the Ambulatory Patient Group (APG) payment method rate that is being used as an APM for an FQHC provider, the APM PPS FQHC 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.
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

Supersedes TN #14-0005

Approval Date October 31, 2017

Effective Date April 1, 2015
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 $110,552,828. 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.
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.
Hospital Outpatient Supplemental Payments - Non-government Owned or Operated General Hospitals


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 [2015] 2016 rate year; and/or must have a facility specific projected disproportionate share hospital payment ceiling for the [2015] 2016 rate year that is greater than zero.

The amount paid to each eligible hospital shall 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, [2014] 2015:

(a) Thirty percent of the payments under this provision shall 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 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 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 [$501,941,380] $400,796,649 in outpatient services reimbursed all eligible hospitals in the [2015] 2016 calendar year.
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.
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

TN #08-30 Approval Date July 26, 2010
Supersedes TN #07-33 Effective Date April 1, 2008
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.
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 comprised 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 provider's 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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TN #91-63  Approval Date  October 31, 1991
Supersedes TN #90-38  Effective Date  August 1, 1991
<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>METHOD OF REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]</td>
<td>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.</td>
</tr>
</tbody>
</table>

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.
New York
2(f)

Reserved

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Method of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Supervised, Ambulatory Substance Abuse Treatment Services (Facilities certified under Article 23 of Mental Hygiene Law)</td>
<td></td>
</tr>
</tbody>
</table>

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 | Approval Date | August 9, 2002 |
| Supersedes TN #91-59 | Effective Date | July 1, 2002 |
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.
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.
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:

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

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.
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.

TN #03-32
Supersedes TN NEW
Approval Date June 18, 2004
Effective Date July 1, 2003
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.
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, [2017] 2018, 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.
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. 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   Click on “Contacts.”

3M APG Crosswalk*:
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:

APG Consolidation Logic; logic is from version 3.13.18.1, updated as of 01/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/   Click on “2018”

APG 3M Definitions Manual; version 3.13 updated as of [01/01/18 and 04/01/18]
07/01/18 and 10/01/18:

APG Investments by Rate Period; updated as of 07/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm   Click on “Investments by Rate Period.”

APG Relative Weights; updated as of [01/01/18] 07/01/18:

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

*Older 3M APG crosswalk versions available upon request.

TN #18-0055 Approval Date 10/19/2018
Supersedes TN #18-0004 Effective Date 07/01/2018
Carve-outs; updated as of 10/01/12. The full list of carve-outs is contained in Never Pay APGs and Never Pay Procedures:

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  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  Click on “If Stand Alone, Do Not Pay APGs.”

If Stand Alone, Do Not Pay Procedures; updated 01/01/18:
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 [01/01/15] 07/01/18:

Never Pay APGs; updated as of 07/01/17:

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

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

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  Click on “No Capital Add-on APGs.”

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TN  #18-0055  
Supersedes TN  #18-0004  
Approval Date  10/19/2018  
Effective Date  07/01/2018
New York  
2(g)(3.1)

**No Capital Add-on Procedures; updated as of [04/01/12 and 07/01/12] 07/01/17:**  
Click on “No Capital Add-on Procedures.”

**Non-50% Discounting APG List; updated as of [04/01/16] 07/01/17:**  
Click on “Non-50% Discounting APG List.”

**Rate Codes Carved Out of APGs; updated as of 01/01/15:**  
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:**  
Click on “Rate Codes Subsumed by APGs – Freestanding Article 28.”

**Statewide Base Rate APGs; updated as of 01/01/14:**  
Click on “Statewide Base Rate APGs.”

**Packaged Ancillaries in APGs; updated as of 01/01/12:**  
Click on “Packaged Ancillaries in APGs.”

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TN _______ #17-0054 _______ Approval Date June 28, 2018__________

Supersedes TN _______ #16-0017 _______ Effective Date July 1, 2017__________
### Freestanding Clinic and Ambulatory Surgery Centers APG Base Rate Table

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Region</th>
<th>Rate Start Date</th>
<th>Base Rate Updated as of [01/01/12] 07/01/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Dental</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$155.38</td>
</tr>
<tr>
<td>Academic Dental</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$147.64</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$113.92</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$99.15</td>
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<tr>
<td>Clinic&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>[$162.19] $165.64</td>
</tr>
<tr>
<td>Clinic&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>[$135.92] $138.81</td>
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<tr>
<td>Clinic MR/DD/TBI&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Downstate</td>
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<td>Clinic MR/DD/TBI&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>Renal</td>
<td>Downstate</td>
<td>09/01/09</td>
<td>$141.29</td>
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<tr>
<td>Renal</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>$126.82</td>
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<tr>
<td>School-Based Health Center (SBHC)&lt;sup&gt;2&lt;/sup&gt;</td>
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<td>09/01/09</td>
<td>[$162.19] $165.64</td>
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<tr>
<td>School-Based Health Center (SBHC)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Upstate</td>
<td>09/01/09</td>
<td>[$135.92] $138.81</td>
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<tr>
<td>Statewide Base Price</td>
<td>Statewide</td>
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</tr>
</tbody>
</table>

<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:


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**TN #12-0014**  
Supersedes **TN #12-0002**  
**Approval Date** November 7, 2017  
**Effective Date** April 1, 2012
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.
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.
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.
**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, [9th] 10th 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.
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].
"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.
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 [six] seven 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 reweightings 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 update] Updates for periods prior to January 1, 2010, will be based on claims data from 2007. The update commencing January 1, 2010, will be based on claims data from the January 1, 2009 through November 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 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 $9.375 million for dates of service from September 1, 2009 through November 30, 2009, and $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 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 through November 15, 2009. Subsequent modifications 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. 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.
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.
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.
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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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

\[
\frac{(51,000,000 + 25,000,000)}{(8.1610 \times 1.05 \times 50,000)} = 177.38 \text{ (Base Rate)}
\]

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.]
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.
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.

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<tr>
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<td>$11.10</td>
<td>$11.80</td>
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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). 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.
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
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.
Attachment 4.19-B

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- 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 #10-06 Approval Date November 7, 2013
Supersedes TN #09-01 Effective Date April 1, 2010
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.

TN #13-0044 Approval Date September 1, 2017
Supersedes TN NEW Effective Date July 1, 2013
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 freestanding 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.
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.
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).
APG Peer Group Base Rates for freestanding OASAS licensed chemical
dependence and opioid treatment programs

<table>
<thead>
<tr>
<th>Type</th>
<th>Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>APG Base Rates for freestanding chemical dependence clinics:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upstate</td>
<td>$147.59</td>
<td>07/01/2011</td>
</tr>
<tr>
<td>Downstate</td>
<td>$172.69</td>
<td>07/01/2011</td>
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<tr>
<td>APG Base Rates for freestanding outpatient rehab clinics:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upstate</td>
<td>$147.59</td>
<td>07/01/2011</td>
</tr>
<tr>
<td>Downstate</td>
<td>$172.69</td>
<td>07/01/2011</td>
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<td>APG Base Rates for freestanding opioid treatment clinics:</td>
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<td></td>
</tr>
<tr>
<td>Upstate</td>
<td>$136.04</td>
<td>07/01/2011</td>
</tr>
<tr>
<td>Downstate</td>
<td>$159.17</td>
<td>07/01/2011</td>
</tr>
</tbody>
</table>

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.”
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 mental health clinic peer groups for initial APG implementation: Upstate freestanding clinics; Downstate freestanding clinics; 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.
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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**TN #10-0018**  
**Approval Date** November 1, 2017

Supersedes **TN NEW**  
**Effective Date** July 1, 2010
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.

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/

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.
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

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Base Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upstate freestanding clinics without quality improvement enhancement</td>
<td>$133.83</td>
</tr>
<tr>
<td>Downstate freestanding clinics without quality improvement enhancement</td>
<td>$145.47</td>
</tr>
<tr>
<td>Freestanding mental health clinics operated by a county’s designated local governmental unit without quality improvement enhancement</td>
<td>$186.21</td>
</tr>
<tr>
<td>Upstate freestanding clinics including quality improvement enhancement</td>
<td>$138.97</td>
</tr>
<tr>
<td>Downstate freestanding clinics including quality improvement enhancement</td>
<td>$151.05</td>
</tr>
<tr>
<td>Freestanding mental health clinics operated by a county’s designated local governmental unit including quality improvement enhancement</td>
<td>$193.35</td>
</tr>
<tr>
<td>State-operated mental health clinics</td>
<td>$247.42</td>
</tr>
</tbody>
</table>

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:


(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.


(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

TN #10-0018 Approval Date November 1, 2017
Supersedes TN #10-0006 Effective Date July 1, 2010
(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

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

$51,000,000 / (8.1610 x *1.05 * 50,000) = $119.03 (Base Rate)
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:

(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:


(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.
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 settings 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.

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.

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:


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:


### 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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TN ___#18-0007____ Approval Date __07/30/2018________

Supersedes TN __#10-0018__ Effective Date __01/01/2018________
VI. APG Base Rates for OPWDD certified or operated clinics.

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Base Rate</th>
<th>Effective Date of Base Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Group A</td>
<td>$180.95</td>
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</tr>
<tr>
<td>Peer Group B</td>
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<td>7/1/11</td>
</tr>
<tr>
<td>Peer Group C</td>
<td>$270.50</td>
<td>7/1/11</td>
</tr>
<tr>
<td>Peer Group A</td>
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<td>4/1/15</td>
</tr>
<tr>
<td>Peer Group B</td>
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</tr>
<tr>
<td>Peer Group C</td>
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<td>Peer Group A</td>
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<tr>
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</tr>
<tr>
<td>Peer Group C</td>
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</tbody>
</table>

TN 18-0048 Approval Date 08/10/2018
Supersedes TN 10-0018 Effective Date 04/01/2018
**Minimum Wage – OPWDD-licensed Article 16 Clinics**

**Effective January 1, 2018, 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 OPWDD licensed Article 16 clinics.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City (Large employers)</td>
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<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>New York City (Small employers)</td>
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<td>$15.00</td>
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<tr>
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<td>$11.80</td>
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</tr>
</tbody>
</table>

The APG capital rate that is adjusted for the minimum wage add-on will be posted to the Mental Hygiene Services Rates webpage.

[https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/apg/capital_add_on.htm](https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/apg/capital_add_on.htm)

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, 2018, 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.

      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 CFR 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.

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.
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.
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 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, 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 cost data by March 31, 2018. However, if the state makes the following corrective
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).
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.
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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**TN #11-28**
**Supersedes TN NEW**
**Approval Date** August 15, 2012
**Effective Date** April 1, 2011
New York  
2(w)(i)

**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:

<table>
<thead>
<tr>
<th>Total Excess Visits As % Of Total Paid Visits</th>
<th>Percent Rate Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1% or more</td>
<td>5.00%</td>
</tr>
<tr>
<td>10.1% to 15.0%</td>
<td>4.25%</td>
</tr>
<tr>
<td>5.1% to 10.0%</td>
<td>3.50%</td>
</tr>
<tr>
<td>1.0% to 5.0%</td>
<td>2.75%</td>
</tr>
<tr>
<td>Less than 1.0%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Rate Reduction Period (State Fiscal Year)</th>
<th>Utilization Look-back Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2012 to 3/31/2013</td>
<td>7/1/2011 to 12/31/2011</td>
</tr>
<tr>
<td>4/1/2013 to 3/31/2014</td>
<td>10/1/2011 to 9/30/2012</td>
</tr>
</tbody>
</table>
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.
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.
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.
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.
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.
Collaborative Care Services

Reimbursement for Freestanding Clinics and Hospital Outpatient Departments

Effective January 1, 2015, reimbursement will be provided to freestanding clinics and hospital outpatient departments licensed under Article 28 of the Public Health Law for Collaborative Care Services for patients diagnosed with depression in the form of a monthly case rate, specified below. Effective January 1, 2018, reimbursement will be provided to such providers for Collaborative Care Services for patients with other mental illness diagnoses at the same rates. Reimbursement shall be the same for both governmental and non-governmental providers.

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Description</th>
<th>Gross Rate</th>
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</thead>
<tbody>
<tr>
<td>5246</td>
<td>Collaborative Care Monthly Case Rate - Year 1</td>
<td>$150.00*</td>
</tr>
<tr>
<td>5247</td>
<td>Collaborative Care Monthly Case Rate - Year 2</td>
<td>$100.00*</td>
</tr>
<tr>
<td>5248</td>
<td>Collaborative Care Retainage Monthly - Year 1</td>
<td>$37.50</td>
</tr>
<tr>
<td>5249</td>
<td>Collaborative Care Retainage Monthly - Year 2</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

*Twenty-five percent of the full monthly case rate will be withheld by the State and reimbursed to the provider in the form of a monthly retainage payment based on criteria specified below. The monthly withholding during year one is $37.50, resulting in a net monthly case payment of $112.50. The monthly withholding during year two is $25.00, resulting in a net monthly case payment of $75.00.

Providers shall be eligible to receive the monthly Collaborative Care Retainage withheld by the State after the patient has been enrolled in the Collaborative Care program for a minimum of three months and if one of the following criteria is met:

1. Demonstrable clinical improvement as defined by a decrease in the patient’s baseline score on the PHQ-9, GAD-7, or other applicable evidenced-based assessment tool as further described in OMH guidelines available at https://www.omh.ny.gov/omhweb/medicaid_reimbursement.

2. In cases where there is no demonstrable clinical improvement as described in criterion 1, there must be documentation in the medical record of one of the following:
   a. Psychiatric review of the case by the designated consulting psychiatrist with either the care manager or primary care provider and a recommendation to change the treatment plan; or
   b. A change in treatment plan.

After completion of a patient’s third month of enrollment, providers who have met one of the criteria above may be reimbursed a lump sum for the first three months of Collaborative Care Retainage withheld and the monthly retainage withheld in each additional month of treatment, up to the completion of 12 months of treatment.

If a provider receives approval to provide Collaborative Care Services for an additional 12 months, the provider shall not be eligible to receive the Collaborative Care Retainage withheld until after the completion of three months and subject to the same eligibility requirements as in the first 12 months.
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.
Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures - FQHC’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:

<table>
<thead>
<tr>
<th>Federally Qualified Health Centers (FQHCs):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Hudson River Healthcare</td>
</tr>
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<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

TN #11-0026 Approval Date June 9, 2015
Supersedes TN NEW Effective Date April 1, 2012
Federally Qualified Health Centers (FQHCs):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRC Health Care, Inc. (d/b/a ACCESS Community Health Center)</td>
<td>$74,937</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$299,749</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$160,152</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Anthony L. Jordan Health Center</td>
<td>$40,268</td>
<td>01/01/2014 – 03/31/2014</td>
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<tr>
<td></td>
<td>$161,073</td>
<td>04/01/2014 – 03/31/2015</td>
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<tr>
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<td>$81,295</td>
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<tr>
<td>Asian &amp; Pacific Islander Coalition on HIV/AIDS, Inc. (d/b/a APICHA Community Health Center)</td>
<td>$67,633</td>
<td>01/01/2014 – 03/31/2014</td>
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<tr>
<td></td>
<td>$88,661</td>
<td>04/01/2014 – 03/31/2015</td>
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<td>$92,118</td>
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<tr>
<td>East Hill Family Medical Inc.</td>
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</tr>
<tr>
<td>Morris Heights Health Center, Inc.</td>
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<tr>
<td></td>
<td>$97,725</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$96,557</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Mount Vernon Neighborhood Health Center Network</td>
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<td>01/01/2014 – 03/31/2014</td>
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<tr>
<td></td>
<td>$41,170</td>
<td>04/01/2014 – 03/31/2015</td>
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<tr>
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<td>$43,000</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>The Floating Hospital</td>
<td>$29,476</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$29,476</td>
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</tr>
</tbody>
</table>

TN #13-0074  
Supersedes TN NEW  
Approval Date December 10, 2015  
Effective Date January 1, 2014
New York
2(al)(2)

Federally Qualified Health Centers (FQHCs):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Institute for Family Health</td>
<td>$409,456</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$359,858</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$78,346</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
</tbody>
</table>

December 10, 2015

TN #13-0074 Approval Date December 10, 2015
Supersedes TN NEW Effective Date January 1, 2014
### Federally Qualified Health Centers (FQHCs):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finger Lakes Migrant Health Care Project (d/b/a Finger Lakes Community Health)</td>
<td>$18,835</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$75,342</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$75,342</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td>Rochester Primary Care Network Inc./Rushville Health Center, Inc. – Finger Lake Region</td>
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<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$93,926</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$93,926</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
</tbody>
</table>
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.

TN #16-0046 Approval Date December 14, 2016
Supersedes TN #NEW Effective Date July 28, 2016
Federally Qualified Health Centers (FQHCs) Safety Net Payment

d. Each eligible FOHC will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

<table>
<thead>
<tr>
<th>% of eligible uninsured visits to total visits</th>
<th>Upstate</th>
<th></th>
<th></th>
<th></th>
<th>Downstate</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (At Least)</td>
<td>High (Less Than)</td>
<td>Amt</td>
<td>Tier</td>
<td>Low (At Least)</td>
<td>High (Less Than)</td>
<td>Amt</td>
<td>Tier</td>
<td></td>
</tr>
<tr>
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<td>5%</td>
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<td>0</td>
<td>0%</td>
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<tr>
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<td>$15</td>
<td>1</td>
<td>5%</td>
<td>15%</td>
<td>$32</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>15%</td>
<td>$25</td>
<td>2</td>
<td>15%</td>
<td>20%</td>
<td>$42</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>15%</td>
<td>20%</td>
<td>$36</td>
<td>3</td>
<td>20%</td>
<td>25%</td>
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<td>$48</td>
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<td>25%</td>
<td>35%</td>
<td>$65</td>
<td>4</td>
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</tr>
<tr>
<td>25% or more</td>
<td></td>
<td>$61</td>
<td>5</td>
<td>35% or more</td>
<td></td>
<td>$78</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

e. Safety net payments will be calculated by multiplying each facility's rate add-on, based on the tiers in paragraph (1)(d), by the number of Medicaid fee-for-service and Medicaid managed care visits reported in the base year certified cost report.

f. The safety net rate adjustment for each eligible FQHC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible FQHCs.

g. The payments for this alternative payment method, which are made pursuant to this section, will be made quarterly as aggregate payments to eligible FQHCs and will not be subject to subsequent adjustment or reconciliation.

2. In the event that a provider that is included in the Diagnostic and Treatment Centers (D&TCs) Safety Net Payment State Only program receives FQHC designation during a state fiscal year, the newly designated FQHC will be removed from the D&TCs Safety Net Payment State Only program and included in this section as follows:

a. The effective date of the transfer will be the later of the following:

i. The first state fiscal year distribution calculation after the FQHC designated approval date; or

ii. The first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation.

b. The funds that were allocated to the new FQHC provider in the D&TCs Safety Net Payment State Only program will be transferred to this FQHCs Safety Net Payment section based on the prior state fiscal year calculation distribution.
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.
Federally Qualified Health Centers (FQHCs) Safety Net Payment

e. The provider will be removed from the distribution calculated in the FQHC 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 FQHC designation.

f. The funds allocated to the provider in this FQHC 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.
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.
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.

The capital component shall include property, equipment, and start-up costs. The capital component will not be subject to trend factor.

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.

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).

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).

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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**TN #91-29** Approval Date December 8, 1992
Supersedes TN #89-33 Effective Date April 1, 1991
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.
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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 (I) 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 (I) - 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,
New York 3d

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)(g)(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.
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.
(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 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.
(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 adjusted 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.

Supersedes TN #97-09  
Effective Date January 1, 1999

Approval Date February 10, 2000
(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 feed 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.
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:
(a) 75% reimbursement of the increased costs incurred during the transition\[al\] 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\[al\] 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.
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.

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.

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.

For those providers with a reported deficit, this deficit shall be considered the final deficit amount for the purpose of this calculation.

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:

- less than $1 million, the exempt amount shall be $10,000.
- between $1 million and less than $3 million, the exempt amount shall be $22,500.
- between $3 million and $7 million, the exempt amount shall be $35,000.
- over $7 million, the exempt amount shall be $40,000.
(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.
### New York
#### 3h6

#### REGION ONE

Program Cost in Millions of Dollars (< less than: > greater than)

<table>
<thead>
<tr>
<th>Cost Range</th>
<th>Administration Percentage</th>
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<tr>
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<td>.2600 .3099</td>
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#### REGION TWO

Program Cost in Millions of Dollars (< less than: > greater than)

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<td>.2900 .3099</td>
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<td>$3 to $7</td>
<td>.2150 .2899</td>
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#### REGION THREE

Program Cost in Millions of Dollars (< less than: > greater than)

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**TN #96-39**

Supersedes TN **NEW**

**Attachment 4.19-B**

**Approval Date** December 19, 1996

**Effective Date** July 1, 1996
(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.

<table>
<thead>
<tr>
<th>OA2</th>
<th>S2</th>
<th>17.00 %</th>
<th>S1</th>
<th>16.00 %</th>
<th>BE</th>
<th>15.00 %</th>
<th>D1</th>
<th>14.00 %</th>
<th>D2</th>
<th>13.00 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>OA1</td>
<td>S1</td>
<td>16.25 %</td>
<td>S2</td>
<td>15.25 %</td>
<td>BE</td>
<td>14.25 %</td>
<td>D1</td>
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<tr>
<td>AV</td>
<td>S2</td>
<td>15.50 %</td>
<td>S1</td>
<td>14.50 %</td>
<td>BE</td>
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<td>D1</td>
<td>12.50 %</td>
<td>D2</td>
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</tr>
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<td>13.75 %</td>
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<td>13.00 %</td>
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<td>12.00 %</td>
<td></td>
<td>11.00 %</td>
<td></td>
<td>10.00 %</td>
</tr>
</tbody>
</table>

(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.
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.

<table>
<thead>
<tr>
<th>PERCENTILE RANK</th>
<th>NET WEIGHTED TRANSPORTATION AVERAGE</th>
<th>PERCENTAGE OFFSET</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 or &lt;</td>
<td>$0 - $7.26</td>
<td>5</td>
</tr>
<tr>
<td>6 to 9</td>
<td>$7.27 - $8.13</td>
<td>7.5</td>
</tr>
<tr>
<td>10 to 29</td>
<td>$8.14 - $10.20</td>
<td>10</td>
</tr>
<tr>
<td>30 to 49</td>
<td>$10.21 - $13.32</td>
<td>12.5</td>
</tr>
<tr>
<td>50 to 59</td>
<td>$13.33 - $13.80</td>
<td>15</td>
</tr>
<tr>
<td>60 to 69</td>
<td>$13.81 – $14.01</td>
<td>16.5</td>
</tr>
<tr>
<td>70 to 79</td>
<td>$14.02 – $14.97</td>
<td>20</td>
</tr>
<tr>
<td>80 to 84</td>
<td>$14.98 - $15.77</td>
<td>22.5</td>
</tr>
<tr>
<td>85 or &gt;</td>
<td>Over $15.77</td>
<td>25</td>
</tr>
</tbody>
</table>
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.

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.
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:

<table>
<thead>
<tr>
<th>REGION</th>
<th>AVERAGE</th>
<th>75 PERCENT OF AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21.37</td>
<td>$16.03</td>
</tr>
<tr>
<td>2</td>
<td>$21.17</td>
<td>$15.88</td>
</tr>
<tr>
<td>3</td>
<td>$15.97</td>
<td>$11.98</td>
</tr>
</tbody>
</table>

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.
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.

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.

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.

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.
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.

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.

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.

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.

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.

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.
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:

<table>
<thead>
<tr>
<th>Corp Name</th>
<th>Site</th>
<th>Rate Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Residence &amp; Essential Enterprises</td>
<td>28 Research Way</td>
<td>4170 Full Day: $128.16</td>
</tr>
<tr>
<td>Family Residence &amp; Essential Enterprises</td>
<td>120 Plant Avenue</td>
<td>4170 Full Day: $203.94</td>
</tr>
<tr>
<td>Monroe County ARC</td>
<td>1651 Lyell Avenue</td>
<td>4170 Full Day: $0.00</td>
</tr>
<tr>
<td>Otsego County ARC</td>
<td>3 Chenango Road</td>
<td>4170 Full Day: $98.49</td>
</tr>
<tr>
<td>Rehabilitation Center of Cattaraugus</td>
<td>3799 South Nine Mile Road</td>
<td>4170 Full Day: $106.52</td>
</tr>
<tr>
<td>UCP Nassau</td>
<td>380 Washington Avenue</td>
<td>4170 Full Day: $169.06</td>
</tr>
<tr>
<td>UCP Putnam &amp; Southern Dutchess Counties</td>
<td>40 Jon Barret Road</td>
<td>4170 Full Day: $141.54</td>
</tr>
<tr>
<td>UCP Niagara</td>
<td>2103 Mckenna Avenue</td>
<td>4170 Full Day: $0.00</td>
</tr>
<tr>
<td>UCP Suffolk</td>
<td>250 Marcus Boulevard</td>
<td>4170 Full Day: $151.05</td>
</tr>
<tr>
<td>UCP Westchester</td>
<td>1186 King Street</td>
<td>4170 Full Day: $191.36</td>
</tr>
</tbody>
</table>

TN #10-0018 ___________________________ Approval Date ___________________________
Supersedes TN NEW ______________________ Effective Date ___________________________
Effective April 1, 2013, the methodology described in the Rate Setting and Financial Reporting for Medicaid Service Coordination (MSC) services provided by OPWDD and voluntary agency providers.

Definitions (applicable to this section)

**Regular-Basic** - MSC service provided for an individual residing in a certified OPWDD setting, i.e. Supervised or Supportive IRA or a Supervised or Supportive Community Residence.

**Transition-Basic** - MSC service provided for an individual that is new to the MSC service or transitioning from a certified OPWDD setting into the community. Transition payments are available when the individual with developmental disabilities is new to service coordination, that is, the person has never received any type of service coordination/case management service through OPWDD’s system, i.e., MSC, CMCM, PCSS, HCBS Waiver, state paid service coordination, Care at Home, etc. Transition payments are also available when the person moves from an OPWDD certified supervised or supportive IRA or supervised or supportive Community Residence to his or her own home or apartment and is responsible for his or her own expenses. It is a onetime payment made in the first month of services, or when a qualifying move occurs.

**Regular-Willowbrook** - MSC service provided for an individual who is designated as a member of the Willowbrook Class as defined by The Willowbrook Permanent Injunction and who resides in a certified OPWDD setting, i.e. Supervised or Supportive IRA or a Supervised or Supportive Community Residence.

**Transition-Willowbrook** - MSC service provided for an individual who is designated as a member of the Willowbrook Class as defined by The Willowbrook Permanent Injunction and who is transitioning from a certified OPWDD setting into the community. Transition payments are available when the individual with developmental disabilities is new to service coordination, that is, the person has never received any type of service coordination/case management service through OPWDD’s system, i.e., MSC, CMCM, PCSS, HCBS Waiver, state paid service coordination, Care at Home, etc. Transition payments are also available when the person moves from an OPWDD certified supervised or supportive IRA or supervised or supportive Community Residence to his or her own home or apartment and is responsible for his or her own expenses. It is a onetime payment made in the first month of services, or when a qualifying move occurs.

1. For voluntary agency providers, the method of reimbursement will be a monthly 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 to contracted voluntary providers is as follows:

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Definition</th>
<th>Locator Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5211</td>
<td>Regular-Basic</td>
<td>03</td>
<td>$252.98</td>
</tr>
<tr>
<td>5211</td>
<td>Transition-Basic</td>
<td>04</td>
<td>$758.94</td>
</tr>
<tr>
<td>5214</td>
<td>Regular-Willowbrook</td>
<td>03</td>
<td>$474.34</td>
</tr>
<tr>
<td>5214</td>
<td>Transition-Willowbrook</td>
<td>04</td>
<td>$1,423.02</td>
</tr>
</tbody>
</table>

**TN #12-0030 Approval Date 4/16/18**

Supersedes TN NEW Effective Date 4/01/13
The reporting requirements for voluntary providers are the same as those described in paragraph (n) of Attachment 4.19-D - Part II.

i. Effective April 1, 2015, the MSC fees will reflect 2% COLA increases as follows:

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Definition</th>
<th>Locator Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5211</td>
<td>Regular-Basic</td>
<td>03</td>
<td>$256.52</td>
</tr>
<tr>
<td>5211</td>
<td>Transition Basic</td>
<td>04</td>
<td>$769.55</td>
</tr>
<tr>
<td>5214</td>
<td>Regular-Willowbrook</td>
<td>03</td>
<td>$480.97</td>
</tr>
<tr>
<td>5214</td>
<td>Transition-Willowbrook</td>
<td>04</td>
<td>$1,442.92</td>
</tr>
</tbody>
</table>

Effective April 1, 2013 through December 31, 2014, for state-provided services, the method of reimbursement will be a monthly 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 to State Operated providers as follows:

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Definition</th>
<th>Locator Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5210</td>
<td>Medicaid Service Coordination State - Regular</td>
<td>03</td>
<td>$438.23</td>
</tr>
<tr>
<td>5210</td>
<td>Medicaid Service Coordination - Transition</td>
<td>04</td>
<td>$1,314.69</td>
</tr>
</tbody>
</table>

2. To reconcile Medicaid Service Coordination the following method will be followed:
   1. Medicaid Service Coordination –
      (a) Total Operating Costs from CFR1 Line 64;
      (b) Less/ Plus Adjustments from CFR1 Line 66;
      (c) The result of (a) and (b) results in the Total Operating Adjusted;
      (d) The sum of (c) and CFR1 Property and Equipment, Lines 48 and 63, is divided by the Units of Service as reported on CFR1 Line 13.
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.
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 Approval Date November 1, 2017
Supersedes TN #98-0028 Effective Date July 1, 2010
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)

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Downstate Region</th>
<th>Western Region</th>
<th>Upstate Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>4310</td>
<td>Half Day 1-40 Cumulative Hours</td>
<td>$31.04</td>
<td>$27.96</td>
<td>$27.47</td>
</tr>
<tr>
<td>4311</td>
<td>Half Day 41-64 Cumulative Hours</td>
<td>$23.28</td>
<td>$23.30</td>
<td>$23.32</td>
</tr>
<tr>
<td>4312</td>
<td>Half Day 65+ Cumulative Hours</td>
<td>$17.16</td>
<td>$17.17</td>
<td>$17.19</td>
</tr>
<tr>
<td>4316</td>
<td>Full Day 1-40 Cumulative Hours</td>
<td>$62.07</td>
<td>$55.92</td>
<td>$54.92</td>
</tr>
<tr>
<td>4317</td>
<td>Full Day 41-64 Cumulative Hours</td>
<td>$46.56</td>
<td>$46.60</td>
<td>$46.63</td>
</tr>
<tr>
<td>4318</td>
<td>Full Day 65+ Cumulative Hours</td>
<td>$34.30</td>
<td>$34.34</td>
<td>$34.36</td>
</tr>
<tr>
<td>4325</td>
<td>Collateral Visit</td>
<td>$31.04</td>
<td>$27.96</td>
<td>$27.47</td>
</tr>
<tr>
<td>4331</td>
<td>Group Collateral Visit</td>
<td>$31.04</td>
<td>$27.96</td>
<td>$27.47</td>
</tr>
<tr>
<td>4337</td>
<td>Crisis Visit</td>
<td>$31.04</td>
<td>$27.96</td>
<td>$27.47</td>
</tr>
<tr>
<td>4346</td>
<td>Preadmission Visit</td>
<td>$31.04</td>
<td>$27.96</td>
<td>$27.47</td>
</tr>
</tbody>
</table>

TN 10-0018 Approval Date November 1, 2017
Supersedes TN #NEW Effective Date July 1, 2010
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)

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Statewide Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4310</td>
<td>Half Day 1-40 Cumulative Hours</td>
<td>$137.00</td>
</tr>
<tr>
<td>4311</td>
<td>Half Day 41-64 Cumulative Hours</td>
<td>$102.75</td>
</tr>
<tr>
<td>4312</td>
<td>Half Day 65+ Cumulative Hours</td>
<td>$75.35</td>
</tr>
<tr>
<td>4316</td>
<td>Full Day 1-40 Cumulative Hours</td>
<td>$274.00</td>
</tr>
<tr>
<td>4317</td>
<td>Full Day 41-64 Cumulative Hours</td>
<td>$205.50</td>
</tr>
<tr>
<td>4318</td>
<td>Full Day 65+ Cumulative Hours</td>
<td>$150.70</td>
</tr>
<tr>
<td>4325</td>
<td>Collateral Visit</td>
<td>$137.00</td>
</tr>
<tr>
<td>4331</td>
<td>Group Collateral Visit</td>
<td>$137.00</td>
</tr>
<tr>
<td>4337</td>
<td>Crisis Visit</td>
<td>$137.00</td>
</tr>
<tr>
<td>4346</td>
<td>Preadmission Visit</td>
<td>$137.00</td>
</tr>
</tbody>
</table>

TN ___ #10-0018 _______ Approval Date _November 1, 2017_ ________
Supersedes TN ___ NEW _______ Effective Date _July 1, 2010_ __________
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)**

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Statewide Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4310</td>
<td>Half Day 1-40 Cumulative Hours</td>
<td>$41.65</td>
</tr>
<tr>
<td>4311</td>
<td>Half Day 41+ Cumulative Hours</td>
<td>$31.23</td>
</tr>
<tr>
<td>4316</td>
<td>Full Day 1-40 Cumulative Hours</td>
<td>$62.16</td>
</tr>
<tr>
<td>4317</td>
<td>Full Day 41+ Cumulative Hours</td>
<td>$46.62</td>
</tr>
<tr>
<td>4325</td>
<td>Collateral Visit</td>
<td>$41.65</td>
</tr>
<tr>
<td>4331</td>
<td>Group Collateral Visit</td>
<td>$41.65</td>
</tr>
<tr>
<td>4337</td>
<td>Crisis Visit</td>
<td>$41.65</td>
</tr>
<tr>
<td>4346</td>
<td>Preadmission Visit</td>
<td>$41.65</td>
</tr>
</tbody>
</table>

TN  #10-0018  Approval Date November 1, 2017
Supersedes TN  NEW  Effective Date July 1, 2010
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.
New York 3J-A

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Method of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Treatment for Adults, Clinic Treatment for Children, Clinic and Continuing Day Treatment Programs</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.
- **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
### Regional Partial Hospitalization Rates for Freestanding Clinic and Outpatient Hospital

#### Partial Hospitalization Services effective June 1, 2017

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Long Island Region</th>
<th>NYC Region</th>
<th>Hudson River Region</th>
<th>Central Region</th>
<th>Western Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>4349</td>
<td>Service Duration 4 hours</td>
<td>$116.39</td>
<td>$152.90</td>
<td>$128.40</td>
<td>$88.49</td>
<td>$109.12</td>
</tr>
<tr>
<td>4350</td>
<td>Service Duration 5 hours</td>
<td>$145.49</td>
<td>$191.12</td>
<td>$160.50</td>
<td>$110.62</td>
<td>$136.40</td>
</tr>
<tr>
<td>4351</td>
<td>Service Duration 6 hours</td>
<td>$174.58</td>
<td>$229.35</td>
<td>$192.60</td>
<td>$132.74</td>
<td>$163.68</td>
</tr>
<tr>
<td>4352</td>
<td>Service Duration 7 hours</td>
<td>$203.68</td>
<td>$267.57</td>
<td>$224.70</td>
<td>$154.87</td>
<td>$190.96</td>
</tr>
<tr>
<td>4353</td>
<td>Collateral 1 hour</td>
<td>$29.10</td>
<td>$38.22</td>
<td>$32.10</td>
<td>$22.12</td>
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<tr>
<td>4354</td>
<td>Collateral 2 hours</td>
<td>$58.19</td>
<td>$76.45</td>
<td>$64.20</td>
<td>$44.25</td>
<td>$54.56</td>
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<tr>
<td>4355</td>
<td>Group Collateral 1 hour</td>
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<td>$38.22</td>
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<td>$64.20</td>
<td>$44.25</td>
<td>$54.56</td>
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#### Crisis effective June 1, 2017

<table>
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<th>Description</th>
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<td>4363</td>
<td>Crisis 7 hours</td>
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<td>$224.70</td>
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#### Preadmission effective June 1, 2017

<table>
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<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Long Island Region</th>
<th>NYC Region</th>
<th>Hudson River Region</th>
<th>Central Region</th>
<th>Western Region</th>
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</thead>
<tbody>
<tr>
<td>4357</td>
<td>Preadmission 1 hour</td>
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<td>$38.22</td>
<td>$32.10</td>
<td>$22.12</td>
<td>$27.28</td>
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<tr>
<td>4358</td>
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<td>4359</td>
<td>Preadmission 3 hours</td>
<td>$87.29</td>
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<td>4351</td>
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<td>$174.58</td>
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<td>4352</td>
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<td>$203.68</td>
<td>$267.57</td>
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<td>$154.87</td>
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**TN #10-0018** Approval Date **November 1, 2017**
Supersedes TN **NEW** Effective Date **July 1, 2010**
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)

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>New York City</th>
<th>Rest of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>4060</td>
<td>Full Day</td>
<td>$98.36</td>
<td>$95.08</td>
</tr>
<tr>
<td>4061</td>
<td>Half Day</td>
<td>$49.19</td>
<td>$47.54</td>
</tr>
<tr>
<td>4062</td>
<td>Brief Day</td>
<td>$32.79</td>
<td>$31.64</td>
</tr>
<tr>
<td>4064</td>
<td>Crisis Visit</td>
<td>$98.36</td>
<td>$95.08</td>
</tr>
<tr>
<td>4065</td>
<td>Preadmission Full Day</td>
<td>$98.36</td>
<td>$95.08</td>
</tr>
<tr>
<td>4066</td>
<td>Collateral Visit</td>
<td>$32.79</td>
<td>$31.64</td>
</tr>
<tr>
<td>4067</td>
<td>Preadmission Half Day</td>
<td>$49.19</td>
<td>$47.54</td>
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</table>

TN #10-0018 Approval Date November 1, 2017
Supersedes TN NEW Effective Date July 1, 2010
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**

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
<th>Statewide Rate</th>
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<tbody>
<tr>
<td>4060</td>
<td>Full Day</td>
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<tr>
<td>4061</td>
<td>Half Day</td>
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<td>4062</td>
<td>Brief Day</td>
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<tr>
<td>4064</td>
<td>Crisis Service</td>
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</tr>
<tr>
<td>4065</td>
<td>Preadmission Full Day</td>
<td>$375.00</td>
</tr>
<tr>
<td>4066</td>
<td>Collateral</td>
<td>$124.55</td>
</tr>
<tr>
<td>4067</td>
<td>Preadmission Half Day</td>
<td>$187.50</td>
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</table>

**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
Regional Day Treatment for Children Rates for Outpatient Hospital Services
(Non-State Operated)

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Description</th>
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<th>Rest of State</th>
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<tbody>
<tr>
<td>4060</td>
<td>Full Day</td>
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<tr>
<td>4064</td>
<td>Crisis Visit</td>
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<td>$95.08</td>
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<td>4065</td>
<td>Pre-Admission Full Day</td>
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<td>$95.08</td>
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<tr>
<td>4066</td>
<td>Collateral Visit</td>
<td>$32.79</td>
<td>$31.64</td>
</tr>
<tr>
<td>4067</td>
<td>Pre-Admission Half Day</td>
<td>$49.19</td>
<td>$47.54</td>
</tr>
</tbody>
</table>

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.
New York
3L

TYPE OF SERVICE

Intensive Psychiatric Rehabilitation Treatment

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.

Rehabilitative Services for Residents of Community-based Residential Programs Licensed by the Office of Mental Health

Program Type 1:

1) Community Residences

Program Categories
a) congregate-type
b) apartment-based

Program Type 2:

1) Family Based Treatment

Program Type 3

1) Teaching Family Homes

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.

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 Approval Date September 23, 1996
Supersedes TN #94-27 Effective Date May 1, 1996
New York
3L-1

**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.

TN #03-45 Approval Date June 3, 2004
Supersedes TN NEW Effective Date May 1, 2004
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.
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

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.

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<tr>
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<td>#07-06</td>
<td>Effective Date</td>
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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 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 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.

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 be applied. Effective on and after April 1, 2009 the otherwise applicable final trend factor attributable to the 2009 calendar year period shall 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 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 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 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 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 be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.
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, 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.
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.
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.

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.

Agency specific case mix indexes (CMI) will be calculated for each agency and applied to the statewide average CMI. Computation of such CMI 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.

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 agency.
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
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.
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.
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


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.
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:

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Nurse Association of Long Island, Inc.</td>
<td>$168,006</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$672,020</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$672,020</td>
<td>04/01/2015 – 06/30/2015</td>
</tr>
<tr>
<td>Jefferson County Public Health Service</td>
<td>$63,306</td>
<td>01/01/2014 – 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$253,222</td>
<td>04/01/2014 – 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$253,222</td>
<td>04/01/2015 – 03/31/2016</td>
</tr>
<tr>
<td></td>
<td>$189,916</td>
<td>04/01/2016 – 12/31/2016</td>
</tr>
</tbody>
</table>

TN #13-0071A Approval Date August 26, 2015
Supersedes TN #13-0071 Effective Date January 1, 2014
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:**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Country Homes</td>
<td>$1,045,000</td>
<td>02/01/2016 - 3/31/2016</td>
</tr>
<tr>
<td></td>
<td>$1,621,300</td>
<td>04/01/2016 - 3/31/2017</td>
</tr>
<tr>
<td></td>
<td>$ 46,200</td>
<td>04/01/2017 - 3/31/2018</td>
</tr>
<tr>
<td></td>
<td>$ 450,000</td>
<td>07/01/2017 - 03/31/2018</td>
</tr>
<tr>
<td></td>
<td>$1,500,000</td>
<td>05/10/2018 - 03/31/2019</td>
</tr>
</tbody>
</table>

TN #18-0047 Approval Date August 10, 2018
Supersedes TN #17-0051 Effective Date May 10, 2018
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
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.

TN #17-0042 Approval Date September 26, 2017
Supersedes TN #14-0025 Effective Date April 1, 2017
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 check.
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 check.
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 ___ #06-70
Supersedes TN ___ #06-53

Approval Date June 18, 2007
Effective Date September 1, 2006
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.
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:

TN #07-45
Supersedes TN NEW
Approval Date December 14, 2010
Effective Date October 1, 2007
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

December 14, 2010

TN #07-45 Approval Date December 14, 2010
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 ____18-0043______ Approval Date 07/18/2018

Supersedes TN #16-0015 Effective Date 04/01/2018
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.
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 offset 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.
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 period 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 period will mean January 1, 2018 through November 30, 2018, and the 2019 target period will mean January 1, 2019 through November 30, 2019 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).
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, [and] prior to February 1, 2017, prior to February 1, 2018, and prior to February 1, 2019, 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.

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.

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 #17-0034 Approval Date September 25, 2017
Supersedes TN #15-0028 Effective Date April 1, 2017
New York
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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, [and] 2017, 2018, and 2019, 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.

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, [and] 2017, 2018, and 2019, 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.

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.
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 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 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].

Attachment 4.19-B

TN      #07-32     ______
Supersedes TN      #05-49
Approval Date       April 8, 2008
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.
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.
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 fingerprint 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 #06-70 Approval Date June 18, 2007
Supersedes TN #06-53 Effective Date September 1, 2006
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 payment 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.
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;
(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 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.
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]
[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.]
[Type of Service] Assisted Living Programs

[Method of Reimbursement] 

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 are payment-in-full for the [Title XIX] personal care 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

Payment rates are established for 1992 for each of sixteen patient classification groups in each of sixteen regions, and the 1992 payment rates 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/

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

TN#: #12-0022 Approval Date: 3/27/18

Supersedes TN#: #97-0010 Effective Date: 4/26/12
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:

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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

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:


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**TN#: #17-0008**  
**Approval Date:** May 17, 2018

**Supersedes TN#: NEW**  
**Effective Date:** January 01, 2017
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 $10.08.

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.
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.
7. Practitioner-administered drugs billed under the medical benefit are reimbursed as follows:
   a. When administered during an office visit, payment is made at actual acquisition cost by invoice, not to exceed Medicare Part B price. No professional dispensing fee is paid.

   b. When administered by a practitioner in an ordered ambulatory setting, payment is at actual acquisition cost, not to exceed Medicare Part B price. Drugs purchased by covered entities at the prices authorized under Section 340B of the Public Health Services Act must be billed at their actual acquisition cost. No professional dispensing fee is paid.

   c. When administered in an outpatient setting to a patient of a disproportionate share hospital, clinic, or emergency department, payment may be made through either the Ambulatory Patient Group (APG) classification and reimbursement system, as referenced in page 1(b)(ii) of this Attachment, or, if carved out of the APG system, in accordance with Section 7.b.

Reimbursement for drugs in the APG reimbursement are paid as follows:
   1. Practitioner-administered drugs assigned to an APG and paid through the APG drug band are reimbursed based on the weighted average, using Medicaid paid claims data. Payment for drugs purchased by covered entities at the prices authorized under Section 340B of the Public Health Services Act and paid through the APG drug band are paid at 75% of the drug's APG band payment amount.
   2. Practitioner-administered drugs assigned to an APG and paid through the APG Fee Schedule are paid in accordance with Section 7.b.

   No professional dispensing fee is paid.

   d. Federally Qualified Health Centers (FQHC) and Indian Health Services/Tribal/Urban Indian Clinic Facilities have the option of receiving their payment through the Federal Prospective (PPS) rate, or through the APG reimbursement methodology as an “alternative rate setting methodology”. In the event the facility chooses to be reimbursed through the Federal PPS Rate, the rate is considered inclusive of any practitioner administered drugs. In the event the facility has opted for the APG reimbursement methodology, payment for drugs administered by a practitioner during a visit to the facility will be in accordance with Section 7.c. If a facility's Medicaid reimbursement under APGs is lower than what their payment would have been under the Federal PPS rate, the facility is entitled to receive a supplemental payment reflecting the difference between what they were paid under APGs and what they would have been paid using the PPS rate. No professional dispensing fee is paid.

8. Reimbursement for Investigational Drugs is not a covered service. The Department may consider Medicaid coverage on a case by case basis for life-threatening medical illnesses when no other treatment options are available. If/when approved by a Medical Director, reimbursement is at actual acquisition cost. When dispensed by a pharmacy enrolled in the NYS Medicaid FFS Program, reimbursement includes the professional dispensing fee in Section 2.
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.
An e-prescription financial incentive will be paid to retail pharmacies for the purpose of encouraging the electronic transmission of prescriptions and 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.
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. 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.
Pharmacists as Immunizers

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. 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

The agency's fee schedule is effective for services provided on or after October 15, 2009.

Diabetes Self-Management Training

The 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

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.
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.
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, 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
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.
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.
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
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Method of Reimbursement</th>
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<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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<tr>
<td>Medical/Surgical Supplies</td>
<td>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.</td>
</tr>
<tr>
<td>General Formula</td>
<td>Purchase: reimbursement is the lower of the cost to the provider plus 50% or the usual and customary price charged to the general public.</td>
</tr>
<tr>
<td>Transportation</td>
<td>[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:</td>
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<td></td>
<td>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.]</td>
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<td>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.</td>
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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.
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.]
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 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 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.

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 be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period shall 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 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 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 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 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 be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.
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.
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:

For non New York City Personal Care:
https://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/

<table>
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<th>Minimum Wage Chart</th>
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<tr>
<td>New York City (Large employers)</td>
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<tr>
<td>New York City (Small employers)</td>
</tr>
<tr>
<td>Nassau, Suffolk, &amp; Westchester counties</td>
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<tr>
<td>Remainder of the State</td>
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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.
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.
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.
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.
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, 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

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.
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.
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 or counties within the state which have populations in excess of one million 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 relationship of the provider’s Medicaid annual hours of service to the total Medicaid annual hours of service by all of the providers, 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.
New York
6(a)(iii)

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.

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, 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.

Criminal Background Checks for Personal Care Service Agencies

Effective April 1, 2005, personal care service 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 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 $5,600,000 for the April 1, 2006 through 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 amount 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.
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:
(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 aggregate amount of $16,000,000 annually for the periods June 1, 2006 through March 31, 2007, 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.
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)

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>State Program</th>
<th>Current Rate</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>2602, 2622,</td>
<td>Personal Care</td>
<td>$20.21/hr*</td>
<td>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</td>
</tr>
<tr>
<td>2595, 2596,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2681, 2631,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2671, 2815,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2816, 3855,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3856, 3145,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9795, 9863</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2622, 2423,</td>
<td>Fiscal Intermediaries</td>
<td>$17.41/hr*</td>
<td>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</td>
</tr>
<tr>
<td>4764, 4769,</td>
<td></td>
<td></td>
<td>Or statewide fees based on the level of service provided as set forth in Appendix C of the OPWDD Comprehensive HCBS Waiver (NY 0238).</td>
</tr>
<tr>
<td>4770, 4771,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4772, 4777</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2611, 2695,</td>
<td>Home Health Care (aide only)</td>
<td>$23.18/hr*</td>
<td>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</td>
</tr>
<tr>
<td>3850, 3865</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9997, 9994,</td>
<td>Transportation</td>
<td>Varies</td>
<td>Fee schedule available at: <a href="https://www.emedny.org/ProviderManuals/Transportation/index.aspx">https://www.emedny.org/ProviderManuals/Transportation/index.aspx</a></td>
</tr>
<tr>
<td>9991</td>
<td></td>
<td>depending on mode, region</td>
<td></td>
</tr>
</tbody>
</table>

*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.*
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.

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Service</th>
<th>Current Rate</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>4722, 4723, 4724, 4725, 4741, 4742, 4743, 4744, 4755, 4756, 4757, 4758, 4765, 4766, 4767, 4768, 4796, 4797, 4798, 4799</td>
<td>Community Habilitation</td>
<td>N/A</td>
<td>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)</td>
</tr>
</tbody>
</table>

3. Back-up systems or mechanisms to ensure continuity of services and supports.

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Service</th>
<th>Current Rate</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>2609, 2616, 2809, 2818, 3823, 3831, 3858, 9981</td>
<td>Personal Emergency Response (PERS)</td>
<td>$23.11/month*</td>
<td>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_lhhc_rates.htm">http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lhhc_rates.htm</a></td>
</tr>
</tbody>
</table>

*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.
### New York
#### 6(a)(viii)

### Permissible services/Substitute for human assistance

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Service</th>
<th>Current Rate</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>3143, 4482, 4483, 4484, 4485, 9752</td>
<td>Assistive Technology</td>
<td>100% of claim determined reasonable by the state.</td>
<td>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. <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></td>
</tr>
<tr>
<td>9750</td>
<td>Vehicle Adaptation</td>
<td>100% of billed cost determined reasonable by the state</td>
<td>NHTD current methodology, limit $15,000; separate from e-Mods limit <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></td>
</tr>
<tr>
<td>3144, 4786, 9758, 9867</td>
<td>Community Transitional Services (establishing a household in the community from an institutional setting)</td>
<td>100% of claim/approved cost</td>
<td>One-time payment not to exceed $5,000. Specific amount will be based on State review and approval of cost projections.</td>
</tr>
<tr>
<td>N/A</td>
<td>Durable Medical Equipment</td>
<td></td>
<td>Fee schedule available at: <a href="https://www.emedny.org/ProviderManuals/DME/index.aspx">https://www.emedny.org/ProviderManuals/DME/index.aspx</a></td>
</tr>
<tr>
<td>4476, 4477, 4478, 4479, 9992, 9995, 9998, 9762, 9874</td>
<td>Environmental Modifications</td>
<td>100% of claim determined reasonable by the State</td>
<td>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: <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></td>
</tr>
</tbody>
</table>

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TN #13-0035 Approval Date October 23, 2015
Supersedes TN NEW Effective Date July 1, 2015
4. Permissible services / Substitute for human assistance (continued):

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Service</th>
<th>Current Rate</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>2682, 2685, 2835, 3874, 9781</td>
<td>Home Delivered Meals</td>
<td>$5.79/Meal*</td>
<td>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></td>
</tr>
<tr>
<td>2638, 2830, 3872</td>
<td>Congregate Meals</td>
<td>$5.07/Meal*</td>
<td>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></td>
</tr>
<tr>
<td>2636, 2831, 3870, 9787</td>
<td>Moving Assistance (transport of personal belongings)</td>
<td>$58.79/hr*</td>
<td>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></td>
</tr>
</tbody>
</table>

*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.
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**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>$10.50</td>
<td>$12.00</td>
<td>$13.50</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Nassau, Suffolk, &amp; Westchester counties</td>
<td>$10.00</td>
<td>$11.00</td>
<td>$12.00</td>
<td>$13.00</td>
<td>$14.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Remainder of the State</td>
<td>$9.70</td>
<td>$10.40</td>
<td>$11.10</td>
<td>$11.80</td>
<td>$12.50</td>
<td>$12.50</td>
</tr>
</tbody>
</table>

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**
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.
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/
New York
7

RESERVED

TN      #00-05
Supersedes TN      #99-01
Approval Date    January 8, 2001
Effective Date   January 1, 2000
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.
(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 Attachment.
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 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.

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 be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period shall 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 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 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 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 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 be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.
(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.
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
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.
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.
(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 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 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.
### Type of Service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Method of Reimbursement</th>
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| Outpatient Hospital Mental Health Services | [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:]

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**TN #10-0018** Approval Date **November 1, 2017**

Supersedes **TN #87-0031** Effective Date **July 1, 2010**
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.

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.

TN #10-0018 Approval Date November 1, 2017
Supersedes TN #87-0031 Effective Date July 1, 2010
### Type of Service

<table>
<thead>
<tr>
<th>Type of Service</th>
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<tbody>
<tr>
<td>Ambulatory Services in Facilities Certified Under Article 31 of the State Mental Hygiene Law:</td>
</tr>
<tr>
<td>- OMH Clinic, Day and Continuing Treatment Programs</td>
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<tr>
<td>- Intensive Day Treatment Program (programs certified by OMH pursuant to 14 NYCRR Part 581)</td>
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</tbody>
</table>

### Method of Reimbursement

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<th>Method of Reimbursement</th>
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<tr>
<td>[Flat fee developed by OMH and approved by the Division of the Budget.]</td>
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**TN #10-0018**

**Approval Date November 1, 2017**

**Supersedes TN #87-0031**

**Effective Date July 1, 2010**
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 1, 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 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
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.
<table>
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<tr>
<th>Type of Service</th>
<th>Method of Reimbursement</th>
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| 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 for People with [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. The above reimbursement methodology sunsets effective December 31, 2015. |

**TN #10-0018**

**Supersedes TN #92-0054**

**Approval Date November 1, 2017**

**Effective Date July 1, 2010**
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 [86-2.10(c)(5)] the Wage Equalization Factor section of this Attachment [4.19-A of the State Plan]. 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:

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.
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 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.
[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.]
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.]
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]
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.]
Psychological Evaluations

The fee is fee-for-service and is made up of 1) directs 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.]
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.
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 if 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.
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 n 14NYCRR Part 587.
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 Managers and Supportive Case Managers 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.
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 underserviced 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.
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.
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.
**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 that 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.
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.
TYPE OF SERVICE
Case Management Services
Target Groups: A & E

A. Categorically or medically needy Persons under age 21, pregnant Parenting or at risk of pregnancy

E. Categorically or medically needy women of child-bearing age who are pregnant, and infants under one year of age.

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.
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.
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.
New York 11-A

Type of Service
Case Management Services
Target Group: C

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.

Method of Reimbursement

The proposed methodology includes the following characteristics:

- Provider-specific rates are replaced with a regional rate structure
- Economics of scale associated with larger programs are accounted for;
- Direct service components are established with a fixed percentage allowance for indirect costs.
- An annual trend factor approved by the State Division of the Budget is applied in subsequent years;
- 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.

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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.
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.
**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:
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.
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.
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.
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. Expect as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.
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:


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.
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.
### FFY 1995 Medicaid Utilization Data for Selected Physician Procedure Codes

**PROCEDURE CLAIMS AMOUNT PAID RECIPIES AVG. S/CLAIM**

#### Maternity Care and Delivery

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#### Evaluation and Management

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</tr>
<tr>
<td>99383 1,738</td>
<td>$58,288</td>
<td>1,677</td>
<td>$33.54</td>
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<tr>
<td>99384 1,014</td>
<td>$32,917</td>
<td>987</td>
<td>$32.46</td>
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<tr>
<td>99391 8,617</td>
<td>$267,553</td>
<td>5,246</td>
<td>$31.05</td>
<td></td>
</tr>
<tr>
<td>99392 12,736</td>
<td>$419,094</td>
<td>10,206</td>
<td>$32.91</td>
<td></td>
</tr>
<tr>
<td>99393 7,633</td>
<td>$255,916</td>
<td>7,375</td>
<td>$33.53</td>
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<tr>
<td>99394 3,412</td>
<td>$108,266</td>
<td>3,333</td>
<td>$31.14</td>
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**Source:** FFY 1995 Physician and CTHP 8-79 Reports.

**Questions:** Nancy Hansen @ 518-473-8797

---

**TN #97-11**

**Attachment 4.19-B**

**New York 12**

**Approval Date April 23, 1997**

**Effective Date April 1, 1997**

**Supersedes TN **NEW **
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

<table>
<thead>
<tr>
<th>Region</th>
<th>OB/GYN</th>
<th>Family Practitioner</th>
<th>Pediatricians</th>
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<tr>
<td></td>
<td>Estimated Physicians</td>
<td>Participating Physicians</td>
<td>%</td>
</tr>
<tr>
<td>I</td>
<td>221</td>
<td>199</td>
<td>90%</td>
</tr>
<tr>
<td>II</td>
<td>189</td>
<td>173</td>
<td>92%</td>
</tr>
<tr>
<td>III</td>
<td>227</td>
<td>245</td>
<td>108%</td>
</tr>
<tr>
<td>IV</td>
<td>188</td>
<td>185</td>
<td>98%</td>
</tr>
<tr>
<td>V</td>
<td>967</td>
<td>775</td>
<td>80%</td>
</tr>
<tr>
<td>VI (NYC)</td>
<td>1073</td>
<td>770</td>
<td>72%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>1792</td>
<td>1577</td>
<td>88%</td>
</tr>
<tr>
<td>Statewide</td>
<td>2865</td>
<td>2347</td>
<td>82%</td>
</tr>
</tbody>
</table>

### New York 12-2

#### February 1997-New York
**Preferred Physician & Childrens Program**

<table>
<thead>
<tr>
<th>Upstate</th>
<th>Downstate</th>
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<tbody>
<tr>
<td>W5000* Well Child - Healthy New Borns &amp; Children Under 18 Years</td>
<td>$44.00</td>
</tr>
<tr>
<td>$36.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Class I Condition</td>
<td>$39.00</td>
</tr>
<tr>
<td>$33.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Medication Administration</td>
<td>$37.00</td>
</tr>
<tr>
<td>$31.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Generally Healthy Children 17-21</td>
<td>$50.00</td>
</tr>
<tr>
<td>$42.00</td>
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</tr>
<tr>
<td>W5000* Class II Condition</td>
<td>$44.00</td>
</tr>
<tr>
<td>$37.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Gynecological Exam Females under 21 years</td>
<td>$45.00</td>
</tr>
<tr>
<td>$38.00</td>
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</tr>
<tr>
<td>W5000* Reproductive – all patients males or females under 21 w/reproductive</td>
<td>$44.00</td>
</tr>
<tr>
<td>$37.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Class III Condition</td>
<td>$45.00</td>
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<tr>
<td>$38.00</td>
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</tr>
<tr>
<td>W5000* Chemotherapy</td>
<td>$83.00</td>
</tr>
<tr>
<td>$69.00</td>
<td></td>
</tr>
<tr>
<td>W5000* Class IV Condition</td>
<td>$53.00</td>
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<tr>
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<tr>
<td>W5000* Class V Condition</td>
<td>$42.00</td>
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<tr>
<td>$36.00</td>
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</tr>
<tr>
<td>W5000* Ophthalmology</td>
<td>$34.00</td>
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<tr>
<td>$29.00</td>
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**TN #97-11**

**Supersedes TN #96-11**

**Approval Date** April 23, 1997

**Effective Date** April 1, 1997
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>W5000*</td>
<td>Default - used when there is some minor information missing from a valid claim</td>
<td>$34.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$29.00</td>
</tr>
<tr>
<td>W5004*</td>
<td>Emergency Room Visit (OB/GYN)</td>
<td>$30.00</td>
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<tr>
<td></td>
<td></td>
<td>$36.00</td>
</tr>
<tr>
<td>W5000</td>
<td>1st Prenatal – females under 21 years with confirmed pregnancy</td>
<td>$67.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$83.00</td>
</tr>
<tr>
<td>W5000</td>
<td>Prenatal revisits – females under 21 years with confirmed pregnancy</td>
<td>$40.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$48.00</td>
</tr>
<tr>
<td>W5000</td>
<td>Postpartum pregnant females under 21 years (revised 1/94)</td>
<td>$50.00</td>
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<td></td>
<td></td>
<td>$50.00</td>
</tr>
</tbody>
</table>
New York
12-4

MEDICAID OBSTETRICAL AND MATERNAL SERVICES (MCMS)
PROCEDURE AND FEE SCHEDULE
CURRENT as of February 1997

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Global Fee</td>
<td>$1,440.00</td>
</tr>
<tr>
<td>59410</td>
<td>Vaginal Delivery or Cesarean</td>
<td>$960.00</td>
</tr>
<tr>
<td>59420</td>
<td>Antepartum care only initial visit</td>
<td>$69.00</td>
</tr>
<tr>
<td>W0003</td>
<td>Antepartum care only subsequent visit</td>
<td>$59.00</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care only</td>
<td>$59.00</td>
</tr>
</tbody>
</table>

TN #97-11
Supersedes TN #96-11
Approval Date April 23, 1997
Effective Date April 1, 1997
Child Teen Health Program  
As of February 1997

NEW PATIENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>99384</td>
<td>Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99383</td>
<td>late childhood (age 5 through 11 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99382</td>
<td>early childhood (age 1 through 4 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99381</td>
<td>infant (age under 1 year)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99381</td>
<td>not listed separately procedure code 99831 should be used.</td>
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</table>

ESTABLISHED PATIENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>99394</td>
<td>Interval history and examination related to the healthy individual, including anticipatory guidance; periodic type of examination; adolescent (age 12 through 17 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99393</td>
<td>late childhood (age 5 through 11 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99392</td>
<td>early childhood (age 1 through 4 years)</td>
<td>$29.00</td>
</tr>
<tr>
<td>99391</td>
<td>infant (age under 1 year)</td>
<td>$29.00</td>
</tr>
</tbody>
</table>
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.
# New York State Department of Social Services Regions

<table>
<thead>
<tr>
<th>REGION</th>
<th>DISTRICTS</th>
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<tbody>
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<td>I</td>
<td>Allegany</td>
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<tr>
<td></td>
<td>Genesee</td>
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<tr>
<td></td>
<td>Cattaraugus</td>
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<td></td>
<td>Niagara</td>
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<td></td>
<td>Chautauqua</td>
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<td>Orleans</td>
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<td></td>
<td>Erie</td>
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<td></td>
<td>Wyoming</td>
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<tr>
<td>II</td>
<td>Chemung</td>
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<td>Livingston</td>
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<td>Seneca</td>
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<td>Monroe</td>
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<td>Steuben</td>
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<td>Ontario</td>
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<td>Wayne</td>
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<td>Schuyler</td>
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<td>Yates</td>
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<tr>
<td>III</td>
<td>Broome</td>
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<td></td>
<td>Madison</td>
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<td></td>
<td>Cayuga</td>
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<td>Oneida</td>
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<td>Chenango</td>
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<td>Oswego</td>
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<td>Delaware</td>
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<td>Washington</td>
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<td>Dutchess</td>
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<td></td>
<td>Nassau</td>
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<td>Suffolk</td>
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<td>Orange</td>
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<td></td>
<td>Sullivan</td>
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<td>Putnam</td>
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<td></td>
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<tr>
<td></td>
<td>Westchester</td>
</tr>
<tr>
<td>VI</td>
<td>New York City</td>
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</table>

**TN #97-11**

**Approval Date** April 23, 1997

**Supersedes TN #96-11**

**Effective Date** April 1, 1997
<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>METHOD OF REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services for Illegal Aliens</td>
<td>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.</td>
</tr>
</tbody>
</table>

**New York**

13

<table>
<thead>
<tr>
<th>TN</th>
<th>#87-47</th>
<th>Approval Date</th>
<th>November 21, 1991</th>
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<tbody>
<tr>
<td>Supersedes TN</td>
<td>NEW</td>
<td>Effective Date</td>
<td>October 1, 1987</td>
</tr>
</tbody>
</table>
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.
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
Supersedes TN NEW
Approval Date December 9, 1999
Effective Date July 1, 1999
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.
New York
16

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>METHOD OF REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Case Management</td>
<td>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.</td>
</tr>
</tbody>
</table>

TN      #00-43     ____
Supersedes TN      NEW     ____
Approval Date       March 28, 2001
Effective Date     October 1, 2000
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.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Method of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN</th>
<th>#02-01</th>
<th>Approval Date</th>
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<td>Supersedes TN</td>
<td>NEW</td>
<td>Effective Date</td>
<td>January 1, 2002</td>
</tr>
</tbody>
</table>
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, QI1, and QI2 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.
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.

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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.
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.
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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__
 Fees will be established for each service or procedure and, except for Special Transportation, such fees shall be set at 100\% 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 \% 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 \% 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
Supersedes TN #09-0061 Effective Date July 1, 2017
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.

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**TN #17-0057**
**Supersedes TN #09-0061**

**Approval Date** November 28, 2017
**Effective Date** July 1, 2017
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.
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.
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.
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 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 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.
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/

and the State Education Department website at:


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
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/

and the State Education Department website at:


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.
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.
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.

\[
\text{Direct Medical Service Percentage} = \frac{D}{A} \times \left( \frac{R}{A - R - U} \right)
\]

4. **IEP Medicaid Eligibility Ratio:** A district-specific IEP Ratio will be established for
each participating school-district. 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 [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, 2013, the
IEP Ratio will be based on the [student] count of students with an IEP at any time
during the from July 1, 2012 through June 30, 2013 school year [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 SSHS
program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student
counts, as described above, [of the first Wednesday of October] and MMIS data for the
fiscal year for which the cost report is completed.

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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:

   - Bus Drivers;
   - Attendants;
   - Mechanics; and
   - Substitute Drivers.

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**Attachment 4.19-B**

**New York**

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**Supersedes TN** New

**Effective Date** October 1, 2011

**Approval Date** December 22, 2014

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**TN #11-39-A**
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.
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 1st through June 30th period. The cost report is due on or before December 31st 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.
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 1st through June 30th, the annual SSHSP Cost Report is due on or before December 31st of the same year. The final reconciliation will occur prior to the 24th 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].
Preschool Supportive Health Services Program (PSSHSP)

A. Reimbursement Methodology for PSSHSP

Preschool-based services, known as Preschool Supportive Health Services (PSSHS), 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 PSSHS 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.
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.
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/

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.
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
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/

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.**
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 Service 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.

\[ \text{Direct Medical Service Percentage} = \frac{D + \left( \frac{D}{A - R - U} \right) * R}{A} \]

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, 2013.
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.
New York 17(t)

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.

   Approval Date: December 22, 2014
   Effective Date: October 1, 2011
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 1st through June 30th. The cost report is due on or before December 31st of the same year of the reporting period. The primary purposes of the cost report are:

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 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 1st through June 30th, the annual PSSHSP Cost Report is due on or before December 31st of the same year. The final reconciliation will occur prior to the 24th 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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STATE PLAN 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).
Supplement 1 to Attachment 4.19-B

New York

STATE PLAN 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

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<td>Part B MR Deductibles [MR] NR Coinsurance</td>
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TN #03-38 Approval Date December 24, 2003
Supersedes TN #93-28 Effective Date July 1, 2003
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.

[5]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.

[6]7. If the service is a Products of Ambulatory Care Clinic, a clinic primarily serving the developmentally disabled, [or] a Mental Health comprehensive outpatient program services (COPS) program, 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.

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Footnote:

1 Effective 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, Day Treatment for Children and Intensive Psychiatric Rehabilitation and Treatment Services.
[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”.
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.

TN ___ #16-0026 _____________ Approval Date: _Aug 12, 2016_______

Supersedes TN_ NEW __ __ Effective Date: _April 01, 2016______
PAYMENT FOR RESERVED BEDS IN MEDICAL INSTITUTIONS

LIMITATIONS

A. RESERVED BEDS DURING LEAVES OF ABSENCE (Defined to mean overnight absences including visits with relatives/friends, or leaves to participate in medically acceptable therapeutic or rehabilitative plans of care).

When patient's/resident's plan of care provides for leaves of absence:

General Hospital Patients
Eligibility restricted to patients receiving care in certified psychiatric or rehabilitation units, without consideration of any vacancy rate. A psychiatric patient must be institutionalized for 15 days during a current spell of illness; a rehabilitation patient must be institutionalized for 30 days. Leaves must be for therapeutic reasons only and carry a general limitation of no more than 18 days in any 12 month period, and 2 days per any single absence. Broader special limits are possible when physicians can justify them, subject to prior approval.

Nursing Facility (NF) Patients
A reserved bed day is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance while he or she is temporarily hospitalized or on leave of absence from the facility. All such reserve bed days during leaves of absences shall be pursuant to the residents’ plan of care.

All recipients eligible after 30 days in the facility, subject to a facility vacancy rate, on the first day of the patient's/resident's absence of no more than 5%. [General limitations of no more than 18 days in any 12 month period with broader special limits possible when physicians can justify them, subject to prior approval.]

Effective July [19, 2010] 1, 2012, for reserved bed days provided on behalf of persons 21 years of age or older:

(i) payments for reserved bed days related to hospitalization will be made at [95%] 50% of the Medicaid rate, and payments for reserved bed days related to non-hospitalization leaves of absence will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided [on behalf of ] to such person;

(ii) payment to a facility for reserved bed days provided [on behalf of] for such person for [temporary] hospitalizations and therapeutic leave that is consistent with a plan of care ordered by the patient's treating health care professional for visits to a health care professional that is expected to improve the patients’ physical condition or quality of life may not exceed 14 days in any 12-month period; and

(iii) payment to a facility for reserved bed days provided [on behalf of such person for non-hospitalization leaves of absence] for patients on leave for purposes other than hospitalization or eligible therapeutic leave may not exceed 10 days in any 12-month period.

(iv) Broader special limits are possible when physicians can justify them, subject to prior approval.

Reserved bed days provided on behalf of persons younger than 21 years of age will be made at 100% of the Medicaid rate.

In computing reserved bed days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.

TN #12-24
Supersedes TN #10-22-A
Approval Date December 19, 2012
Effective Date July 1, 2012
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) - General

Absences from all ICF/IIDs, other than for hospitalization, must be provided for in an individual’s plan of care.

State Government Owned and Operated ICF/IID Facilities

All recipients eligible after 30 days in the facility. There is no limitation on the number of days a resident may be absent.

(i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.

All Other [Intermediate Care Facilities for the Mentally Retarded and Specialty Hospitals for the Developmentally Disabled (ICF/MR)] ICF/IID [Non-state Government Owned & Operated Facilities]

All recipients eligible after 30 days in the facility [, subject to a facility vacancy rate, on the first day of the resident’s absence, of no more than 5%. ICF/MR with a bed capacity in excess of 30 beds is exempt from this vacancy rate requirement]. There is no limitation on the number of days a patient/resident may be absent.

(i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.

Psychiatric or Rehabilitation Facility Patients (Other than RTFs)

As provided for recipients receiving similar treatment in general hospitals, as described [above] in the General Hospital Patients section of this Attachment.

TN ____ #10-22-B ________ Approval Date __ May 31, 2013 ___
Supersedes TN ____ #10-22-A ________ Effective Date __ April 1, 2013 ___
Residential Treatment Facilities for Children and Youth (RTFs)

All recipients eligible who have been institutionalized for 15 days during a current spell of illness, subject to a vacancy rate, on the first day of a resident's absence of no more than 5% for 2 vacant beds, whichever is greater, in the distinct part of the RTF to which the recipient is to return. Leaves of absence carry a general limitation of no more than 75 days in any 12 month period, and 4 days per any single absence. Limitations may be waived when justified by recipient’s physician, subject to prior approval by a designee of the Commissioner of the Office of Mental Health.

B. RESERVED BEDS DURING PERIODS OF HOSPITALIZATION

All recipients eligible after 30 days in:

1) an NF;
2) an ICF/MR;
3) a specialty hospital;
4) a rehabilitation facility or rehabilitation units of general hospitals;
5) a hospice

All recipients eligible who have been institutionalized for at least 15 consecutive days in:

1) a psychiatric facility or psychiatric units of general hospitals;
2) an RTF

The 15 day requirement may be waived if prior approval by a designee of the Commissioner of the Office of Mental Health.

For other than Residential Treatment Facilities:

Without prior approval, not to exceed 15 days during period of hospitalization for acute conditions, for any single hospital stay, when patient returns immediately following a period during which their bed was reserved to his/her originating facility in 15 days or less.
New York
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With prior approval, not to exceed 20 days during period of hospitalization for acute
conditions, for any single hospital stay, when patient does not return to his/her
originating facility immediately following a period during which their bed was reserved or
does not return in 15 days or less.

For Residential Treatment Facilities:

Without prior approval, not to exceed 15 days during period of hospitalization for acute
conditions, for any single hospital stay, when patient returns immediately following a
period during which their bed was reserved to his/her originating facility in 15 days or
less.

With prior approval, not to exceed 20 days during period of hospitalization for acute
medical (non-psychiatric) conditions for any single hospital stay, when patient does not
return to his/her originating facility immediately following a period during which their
bed was reserved, or does not return in 15 days or less.

With prior approval not to exceed 30 days during period of hospitalization for acute
psychiatric conditions, for any single hospital stay, when patient does not return to
his/her originating facility immediately following a period during which their bed was
reserved, or does not return in 15 days or less.

All of the above provisions subject to a facility vacancy rate of no more than 5% on the
first day of patient's/resident's absence. For RTFs, the above is subject to a vacancy
rate, on the first day of a resident’s absence of no more than 5% or 2 vacant beds,
whichever is greater, in the distinct part of the RTF to which the recipient is to return.

Special broader limits, subject to approval of the State Commissioner of Social Services,
may be established for residents of institutions for the mentally
retarded/developmentally disabled on an individual case basis, and for residents of RTFs
on an individual basis.
SUBPART 86-2

RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, §§2803[2], 2808)

Sec.
86-2.1 Definition
86-2.2 Financial and statistical data required
86-2.3 Uniform system of accounting and reporting
86-2.4 Generally accepted accounting principles
86-2.5 Accountant’s certification
86-2.6 Certification by operator or officer
86-2.7 Audits
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86-2.10 Computation of basic rate
86-2.11 Adjustments to direct component of the rate
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86-2.13 Adjustments to provisional rates based on errors
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86-2.25 Compensation of operators or relatives of operators
86-2.26 Costs of related organizations
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86-2.29 Payments to receivers
86-2.30 Patient assessment for certified rates
Across-the-Board Reductions to Payments – Effective 9/16/10 – 3/31/11

(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:

Part I – Residential Health Care Facilities
a) Voluntary Health Care Facility Right Sizing Program. Page 16
b) Services provided by Residential Health Care Facilities, excluding proportionate share payments to non-state operated public facilities (found on page 47(x)(2)(b)). Pages 17-87

Part III – Methods and Standards for Establishing Payment Rates (Out of State Services) – Nursing Facilities
c) Services provided by nursing facilities out of state. Page 1


(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:

d) Services provided by nursing facilities out of state. Page 1
**Supplemental Payments**

1. Effective July 1, 2015 and State Fiscal Years thereafter, supplemental payments will be distributed to all nursing home facilities through lump sum or monthly payments and calculated as follows:

   a) An individual facility revenue will be calculated by taking each facility’s promulgated rate in effect for the given period multiplied by actual Medicaid days for the corresponding period as reported in the facility’s cost report or an estimate of Medicaid days based on most recent available data. If a facility fails to submit a timely filed cost report, the most recent cost report will be utilized.

   b) The resulting individual facility revenue will be divided by total Medicaid revenues of all facilities. The result will be multiplied by the appropriate total dollar amount to be distributed per the chart below to determine each facility’s portion of the supplemental payment.

2. After the end of each State Fiscal Year, a reconciliation of any estimated Medicaid days to actual Medicaid days will be conducted. Any resulting payment adjustments will be made within the 2-year claiming rule.

### Supplemental Payment Schedule

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<tr>
<th>State Fiscal Year</th>
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<td>2022-2023 and SFYs thereafter</td>
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<td>$52.5</td>
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<td></td>
<td><strong>$70.00</strong></td>
<td></td>
</tr>
</tbody>
</table>
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New York State provides public access to governmental records, including data and the methodology used in establishing payment rates for nursing facilities under Medicaid. The State Freedom of Information Law (Public Officers Law, Article 6) is the principal statute providing public access to information and records. Regulations related to the process of obtaining access to the Department of Health’s records are contained in Sub-part 50-1 of Title 10NYCRR. These records include, but are not limited to, facility cost reports, case mix indices and the methodologies by which reimbursement rates are set for hospitals, nursing homes and other health care providers.

Anyone wishing to inspect or obtain public records must apply to the Department’s Records Access Officer in writing. The officer is responsible for insuring appropriate agency response to requests for public access to records, and will coordinate the Department’s response as per the process contained in the New York State Department of Health Administrative Policy and Procedure Manual, 100.0 – RELEASE OF INFO TO OUTSIDE GROUP/FREEDOM OF INFO/RECORD ACCESS.

October 1, 1990
TN #90-10 Approval Date October 1, 1990
Supersedes TN NEW Effective Date October 1, 1990
Section 86-2.1 Definitions.

As used in this Subpart, the following definitions shall apply:

[(1)] (a) Residential health care facility, medical facility or facility shall mean all facilities or organizations covered by the term nursing home [or health-related facility] as defined in article 28 of the Public Health Law, including hospital-based residential health care facilities, and NURSING FACILITIES as defined in Section 1919 of the federal Social Security Act, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and, where required, has been established by the Public Health Council.

[(2)] (b) Patient classification groups shall mean patient categories contained in the classification system, Resources Utilization Groups – II (RUG-II), which identifies the relative resource consumption required by different types of long term care patients as specified in Appendix [6] 13-A, infra.

[(3)] (c) Case mix shall mean the patient population of a facility as classified and aggregated into patient classification groups.
86-2.2 Financial and statistical data required.

(a) Each residential health care facility shall complete and file, with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII of the Federal Social Security Act (Medicare) shall use the same fiscal year for title XIX of the Federal Social Security Act (Medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977, forward on a calendar-year basis.

(1) Hospital based residential health care facilities whose affiliation changes to freestanding pursuant to subdivision (a) of section 86-2.34 of this Subpart shall complete and file the freestanding annual cost report (RHCF-4) supplied by the department and/or its agent for the first full calendar-year following actual complete closure of the acute care beds of its affiliated hospital.

(b) Federal regulations require the submission of cost reports to the State agency no later than three months after the close of the cost reporting year. State agencies requiring certified reports may grant an extension of 30 days. Since the reports from all residential health care facilities are required to be certified, an extension of 30 days is automatically provided in this subdivision so that all required financial and statistical reports shall be submitted to the department no later than 120 days following the close of the fiscal period. Further extensions of time for filing reports may be granted upon application received prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.
(c) In the event a residential health care facility fails to file the required financial and statistical reports on or before the due dates, or as
the same may be extended pursuant to subdivision (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which said required reports are filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health, on required reports, budgets or appeals for rate revisions intended for use in establishing rates, is inaccurate or incorrect, whether by reason or subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) Except as identified in section 86-2.10(k)(6) and 86-2.15(e), a cost report shall be filed in accordance with this section by each new facility for the first [six-month] twelve-month period during which the facility has had an overall average utilization of at least 90 percent of bed capacity. This report shall be filed and properly certified within 60 days following the end of the [six-month] twelve-month period covered by the report. Failure to comply with this subdivision shall result in application of subdivision (c) of this section.

(f) If the financial and statistical reports required by this Subpart are determined by the department to be incomplete, inaccurate or incorrect, the residential health care facility will have 30 days from the date of receipt of notification to provide the corrected or additional data. Failure to file the
corrected or additional data that was previously required within that period will result in a reduction of the current rate in accordance with subdivision (c) of this section. Lack of the respective certifications by both the operator and accountant, as required pursuant to section 86-2.5 and 86-2.6 of this Subpart, shall render a financial and statistical report incomplete, and the facility shall not be entitled to the 30-day period to submit the certifications.

(g) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which include and are limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey and a malpractice insurance survey, must be provided by the residential health care facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in a reduction of the current rate in accordance with subdivision (c) of this section, unless the residential health care facility can prove by documentary evidence that the data being requested is not available.
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[(h) each residential health care facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions set forth in subdivision (c) of this section.]

RESERVED
86-2.3 Uniform system of accounting and reporting.

(a) Residential health care facilities shall maintain their records in accordance with:

(1) section 414.13 of Article 3 Subchapter A of Chapter V of this Title; and

(2) for the 1980 calendar year in substantial compliance, and thereafter in full compliance, with Article 9 of Subchapter A of Chapter V of this Title. *Substantial compliance* shall be defined as the result that would be expected from a good-faith effort taken by an informed, responsible person.

(b) For purposes of rate setting, the report required for the fiscal year beginning on or after January 1, 1980 by residential health care facilities shall be made in accordance with the policies and instructions set forth in Article 9 of Subchapter A of Chapter V of this Title for financial presentation purposes.

(c) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the reporting requirements of this Subpart, section 414.13 and Article 9 of Subchapter A of Chapter V of this Title. For the purpose of certifying rates, compliance with reporting requirements of Article 9 of Subchapter A of Chapter V of this Title will include, but not be limited to, the timely filing of properly certified reports which are complete and accurate in all material respects.
(d) Failure of residential health care facility to file the reports required pursuant to this section will subject the residential health care facility to a rate reduction as set forth in section 86-2.2 of this Subpart. However, there may be instances where a facility is not in compliance with Article 9 of Subchapter A of Chapter V of this Title, resulting in reports which are inaccurate, incomplete or incorrect, and the area of noncompliance cannot, for the reporting period, be corrected. In such instances a rate reduction shall, with respect to the report for such reporting period, begin on the first day of the calendar month following the original due date of the required report and continue until the last day of the calendar year in which the report was required to be filed.
86-2.4 Generally accepted accounting principles.

The completion of the financial and statistical report form shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorized specific variation in such principles.
86-2.5 Accountant’s certification.

(a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term “independent” shall be the standard used by the State Board of Public Accountancy.

(b) Effective with report periods beginning on or after January 1, 1977, the requirements of subdivision (a) of this section shall apply to residential health care facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section except that those medical facilities for which an annual reimbursement audit by a State agency is required by law shall be required to comply herewith effective with report periods beginning on or after January 1, 1978.
86-2.6 Certification by operator or officer.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical reports forms provided by the State Commissioner of Health.
86-2.7 Audits

(a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the residential health care facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified by the State Commissioner of Health based on the initial submission of base year data and reports will be construed to represent a provisional rate until such audit is performed and completed, at which time such after or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted by the records of residential health care facilities, in a time, manner and place to be determined by the State Department of Health.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit the residential health care facility shall be afforded a closing conference. The residential health care facility
may appear in person or by anyone authorized in writing to act on behalf of the residential health care facility. The residential health care facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The residential health care facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the residential health care facility initiates a bureau review by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and such other material as the provider wishes to submit in its behalf and forwarding all material documentation in support of the residential health care facility's position.

(f) The residential health care facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation and policy. The audit finding as adjusted in accordance with the determination of the bureau review shall be final, except that the residential health care facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the residential health care facility presenting a factual issue by serving on the commissioner, by certified or register mail, a notice containing a statement
of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the residential health care facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

   (i) designate a hearing officer to hear and recommend;
   (ii) establish a time and place for such hearing;
   (iii) notify the residential health care facility of the time and place of such hearing at least 15 days prior thereto; and
   (iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the residential health care facility.

(2) The issues and documentation presented by the residential health care facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the residential health care facility to prove by substantial evidence that the items therein contained are incorrect. At such hearing, the residential health care facility shall have the obligation to initially present such evidence in support of its position. Failure to do so shall result in termination of the hearing.
The hearing shall be conducted in conformity with section 12-a of the Public Health Law and State Administrative Procedure Act.

At the conclusion of the hearing the residential health care facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall be part of the official record of the hearing.

Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.
86-2.8 Patient days.

(a) A patient day is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

(d) Reserved bed patient days shall be computed separately from patient days. A reserved bed patient day is the unit of measure denoting an overnight stay away from the residential health care facility for which the patient, or patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

(e) In computing reserved bed patient days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.
The voluntary health care facility right-sizing program is intended to address excess capacity in residential health care facilities. Under this program, a residential health care facility may apply to temporarily decertify, or permanently convert, a portion of its existing certified beds to another level of care. The Commissioner of Health may approve temporary decertification and permanent bed conversions, which total no more than [2,500] 5,000 residential health care beds on a statewide basis.

A residential health care facility may temporarily decertify beds for up to five years. Temporarily decertified beds will remain on the facility’s license during and after the five-year period.

The following adjustments to the calculation of Medicaid rates of payment for residential health care centers will be made for facilities that have temporarily decertified beds under this program:

- Capital cost reimbursement will be adjusted to reflect the new bed capacity;
- The facility’s peer group assignment for indirect cost reimbursement will be based upon total certified beds less the number of temporarily decertified beds; and
- The facility’s vacancy rate, for the purpose of determining eligibility for reserved bed day payments, will be calculated on the basis of the facility’s total certified beds less the number of temporarily decertified beds. Payments for reserved bed days for facilities that have temporarily decertified beds will be in an amount that is fifty percent of the otherwise applicable payment amount for such beds.

December 17, 2010

TN #10-29 Approval Date December 17, 2010
Supersedes TN #05-60 Effective Date August 1, 2010
86-2.10 Computation of basic rate.

(a) Definitions.

For the purposes of this section the following definitions shall apply:

(1) Direct price shall mean the monetary amount established for the direct component of the rate, based on the direct costs of all facilities after application of the regional direct input price adjustment factor, divided by patient days and the average statewide case mix index.

(2) Indirect price shall mean the monetary amount established for the indirect component of the rate, based on the indirect costs for each facility in a peer group, after application of a regional indirect price adjustment factor, divided by total peer group patient days.

(3) Peer group shall mean a set of facilities distinguished by like characteristics which are grouped for purposes of comparing costs and establishing payment rates using such criteria as affiliation (i.e., hospital-based or freestanding) case mix index (i.e., high intensity, case mix index greater than .83, or low intensity, case mix index less than or equal to .83), and size (i.e., less than 300 beds or 300 or more beds).

(4) Cost center shall mean categories into which related costs are grouped in accordance with and defined in Part 455 of this Title.

(5) Case mix index shall mean the numeric weighting of each patient classification group in terms of relative resource utilization as specified in Appendix 13-A, infra.

(6) Rate shall mean the aggregate governmental payment to facilities per patient day as defined in section 86-2.8 of this Subpart, for the care
of medicaid patients which shall include a Direct, Indirect Non-Comparable and Capital component.

(7) Operating portion of the rate shall mean the portion of the rate consisting of the Direct, Indirect and Non-Comparable components after application of the roll factor promulgated by the department.

(8) Role Factor shall mean the cumulative result of multiplying one year’s trend (inflation) factor times one or more other years trend factor(s) which is used to inflate costs from a base period to a rate period.

(9) Capital Costs shall mean costs reported in the Depreciation, Leases and Rentals, Interest on Capital Debt and/or Major Movable Equipment Depreciation Cost Centers, as well as costs reported in any other cost center under the major natural classification of Depreciation, Leases and Rentals on the facilities annual cost report (RHCF-4).

(10) Base shall mean, as applicable to cost or price, a minimum cost or price.

(11) Ceiling shall mean, as applicable to cost or price, a maximum cost or price.

(12) Corridor shall mean the difference between a base and a ceiling.

(13) Hospital based shall mean as follows:

(i) For facilities receiving initial operating certificates prior to January 1, 1983, hospital based shall mean those facilities that are considered by the federal Health Care Financing
New York Administration (HCFA) to be hospital based or hospital rated (as pertaining to cost allocation) and which derive and report costs on the basis of a Medicare cost allocation methodology from an affiliated hospital.

ii. For facilities receiving operating certificates after January 1, 1983 the Commissioner shall review and determine whether or not such facilities are hospital based utilizing the following criteria:

a. the nature of any construction approval received pursuant to Section 2802 of the Public Health Law;

b. the nature of any establishment approval received pursuant to Section 2801-a of the Public Health Law;

c. the architectural configuration for the residential health care facility unit as related to the hospital physical plant;

d. the method and amount of cost allocation;

e. whether a determination that such a facility is hospital based would result in the efficient and economic operation of such facility.

(b) (1) **The rate for 1986 and subsequent rate years shall**

i. be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ending December 31, 1983, as contained in parts I, II, III and IV of the facility’s annual cost report (RHCF-4) and for hospital based facilities, the annual cost report (RHCF-2) and the institutional cost report of its related hospital. Beginning with the annual cost report filed for 2005 and for each year thereafter; in the event the operating costs reported by a facility are less than 90 percent of the operating costs reported in the cost report utilized to compute the facility’s rates, trended to 2005 and each year thereafter, the facility’s rates shall be recalculated utilizing the more recent reported operating cost data.
(ii) Consist of the following four separate and distinct components, as defined in this section.

(a) Direct

(b) Indirect

(c) Non-comparable

(d) Capital

(2) The operating portion of the rate for 1986 and subsequent rate years shall consist of the sum of the Direct, Indirect and Non-Comparable Components of the rate determined in accordance with this section trended to the rate year by the applicable roll factor promulgated by the department.

(3) Allocation and adjustments of Reported Costs.

(i) The computation of the rate for 1986 and for subsequent rate years shall incorporate the use of the single stepdown method of cost allocation as defined in section 451.249 of Article 9 of Subchapter A of Chapter V of this Title.

(ii) Individual discrete ceilings shall be applied to renumeration for the facility's administrator, assistant administrator and operator as specified in Appendix 6a infra.

(iii) Reported Costs of 1983 shall be adjusted through the apportionment of retroactive adjustments due to operating appeals which were as a result of significant increases in staff specifically mandated by the Commissioner. Such adjustments shall be limited to

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those related to staff hired subsequent to December 31, 1982 and those appeal requests received by the department prior to July 1, 1985.

(iv) In the determination of rates, reported costs shall be subject to the limitations and adjustments contained in sections 86-2.12, 86-2.17, 86-2.18, 86-2.25, and 86.2.26 of this Subpart.

(v) Salaries paid to related parties shall be subject to an initial maximum not to exceed $17,000. This limitation may be waived by the department pursuant to the provisions of section 86-2.14(a)(7) or this Subpart.

(c) Direct component of the rate.

(1) Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending.

(i) nursing administration;

(ii) activities;

(iii) social services;

(iv) transportation;

(v) physical therapy;

(vi) occupational therapy;

[(vii) laundry and linen]
(vii) speech and hearing therapy - (speech therapy portion only);

(viii) pharmacy;

(ix) central service supply; and

[(x)] residential health care facility.

(2) For purposes of calculating the direct component of the rate, the department shall utilize the allowable direct costs reported by all facilities with the exception of specialty facilities as defined in subdivision (1) of this section.

(3) [Except as provided for in subparagraph (4) (viii) of this subdivision. The] The statewide mean, base and ceiling direct price for patients in each patient classification group shall be determined as follows:

(i) Allowable costs for the direct cost centers for each facility after first deducting capital costs and items not subject to trending, shall be multiplied by the appropriate Regional Direct Input Price Adjustment Factor (“RDIPAF”), as determined pursuant to paragraph (5) of this subdivision. The RDIPAF neutralizes the difference in wage and fringe benefit costs between and among the regions caused by differences in the wage scaled of each level of employee.

(ii) The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing
the patient data obtained in the patient assessment period, March 1, 1985 through September 30, 1985, conducted pursuant to Section 86-2.30 of this Subpart.

(iii) A statewide mean direct case mix neutral cost, a statewide base direct case mix neutral cost and a statewide ceiling direct case mix neutral cost shall be determined as follows:

(a) Allowable direct costs for each facility, after first deducting capital costs and items not subject to trending and adjusted by applying the RDIPAF shall be summed to determine total statewide direct costs.

(b) The aggregate statewide case mix index shall be determined by multiplying number of patients on a statewide basis in act patient classification group by the case mix index for each patient classification group and the results summed.

(c) A statewide mean direct cost per day shall be determined by dividing total statewide direct costs by the aggregate number of statewide 1983 patient days.

(d) A statewide mean direct case mix neutral cost per day shall be determined by dividing the statewide mean direct cost per day by the ratio of the aggregate statewide case mix index to the number of patient review instruments received pursuant to section 86-2.00 of this Subpart.
(e) The statewide mean direct case mix neutral cost per day shall be the basis to establish a corridor between the statewide base direct case mix neutral cost per day and the statewide ceiling direct case mix neutral cost per day.

(f) The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the statewide mean direct case mix neutral cost per day.

(g) A statewide base direct case mix neutral cost per day shall be determined by multiplying the base factor times the statewide mean direct case mix neutral cost per day.

(h) A statewide ceiling direct case mix neutral cost per day shall be determined by multiplying the ceiling factor times the statewide mean direct case mix neutral cost per day.

(i) A statewide mean direct price per day for each patient classification group shall be determined by multiplying the statewide mean direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(j) A statewide base direct price per day for each patient classification group shall be determined by multiplying the statewide base direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.
(k) A statewide ceiling direct price per day for each patient classification group shall be determined by multiplying the statewide ceiling direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.
New York
25(a)

(1) The corridor referred to in clause (e) of this subparagraph shall be calculated as follows:

(1) The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent effective January 1, 1996 and thereafter. The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through December 31, 1992, such factor shall be increased to approximately 95 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be approximately 90 percent.

(2) The ceiling factor referred to in clause (f) of this subparagraph shall be approximately 115 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987 such factor shall be reduced to approximately 110 percent. For the period January 1, 1988 through December 31, 1988, and thereafter such factor shall be reduced to approximately 105 percent.
(iii) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in this clause shall initially be determined to result in a 20 percent corridor. The ceiling factor shall then be increased by 5 percent. For the period January 1, 1987 through December 31, 1987, the application of the base factor and ceiling factor contained in this clause shall result in a 20 percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in this clause shall result in a 10 percent corridor.

(4) **The facility specific direct adjusted payment price per day shall be determined as follows:**

(i) The facility specific mean direct price per day shall be determined by multiplying the statewide mean direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(ii) The facility specific base direct price per day shall be
determined by multiplying the statewide base direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iii) The facility specific ceiling direct price per day shall be determined by multiplying the statewide ceiling direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iv) The facility specific cost based direct price per day shall be determined by dividing a facility's adjusted allowable reported direct costs after first deducting capital costs and items not subject to trending and, after application of the RDIPAF, by the facility's 1983 total patient days.
Except as contained in subparagraph (vi) of this paragraph, the facility specific direct adjusted payment price per day shall be determined by comparison of the facility specific cost based price per day with the facility specific base direct price per day and the facility specific ceiling direct price per day pursuant to the following table:

<table>
<thead>
<tr>
<th>Facility Specific Cost based Direct Price Per Day</th>
<th>Facility Specific Direct Adjusted Payment Price Per Day</th>
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</thead>
<tbody>
<tr>
<td>Below Facility Specific Base Direct Price Per Day</td>
<td>Facility Specific Base Direct Price Per Day</td>
</tr>
<tr>
<td>Between Facility Specific Base Direct Price Per Day and Facility Specific Ceiling Direct Price Per Day</td>
<td>Facility Specific Cost Based Direct Price Per Day</td>
</tr>
<tr>
<td>Above Facility Specific Ceiling Direct Price Per Day</td>
<td>Facility Specific Ceiling Direct Price Per Day</td>
</tr>
</tbody>
</table>

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Supersedes TN #84-26 Effective Date January 1, 1986
(vi) The facility specific direct adjusted payment price per day shall be considered to be the facility specific cost based direct price per day when such price is below the facility specific base direct price per day subject to the provisions of paragraph 6 of this subdivision for the following operators of residential health care facilities:

(a) An operator who has had an operating certificate revoked pursuant to Section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an Order of the Commissioner of this department;

(b) An operator of a facility in which the federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to Section 1866(f) of the federal Social Security Act until the lifting of the ban in writing by HCFA.

(vii) The direct component of a facility's rate shall be the facility specific direct adjusted payment price per day determined in subparagraph (v) or (vi) of this paragraph as applicable after applying the RDIPAF.
New York
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[RESERVED]

Supersedes TN #90-10

Effective Date April 1, 1991

Approval Date July 11, 1994

TN #91-25
(5) The RDI PAF shall be based on the following factors:

(i) Residential health care facilities shall be grouped, by county, into 16 regions within the State as outlined in Appendix 13-A, infra.

(ii) The [facilities] facility’s staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the [most recent] PRI’s submitted by each facility [prior to January 1st] for the fourth quarter of the preceding calendar year, in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such a time as the PRIs for the fourth quarter of the preceding calendar year are available.

(iii) The proportion of salaries and fringe benefit costs for the direct care cost[s] centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.
(6) **Case mix adjustment.**

A facility shall receive an increase or decrease in the direct component of its rate if the facility has increased or decreased its case mix from one assessment period to the next and, in accordance with subparagraph (v) of paragraph (4) of this subdivision, would not have received any change in the direct component of its rate from that determined as of January 1, 1986 to the current calculation date. The increases or decreases in the direct component of the rate shall be determined as follows:

(i) The facility specific mean price per day effective January 1, 1986 as determined in accordance with section 86-2.10(4)(i) shall be compared to the facility specific mean price per day determined as a result of the submissions required in accordance with section 86-2.11(b) of this subpart. Any increase or decrease determined as a result of such comparison, shall be expressed as a percentage, positive or negative, of the facility specific mean price per day effective January 1, 1986.

(ii) This percentage shall be applied to the Facility Specific Cost Based Direct Price Per Day determined as of January 1, 1986 and an adjustment factor shall be determined.

(iii) This adjustment factor shall be added to or subtracted from the facility specific cost based direct price per day determined as of January 1, 1986, to arrive at an adjusted facility specific cost based direct price per day which shall become for a facility
their facility specific adjusted payment price per day for applicable rate period for which payment rates are adjusted pursuant to section 86-2.11 of this Subpart.

(d) **Indirect component of the rate.**

(1) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility’s annual cost report (RHCF-4) or extracted from a hospital based facility’s annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

(i) fiscal services;

(ii) administrative services;

(iii) plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);

(iv) grounds;

(v) security;

(vi) laundry and linen;

[(vi)(vii) housekeeping;

[(vii)(viii) patient food services;

[(viii)(ix) cafeteria;

[(ix)(x) non-physician education;

[(x)(xi) medical education;

[(xi)(xii) housing; and

[(xii)(xiii) medical records.
New York 33(a)

For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through [March] December 31, 2006, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers as specified in subparagraphs (i) and (ii) of this paragraph of a provider of services, excluding a provider of services reimbursed on an initial budget basis, shall not, except as otherwise provided in this paragraph, exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group ceilings or guidelines. Effective for rates of payment commencing July 1, 2000, a separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July 1, 2000 through March 31, 2001, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through [March] December 31, 2006, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of this separate statewide average result in a change in the statewide average determined pursuant to this paragraph. The limitation on reimbursement for provider administration and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.
(2) For the purposes of establishing the allowable indirect component of the rate, facilities shall be combined into peer groups as follows:

(i) **Size:**
   (a) less than 300 beds;
   (b) 300 or more beds

(ii) **Affiliation:**
   (a) free-standing
   (b) hospital-based

(iii) **Case mix index:**
   (a) high intensity, case mix index greater than .83;
   (b) low intensity, case mix index less than or equal to .83.

(3) If any peer group contains fewer than five facilities, those facilities shall be included in a peer group of a similar type.

(4) For each of the peer groups, the indirect component of the rate shall be determined as follows:

(i) A mean indirect price per day shall be computed as follows:

   (a) Reported allowable costs for the indirect costs centers for each facility in the peer group, after first deducting capital costs and allowable items not subject to trending shall be adjusted by applying the Regional Indirect Input Price Adjustment Factor ("RIIPAF"), as determined pursuant to paragraph (6) of this subdivision.
(b) The results of the calculation in clause (a) of this subparagraph shall be aggregated and divided by total 1983 patient days of all facilities in the peer group.

(ii) The mean indirect price per day shall be the basis to establish a corridor between the base indirect price per day and the ceiling indirect price per day. The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the mean indirect price per day.

(a) The base factor shall be approximately 90 percent effective January 1, 1996 and thereafter. The base factor shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be increased to approximately 95 percent. For the period January 1, 1988 through December 31, 1992, such factor shall be increased to approximately 97.5 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be approximately 92.5 percent.

(b) The ceiling factor shall be approximately 110 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, and thereafter, such factor shall be reduced to approximately 105 percent.

(iii) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph, shall result in a 20 percent corridor. For the
period January 1, 1987 through December 31, 1987, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall result in a 10 percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall initially be determined to result in a five percent corridor. The ceiling factor shall then be increased by 2.5 percent.

(iv) The base indirect price per day shall be determined by multiplying the base factor times the mean indirect price per day.

(v) The ceiling indirect price per day shall be determined by multiplying the ceiling factor times the mean indirect price per day.

(vi) The facility specific indirect adjusted payment price per day shall be determined by comparison of a facility's adjusted reported indirect costs after deducting capital costs and items not subject to trending and after application of the RIIPAF, divided by the facility's total 1983 patient days, with the base indirect price per day and the ceiling indirect price per day. Except as outlined in subparagraph (vii) of this paragraph, the facility specific indirect adjusted payment price per day shall be established as presented by the following table:

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<td>January 1, 1988</td>
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<tr>
<td>Facility Adjusted Costs</td>
<td>Facility Specific Indirect Adjusted Payment Price Per Day</td>
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<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Divided by Patient Days</td>
<td>Price Per Day</td>
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</tbody>
</table>

Below Base Indirect Price Per Day | Base Indirect Price Per Day

Between Base Indirect Price Per Day and Ceiling Indirect Price Per Day | Report Adjusted Costs Per Day

Above Ceiling Indirect Price Per Day | Ceiling Indirect Price Per Day

(vii) The facility specific indirect adjusted payment price per day shall be considered to be the facility specific cost based indirect price per day when such price is below the facility specific base indirect price per day for the following operation of residential health care facilities:

(a) An operator who has had an operating certificate revoked pursuant to Section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an Order of the Commissioner of this department;

(b) An operator of a facility in which the federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a

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TN #86-4 Approval Date June 29, 1987
Supersedes TN #84-26 Effective Date January 1, 1986
specified date pursuant to section 1866(f) of the federal Social Security Act until the lifting of the ban in writing by HCFA.

(5) For each rate year, a facility’s indirect costs shall be compared to the peer groups identified in paragraph (2) of this subdivision as follows:

(i) A facility’s peer group established pursuant to paragraphs (2)(i) and (ii) of this subdivision shall be based on that facility’s affiliation status prior to the effective rate period, contingent upon the provisions of section 86-2.34 of this Subpart, and total certified bed capacity listed on the operating certificate.

(ii) Those facilities having 80% or more of all patients falling into patient classification groups with weights greater than .83 shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of this subdivision.

(iii) Those facilities having 80% or more of all patients falling into patient classification groups with weights equal to or less than .83 shall be compared to the peer group established pursuant to clause (c) of subparagraph (iii) of paragraph (2) of this subdivision.

(iv) Those facilities who do not meet either of the above conditions identified in subparagraphs (ii) and (iii) of this paragraph, shall be compared to a blended peer group mean price per day. Such price shall be determined by blending the number of a facility’s patients which have patient classification group weights above .83 at the high intensity peer group mean price and the number of a facility’s patients at or below .83 at the low intensity peer group mean price as defined pursuant to paragraph (4) of this subdivision.

(v) The peer group mean price effective January 1st of each rate year shall be based on the PRI’s submitted by each facility for the fourth quarter.
New York
38(a)

of the preceding calendar year in accordance with 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the peer group mean price shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The peer group mean price shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available.

[(5)] (6) The indirect component of a facility’s rate shall be the facility specific indirect adjusted payment price per day determined in accordance with subparagraphs (vi) and (vii), as applicable of paragraph (4) of this subdivision after application of the RIIPAF.

[(6)] (7) The RIIPAF shall be based on the following factors:

[(a)] (i) residential health care facilities shall be grouped by county, into 16 regions within the State as outlined in Appendix 13(b) infra.

[(b)] (ii) the facility’s staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the [most recent] PRI’s submitted by each facility [prior to January 1st], for the fourth quarter of the preceding calendar year, in accordance with sections 86.2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available; and
New York
38(b)

[(c)] (iii) the proportion of salaries and fringe benefits costs for the indirect care cost centers indicated in paragraph 1 of this subdivision to the total costs of such indirect care cost centers.

(e) Gain or Loss Limitation for the Direct and Indirect Component of the Rate:

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<td>#91-25</td>
<td>July 11, 1994</td>
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Supersedes TN **NEW**

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<th>Effective Date</th>
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<tbody>
<tr>
<td>April 1, 1991</td>
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</table>
Gain or losses resulting from using the Regional direct or indirect input price adjustment factors rather than individual facility specific direct or indirect input price adjustment factors shall be determined as follows:

(1) A facility's allowable direct costs divided by the facility's 1983 total patient days shall be compared to the facility's direct component and a direct gain or loss per day calculated.

(2) A facility's allowable indirect costs divided by the facility's 1983 total patient days shall be compared to the facility's indirect component and an indirect gain or loss per day calculated.

(3) The facility's direct gain or loss per day and indirect gain or loss per day shall be summed to arrive at a facility's net composite gain or loss per day.

(4) If a facility's net composite gain or loss per day is greater than $3.50, for the rate year 1986, a limitation shall be applied for rate years 1986 through 1988 as follows:

   (i) For 1986 rates, if a facility has a net composite gain, then a facility's direct or indirect cost per day shall be determined by utilizing the Regional or the individual facility specific input price adjustment factor, whichever factor when applied would reduce the gain.

   (ii) For 1986 rates, if a facility has a net composite loss, then a facility's direct or indirect costs per day shall be determined by utilizing the Regional or the individual facility specific input price adjustment factor, whichever factor, when applied, would reduce the loss.
(iii) If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the Regional input price adjustment factor, such factor shall be utilized in all subsequent rate years.

(iv) If a facility's direct or indirect costs per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the individual facility specific input price adjustment factor, the following shall apply to subsequent rate years:

(a) For 1987 rates, a facility's direct or indirect cost per day shall be determined by using a composite of 50% of the Regional and 50% of the facility specific input price adjustment factor.

(b) For 1988 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 75% of the Regional and 25% of the facility specific input price adjustment factor.

(c) For 1989 and subsequent rate years, a facility's direct costs per day shall be determined by using the Regional input price adjustment factors.

(5) The limitations of this subdivision shall not be applicable to specialty facilities as defined in subdivision (i) of this section.
(f) Non-comparable Component of the Rate:

(1) The non-comparable component of the rate shall consist of costs which represent allowable costs reported by a facility which because of their nature are not subject to peer group comparisons.

(2) Allowable costs for the non-comparable component of the rate shall include the costs associated with supervision of facility volunteers and costs reported in the following functional cost centers as reported on the facility's annual cost report (RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting capital cost and allowable items not subject to trending:

   i. Laboratory Services
   ii. ECG
   iii. EEG
   iv. Radiology
   v. Inhalation Therapy
   vi. Podiatry
   vii. Dental
   viii. Psychiatric
   ix. Speech and Hearing Therapy – (Hearing Therapy Only)
   x. Medical Director Office
   xi. Medical Staff Services
xii. Utilization Review

xiii. Other Ancillary

xiv. Plant Operations and maintenance – (cost for facilities and real estate and occupancy taxes only).

(3) The allowable facility specific non-comparable component of the rate shall be reimbursed at a payment rate equal to adjusted reported non-comparable costs, after first deducting capital costs and allowable items not subject to trending, divided by the facility’s total 1983 patient days.

(g) **Capital Component of the Rate.**

The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with section 86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the department to be non-trendable divided by the facility’s patient days in the base year determined applicable by the department.

(h) A facility's payment rate for 1986 and subsequent rate years shall be equal to the sum of the operating portion of the rate as defined in paragraph (2) of subdivision (b) of this section and the capital component as defined in subdivision (g) of this section.

(i) **Specialty Facilities.**

Facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems shall be considered
specialty facilities and shall not be subject to the provisions of paragraphs (c)(3), (c)(4), (d)(4), (d)(5) and (d)(6) of this section. The direct component of such facilities’ rates shall be calculated based on allowable 1983 direct costs as defined in paragraph (c)(1) of this section, divided by the facilities’ total 1983 patient days. The indirect component of such facilities’ rates shall be calculated based on allowable 1983 indirect costs as defined in paragraph (d)(1) of this section, divided by the facilities’ total 1983 patient days.

(k) Receiverships and new operators.

(1) The appointment of a receiver or the establishment of a new operator to an ongoing facility shall require such receiver or operator to file a cost report for the first [six-month] twelve-month period of operation in accordance with section 86-2.2(e) of this Subpart. This report shall be filed and properly certified within 60 days following the end of the [six-month] twelve-month period covered by the report. Failure to comply with this subdivision shall result in [a reduction of the current rate in accordance with] application of the provisions of section 86-2.2(c) of this Subpart.

(2) The initial rate for facilities covered under this subdivision shall be the higher of (i) the rate in effect on the date of the appointment of a receiver or the date of transfer of ownership as applicable[,] or (ii) the rate in effect on the date of appointment of a receiver or the date of transfer of ownership as applicable with the direct and indirect component of such rate calculated as follows:

(a) The direct component of the rate shall be equivalent to the facility-specific mean direct price per day after application of the RDIPAF as determined in section 86-2.10(c) of this Subpart. The PRIs used in the computation of the facility-specific mean direct price per day shall be the PRIs used to calculate the rate in effect on the date of appointment of a receiver or the date of transfer of ownership.

(b) The indirect component of the rate shall be equivalent to the mean indirect price per day, determined using the PRIs used to calculate the rate in effect on the date of appointment of a receiver or date of transfer of ownership, and adjusted by the RIIPAF as determined in section 86-2.10(d) of this Subpart.

(3) The facility shall perform an assessment of all patients, pursuant to Section 86-2.30 of this subpart, at the beginning of the fourth month of operation. The direct component of the rate shall be adjusted pursuant to this subpart effective the first day of the assessment period based on the facility’s case mix.

TN  #93-04        Approval Date    July 24, 1996
Supersedes TN  #91-25 Effective Date April 1, 1993
(4) The twelve-month cost report referred to in paragraph (1) of this subdivision shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the twelve-month cost report period.

(5) (i) For purposes of this subdivision, and except as identified in paragraph (7) herein, the terms “new operator” and “receiver” shall not include any operator or receiver approved to operate a facility when:

(a) a stockholder, officer, director, sole proprietor or partner of such operator or receiver was also a stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility;

(b) the approved operator was the prior receiver of the facility;

(c) any prior corporate operator or receiver is a corporate member of the approved operator or receiver, is otherwise affiliated with the approved operator or receiver through direct or indirect sponsorship or control or when the approved operator or receiver and prior operator or receiver are subsidiaries of a common corporate parent; or

(d) a principal stockholder (owning 10 percent or more of the stock), officer, director, sole proprietor or partner of an approved proprietary operator or receiver is the spouse or child of a principal stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility, regardless of whether such relationship arises by reason of birth, marriage or adoption.

(ii) Rates of reimbursement for operators which are not considered new operators under this subdivision shall not be subject to adjustment under this subdivision.

(6) Notwithstanding the provisions of this subdivision, a receiver or new operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993 but after the date on which the receiver was appointed or new operator became the operator shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for the purpose[s] of this subdivision in lieu of the twelve-month cost report identified in paragraph (1) of this subdivision.

(7) (i) Notwithstanding the provisions of this subdivision, when a receiver of a proprietary nursing facility is appointed or a new operator of a previously established proprietary nursing facility is established and a stockholder, sole proprietor, partner or limited liability company member of such receiver or new operator is the child of a stockholder, sole proprietor, partner or member of the limited liability company of the prior operator or receiver of the facility, such receiver or new operator shall receive rates of reimbursement adjusted pursuant to paragraphs (1)-(4) and (6) of this subdivision. For

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<th>March 13, 2002</th>
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<td>Supersedes TN #93-04</td>
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purposes of this paragraph, child shall mean a child or stepchild by birth, adoption, or marriage. Rates of reimbursement for any subsequent operator of such facility who is established within 10 years of the date of appointment or establishment of such child or stepchild shall not be subject to adjustment under this subdivision.

(ii) For purposes of this paragraph, the terms “new operator” and “receiver” shall not include any operator or receiver with a stockholder, sole proprietor, partner, or limited liability company member who was a stockholder, sole proprietor, partner, or limited liability company member who was a stockholder, sole proprietor, partner or limited liability company member of the prior operator or receiver of such facility.

(iii) For purposes of this paragraph, “new operator” shall also mean an established operator which has undergone a total change in owners, stockholders, partners or limited liability company members.

(iv) This paragraph shall apply to appointments of receivers and/or establishment of a new operator on or after the effective date of this paragraph.

(I) Adjustments to the opening component of the rate.

(1) Notwithstanding any other provision of this section, the department shall make available the sum of $10 million for rate year 1986 and $5 million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

(2) To determine eligibility for such adjustments, facilities shall also have suffered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility’s composite 1983 allowable costs for the direct and indirect components.
(I) **Adjustments to the operating component of the rate.**

(1) Notwithstanding any other provision of this section, the department shall make available the sum of $10 million for rate year 1986 and $5 million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

(2) To determine eligibility for such adjustments, facilities shall also have offered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility's composite reimbursement for the direct and indirect components of the rate is less than such a facility's composite 1983 allowable costs for the direct and indirect components.
(3) The transfer amount referred to in paragraph (1) of this subdivision shall be made available by reductions in the operating components of facilities rates whose composite reimbursement for the Direct and Indirect Components of their rates is more than their composite 1983 allowable costs for the Direct and Indirect Components, herein referred to as aggregate gains.

(4) The transfer amounts referred to in paragraph (1) of this subdivision shall be distributed, for the applicable rate years, to eligible facilities by a per diem adjustment in the operating component of their rates in accordance with the following procedure:

(i) The indirect losses of all eligible facilities shall be summed to arrive at total indirect losses.

(ii) The proportion of a facility's indirect loss to total indirect losses shall be expressed as a percentage, herein referred to as a sharing percentage.

(iii) The sharing percentage for an eligible facility shall be multiplied by the transfer amount to arrive at a facility's share of the transfer amount.

(iv) A facility's share of the transfer amount shall be divided by 1983 patient days to arrive at a per diem adjustment to the operating component of a facility's rate.

(5) The transfer amounts referred to in paragraph (1) of this subdivision shall be accumulated from facilities referred to in paragraph (3) of this subdivision by a per diem adjustment to the operating component of their rates in accordance with the following procedure:
(i) The aggregate gains of a facility shall be expressed as a percentage of their composite 1983 allowable costs for the Direct and Indirect Components. Such percentage shall be herein referred to as percentage gain.

(ii) The percentage gain for all facilities shall be ranked from highest to lowest.

(iii) A methodology shall be employed where, beginning with a set percentage, percentage gains in excess of such set percentage shall be noted, arrayed by facility and herein referred to as excess percentage gain.

(iv) The excess percentage gain shall be multiplied by each facility’s allowable composite 1983 costs for the Direct and Indirect Components and such total for all facilities accumulated as a funded amount. The excess percentage gain shall also then be subtracted from a facility’s percentage gain and the net percentage gain utilized as a facility’s percentage gain for subsequent calculations.

(v) Such process shall continue, decreasing the set percentage used as a standard against which percentage gains of facilities is compared and the funded amounts accumulated until the transfer amounts referred to in paragraph (1) of this subdivision are realized.

(vi) If in this process, moving to the next set percentage used as a standard against which percentage gains of facilities is compared shall result in a total transfer amount in excess of the
New York
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transfer amounts referred to in paragraph (1) of this subdivision, the following procedure shall be utilized to determine the amounts necessary to be funded by each facility in the final step of this process to attain the transfer amounts referred to in paragraph (1) of this subdivision:

(a) A facility’s percentage gain shall be compared to the next lower set percentage that would be utilized as a standard and an excess percentage gain determined.

(b) The excess percentage gain for a facility, at that time, shall be multiplied by the facility’s allowable composite 1983 costs for the direct and indirect components and the result herein referred to as an interim funded amount.

(c) The interim funded amount for each facility, expressed as a percentage of the aggregate of the interim funded amount for all facilities shall be multiplied by the remaining amount to be funded for a given rate year to arrive at a facility’s portion of the final amount to be funded.

(vii) The funded amounts for a facility arrived at as a result of this paragraph shall be summed, divided by total 1983 patient days and deducted as a per diem adjustment from a facility’s operating per diem in the appropriate rate year.

(m) Computation of regional input price adjustment factors applied for purposes other than determining, pursuant to this section, the statewide direct and peer group indirect prices.
(1) The regional direct input price adjustment factor (RDIPAF) as contained in subparagraphs (c)(4)(iv) and (vii) of this section, the regional indirect input price adjustment factor (RIIPAF), as contained in subparagraph (d)(4)(vi) and paragraph (d)(5) of this section and the regional input price adjustment factor as contained in subparagraph (iv) of paragraph (4) of subdivision (e) of this section, hereinafter referred to as factors shall, be based on the regional average dollar per hour (RAP) calculated using the financial and statistical data required by §86-2.2 of this Subpart, reported solely for 1983 calendar year operations, adjusted as follows:

(i) RAP’s shall be adjusted for the variation in wage and fringe benefit costs for each region relative to such variation for all other regions through the use of a variable corridor.

(ii) The measurement of the region’s variation shall be accomplished by means of the statistical measure of variation, the coefficient of variation, in wage and fringe benefit costs.

(iii) The region with the smallest variation shall receive no corridor. The region with the highest variation shall receive a corridor no greater than a maximum percentage such that the average corridor for all regions in the State shall be approximately plus or minus 10 percent.

(iv) For rate years beginning on or after January 1, 1991, for those regions of the state described in Appendix 13-A, infra, whose Regional Average Dollar Per Hour (RAP), calculated using the financial and statistical data required by §86-2.2 of this Subpart reported solely for 1987 calendar year operations (1987 RAP) expressed as a percentage of the Statewide RAP for such year in greater than the percentage calculated using the same data reported for the 1983 calendar year operations, (1983 RAP), the factors shall be determined utilizing 1987 RAPs and adjusted pursuant to subparagraph (i), (ii) and (iii) of this paragraph.
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(a) Notwithstanding this subparagraph if the utilization of 1987 RAPS to
do

determine the factors would, for any facility within a region described in

dthis subparagraph, result in less reimbursement than the continued

dutilization of the 1983 RAPS to determine the factors, the factors

dutilized for such facility shall continue to be based on 1983 calendar

dyear data.

(v) For purposes of establishing rates of payment by governmental agencies for

dresidential health care facilities for services provided on and after January 1,

d1998, the regional direct and indirect input price adjustment factors to be

dapplied to any such facility’s rate calculation shall be based upon the

dutilization of either 1983, 1987 or 1993 calendar year financial and statistical

data. The determination of which calendar year’s data to utilize shall be

dbased upon a methodology that ensures that the particular year chosen by

each facility results in a factor that yields no less reimbursement to the

dfacility than would result from the use of either of the other two years’ data.

Such methodology shall utilize the 1983 and 1987 regional direct and indirect

dinput price adjustment factor corridor percentages in existence on January 1,

d1997 as well as 1993 regional direct and indirect input price adjustment

dfactor corridor percentage calculated in the same manner as the 1983 and

d1987 direct and indirect input price adjustment factor corridor percentages in

dexistence on January 1, 1997.

(vi) For purposes of establishing rates of payment for residential health care

dfacilities for services provided on and after April 1, 2004, the regional direct

dand indirect input price adjustment factors to be applied to any such facility’s

drate calculation shall be based upon the utilization of either 1983, 1987, 1993

or 2001 calendar year financial and statistical data provided, however, the

total amount of rate increases attributable to the utilization of 2001 calendar

dyear data shall be no more than $47.5 million on a pro rata basis per

calendar year. The determination of which calendar year’s data to utilize shall

dbe based upon a methodology that ensures that the particular year chosen by

each facility results in a factor that yields no less reimbursement to the

dfacility than would result from the use of the other three years’ data. Such

methodology shall utilize the 1983 and 1987 regional direct and indirect input

dprice adjustment factor corridor percentages in existence on January 1, 1997,
as well as the 1993 regional direct and indirect input price adjustment factor

corridor percentage in existence on January 1, 2004, as well as a 2001

dregional direct and indirect input price adjustment factor corridor percentage

calculated in the same manner as the 1993 direct and indirect input price


TN #04-24 Approval Date September 28, 2004
Supersedes TN #98-04 95-23 Effective Date April 1, 2004
(2) The corridor established in paragraph (1) of this subdivision shall be applied in each region as follows:

(i) The regional corridor percentage referred to in subparagraph (iii) of paragraph (1) of this subdivision, shall be applied, both negatively and positively to the RAP to arrive at an amount which when added to or subtracted from the RAP shall represent the maximum and minimum regional dollar per hour, for the region hereafter referred to as the maximum and minimum respectively.

(ii) The facility in each region with the highest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the maximum.

(iii) The facility in each region with the lowest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the minimum.

(iv) Facilities in a region with facility wage and fringe benefit dollars per hour between the highest and lowest facility wage and fringe benefit dollar per hour in such region shall be assigned a facility RAP on a sliding scale, based on the relatively of such facility’s labor costs to the RAP and to the highest or lowest labor costs in the region, as applicable.
(n) **Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI).**

[Adjustments to the operating portion of the rates for facilities] Facilities which have been approved to operate discrete units for care of [patients] residents under the long-term inpatient rehabilitation program for [head-injured patients HI] TBI patients [established pursuant to section 416.11 of this Title] shall [be made] have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) In determining the facility-specific direct [adjustment] adjusted payment price per day pursuant to paragraph (c)(4) of this section for [patient] residents meeting the criteria for and residing in [the HI] a TBI unit, [separate and distinct statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base and ceiling direct cost per day, respectively.] the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an

**TN #93-04** Approval Date July 24, 1996

Supersedes TN #89-4 Effective Date April 1, 1993
increment of 1.49. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.49.

(a) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by the Department to operate a TBI unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to the increment.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for residents meeting the criteria for and residing in a TBI unit, a facility's indirect costs shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of subdivision (d) of this section.

(3) The noncomparable component of such facilities' rates shall be
determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this section Subpart including approved actual costs in such cost report for personnel identified in required by section 415.36 of this title Appendix 1 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

[(4) The provisions of this subdivision will expire on December 31, 1994.]
(o) (1) [For rate year 1988,] A per diem amount of $4.00 (subject to adjustment pursuant to the provisions of paragraph (2) of this subdivision) increased to the rate year by the projection factors determined pursuant to section 86-2.12 of this Subpart, adjusted by the RDIPAF[,] determined pursuant to paragraph (5) of subdivision (c) of this section, shall be added to each facility's payment rate for each patient whose primary medical problem, as reported in section V.29 of the patient review form (PRI) as contained in subdivision (i) of section 86-2.30 of this Subpart, is dementia, as defined in paragraph (4) of this subdivision, and who is properly assessed and reported by the facility in one of the following patient categories as listed in Appendix 13-A of this Title:

- Clinically Complex A
- Behavioral A
- Reduced Physical Functioning A
- Reduced Physical Functioning B

(2) Based on the most current 1986 PRI's filed with the Department, the number of eligible dementia patient days [in 1988,] for Medicaid patients admitted prior to December 31, 1987, is estimated to be 1,750,000. Aggregate changes in such number in excess of 5% shall be deemed to be attributable to factors other than changes in patient condition and shall result in the recalculation and proportionate, prospective reduction of the per diem amount referred to in paragraph (1) of this subdivision.

(3) Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which positive outcomes are not demonstrated.
(4) The per diem amount referred to in paragraph (1) of this subdivision shall be paid for any patients with the following dementia diagnoses. The dementia diagnosis and related codes and descriptions are taken from the International Classification of Diseases, 9th Revision, Clinical Modification, volume 3 (ICD-9-CM).

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<tr>
<td>290.0</td>
<td>Senile dementia</td>
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<td>Uncomplicated senile dementia NOS, simple type excludes memory disturbance</td>
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<td>Alzheimer's disease</td>
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<td>Jakob-Croutzfeldt disease</td>
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<td>Pick's disease of the brain</td>
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<td>Presenile dementia with acute confusional state</td>
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<td>290.12</td>
<td>Presenile dementia with delusional feature</td>
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### New York 47f

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<td>290.21</td>
<td>Senile dementia with depressive features</td>
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<td>Organic Brain Syndrome</td>
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<td>294.8</td>
<td>Other specified organic brain syndrome</td>
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<td>294.9</td>
<td>Unspecified organic brain syndrome</td>
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<tr>
<td>310.1</td>
<td>Organic personality syndrome</td>
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<td>310.8</td>
<td>Other specified non-psychotic mental disorders, following organic brain damage</td>
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**TN #89-4**

**Approval Date** February 26, 1990

**Supersedes TN #88-4**

**Effective Date** January 1, 1989
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Acquired Immune Deficiency Syndrome (AIDS).

(1) For rate year 1988 and thereafter, payment rates shall be adjusted, pursuant to this subdivision to provide additional payments to facilities for patients residing in [designated AIDS beds and/or] a residential health care facility designated as an AIDS facility or having a discrete AIDS unit[s] approved by the commissioner pursuant to Part 710 of this Title, or a facility which has received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose [primary] medical [problem] condition is [Acquired Immune Deficiency Syndrome (AIDS) as defined in section 416.12, section 421.14 and section 422.1 of this Title.] HIV Infection Symptomatic. Such patients shall hereinafter be referred to as [an] AIDS patients.

(2) Separate and distinct payment rates shall be calculated pursuant to this paragraph for AIDS facilities or discrete AIDS units approved by the commissioner pursuant to Part 710 of this Title. [For residential health care facilities (RHCF), adjustments to payment rates shall be made as follows:]

(i) [In determining the] The facility specific direct adjusted price per day shall be determined pursuant to paragraphs (3) and (4) of subdivision (c) of this section and further adjusted as follows [for an AIDS patient, the statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this paragraph times the statewide mean, base and ceiling direct case mix neutral cost per day respectively. The case mix proxy for an AIDS patient shall be determined as follows:

(a) An AIDS patient shall be assigned a case mix proxy based on the sum of the responses to section III – Activities of Daily Living (ADLs), questions 19, 21 and 22 of the patient review instrument (PRI) as contained in section 86-2.30(i) of this Subpart as follows:

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(a) In determining the direct component of a facility's rate pursuant to paragraphs (3) and (4) of subdivision (c) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the case mix index for the AIDS patient shall be increased by an increment which shall be determined on the basis of the difference between allowable actual direct staffing levels and cost expenditures for the care of AIDS patients in specific patient classification groups and those of non-AIDS patients which are classified in the same patient classification groups based on data submitted by the facility. The increment to be included in a facility's rate shall be approved by the [c]Commissioner, but in no event shall the increment exceed 1.0. The facility's direct ceiling price shall be further increased by an occupancy factor of 1.089. Effective April 1, 2009, however, the operating component shall not reflect an occupancy factor increase.

(b) For purposes of this paragraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a non-comparable cost.

ii. Except as identified in subparagraph (iii) of this paragraph, in determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the peer group ceiling indirect price shall be increased by a factor of 1.20.

iii. In determining the indirect component of a facility's rate pursuant to paragraphs (4) and (5) of subdivision (d) of this section for a facility with a total bed complement of less than 40 beds all of which are approved by the [c]Commissioner pursuant to Part 710 of this Title solely for the care and management of AIDS patients, the peer group ceiling indirect price shall be increased by a factor of 2.00 for those facilities that are less than or equal to 16 beds and such factor shall be decreased by 0.033 for every additional bed thereafter.
Attachment 4.19-D
Part I

New York
47(j)

-Deleted -

TN #90-10
Supersedes TN #88-34

Approval Date October 1, 1990
Effective Date October 1, 1990
New York
47(l)

(3) [A cost report shall be filed in accordance with section 86-2.2 of this Subpart for the first six month period during which a new facility which has been certified for the purpose of providing services solely to AIDS patients has received an overall average utilization of at least 80 percent of bed capacity. This report shall be properly certified within 60 days.

TN #91-25
Supersedes TN #90-10

Approval Date June 11, 1994
Effective Date April 1, 1991
following the end of the six month period covered by the report. Failure to comply with this subparagraph shall result in a reduction of the current rate in accordance with subdivision (c) of section 86-2.2 of this Subpart. For facilities which have received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates pursuant to paragraph (2) of this subdivision, the patient classification group case mix index for AIDS patients which is used to establish direct cost reimbursement shall be increased by an increment of 1.0.

New York
47(m)
Long term ventilator dependent residents.

Facilities which have been approved to operate discrete units for the care of long-term ventilator dependent residents [as established pursuant to section 416.13 of this Title] shall have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) The facility specific direct adjusted price per day shall be determined as follows:

[(1)] (a) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for patients residents meeting the criteria [established in section 416.13 of this Title] and residing in a discrete unit for the care of long-term ventilator dependent patients residents, [separate and distinct statewide mean, base, and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base, and ceiling direct case mix neutral cost per day respectively.] the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.15. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.15.
(b) The increments established in subparagraph (a) of paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility’s cost report submitted pursuant to this Subpart is less than the staffing pattern required by the Department to operate a ventilator-dependent unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to this increment.

(c) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

(d) The allowable costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section.

[(2) For purposes of this subdivision, the case mix proxy solely for patients residing in a discrete unit for the care of long term ventilator dependent patients shall be defined as a case mix index of 2.52.]

(2) In determining the indirect component of a facility’s rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for residents meeting the criteria.
New York 47(q)(2)

and residing in a discrete unit for the care of long-term ventilator dependent residents, a facility’s indirect costs shall be compared to the per group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities’ rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this part Subpart including approved actual costs in such cost report for personnel required be identified in section 415.38 of this title Appendix 2 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

(4) The provisions of this subdivision will expire on December 31, 1994.
Nursing salary adjustment.

(1) The adjustment to the operating portion of the rate to reflect the costs of retaining and recruiting nursing services shall be made as follows:

(i) A percentage figure shall be determined as follows:

(a) An average annual statewide increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based on the available ratified nursing contracts for general hospital services and an average annual regional increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year 1988 shall be determined based upon available information for residential health care facilities.

(b) The average annual regional and statewide increase in salaries shall be multiplied by the total number of nursing staff in the region and the total number of nursing staff statewide respectively to arrive at the total regional and statewide adjustment to be made to facilities. The total regional adjustments shall be determined using the regions contained in Appendix 13-A herein.

(c) The adjusted base shall be determined by the multiplying the facility specific mean price per day determined pursuant to subparagraph (i) of paragraph (4) of subdivision (c) of this section by total patient days for each facility and the result shall be summed on a regional and statewide basis.

(d) The total adjustment to be made for all facilities determined pursuant to clause (b) of this subparagraph shall be divided by the adjusted base determined pursuant to clause (c) of this subparagraph on a regional and statewide basis to determine the regional percentage increase and the statewide percentage increase.
New York
47(s)

(e) The facility specific percentage shall be determined by summing 40 percent of the statewide percentage and 60 percent of the corresponding regional percentage determined pursuant to clause (d) of this subparagraph.

(ii) The adjustment to the rate for a facility shall be determined by applying the facility specific percentage figure calculated in subparagraph (i) of this paragraph to a facility’s adjusted base and added to the operating portion of the rate.
Huntington's disease

For periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by existing residential health care facilities with more than 40 beds that operate discrete units for the treatment of residents with Huntington's disease will be increased by a rate add-on amount. The aggregate amount of such rate add-ons for the period July 1, 2011 through December 31, 2011 will be $850,000 and for calendar year 2012 and each year thereafter will be $1,700,000. Payments will be calculated as follows:

1. Amounts will be allocated to each eligible residential health care facility proportionally based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units based on the bed capacity reported in certified cost reports submitted to the Department of Health for the calendar year period two years prior to the applicable rate year.

2. Rate add-ons will be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department of Health for the calendar year period two years prior to the applicable rate year.

3. Rate add-ons shall not be subject to subsequent adjustment or reconciliation.

4. Payments under this section end on October 31, 2016.

Specialized programs for residents with neurodegenerative disease providing care to patients diagnosed with Huntington's disease and Amyotrophic Lateral Sclerosis (ALS) Disease.

Effective November 1, 2016, new and existing facilities which have been approved to operate discrete specialty units specifically designated for the purpose of providing care to residents with Huntington's disease and amyotrophic lateral sclerosis, will have rates calculated for Medicaid reimbursement separate and distinct from the general nursing home rate. Rates established in these new specialty units will be based on budgeted cost as submitted by the facility and approved by the department. Budgeted rates will be in effect until such time the specialty facility files a calendar year certified cost report reflecting such specialty unit's first twelve months of operation at an occupancy level of 90% or more. The department will thereafter issue such facilities rates with non-capital components reflecting such cost report and such rates will be effective as of January 1 of the calendar year in which the facility reaches at least a 90% occupancy rate based on a filed cost report of that given year. The capital component will be a continuation of the budget updated for current indebtedness. Should a facility fail to reach 90% occupancy after five (5) years, the Department will review the continued need for a specialty unit in that facility.

The facility specific rate will be calculated as follows:

TN #16-0009______________ Approval Date January 30, 2017_______
Supersedes TN #11-0010_______ Effective Date November 1, 2016______
a. **The facility specific direct component of the rate will include allowable costs reported in**
the following functional cost centers on the facility's annual cost report (RHCF-4) or
extracted from a hospital-based facility's annual cost report (RHCF-2) and the
institutional cost report of its related hospital, after first deducting for capital costs and
allowable items not subject to trending:

(i) nursing administration;
(ii) activities;
(iii) social services;
(iv) transportation;
(v) physical therapy;
(vi) occupational therapy;
(vii) laundry and linen;
(viii) speech and hearing therapy – (speech therapy portion only);
(ix) central service supply; and
(x) specialty unit.

Direct component costs are not subject to case mix adjustment.

b. **The facility specific indirect component of the rate will include costs reported in the**
following functional cost centers on the facility's annual cost report (RHCF-4) or
extracted from a hospital based facility's annual cost report (RHCF-2) and the
institutional cost report of its related hospital, after first deducting for capital costs and
allowable items not subject to trending:

(i) fiscal services;
(ii) administrative services;
(iii) plant operations and maintenance (with the exception of utilities
and real estate and occupancy taxes);
(iv) grounds;
(v) security;
(vi) laundry and linen;
(vii) housekeeping;
(viii) patient food services;
(ix) cafeteria;
(x) non-physician education;
(xi) medical education;
(xii) housing; and
(xiii) medical records

c. **The facility specific noncomparable component of the rate will include allowable costs**
associated with supervision of facility volunteers and costs reported in the following
functional cost centers as reported on the facility's annual cost report (RHCF-4) or
extracted from a hospital based facility's annual cost report (RHCF-2) and the
institutional cost report of its related hospital, after first deducting capital cost and
allowable items not subject to trending:
New York
47(s)(iii)

i. Laboratory Services;
ii. ECG;
iii. EEG;
iv. Radiology;
v. Inhalation Therapy;
vi. Podiatry;
vii. Dental;
viii. Psychiatric;
ix. Speech and Hearing Therapy – (Hearing Therapy Only);
x. Medical Director Office;
xi. Medical Staff Services;
 xii. Utilization Review;
xiii. Other Ancillary; and
xiv. Plant Operations and maintenance – (cost for facilities and real estate and occupancy taxes only).

Nothing in this subparagraph will be understood as exempting specialty facilities which have not yet achieved 90% occupancy from the generally applicable requirement to file annual calendar year cost reports.
New York
47(t)

The Commissioner of Health shall adjust medical assistance rates of payment for services provided on or after April 1, 2002, established pursuant to this section for non-public residential health care facilities for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

For non-public residential health care facilities, $53.5 million on an annualized basis for the period April 1, 2002 through December 31, 2002; $83.3 million on an annualized basis for the period January 1, 2003 through December 31, 2003; $115.8 million on an annualized basis for the period January 1, 2004 through December 31, 2006; $57.9 million for the period January 1, 2007 through June 30, 2007; $57.9 million for the period July 1, 2007 through March 31, 2008; and $64.8 million for the period May 8, 2008 through March 31, 2009[, and $26.2 million for the period April 1, 2009 through March 31, 2010].

For periods through June 30, 2007, for non-public residential health care facilities, such increases shall be allocated proportionally based on each non-public residential health care facility’s reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF-4 cost report or exhibit 11 of the 1999 institutional cost report as submitted on or before November 1, 2001, where applicable, to the total of such reported costs for all non-public residential health care facilities.

For periods on and after July 1, 2007, for non-public residential health care facilities, 50% of such increases shall be allocated proportionally based on each such facility’s salary and fringe benefit costs as reported on Exhibit H in the 1999 cost report submitted prior to November 1, 2001, to the total of such costs for all non-public facilities. The remaining 50% of such increases shall be allocated proportionally based on each non-public facility’s Medicaid revenue as reported in the applicable 2005 cost report submitted prior to November 1, 2006, to the total of such Medicaid revenue for all non-public facilities.

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 RHCF-4 cost reports or 1999 institutional cost reports, but which have submitted such reports for cost years subsequent to 1999, shall have such increases allocated based on total gross salary and fringe benefit costs on exhibit H of the earliest subsequently submitted RHCF-4 cost report or exhibit 11 of the earliest subsequently submitted institutional cost report, as trended downward to 1999 using authorized trend factors. These trend factors shall be developed in accordance with Page 51(a) of this Attachment and will be consistent with those used in the calculation of the facility’s reimbursement rates.
New York
47(t)(1)

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 or subsequent RHCF-4 cost reports or institutional cost reports, shall have such increases allocated based on imputed total gross salary and fringe benefit costs reflecting the average of such 1999 actual reported costs in the region in which each facility is located. Facilities receiving allocations pursuant to this paragraph which subsequently submit RHCF-4 cost reports or institutional cost reports shall, for the purpose of setting medical assistance rates of payment, have such allocations adjusted to reflect costs which were incurred in connection with such allocations and which are contained in such cost reports.

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.
Criminal Background Checks

Effective April 1, 2005, residential health care facility 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 check, including, but not limited to, a fingerprint 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 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 are 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 for the April 1, 2006 through 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.

Effective September 1, 2006, residential health care facilities 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 will consist of both a state and a national criminal history check.

Residential health care facilities 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 certain other costs associated with obtaining the fingerprints. 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 and will be determined by the percent of Medicaid utilization to total utilization for each provider.
New York 47(u)

Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.

(1) Rate changes resulting from the [Amendments] amendments to sections 86-2.1(a), 86-2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) & (2) and (p)(2) [and (3) [& (4)], and 86-2.30(c)(3) of this Title effective October 1, 1990, and amendments to sections 86-2.10(a)(3), (c)(1), (3) and (5), (d)(1), (2) and (4)-(7), (p)(1)-(3), and (b)(1) and (2) of this Title effective April 1, 1991 shall be [reflected in 1990 and 1991 rates pursuant to the following schedule] as follows:

(i) For rates with effective dates commencing between October 1, 1990 to [March 31, 1991] and June 30, 1992, [actual rate change shall not exceed 0 percent] the rate shall be computed using the rate methodology in effect on September 30, 1990, adjusted by the most recent PRI submissions applicable to the effective period of the rate, and the adjustment to the regional direct and indirect input price adjustment factors pursuant to subparagraph (iv) of paragraph (1) of subdivision (m) of this section.

(ii) [For rates with effective dates commencing between April 1, 1991 to June 30, 1991, actual rate change shall not exceed 2 percent.

(iii) For rates with effective dates commencing between July 1, 1991 to September 30, 1991, actual rate changes shall not exceed 4 percent.

(iv) For rates with effective dates commencing on or after [October 1, 1991] July 1, 1992, the full impact of the [methodology] rate changes [effective on October 1, 1990] cited in paragraph (1) of this subdivision shall be reflected in rates.

(iii) Those facilities with an initial budgeted rate or revised cost-based rate which reflects a change in base year and which is effective after April 1, 1991, shall receive the full impact of the methodology changes cited in paragraph (1) of this subdivision on the effective date of such rate.

(2) For facilities having multiple rates based on levels of care prior to October 1, 1990, such rates shall be combined for the establishment of rates effective October 1, 1990 to [March 31, 1991] June 30, 1992 based on a weighted average of reported Medicaid days for each previous level of care for the latest available cost reporting period. Where the Department is authorized expressly by statute to adjust rates retrospectively, for both positive and negative rate adjustments, such combined rate shall be adjusted by a reconciliation of reported Medicaid days to actual billed Medicaid days for the effective period, provided that such adjustment results in a combined direct and indirect component rate change of more than 5%. Such combined rate shall reflect the amendments referenced in paragraph (1) of this subdivision pursuant to the schedule set forth therein.

(3) Notwithstanding the provisions of paragraph (1) of this subdivision, residential health care facilities which have been identified by the department as requiring registered nurse staffing increases to provide seven days a week, eight hours per day of day shift registered nurse coverage shall receive rate changes effective October 1, 1990 at a level sufficient to compensate.

TN  #91-25 Approval Date  July 11, 1994
Supersedes TN  #90-10 Effective Date April 1, 1991
facilities for additional expenses of expanding registered nurse coverage based upon a survey of costs to be incurred by affected facilities.

(4) Nothing within this subdivision shall preclude the Department from fully implementing rate adjustments on or after October 1, 1990, which are unrelated to methodology changes referenced in paragraph (1) of this subdivision.

(t) **Base Year Adjustment for Facilities Who have Bed Conversions.**

* A facility shall be eligible for an adjustment to its base year costs if its proportion of beds identified as skilled nursing facility beds and health related facility beds as of the first day of its base period differs from the proportion of beds identified as skilled nursing facility beds and health related facility beds as of September 30, 1990. The adjustment shall be separately determined for the direct, indirect, and non-comparable components of a facility's allowable base period costs, and each adjustment shall be added to a facility's allowable direct, indirect and non-comparable costs, respectively, prior to group comparisons. The amount of the adjustment shall be determined as follows:

(1) Base period direct, indirect, and non-comparable costs per bed adjusted for occupancy level shall be separately calculated for both skilled nursing and health related facility beds. The changes in skilled nursing and health related facility beds for the period defined in the above paragraph shall be multiplied by the applicable cost per bed and added together to arrive at each adjustment amount.

(2) An adjustment to allowable days shall also be made for a facility whose total number of beds has changed for the period described in this subdivision to reflect the skilled nursing facility and health related facility occupancy levels used in the calculation of rates effective September 30, 1990. Base period days shall be adjusted by the proportion of total new beds as of September 30, 1990 to total base year beds prior to the determination of the

* for rates effective July 1, 1992
facility-specific price per day for the facility’s direct, indirect, and non-comparable cost components.

(u) **Adjustment for Additional Federal Requirements.**

A facility whose rate is based on allowable or budgeted costs for a period prior to April 1, 1991 shall be considered eligible to receive a per diem adjustment to its rate as follows:

1. A per diem adjustment shall be incorporated into each facility’s rate to take into account the additional reasonable costs incurred by facilities in complying with the requirements of subsection (b), (other than paragraph 3(F) thereof), (c), and (d) of section 1919 of the federal Social Security Act effective October 1, 1990 as added by the federal Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Additional reasonable costs resulting from such federal requirements shall include additional reasonable costs in the following areas: the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aide registry costs, psychotropic drug reviews, and surety bond requirements.

   (i) The per diem adjustment shall be forty-five cents computed on a statewide basis and shall be regionally adjusted to reflect differences in registered nurse salary levels for calendar year 1987. Any costs over the per diem adjustment shall be deemed attributable to factors other than compliance with the federal requirements referenced in this subdivision.

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**TN #97-03**

**Approval Date** June 30, 1997

**Supersedes TN #96-03**

**Effective Date** October 1, 1997
(ii) For purposes of inclusion in facility rates for 1991, the annual incremental per
diem add-on shall be effective for the nine month period beginning April 1,
1991 and further adjusted so that the nine months of incremental cost are
reflected in a per diem adjustment for July 1, 1991 through December 31,
1991 rates.

(2) For rates years beginning on or after January 1, 1992, the annual incremental per
diem add-on calculated pursuant to subparagraph (i) of paragraph (1) shall be
trended forward by the applicable facility trend factor. ¹

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¹Trend factors are computed in accordance with Section 86-2.12 of this Plan.

TN #97-03 Approval Date June 30, 1997
Supersedes TN NEW Effective Date October 1, 1997
Description of the Specific Methodology Used in Determining the Adjustment.

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and comprehensive assessments, the additional cost pertains to completion of the MDS+ document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessments of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or (.5) (.45) + (.5) = .48. The total number of assessments per bed would be 1.48 = 1.48.

2 MDS+ (Minimum Date Set Plus for Nursing Home Residents Assessment and Care Screening)
New York
47(w)(3)

Based on a time study of the MDS\(^3\), it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of $24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

\[
(\# \text{ assessments/bed}) \times (\# \text{ beds}) \times (\text{incremental time/assessment})
\]

\[
(1.48) \times (105,000) \times (.75) \times ($24) = $2,797,200 \text{ for comprehensive assessments}
\]

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

\[
(2.2) \times (105,000) \times (.5) \times ($24) = $2,772,000 \text{ for quarterly assessments}
\]

\(^3\) MDS (Minimum Data Set)

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<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>#97-03</td>
<td>June 30, 1997</td>
<td>October 1, 1997</td>
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Supersedes TN NEW
New York
47(w)(4)

Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received occupational therapy. Based on the new code requirements, it is estimated that twice this number or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of $31.50 for physical therapists and $30.00 for occupational therapists, the added cost would be $15.74 for PT and $15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activities worker care planning time for 100 of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were $24.00, for social workers $15.40, for dieticians $21.00, for activities workers $10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation as follows:

\[
\text{statewide cost} = (1.48) \times (105,000) \times \left(0.5 \times 24 \times 0.1 \right) + 0.5 \times 15.40 \times 0.1 \right) + \left(0.5 \times 21.00 \times 0.1 \right) + \left(0.5 \times 10.00 \times 0.1 \right) + \left(0.5 \times 31.50 \times 0.42 \right) + \left(0.5 \times 30.00 \times 0.18 \right) = 6,917,631
\]
Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of $6.00 per review was used:

\[(\text{# care plans/bed}) \times (\text{# beds}) \times (\text{incremental cost/plan}) = \text{statewide cost}\]

\[(2.2) \times (105,000) \times ($6.00) = 1,386,000\]

Training on MDS+\(^4\) Assessment

An estimate of 70,020 was used, based on the industry's estimate which was found acceptable

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<th>Cost of training for up to 80 beds</th>
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<td>80 bed increments</td>
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<td>$370,020</td>
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\(^4\) MDS+ (Minimum Data Set Plus For Nursing Home Residents Assessment and Care Screening)
Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director and a representative from medical records. The net added expense estimated by the industry was $600,264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is $25.00 per aide. The total recertification cost is $434,525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at physician cost of $150 per hour.

\[ 105,000 \times 20\% \times 0.5 \times 150 = 1,575,000 \]
New York  
47(w)(7)

Surety Bonds

The industry has estimated that $189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is $17,041,640.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Resident Assessment</td>
<td>$2,797,200</td>
</tr>
<tr>
<td>Quarterly Resident Assessment</td>
<td>2,772,000</td>
</tr>
<tr>
<td>Comprehensive Care Plan</td>
<td>6,917,631</td>
</tr>
<tr>
<td>Quarterly Care Plan Review</td>
<td>1,386,000</td>
</tr>
<tr>
<td>Training of MDS+⁵ Assessment</td>
<td>370,020</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>600,264</td>
</tr>
<tr>
<td>Nurse Aide</td>
<td>434,525</td>
</tr>
<tr>
<td>Psychotropic Drug Review</td>
<td>1,575,000</td>
</tr>
<tr>
<td>Surety Bonds</td>
<td>189,000</td>
</tr>
<tr>
<td>Total Incremental Cost</td>
<td>$17,041,640</td>
</tr>
</tbody>
</table>

⁵ MDS+ (Minimum Data Set Plans for Nursing Home Residents Assessment and Care Screening)

<table>
<thead>
<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#97-03</td>
<td>June 30, 1997</td>
<td>October 1, 1997</td>
</tr>
</tbody>
</table>
Costs are to be reflected in facility rates beginning July 1, 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility’s rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

\[
\frac{17,041,640}{105,000} / 365 = \frac{.45}{\text{add-on}}
\]

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be increased by the appropriate trend factor.\(^6\)

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\(^6\) Trend factors are computed in accordance with Section 86-2.12 of this Plan.
**New York 47(w)(9)**

**Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement**

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

**TN #97-03**

**Approval Date** June 30, 1997

**Supersedes TN NEW**

**Effective Date** October 1, 1997
Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource “weight” representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12 of this Plan.
New York
47(w)(11)

Description of the specific methodology for determining the adjustment Bloodborne Pathogens

**Hepatitis B Vaccination:**

Beginning January 1, 1993 and thereafter, provider rates contain a facility specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reported by the providers two years prior to the state of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is $128.50 for a three vial series per employee.

**Gloves:**

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, and $.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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TN #97-03
Supersedes TN NEW

Approval Date June 30, 1997
Effective Date October 1, 1997
Reserved.

New York
47(x)

Attachment 4.19-D
Part I

TN #97-03
Supersedes TN #96-03
Approval Date June 30, 1997
Effective Date October 1, 1997
New York
47(x)(1)

(v) Extended care of residents with traumatic brain injury.

(1) (i) Except as provided in subparagraph (ii) of this paragraph, effective April 1, 1993, a per diem amount of $25, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, and increased in rate years thereafter, by the projection factors determined pursuant to section 86-2.12 shall be added to a facility’s payment rate determined pursuant to this Subpart for each resident with traumatic brain injury identified as requiring extended care and receiving services pursuant to section of this Title.

(ii) Effective with rates revised based upon patient review instrument (PRI) assessment data for an assessment period set forth in Section 86-2.11(b) of this Subpart beginning on or after November 1, 1994, a TBI patient per diem amount shall be added to a facility’s average Medicaid payment rate determined pursuant to this Subpart only for Medicaid residents with traumatic brain injury identified as requiring extended care which shall mean a person who is at least three months post-injury and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage, or anoxia, and who in addition has participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home and has been assessed by a neurologist or physiatrist who determined that the individual would no longer benefit from an intensive rehabilitation program. The TBI patient per diem amount shall be determined as follows: The total number of Medicaid traumatic brain injury (TBI) extended care residents shall be multiplied by $25 per patient day times by 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RPIDAF, determined pursuant to subdivision (c)(5) of this section, to establish the allowable TBI dollars. The allowable TBI dollars shall be divided by the facility total annual Medicaid days to determine the facility TBI patient per diem amount. The TBI patient per diem amount shall be increased annually by the projection factor determined pursuant to section 86-2.12 of this Subpart. For purposes of this subdivision, a Medicaid resident is defined as a resident whose primary payor description is coded as Medicaid on the PRI assessment data.

(2) Residents reimbursed pursuant to this subdivision shall not be reimbursed pursuant to subdivision (n) and (o) of this section.

TN #95-04 Approval Date June 4, 1999
Supersedes TN #94-44 Effective Date January 1, 1995
Rates of payment for non-state operated public residential health care facilities shall be increased in an aggregate amount of $100 million for payments for services provided during the period July 1, 1995 through March 31, 1996. To be eligible, the facility must be operating at the time the pool is distributed. Payment to each eligible facility shall be in proportion to the facility’s 1994 Medicaid days relative to the sum of 1994 Medicaid days for all eligible facilities.
For the period August 1, 1996 through March 31, 1997, proportionate share payments in the aggregate amount of $257 million shall be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. Payments shall be made as a lump sum payment to each eligible residential health care facility.

The amount allocated to each eligible public residential health care facility shall be calculated as the result of $257 million multiplied by the ratio of 1994 facility Medicaid patient days for all eligible public residential health care facilities. The payments are made contingent upon receipt of all approvals required by federal law or regulation.
New York
47(x)(2)(b)

For the period April 1, 1997 through March 31, 1999, proportionate share payments in an annual aggregate amount of $631.1 million will be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999 through March 31, 2000, proportionate share payments in an annual aggregate amount of $982 million will be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, 2009, proportionate share payments in an annual aggregate amount of up to $991.5 million and $150.0 million, respectively, for state fiscal year April 1, 2009 through March 31, 2010, $167 million, and for state fiscal years commencing April 1, 2010 through March 31, 2011, $189 million in an annual aggregate amount, and for the period April 1, 2011 through March 31, 2012 an aggregate amount of $172.5 million and for state fiscal years commencing April 1, 2012 through March 31, 2013, an aggregate amount of $293,147,494, and for the period April 1, 2013 through March 31, 2014, $246,522,355, and for the period April 1, 2014 through March 31, 2015, $305,254,832, and for the period April 1, 2015 through March 31, 2016, $255,208,911, for the period April 1, 2016 through March 31, 2017, $198,758,133 in an annual aggregate amount, and for the period April 1, 2017 through March 31, 2018, the aggregate amount of $167,600,071, will be paid semi-annually in September and March, and for the period April 1, 2018 through March 31, 2019, the aggregate amount of $225,104,113, will be paid semi-annually in September and March, which will be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997 through March 31, 1998 will be calculated as the result of $631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998 through March 31, 1999 will be calculated as the result of $631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999 through March 31, 2000 will be calculated as the result of $982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, 2009, and for state fiscal years commencing April 1, 2009 through March 31, 2011; April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; April 1, 2013 through March 31, 2014; and April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; April 1, 2016 through March 31, 2017; April 1, 2017 through March 31, 2018; and April 1, 2018 through March 31, 2019 will be calculated as the result of the respective annual aggregate amount multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior provided, however, that an additional amount of $26,531,995 for the April 1, 2013 through March 2014 period will be distributed to those public residential health care facilities in the list which follows.

TN #18-0026 Approval Date July 26, 2018
Supersedes TN #17-0038 Effective Date April 1, 2018
The $26,531,995 will be distributed to the following facilities in the following amounts:

<table>
<thead>
<tr>
<th>Facility</th>
<th>2013 Additional Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany County Nursing Home</td>
<td>$6,524,997</td>
</tr>
<tr>
<td>Erie County Home</td>
<td>$8,697,386</td>
</tr>
<tr>
<td>Erie County Medical Center</td>
<td>$1,989,503</td>
</tr>
<tr>
<td>Golden Hill Health Care Center</td>
<td>$3,274,412</td>
</tr>
<tr>
<td>Monroe Community Hospital</td>
<td>$2,009,348</td>
</tr>
<tr>
<td>Sullivan County Adult Care Center</td>
<td>$2,102,457</td>
</tr>
<tr>
<td>Willow Point Nursing Home</td>
<td>$1,933,892</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$26,531,995</strong></td>
</tr>
</tbody>
</table>

Payments shall be made as a lump sum payment to each eligible residential health care facility.
prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facilities cost report submitted pursuant to this Subpart is less than the staffing pattern required by identified in section 415.39 of this title Appendix 3 of this State Plan.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (d) (4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The non-comparable component of such facilities’ rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel that would be reported in the functional cost centers identified in subdivision (f) of this section.

[(4) The provision of this subdivision will expire on December 31, 1994.]
Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate years by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

(iii) Effective April 1, 1996 through March 31, 1999 and on or after July 1, 1999 through [March] December 31, 2006 residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.
(w) Specialized programs for residents requiring behavioral interventions.

Facilities which have been approved to operate discrete units specifically designed for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates calculated pursuant to this section except as follows:

(1) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the case mix index used to establish the statewide ceiling price per day for each patient classification group pursuant to subparagraph (c)(3)(iii) of this section for such residents shall be increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (c)(6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.40.

(i) Specific interventions that the Department has approved which qualify for payment are a combination of medical and behavioral interventions such as counseling, recreation and exercise carried out in a therapeutic environment and provided on-site.

Nursing resident criteria to be used in determining eligibility for payment include assessment of whether the resident is a danger to self or others and displays violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. The behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(ii) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or

TN #94-04
Supersedes TN NEW
Approval Date September 8, 1998
Effective Date March 16, 1994
prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility’s cost report submitted pursuant to this Subpart is less than the staffing pattern required below.

A current period audit of current period expenses will result in an incremental adjustment implemented on a prospective basis. An audit of prior period expenses will result in a retrospective adjustment in a lump sum payment. The staffing pattern required by the department is as follows:

(a) The unit shall be managed by a program coordinator;

(b) A physician shall be responsible for medical director and oversight of the program;

(c) A qualified specialist in psychiatry, a psychologist and a social worker shall be available on staff on a consulting basis;

(d) Other than the program coordinator, there shall be at least one registered professional nurse on each shift.

(2) In determining the indirect component of a facility’s rate pursuant to paragraphs (d)(4) - (6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility’s indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities’ rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(4) The provision of this subdivision will expire on December 31, 1994.
Medicare Utilization.

(1) (a) Prior to February 1, 1996 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the 1995 statewide target percentage.

(b) Prior to February 1, 1997, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing January 1, 1996 through November 30, 1996 based on such data for such period as is available and reasonably accurate. This value shall be called the 1996 statewide target percentage.

(c) Prior to February 1, 1998, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing January 1, 1997 through November 30, 1997 based on such data for such period as is available and reasonably accurate. This value shall be called the 1997 statewide target percentage.
social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1997 through November 30, 1997 based on such data as is available and reasonably accurate. This value shall be called the 1997 statewide target percentage.

(d) Prior to February 1, 1999, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1988 through November 30, 1998 based on such data as is available and reasonably accurate for such period. This value shall be called the 1998 target percentage.

(e) Prior to February 1, 2000 the commissioner of health shall calculate the result of the statewide total of residential health care
facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value shall be called the 1999 statewide target percentage.


(2) Prior to February 1, 1996, the Commissioner of Health will calculate the results of the statewide total of health care facility
days of care provided to Medicare beneficiaries, divided by the sum of days of care plus
days of care provided to residents eligible for payments pursuant to title 11 of article 5
of the social services law, expressed as a percentage, for the period April 1, 1994
through March 31, 1995. This value shall be called the statewide base percentage.

(3) (a) If the 1995 statewide target percentage is not at least one percentage point higher
than the statewide base percentage, the commissioner of health shall determine
the percentage by which the 1995 statewide target percentage is not at least one
percentage point higher than the statewide base percentage. The percentage
calculated pursuant to this paragraph shall be called the 1995 statewide reduction
percentage. If the statewide target percentage is at least one percentage point
higher than the statewide base percentage, the statewide reduction percentage
shall be zero.

(b) If the 1996 statewide target percentage is not at least two percentage points
higher than the statewide base percentage, the commissioner of health shall
determine the percentage by which the 1996 statewide target percentage is not at
least two percentage points higher than the statewide base percentage. The
percentage calculated pursuant to this subdivision shall be called the 1996
statewide reduction percentage. If the
1996 statewide target percentage is at least two percentage points higher than
the statewide base percentage, the 1996 statewide reduction percentage will be zero.

target percentages are not for each year at least three percentage points higher than
the statewide base percentage, the Commissioner of Health will determine the
percentage by which the statewide target percentage for each year is not at least
three percentage points higher than the statewide base percentage. The percentage
calculated pursuant to this paragraph will be called the 1997, 1998, 2000, 2001,
statewide target percentage for the respective year is at least three percentage
points higher than the statewide base percentage, the statewide reduction
percentage for the respective year will be zero.

(d) If the 1999 statewide target percentage is not at least two and one-quarter
percentage points higher than the statewide base percentage, the Commissioner of
Health will determine the percentage by which the 1999 statewide target percentage
is not at least two and one-quarter percentage points higher than the statewide base
percentage. The percentage calculated pursuant to this paragraph will be called the
1999 statewide reduction percentage. If the 1999 statewide target percentage is at
least two and one-quarter percentage points higher than the statewide base
percentage, the 1999 statewide reduction percentage will be zero.
(4) (a) The 1995 statewide reduction percentage will be multiplied by $34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage will be zero, there will be no reduction amount.

(b) The 1996 statewide reduction percentage will be multiplied by $68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage will be zero, there will be no reduction amount.

(c) The 1997 statewide reduction percentage will be multiplied by $102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage will be zero, there will be no 1997 reduction amount.

(e) The 1999 statewide reduction percentage will be multiplied by $76.5 million to
determine the 1999 statewide aggregate reduction amount. If the 1999 statewide
reduction percentage will be zero, there will be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount will be allocated by the
Commissioner of Health among residential health care facilities that are eligible to
provide services to Medicare beneficiaries and residents eligible for payments pursuant
to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each
facility's failure to achieve a one percentage point increase in the 1995 target
percentage compared to the base percentage, calculated on a facility specific basis for
this purpose, compared to the statewide total of the extent of each facility's failure to
achieve a one percentage point increase in the 1995 target percentage compared to
the base percentage. This amount will be called the 1995 facility specific reduction
amount.

statewide aggregate reduction amounts will for each year be allocated by the
Commissioner of Health among residential health care facilities that are eligible to
provide services to Medicare beneficiaries and residents eligible for payments pursuant
to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each
facility's failure to achieve a two percentage point increase in the 1996 target
percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002,
2016, [and] 2017, 2018, and 2019, target percentage and a two and one-quarter
percentage point increase in the 1999 target percentage for each year, compared to
the base percentage, calculated on a facility specific basis for this purpose, compared
to the statewide total of the extent of each facility's failure to achieve a two
percentage point increase in the 1996, a three percentage point increase in the 1997, and a

(6) The facility specific reduction amounts will be due to
New York
47(x)(15)

the state from each residential health care facility and may be recouped by the state in a lump sum amount from payments due to the residential health care facility pursuant to title 11 of article 5 of the social services law.

(7) Residential health care facilities shall submit such utilization data and information as the commissioner of health may require for purposes of this section. The commissioner of health may use utilization data available from third party payers.

(8) (a) On or about June 1, 1996, the commissioner of health shall calculate for the period July 1, 1995 through March 31, 1996 statewide target percentage, statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraphs 1(a), 3(a), 4(a) and 5(a) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1995 facility specific reduction amount calculated in accordance with paragraph 5(a) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(a) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision.

If
the amount is less than the amount determined in accordance with paragraph 5(a) of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15, 1996. Residential health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the commissioner of health by April 15, 1996.

(b) On or about June 1, 1997, the commissioner of health shall calculate for the period January 1, 1996 through November 30, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraph 1(b), 3(b), 4(b) and 5(b) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1996 facility specific reduction amount calculated in accordance with paragraph 5(b) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(b) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(b) of this provision, the difference shall be refunded to the residential health care facility by the state no later than
New York
47(y)

Description of the Specific Methodology Used in Determining the Adjustment

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and compressive assessments, the additional cost pertains to completion of the MDS+\(^2\) document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same as prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessment of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or \((.5) ((.45) + (.5)) - .48\). The total number of assessments per bed would be \(1 + .48 = 1.48\).

\(^2\)MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening

<table>
<thead>
<tr>
<th>TN</th>
<th>#96-03</th>
<th>Approval Date</th>
<th>June 26, 1996</th>
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<td>Supersedes TN</td>
<td>#95-03</td>
<td>Effective Date</td>
<td>October 1, 1996</td>
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</table>
Based on a time study of the MDS\(^3\), it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of $24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

\[(\text{# assessments/bed}) \times (\text{# beds}) \times (\text{incremental time/assessment})\]

\[(1.48) \times (105,000) \times (0.75) \times ($24) = $2,797,200\] for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

\[(2.2) \times (105,000) \times (0.5) \times ($24) = $2,772,000\] for quarterly assessments

\(^3\text{MDS (Minimum Data Set)}\)
Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received Occupational Therapy. Based on the new code requirements, it is estimated that twice this number, or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services, an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of $31.50 for physical therapists and $30.00 for occupational therapists, the added cost would be $15.74 for PT and $15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activates worker care planning time for 100% of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were $24.00, for social workers $15.40, for dieticians $21.00, for activates workers $10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation is as follows:

\[(\text{#plans/bed}) \times (\text{# beds for all residents}) \times (\text{incremental time for EACH discipline} \times \text{hourly rate}) \times (\text{percent of care plans involving discipline}) = \text{statewide cost}\]

\[ (1.48) \times (105,000) \times ((0.5 \times $24 \times 100\%) + (0.5 \times $15.40 \times 100\%) + (0.5 \times $21.00 \times 100\%) + (0.5 \times $10.00 \times 100\%) + (0.5 \times $31.50 \times 42\%) + (0.5 \times $30.00 \times 18\%)) = $6,917,631 \]
New York
47(z2)

Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of $6.00 per review was used:

\[(\text{# care plans/bed}) \times (\text{#beds}) \times (\text{incremental cost/plan}) = \text{statewide cost}\]

\[(2.2) \times (105,000) \times ($6.00) = $1,386,000\]

Training on MDS+\(^4\) Assessment

An estimate of $370,020 was used, based on the industry’s estimate which was found acceptable:

Cost of training for up to 80 beds $229,950
80 bed increments $140,070
$370,020

\(^4\text{MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)}\)
Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director, and a representative from medical records. The net added expense estimated by the industry was $600,264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is $25.00 per aide. The total recertification cost is $434,525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at a physician cost of $150 per hour.

105,000 X 20% X .5 X 150 = $1,575,000
Surety Bonds

The industry has estimated that $189,000 of added cost will be incurred for this requirement and was found acceptable.

**SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED**

Total incremental federal code cost to be recognized in facility 1991 rates is $17,041,640.

- Comprehensive Resident Assessment $2,797,200
- Quarterly Resident Assessment $2,772,000
- Comprehensive Care Plan $6,917,631
- Quarterly Care Plan Review $1,386,000
- Training of MDS+ Assessment $370,020
- Quality Assurance $600,264
- Nurse Aide $434,525
- Psychotropic Drug Review $1,575,000
- Surety Bonds $189,000
- Total Incremental Cost $17,041,640

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MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)
Costs are to be reflected in facility rates beginning July 1, 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility’s rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

\[
\frac{17,041,640}{105,000} \div 365 = 0.45 \text{ add-on}
\]

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be by the appropriate trend factor.6

6Trend factors are computed in accordance with Section 86-2.12.
Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions
Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource “weight” representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12.
New York
47(z8)

Description of the specific methodology for determining the adjustment -
Bloodborne Pathogens

**Hepatitis B Vaccination:**

Beginning January 1, 1993 and thereafter, provider rates contain a facility-specific adjustment
to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific
adjustments are based upon each facility’s actual costs recognized up to a maximum cost for
the vaccine. The facility specific adjustment will be determined using costs reposted by the
providers two years prior to the state of the rate year. The maximum cost for the vaccine that is
recognized when setting the facility specific adjustment is $128.50 for a three vial series per
employee.

**Gloves:**

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year
thereafter, an $.18 per diem adjustment will be included in provider's rates for the incremental
cost of gloves.
Rate Adjustment for Financially Disadvantaged RHCFs

(a) The Commissioner of Health shall adjust medical assistance rates of payment for services provided on and after October 1, 2004 through December 31, 2004 and annually thereafter for services provided on and after January 1, 2005 through April 30, 2011, and on and after May 1, 2012 to include a rate adjustment to assist qualifying Residential Health Care Facilities (RHCFs) pursuant to this section, provided that public RHCFs shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April 1, 2009.

Facilities that receive a rate adjustment for the period May 1, 2010 through April 30, 2011, will have their rates reduced for the rate period December 1, 2011 through December 31, 2011, by an amount equal to the payment generated by the May 1, 2010 through April 30, 2011, rate adjustment.

(b) Eligibility for such rate adjustments shall be determined on the basis of each RHCF’s operating margin over the most recent three-year period for which financial data are available from the RHCF-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October 1, 2004 through December 31, 2004, financial information for the calendar years 2000 through 2002 shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.

(c) Each facility’s operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based RHCF’s, for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital’s overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three-year period or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this section, provided that for rate periods on and after April 1, 2009, such disqualification:

i. shall not be applied solely on the basis of a facility’s having a positive total margin in the most recent year of such three-year period;
New York
47(aa)(1)

ii. shall be extended to those facilities in the quartile of facilities with the second smallest negative operating margins; and

iii. shall also be extended to those facilities with an average Medicaid utilization percentage of less than 70% during the most recent year of the three-year period.

(d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this section, the Commissioner of Health shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three provided, that for periods on and after April 1, 2009, the amount of such average annual operating loss shall be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods. For this purpose, for hospital-based RHCFs for which the average annual operating loss cannot be calculated on the basis of submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the RHCF based on the proportion the RHCF's total revenues for the period bears to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss shall then be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods.

(e) For periods prior to April 1, 2009, each such facility’s qualifying operating loss shall be determined by multiplying the facility’s average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this section by the applicable percentage shown in the tables below for the quartile in which the facility's negative operating margin for the three-year period is assigned.

i. For a facility located in a county with a total population of 200,000 or more as determined by the 2000 U.S. Census:

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quartile (lowest operating margins)</td>
<td>30 percent</td>
</tr>
<tr>
<td>Second Quartile</td>
<td>15 percent</td>
</tr>
<tr>
<td>Third Quartile</td>
<td>7.5 percent</td>
</tr>
</tbody>
</table>

ii. For a facility located in a county with a total population of fewer than 200,000 as determined by the 2000 U.S. Census:

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quartile (lowest operating margins)</td>
<td>35 percent</td>
</tr>
<tr>
<td>Second Quartile</td>
<td>20 percent</td>
</tr>
<tr>
<td>Third Quartile</td>
<td>12.5 percent</td>
</tr>
</tbody>
</table>
New York
47(aa)(2)

(f) The amount of any facility’s financially disadvantaged RHCF distribution calculated in accordance with this section shall be reduced by the facility’s rate year benefit of the 2001 update to the regional input price adjustment factors provided that such reduction shall not be applied with regard to rate periods on and after April 1, 2009. After all other adjustments to a facility’s financially disadvantaged RHCF distribution have been made in accordance with this section, the amount of each facility’s distribution shall be limited to no more than $400,000 during the period October 1, 2004 through December 31, 2004, and on an annualized basis, for rate periods through March 31, 2009, and no more than one million dollars for the period April 1, 2009 through December 31, 2009, and for each annual rate period thereafter.

(g) The adjustment made to each qualifying facility’s Medicaid rate of payment determined pursuant to the section shall be calculated by dividing the facility’s financially disadvantaged RHCF distribution calculated in accordance with this section by the facility’s total Medicaid patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October 1, 2004 through December 31, 2004, shall be calculated based on 25% of each facility’s reported total Medicaid patient days as reported in the applicable 2002 cost report. Such amounts will not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged RHCF rate adjustments to eligible facilities for a rate period in accordance with this section shall be $30 million on and after January 1, 2009 through March 31, 2013.
New York
47(aa)(3)

(i) For periods on and after April 1, 2009, Residential Health Care Facilities (RHCFs), which are otherwise eligible for rate adjustments pursuant to this subdivision shall also, as a condition for receipt of such rate adjustments, submit to the Commissioner a written restructuring plan that is acceptable to the Commissioner and which is in accord with the following:

i. Such an acceptable plan shall be submitted to the Commissioner within sixty days of the facility’s receipt of rate adjustments pursuant to this subdivision for a rate period subsequent to March 31, 2008, provided that facilities which are allocated $400,000 or less on an annualized basis shall be required to submit such plans within 120 days, and further provided that these periods may be extended by the Commissioner by no more than thirty days, for good cause shown; and

ii. Such plan shall provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and shall include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan; and

iii. Such plan shall require periodic reports to the Commissioner, in accordance with a schedule acceptable to the Commissioner, setting forth the progress the facility has made in implementing its plan; and

iv. Such plan may include the facility’s retention of a qualified chief restructuring officer to assist in the implementation of the plan, provided that this requirement may be waived by the Commissioner, for good cause shown, upon written application by the facility.

(ii) If a facility fails to submit an acceptable restructuring plan in accordance with the provisions of paragraph (i) of this subdivision, the facility shall, from that time forward, be precluded from receipt of all further rate adjustments made pursuant to this subdivision and shall be deemed ineligible from any future re-application for such adjustments. The Commissioner will annually review each facility’s efforts in achieving substantial progress in implementing its plan or achieving the benchmarks set forth in such plan. Further, if the Commissioner determines that a facility has failed to make a good faith effort in achieving substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the Commissioner will, upon thirty days notice to that facility, disqualify the facility from further participation in the rate adjustments authorized by this subdivision and the Commissioner will require the facility to repay some or all of the previous rate adjustments. During such thirty-day notification period, a facility may submit to the Commissioner additional information which may be used by the Commissioner to reconsider his or her determination that the facility be disqualified from further participation and required to repay some or all of the rate adjustments. The amount required to be repaid from such a facility shall be commensurate with the degree to which a facility has not made progress in implementing its plan or achieving the benchmarks set forth in such plan. Rate adjustments applicable to distributions made for periods prior to 2009 shall not be subject to repayment.

TN #13-36 Approval Date September 12, 2013
Supersedes TN #09-29 Effective Date April 1, 2009
**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures - Nursing Homes**

A temporary rate adjustment will be provided to eligible residential health care 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 residential health care providers, the amount of the temporary rate adjustment, and the duration of each rate adjustment period shall be listed in the table which follows. The total adjustment amount for each period shown below will be paid quarterly during each period in equal installments. The temporary 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.

**Nursing Homes:**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate</th>
<th>Start Date - End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adirondack Medical Center - Mercy Living Center</td>
<td>$6,694</td>
<td>01/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$723,872</td>
<td>04/01/2014 - 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$918,544</td>
<td>06/16/2016 - 03/31/2017</td>
</tr>
<tr>
<td>Adirondack Medical Center - Uihlein Living Center</td>
<td>$2,273,884</td>
<td>01/01/2014 - 03/31/2014</td>
</tr>
<tr>
<td></td>
<td>$2,359,369</td>
<td>04/01/2014 - 03/31/2015</td>
</tr>
<tr>
<td></td>
<td>$821,793</td>
<td>04/01/2015 - 03/31/2016</td>
</tr>
<tr>
<td></td>
<td>$1,274,864</td>
<td>06/16/2016 - 03/31/2017</td>
</tr>
<tr>
<td>Adirondack Tri-County Nursing &amp; Rehabilitation Center, Inc.</td>
<td>$225,680</td>
<td>01/01/2014 - 03/31/2014</td>
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<tr>
<td></td>
<td>$1,369,690</td>
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</tr>
<tr>
<td></td>
<td>$1,049,423</td>
<td>06/16/2016 - 03/31/2017</td>
</tr>
</tbody>
</table>

*Denotes provider is part of CINERGY Collaborative.

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TN #16-0027 Approval Date Aug 17, 2016

Supersedes TN #15-0030 Effective Date June 16, 2016
Nursing Homes (Continued):

<table>
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<tr>
<th>Provider Name</th>
</tr>
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<tbody>
<tr>
<td>Amsterdam Nursing Home Corp (Amsterdam House)*</td>
</tr>
<tr>
<td>Baptist Nursing and Rehabilitation</td>
</tr>
<tr>
<td>Beth Abraham Health Services*</td>
</tr>
<tr>
<td>Bronx-Lebanon Special Care Center*</td>
</tr>
<tr>
<td>Brooklyn United Methodist Church Home*</td>
</tr>
<tr>
<td>Buena Vida Continuing Care &amp; Rehab Ctr*</td>
</tr>
<tr>
<td>Cabrini Center for Nursing*</td>
</tr>
<tr>
<td>Carmel Richmond Healthcare and Rehabilitation Center*</td>
</tr>
<tr>
<td>Center For Nursing &amp; Rehabilitation Inc*</td>
</tr>
<tr>
<td>Chapin Home for the Aging*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross Medicaid Rate</th>
<th>Rate Period Effective</th>
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<tbody>
<tr>
<td>Adjustment</td>
<td></td>
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<tr>
<td>$1,430,938</td>
<td>01/01/2015 - 03/31/2015</td>
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<tr>
<td>$1,450,213</td>
<td>04/01/2015 - 03/31/2016</td>
</tr>
<tr>
<td>$1,447,006</td>
<td>04/01/2016 - 03/31/2017</td>
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<tr>
<td>$935,000</td>
<td>10/01/2018 - 03/31/2019</td>
</tr>
<tr>
<td>$910,000</td>
<td>04/01/2019 - 03/31/2020</td>
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<tr>
<td>$347,500</td>
<td>04/01/2020 - 03/31/2021</td>
</tr>
<tr>
<td>$2,460,249</td>
<td>01/01/2015 - 03/31/2015</td>
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<td>$2,493,389</td>
<td>04/01/2015 - 03/31/2016</td>
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<td>$2,487,874</td>
<td>04/01/2016 - 03/31/2017</td>
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<td>$788,294</td>
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<td>$798,912</td>
<td>04/01/2015 - 03/31/2016</td>
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<td>$797,146</td>
<td>04/01/2016 - 03/31/2017</td>
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<tr>
<td>$702,169</td>
<td>01/01/2015 - 03/31/2015</td>
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<tr>
<td>$707,212</td>
<td>04/01/2015 - 03/31/2016</td>
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<tr>
<td>$706,273</td>
<td>04/01/2016 - 03/31/2017</td>
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<tr>
<td>$970,765</td>
<td>01/01/2015 - 03/31/2015</td>
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<tr>
<td>$983,841</td>
<td>04/01/2015 - 03/31/2016</td>
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<td>$981,665</td>
<td>04/01/2016 - 03/31/2017</td>
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<td>$1,130,860</td>
<td>01/01/2015 - 03/31/2015</td>
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<td>$1,146,093</td>
<td>04/01/2015 - 03/31/2016</td>
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<td>$1,143,558</td>
<td>04/01/2016 - 03/31/2017</td>
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<td>$1,084,185</td>
<td>01/01/2015 - 03/31/2015</td>
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<td>$1,098,790</td>
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<td>04/01/2016 - 03/31/2017</td>
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<tr>
<td>$1,179,939</td>
<td>01/01/2015 - 03/31/2015</td>
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<tr>
<td>$1,195,833</td>
<td>04/01/2015 - 03/31/2016</td>
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<td>$1,193,189</td>
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<td>$771,403</td>
<td>01/01/2015 - 03/31/2015</td>
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<td>$781,794</td>
<td>04/01/2015 - 03/31/2016</td>
</tr>
<tr>
<td>$780,065</td>
<td>04/01/2016 - 03/31/2017</td>
</tr>
</tbody>
</table>

*Denotes provider is part of CINERGY Collaborative.
<table>
<thead>
<tr>
<th>Nursing Homes (Continued):</th>
<th>Gross Medicaid Rate Provider Name</th>
<th>Rate Period</th>
<th>Effective Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles T. Sitrin Health Care Center Inc.</td>
<td>$2,000,000</td>
<td>01/01/2015 – 03/31/2015</td>
<td></td>
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<tr>
<td></td>
<td>$591,984</td>
<td>06/16/2016 – 03/31/2017</td>
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<td></td>
<td>$ 25,817</td>
<td>04/01/2017 – 03/31/2018</td>
<td></td>
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<tr>
<td>Concord Nursing Home</td>
<td>$2,011,962</td>
<td>10/01/2018 – 03/31/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,011,962</td>
<td>04/01/2019 – 03/31/2020</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 25,817</td>
<td>04/01/2017 – 03/31/2020</td>
<td></td>
</tr>
<tr>
<td>Crouse Community Center</td>
<td>$645,000</td>
<td>01/01/2014 – 03/31/2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$710,000</td>
<td>04/01/2014 – 03/31/2015</td>
<td></td>
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<tr>
<td></td>
<td>$ 65,000</td>
<td>04/01/2015 – 03/31/2016</td>
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<tr>
<td>Eger Health Care and Rehabilitation Center*</td>
<td>$1,463,808</td>
<td>01/01/2015 – 03/31/2015</td>
<td></td>
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<tr>
<td></td>
<td>$1,483,526</td>
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<td></td>
<td>$1,480,245</td>
<td>04/01/2016 – 03/31/2017</td>
<td></td>
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<tr>
<td>Elderwood at North Creek</td>
<td>$2,434,828</td>
<td>04/01/2018 – 03/31/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,129,788</td>
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*Denotes provider is part of CINERGY Collaborative.
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*Denotes provider is part of CINERGY Collaborative.
## Nursing Homes (Continued):

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*Denotes provider is part of CINERGY Collaborative.
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<th>Effective Date</th>
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### Nursing Homes (Continued):

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Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures - Financially Distressed Nursing Homes

A temporary rate adjustment will be provided to eligible residential health care providers that are financially distressed and that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The funds will be used to help providers achieve financial stability and advance ongoing operational changes to improve community residential long term care services for New York State’s elderly population. The rate adjustment is intended to:

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

Eligible financially distressed residential health care providers, the amount of the temporary rate adjustment, and the duration of each rate adjustment period will be listed in the table which follows. The total adjustment amount for each period shown below will be paid quarterly during each period in equal installments. The temporary 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.

Financially Distressed Nursing Homes:

<table>
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<th>Provider Name</th>
<th>Gross Medicaid Rate</th>
<th>Effective Period</th>
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<td>$1,335,000</td>
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<td>Riverdale Nursing Home</td>
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TN #15-0046-A ________   Approval Date _Aug 05, 2016_______
Supersedes TN #15-0046 ________   Effective Date _April 01, 2015_______
### Financially Distressed Nursing Homes (continued):

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<th>Provider Name</th>
<th>Rate 1</th>
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<th>Effective Date</th>
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**TN #16-0025**

Approval Date: _Aug 25, 2016_

Supersedes TN __#NEW________

Effective Date: _June 1, 2016_
New York
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86-2.11 - Adjustments to Direct Component Of The Rate:

(a) Payments for 1986 and subsequent rate years for the Direct Component of the rate as defined in subdivision (c) of section 2.10 of this Subpart shall be adjusted periodically as described in this section to reflect changes in the case mix of facilities.

(b) Facilities shall report to the department changes in patient case mix follows:

(1) **Full Reassessments:**

   Facilities shall, on a schedule to be established by the department, assess all their patients semi-annually and submit patient review instruments pursuant to section 86-2.30 of this Subpart. The department shall consider, in developing such schedule, that for each of the six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments for all patients in the state.

(2) **Assessment of patients admitted since the last assessment period:**

   Three months from the date facilities are scheduled to perform full reassessments, facilities shall assess patients admitted and still residing in the facility since the last full assessment period. Patient review instruments for such patients shall be submitted pursuant to section 86-2.30 of this Subpart on a schedule to be established by the department. The department shall consider, in developing such schedule that for each six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments of such new admissions.
(3) **Notification to department of patients discharged since last assessment period:**

Facilities shall notify the department of any patients assessed during the previous full reassessment period as described in paragraph one of this subdivision and since discharged concurrent with the submissions required by paragraph (2) of this subdivision for patients admitted since the last assessment period.

(c) **Payment Rates for the Direct Component of the rate as defined in subdivision (c) of section 86-2.10 of this Subpart shall be adjusted, on a facility specific basis for changes in patient case mix retroactive to the beginning date of the month in which the assessment of patients was scheduled by the department and performed by the facility.**

(d) Adjusted payment rates shall be determined by recalculating a facility’s number of patients in each patient classification group as a result of the submissions in accordance with this section and such results shall be used in the calculation of the facility specific direct adjusted payment price per day pursuant to paragraph four of subdivision (c) of section 86-2.10 of this Subpart.

(e) **Trending:**

Payment rates for the operating component of the rate as defined in paragraph (2) of subdivision (b) of section 86-2.10 of this Subpart may be adjusted for changes in the trend factors originally promulgated by the department in accordance with section 86-2.12 of this Subpart.
(a) The operating cost component of residential health care facilities (RHCF’s) rates of payment effective for the January 1, 2007 through December 31, 2007 and January 1, 2008 through December 31, 2008 rate periods, respectively, shall consist of the sum of the Direct, Indirect and Non-Comparable components of the rate

(1) in effect as of October 1, 2006 and adjusted for inflation to the 2007 rate period;

(2) in effect as of December 31, 2006 and adjusted for inflation to the 2008 rate period;

(3) the rates shall be further adjusted as follows:

i. a per diem add-on reflecting the proportional amount of each facility’s projected Medicaid benefit to total Medicaid benefit for all facilities of the imputed rate methodology to be effective April 1, 2009, including use of the allowable operating costs as reported in each facility’s 2002 calendar year cost report, adjusted for inflation to the applicable rate period and reflecting the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments; and

ii. for those facilities which do not receive a benefit from the incorporation of 2002 allowable operating costs, rates for 2007 and 2008 shall be adjusted by a per diem add-on reflecting a proportional benefit of the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments.

(4) aggregate Medicaid payments for the rate adjustments as stated in (i) and (ii) of paragraph (3) of this section will not exceed $137.5 million for the 2007 rate period, and $167.5 million for the 2008 rate period, and such rate adjustments made prior to April 1, 2013 will not be subject to subsequent adjustment or reconciliation.

(b) Additionally, the rates effective January 1, 2007 and January 1, 2008 shall

(1) include any revisions to the 2006 rates occurring on and after January 1, 2007. Such revisions shall be incorporated into the 2007 and 2008 rate periods on an annual basis on or about November 30, 2007 and November 30, 2008, respectively. These rate adjustments shall be made on a retroactive and prospective basis;

(2) include the cost of local property taxes and payments made in lieu of local property taxes as reported in each facility’s cost report for the period two years prior to the rate period;

TN #13-37 Approval Date January 10, 2014
Supersedes TN #09-33 Effective Date April 1, 2013
(3) not be subject to case mix adjustments; however, a facility may request such adjustment for increased case mix equal to or greater than .05 if such facility submits supporting documentation based on a full house schedule or patient review instruments, and continues to do so in accordance with its existing submission schedule for rate periods through December 31, 2008.

(c) Voluntary not-for-profit facilities shall not be required to deposit reimbursement received for depreciation expense into a segregated depreciation account for periods on and after January 1, 2007.

(d) Effective [January] April 1, 2009, the operating component of rates of payment shall consist of the sum of the Direct, Indirect and Non-Comparable components based on allowable operating costs and statistical data as reported in each facility’s cost report for the 2002 calendar year, adjusted for inflation on an annual basis.

(1) For facilities which do not benefit from the use of 2002 cost report data, the operating component of the rates shall not be less than the operating component in effect for the 2008 rate period, adjusted for inflation on an annual basis.

(2) For facilities with an operating cost component which is based on allowable costs from a calendar year cost report subsequent to 2002, the rates shall remain on such costs.

(3) Effective for the period January 1, 2007 through December 31, 2011, appointment of a receiver, establishment of a new operator, or replacement or renovation of an existing facility that occurs on or after January 1, 2007, shall not result in a revised operating component of the rates unless an application for these changes is filed with the Department of Health by December 31, 2006, which is subsequently approved and which otherwise meets existing Department criteria for the establishment of a new base year for rate-setting purposes.
Cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate shall be subject to audit through December 31, 2018. Facilities will therefore retain all fiscal and statistical records relevant to such costs reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

Additionally, the operating component of the rates effective April 1, 2009 shall be subject to a case mix adjustment through application of the relative Resource Utilization Groups System (RUGS-III) used by the federal government for Medicare, revised to reflect NYS wage and fringe benefits, and based on Medicaid only patient data. New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides using the 1995 – 97 federal time study. The minutes from the study are multiplied by the NY average dollar per hour to determine the fiscal resources needed to care for that patient type for one day. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the statewide average. The RUGS-lll weights shall be increased for the following resident categories:

(i) 30 minutes for impaired cognition A;
(ii) 40 minutes for impaired cognition B; and
(iii) 25 minutes for reduced physical functions B.

Medicaid only case mix adjustments shall be made in January and July of each calendar year, except that no case mix adjustment shall be made in January 2011 and July 2011. The adjustments and related patient classifications for each facility shall be subject to audit review in accordance with regulations promulgated by the Commissioner of Health, and effective January 1, 2009 shall incorporate the continuation, through 2009 and subsequent years, of the adjustment for extended care of persons with traumatic brain injury in accordance with the provisions of this Attachment;

(2) incorporate the continuation, through 2009 and subsequent years, of the adjustment for the cost of providing Hepatitis B vaccinations in accordance with the provisions of this Attachment;

(3) reflect a per diem add-on of $8, trended from 2006 to 2009 and thereafter, for each patient who:

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Supersedes TN   #11-03 Effective Date April 1, 2013
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(i) qualifies under both RUG-III impaired cognition and behavioral problems categories; or

(ii) has been diagnosed with Alzheimer's disease or dementia and is classified in reduced physical functions A, B, or C, or in behavioral problems A or B categories, and also has an activities of daily living index of ten or less;

(5) reflect a per diem add on of $17, trended from 2006 to 2009 and thereafter, for each patient whose body mass index is greater than thirty-five (35);

(6) reflect the cost of local property taxes and payments in lieu of local property taxes, as reported in each facility’s cost report for the period two years prior to the rate year.

(f) Direct component of the rate.

(1) allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility’s annual cost report (RHCF-4) or extracted from a hospital-based facility’s annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending.

(i) nursing administration;

(ii) activities;

(iii) social services;

(iv) transportation;

(v) physical therapy (including associated overhead);

(vi) occupational therapy (including associated overhead);

(vii) speech therapy (including associated overhead);

(viii) central service supply; and

(ix) residential health care facility.

(2) For purposes of calculating the direct component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (f) regarding the determination of the allowable cost ceiling.
(3) For purposes of computing the cost ceilings for the direct component, facilities shall be organized into peer groups consisting of:

(i) free-standing facilities with certified bed capacities of less than 300 beds;

(ii) free-standing facilities with certified bed capacities of 300 beds or more; and

(iii) hospital-based facilities.

(4) In determining the direct cost component, for each peer group, a corridor shall be developed around the statewide mean direct price per day, provided, however, that the corridor around each mean direct price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean direct price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each mean direct price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.

(5) Public facilities, and non-public facilities with fewer than 80 certified beds, which have a facility specific direct adjusted price per day that is equal to the applicable ceiling shall have such price per day adjusted by an addition of 50% of the difference between the facility specific price per day and the ceiling price per day. The adjustment to the direct price per day shall be increased to the rate year by the applicable inflation factor, and adjusted by the regional direct input price factor.

(g) Indirect component of the rate.

(1) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility’s annual cost report (RHCF-4) or extracted from a hospital based on facility’s annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:
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(i) fiscal services;
(ii) administrative services;
(iii) plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);
(iv) grounds;
(v) security;
(vi) laundry and linen;
(vii) housekeeping;
(viii) patient food services;
(ix) cafeteria;
(x) non-physician education;
(xi) medical education;
(xii) housing; and
(xiii) medical records.

(2) For purposes of calculating the indirect component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (g) regarding the determination of the allowable cost ceiling:

(3) For purposes of computing the cost ceilings for the indirect component, facilities shall be organized into peer groups consisting of:

(i) free-standing facilities with certified bed capacities of less than 300 beds;
(ii) free-standing facilities with certified bed capacities of 300 beds or more; and
(iii) hospital-based facilities.

(4) In determining the indirect cost component, for each peer group, a corridor shall be developed around the statewide mean indirect price per day, provided, however, that the corridor around each mean indirect price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean indirect price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each
New York
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mean indirect price per day, and further provided, however, that the total financial
impact of the application of the ceiling shall be substantially equal to the total
financial impact of the application of the base.

(5) Public facilities, and non-public facilities with fewer than 80 certified beds, which
have a facility specific indirect adjusted price per day that is equal to the applicable
ceiling shall have such price per day adjusted by an addition of 50% of the
difference between the facility specific price per day and the ceiling price per day.
The adjustment to the indirect price per day shall be increased to the rate year by
the applicable inflation factor, and adjusted by the regional indirect input price
factor.

(h) Non-comparable component of the rate.

(1) The non-comparable component of the rate shall consist of costs, which represent
allowable costs reported by a facility, which because of their nature are not subject
to peer group comparisons.

(2) Allowable costs for the non-comparable component of the rate shall include the
costs associated with supervision of facility volunteers and costs reported in the
following functional cost centers as reported on the facility's annual cost report
(RHCF-4) or extracted from a hospital based facility's annual cost report (RHCF-2)
and the institutional cost report of its related hospital, after first deducting capital
cost and allowable items not subject to trending:

(i) laboratory services
(ii) ECG
(iii) EEG
(iv) radiology
(v) inhalation therapy
(vi) podiatry
(vii) dental
(viii) psychiatric
(ix) speech and hearing therapy – (Hearing Therapy Only)
(x) medical director office
(xi) medical staff services
(xii) utilization review
(xiii) other ancillary
(xiv) plant operations and maintenance – (cost for utilities and real estate and
occupancy taxes)
(xv) pharmacy (including administrative overhead for pharmacy and costs of non-
prescription drugs and supplies).

TN #06-39
Approval Date June 12, 2008
Supersedes TN NEW
Effective Date January 1, 2007
(i) **Capital component of the rate.**

The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with §86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the Department to be non-trendable divided by the facility’s patient days in the base year determined applicable by the Department.

(j) (1) For rate periods on and after January 1, 2007, no less than 65% of the additional Medicaid reimbursement received by a facility from the proportional add-on related to the projected 2002 reported base year costs, must be used for recruitment and retention of non-supervisory or other direct resident care workers or for purposes authorized under the Quality Improvement Demonstration Program. However, facilities shall not be required to spend more than 75% of the additional Medicaid reimbursement for these purposes.

(2) The Commissioner of Health is authorized to perform audits of the facilities to ensure compliance with the requirement established in subparagraph (1) of this paragraph (j), and may recoup any amount determined to be used for other purposes. The Commissioner may waive the requirements for this mandatory use of this Medicaid reimbursement on request of a facility, if it is determined that the funds are not available for these purposes because they have been used to correct deficiencies at a facility that constitute a threat to resident safety.

(k) For the rate periods after 2009 which utilize reported costs from a base year subsequent to 2002, the following categories of facilities shall receive rates that are no less than the rates that were in effect for such facilities on December 31, 2006, trended to the applicable rate year:

(1) AIDS facilities or discrete AIDS units;

(2) discrete units for residents on long-term inpatient rehabilitation for traumatic brain injury;

(3) long-term ventilator discrete units;

(4) discrete units providing specialized programs for residents requiring behavioral interventions; and

(5) facilities or discrete units that provide extensive nursing, medical, psychological and counseling services solely for children.
Effective January 1, 2012, the non-capital component of the rate for specialty facilities shall be the rates in effect for such facilities on January 1, 2009, as adjusted for inflation and rate appeals in accordance with Attachment 4.19-D. Such rates of payment in effect January 1, 2009, for AIDS facilities or discrete AIDS units within facilities shall be reduced by the AIDS occupancy factor.

1) For new specialty facilities without a January 1, 2009, rate but with a rate prior to April 1, 2009, the operating portion of the January 1, 2012, rate will be the rate in effect on the date of opening.

2) For new specialty facilities without a January 1, 2009, rate that open between April 1, 2009, and July 7, 2011, the operating portion of January 1, 2012, rate will be the rate in effect July 7, 2011.

3) For new specialty facilities without a January 1, 2009, rate that open subsequent to July 7, 2011, the operating portion of the January 1, 2012, rate will be calculated as follows:
   i) The initial rate will be calculated using budgeted costs prepared by the facility and approved by the Department and will become effective on the date of opening.
   ii) The facility will file a cost report for the first twelve-month period that the specialty unit or specialty facility, as applicable, achieves 90% occupancy. The rate will become effective the first day of the twelve-month report. A facility that does not achieve 90% or greater occupancy for any year within five calendar years from the date of commencing operation shall be recalculated using the facility's most recently available reported allowable costs divided by patient days imputed at 90% occupancy. The recalculated rates of payment are required to be effective January first of the sixth calendar year following the date the facility commenced operations.

4) There will be no case mix adjustments to specialty rates.
For the rate period May 1, 2009 through March 31, 2010, adjustments to the rates of payment resulting from the rebase to 2002 reported base year costs, including initial adjustments for case mix, shall be held to an aggregate increase of $210 million. If the total adjustments are more or less than $210 million, proportional adjustments to the rates shall be made as necessary to result in an increase in aggregate expenditures of $210 million. Such proportional adjustments shall be based on each facility's proportionate share of total spending from the April 1, 2009 rates that reflect the impact of rebasing and Medicaid only case mix. The rate adjustment required to adjust spending to the required $210 million amount will be reflected as the “scale back adjustment” in the rates effective May 1, 2009 through March 31, 2010. The operating component of such rates shall not be subject to the update adjustments for case mix as otherwise scheduled for January of 2010.

For the annual periods April 1, 2010 through March 31, 2012, if adjustments to the rates of payment prior to the adjustment for inflation results in an increase in total payments for such services on an annual basis, such rates shall be further adjusted proportionally as is necessary to reduce the aggregate increase to no greater than the proportionally adjusted aggregate for the period April 1, 2009 through March 31, 2010. Proportional adjustments made to rates within the aggregate expenditure limit shall not be subject to subsequent correction or reconciliation.

For the period May 1, 2011 through June 30, 2011, the non-capital components of rates will be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of $27,100,000. Such reductions will not be included in the computation of the residential health care facility cap.
Supplemental payments

For the period May 1, 2011 through May 31, 2011, supplemental payments in the form of rate add-ons, in the amount of $221.3 million, will be made to eligible residential health care facilities which the Commissioner has determined have experienced a net reduction in their rate for the period April 1, 2009 through March 31, 2011 as a result of the 2002 rebasing methodology, Medicaid-only case mix methodology, and the application of proportional adjustments required to be made by the application of the residential health care facility cap. In determining the net reduction, the impact of case mix adjustments applicable to July 2010 and Medicaid rate adjustments for appeals and patient review instrument (PRI) case mix updates processed for payment after October 19, 2010 will be disregarded by the Commissioner. The following facilities are eligible for such supplemental payments:

a) Facilities which were eligible for Financially Disadvantaged distributions for the 2009 period; non-public facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds seventy percent (based on either their 2009 cost report or their most recently available cost report); or facilities or distinct units of facilities providing services primarily to children under the age of twenty-one, will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.

b) Facilities other than eligible facilities described in paragraph (a) above will receive supplemental payments equal to 50 percent of their net reduction.

c) Facilities described in paragraph (b) above, which after the application of the rate adjustments described in paragraph (b) remain subject to a net reduction in their inpatient Medicaid revenue that is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years) will have their payments further adjusted such that the net reduction does not exceed two percent.
d) Facilities as described in paragraph (c) above which have experienced a net reduction in their inpatient rates of more than $6 million over the period April 1, 2009 through March 31, 2011 as a result of the application of proportional adjustments required to be made by the application of the residential health care facility cap will have their payments further adjusted so that their net reduction is reduced to zero.

Additional rate adjustments, in the form of rate add-ons, will be made to the eligible facilities described above for the period May 1, 2011 through May 31, 2011 in an aggregate amount equal to 25% of the payments described above (or 25% of $221.3 million which equals $55.3 million). The payments will be distributed to eligible facilities in the same proportion as the total $221.3 million of distributions made to each eligible facility.

The supplemental payments described above will not be subject to subsequent adjustment or reconciliation and will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the residential health care facility cap.
(c) Beginning April 1, 1991, the commissioner, in accordance with the methodology developed pursuant to subdivisions (d), (e) and (f) of this section, shall establish trend factors for residential health care facilities to project allowable cost increases for the effects of inflation during the effective period of the reimbursement rate. The allowable basic rate prior to the addition of capital costs and depreciation and interest related to movable equipment shall be trended, beginning on April 1, 1991, to the applicable rate year by the trend factors developed in accordance with subdivisions (d) through (f) of this section.

(d) The methodology for developing the trend factors shall be established by a panel of four independent consultants with expertise in health economics appointed by the commissioner.

(e) The methodology for developing the trend factors shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.
(f) (1) On or about September first of each year, the consultants shall provide to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The Commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factor for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

(3) for rate periods on and after April 1, 2000, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs.

(a) 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.

(b) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in subparagraph (a) of this paragraph and any difference will be included in the prospective trend factor for the current year.

(c) At the time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.
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(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section will reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision will not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health will adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but will include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 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 April 1, 2017 through March 31, 2019, the rates will reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

(h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 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 April 1, 2017 through March 31, 2019, the Commissioner of Health 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 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%.

(i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health will apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

TN #17-0035 Approval Date September 27, 2017
Supersedes TN #15-0027 Effective Date April 1, 2017
New York
51(a)(1)(a)

(j) For reimbursement of nursing home services provided on and after April 1, 2008, except for the nursing facilities which provide extensive nursing, medical, psychological, and counseling support services to children, the Commissioner of Health shall apply a trend factor equal to 65% of the otherwise applicable trend factor for calendar year 2008 as calculated in accordance with paragraph (f) of this section.
(k) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, the otherwise 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% and no retroactive adjustment to such 2008 trend factor shall 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.

(l) For rates of payment effective for nursing home 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, as calculated in accordance with paragraph (f) of this section, less 1% shall be applied. Effective on and after April 1, 2009, the otherwise applicable trend factor attributable to the 2009 calendar year period shall be zero.

(m) For rates of payment effective for nursing home services provided for the period January 1, 2010 through March 31, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

(n) For rates of payment effective for inpatient services provided by residential health care facilities on or after April 1, 2010, except for residential health care facilities that provide extensive nursing, medical, psychological, and counseling support services to children, the otherwise applicable trend factors attributable to:

i. the 2010 through 2012 calendar year periods shall be no greater than zero.

ii. the 2013 and 2014 calendar year periods shall be no greater than zero.

iii. the 2015 calendar year period shall be no greater than zero for rates effective for the period January 1, 2015 through March 31, 2015 and April 23, 2015 through December 31, 2015.

iv. the 2016 calendar year period shall be no greater than zero.

v. the 2017 calendar year period shall be no greater than zero for rates effective for the period January 1, 2017 through March 31, 2017 and April 1, 2017 through December 31, 2017.

Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data, which becomes available subsequent to the third quarter of 1993, will not be considered in setting or adjusting 1994 payment rates.
TREND AND ROLL FACTORS:

The authorization of an independent Panel of Health Economists to develop trend factors used in the residential health care facility reimbursement methodology is contained in statute. The following is a summary of the major components of the trend factors methodology as adopted by the Panel of Health Economists.

The actual proxies used in the calculation of the trend factors are listed in p.51(c) (d) (e) and (f). The proxies adopted by the Panel as listed in p.51 (c) (d) (e) and (f) may change back to the beginning of the year when data upon which a proxy is based becomes unavailable or by recommendation of the Panel of Health Economists who statutorily are authorized to determine the trend factor methodology.

Projection Methodologies

**Labor** - In order to quantify the labor price movement component of the trend factor, national proxies are used, adjusted by a Regional Adjustment Factor (RAF) to estimate New York State experience. These proxies are weighted to produce a composite labor price movement. In calculating the initial and revised trend factors for a given year, a projection methodology for the labor price movement is used since actual data for the year are not yet available. The projections are based on the compounding of quarterly increases in the proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

All but one of the labor proxies measure increases in compensation and therefore reflect changes in both salaries and fringe benefits. The labor proxy which measures only changes in wages and salaries is adjusted by a Compensation Factor (the ratio of the percent change in the Employment Cost Index-Compensation to the Employment Cost Index-Wages and Salaries) for the appropriate series to incorporate fringe benefits changes.

**Non-Labor** - A number of different proxies are used to measure price movements in non-labor (related) expenses incurred by facilities. In calculating the initial and revised trend factors, an estimate of the non-labor price movement is made based upon the projection of the GDP [GNP] Implicit Price Deflator. The final trend factor calculations are made using the actual changes in the non-labor proxies.
### New York 51(c)

#### 1995 Proxies and Sources
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<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labor</strong></td>
<td></td>
</tr>
<tr>
<td>Executive, Administrative and Managerial Personnel</td>
<td>ECI-Civilian-Compensation-Health Services – Executive, Administrative and Managerial 1/</td>
</tr>
<tr>
<td>Professional and Technical Personnel</td>
<td>ECI-Civilian-Compensation-Service Producing-Industries Service Occupation 41.1% 1/ Professional and Technical 1/</td>
</tr>
<tr>
<td>All Other Personnel</td>
<td></td>
</tr>
<tr>
<td>1. ECI-Civilian-Compensation-Service Producing-Industries-Service Occupation 41.1% 1/</td>
<td></td>
</tr>
<tr>
<td>2. ECI-Civilian-Compensation-Service Producing-Industries-Clerical 45.0% 1/</td>
<td></td>
</tr>
<tr>
<td>3. ECI-Civilian-Compensation-Service Producing-Industries-Blue Collar 8.9% 1/</td>
<td></td>
</tr>
<tr>
<td>4. ECI-Compensation-Private Industry-Workers-Union-Service Producing Industries 5.0% 1/ Collective bargaining Agreements Service Producing Industries 5.0% 2/</td>
<td></td>
</tr>
<tr>
<td>a. ECI Compensation-Private –Industry-Service Producing Industries 3/</td>
<td></td>
</tr>
<tr>
<td>b. ECI Wages and Salaries-Private-Industry-Service Producing Industries 3/</td>
<td></td>
</tr>
<tr>
<td><strong>Regional Adjustment Factor</strong></td>
<td></td>
</tr>
<tr>
<td>Average hourly earnings industry composite-New York and U.S. -50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C, U.S.-50%</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Labor</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Insurance – Malpractice, general liability, umbrella &amp; other</strong></td>
<td></td>
</tr>
<tr>
<td>Weighted average percent change in insurance cost</td>
<td></td>
</tr>
</tbody>
</table>

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**Approval Date** August 3, 1999

**Supersedes TN #94-04**

**Effective Date** January 1, 1998
### New York 51(d)

#### 1995 Proxies and Sources
**Residential Health Care Facilities**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Services</td>
<td>ECI-Compensation-Private Industry Workers-Professional Specialty &amp; Technical 1/</td>
</tr>
<tr>
<td>Auditing Services</td>
<td>ECI-Compensation-Civilian Private Industry Workers – Executive, Administrative and Managerial 1/</td>
</tr>
<tr>
<td>Office Supplies</td>
<td>1. Office Supplies &amp; Accessories (PPI) – (15%) 40%</td>
</tr>
<tr>
<td></td>
<td>2. Unwatermarked Bond, #4 (PPI) 35%</td>
</tr>
<tr>
<td></td>
<td>3. Form Bond, 15 lb. (PPI) 30%</td>
</tr>
<tr>
<td></td>
<td>4. ECI-Compensation-Private Industry Workers – Executive, Administrative and Managerial 20% 1/)</td>
</tr>
<tr>
<td></td>
<td>2. Office Machines NEC – 12.5% (PPI)</td>
</tr>
<tr>
<td></td>
<td>3. Writing and Printing Papers – 20% (PPI)</td>
</tr>
<tr>
<td></td>
<td>4. Pens, Pencils and Marking Devices – 12.5% (PPI)</td>
</tr>
<tr>
<td></td>
<td>5. Classified Advertising – 7.5% (PPI)</td>
</tr>
<tr>
<td></td>
<td>6. Periodicals, Circulation – 7.5% (PPI)</td>
</tr>
<tr>
<td>Management Consulting Fees</td>
<td>Average hourly earnings – Management and Public Relation Services 2/</td>
</tr>
<tr>
<td></td>
<td>a. ECI Private Industry Workers – Compensation – Executive, Administrative and Managerial 3/</td>
</tr>
<tr>
<td></td>
<td>b. ECI – Private Industry Workers – Wages and Salaries – Executive, Administrative and Managerial 3/</td>
</tr>
<tr>
<td>Interest Expense – Working Capital</td>
<td>Predominant prime time</td>
</tr>
<tr>
<td>Real Estate Taxes</td>
<td>1. NYC tax rates</td>
</tr>
<tr>
<td></td>
<td>2. Upstate overall tax rate</td>
</tr>
<tr>
<td>Dietary</td>
<td>1. All Foods (PPI) – 40%</td>
</tr>
<tr>
<td></td>
<td>2a. Food at Home, U.S. City average (CPI) or</td>
</tr>
<tr>
<td></td>
<td>2b. Food at Home, NY-NENJ (CPI) – 40%</td>
</tr>
<tr>
<td></td>
<td>3. Cups and Liquid – Tight Containers (PPI) – 3%</td>
</tr>
<tr>
<td></td>
<td>4. Tableware, Service Pieces, and Nonelectric Kitchenware (CPI) – 7%</td>
</tr>
<tr>
<td></td>
<td>5a. Food Away From Home, (CPI) U.S. City average or</td>
</tr>
<tr>
<td></td>
<td>5b. Food Away From Home, NY-NENJ (CPI) – 10%1</td>
</tr>
<tr>
<td>Maintenance &amp; Repairs</td>
<td>Maintenance &amp; Repairs (CPI)</td>
</tr>
</tbody>
</table>

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## Residential Health Care Facilities

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• #2 Fuel oil</td>
<td>Price, Tank Car Reseller, NYC &amp; Albany</td>
</tr>
<tr>
<td>• #6 Fuel oil</td>
<td>Price, Tank Car Reseller, NYC &amp; Albany</td>
</tr>
<tr>
<td>• Natural Gas</td>
<td>NYS DPS data for Brooklyn Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric &amp; Gas, Orange &amp; Rockland, Rochester Gas &amp; Electric</td>
</tr>
<tr>
<td>• Electric Power</td>
<td>NYS DPS price index for Con-Ed, L.I. Lighting, Orange &amp; Rockland, Central Hudson, NYS Electric &amp; Gas, Niagara Mohawk, Rochester Gas &amp; Electric</td>
</tr>
<tr>
<td>• Water and Sewer</td>
<td>Water and Sewerage Maintenance (CPI)</td>
</tr>
<tr>
<td>• Disposable Linen</td>
<td>Disposable Diapers (PPI)</td>
</tr>
<tr>
<td>• Linen and Bedding</td>
<td>Textile House furnishings (CPI)</td>
</tr>
<tr>
<td>• Housekeeping</td>
<td>Housekeeping Supplies (CPI)</td>
</tr>
<tr>
<td>• Maintenance and Repairs</td>
<td>Maintenance and Repairs (CPI)</td>
</tr>
<tr>
<td>Other Utilities</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>ITEM</th>
<th>PROXY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Drugs</td>
<td>1. Preparations, Ethical (Prescription) (PPI) – 72.0%</td>
</tr>
<tr>
<td></td>
<td>2. Preparation, Prop. (Over the Counter) (PPI) – 5.0%</td>
</tr>
<tr>
<td></td>
<td>3. Prescription Drugs (CPI) – 23.0%</td>
</tr>
<tr>
<td>• Medical Supplies</td>
<td>1. Medical Instruments and Apparatus – (PPI)</td>
</tr>
<tr>
<td>• Physicians Fees</td>
<td>Physicians’ Services (CPI) 4/</td>
</tr>
<tr>
<td>• Other Health Personnel</td>
<td>ECI – Compensation – Private Industry Workers – Professional Specialty and Technical 1/</td>
</tr>
</tbody>
</table>

1/Includes Regional Adjustment Factor
2/Includes Regional Adjustment Factor and Compensation Factor
3/Excludes Regional Adjustment Factor
4/Includes Regional Adjustment Factor and Excludes Compensation Factor

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86-2.13 Adjustments to provisional rates based on errors.

(a) Errors resulting from submission of fiscal and statistical information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 120 days of receipt of the commissioner's initial rate computation sheet. Errors on the part of the State Department of Health resulting from the rate computation process may be corrected if brought to the attention of the commissioner within 120 days of receipt of the commissioner's initial rate computation sheet. Subsequent errors on the part of the State Department of Health resulting from the revision of a rate may be corrected if brought to the attention of the commissioner within 30 days of receipt of the commissioner's revised rate computation sheet. In no event, however, shall a facility have less than 120 days from receipt of the initial rate computation sheets to bring errors to the attention of the commissioner.

(b) Rate appeals pursuant to this section, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures at or prior to the audit exist conference. Such rate appeals shall be recognized only to the extent that they are based upon errors in the cost and/or statistical data submitted by the residential health care facility, or by revisions initiated by a third-party fiscal intermediary, or in the case of a governmental facility, by the sponsor government of errors made by the Department of Health.
86-2.14 Revision in Certified Rates.

(a) The State Commissioner of Health may consider only those applications for revisions of certified rates which are based on:

(1) cost reports filed pursuant to subdivision (e) of section 86-2.2 of this Subpart. Such rate shall become effective on the first day of the [six-month] twelve-month period referred to in section 86-2.2(e) of this Subpart;

(2) six-month cost reports filed pursuant to sections 86-2.10(k)(6) and/or 86-2.15(e). Such rate shall become effective on the first day of the six-month period referred to in sections 86-2.10(k)(6) and 86-2.15(e) of this Subpart;

[(2)](3) errors made by the Department in the rate calculation process and errors in data submitted by a medical facility which have been brought to the attention of the commissioner within the time limits prescribed in section 86-2.13 of this Subpart. This paragraph shall not apply to the patient assessment process as contained in section 86-2.30 of this Subpart;
New York
53(a)

[(3)](4) significant increases in overall operating costs of a residential health care facility resulting from the implementation of additional programs or services specifically mandated for the facility by the commissioner;

[(4)](5) significant increases in the overall operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs or services approved for the facility by the commissioner;

[(5)](6) request for waivers of any provisions of this Subpart for which waivers may be granted by the commissioner as prescribed in specific sections; [and]

[(6)](7) alternative means of allocating costs in the cost-finding process which have been submitted with the annual cost report (RHCF-4c) and approved [in accordance with Section 456.2(b) and (c)]; and

[(7)](8) requests for relief from the provisions of section 86-2.25 of this Subpart relating to compensation of other than the administrative type of services rendered by an operator or relative of an operator. Such requests must contain sufficient documentation to demonstrate
that the services rendered are necessary and are reasonably related to the efficient production of such services.

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Supersedes TN NEW

Approval Date July 24, 1996
Effective Date April 1, 1993
(b) An application by a residential health care facility for review of a certified rate is to be submitted on forms provided by the Department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the Department may request such additional documentation as determined necessary. An application based upon error shall be submitted within the time limit set forth in section 86-2.13 of this Subpart. Beginning with appeals for rate year 1983 and, on an annual basis thereafter for all subsequent rate year appeals, the Commissioner shall act upon all properly documented applications for a rate year based upon errors within one year of the end of the 120-day period referred to in section 86-2.13(a) of this Subpart. The Commissioner shall act upon all other properly documented applications for a rate year.
appeal submitted pursuant to paragraphs (1) and (3) - (7) of subdivision (a) of this Subpart within one year of the aforementioned 120-day period or the receipt of such applications, whichever date is later. In the event the Department requests additional documentation, the one year time limit shall be extended for a mutually agreed upon time period for receipt of the documentation established by the Commissioner in conjunction with the residential health care facility. The deadline will be set according to the nature and quantity of documentation necessary. The one-year time limit shall not apply to rate appeals submitted pursuant to section 86-2.13(b) of this Subpart.

(1) The affirmation or revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a Rate Review Officer on forms supplied by the Department. The request shall contain a statement of factual issues to be resolved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the Rate Review Officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. The Rate Review Officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting forth the factual issues as determined by such Officer. The hearing shall be held in conformity with the provisions of the Public Health Law section 12-a and the State Administrative Procedure Act.
The recommendation of the Rate Review Officer shall be submitted to the commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978, will not be required to be resubmitted subsequent to April 1, 1978.

Any modified rate certified under paragraph (3) and (4) of subdivision (a) of this section shall be effective on the first day of the month in which the respective change is operational.

In reviewing appeals for revisions to certified rates the commissioner may refuse to accept or consider an appeal from a residential health care facility:

1. providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

2. operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

3. where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

4. where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.
In such instances the provisions of subdivision (c) of this section shall not be effective until the date the appeal is accepted by the commissioner.

(e) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(f) Reserved.
86-2.15 Rates for residential health care facilities without adequate cost experience.

(a) (1) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience as set forth in subdivision (e) of section 86-2.2 of this Subpart.

(2) The appointment of a receiver or the establishment of a new operator for an ongoing facility shall not be considered a new facility for the purposes of this section. Reimbursement for such receiver or new operator shall be in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(b) The rates certified for such residential health care facilities as set forth in subdivision (a) of this section, shall be determined in accordance with the following:

(1) Except as identified in paragraph (5) (6) and (7) of this subdivision, for the first three months of operation, the direct component of the rate shall be equivalent to the statewide [base] mean direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to section 86-2.10 of this Subpart. The facility shall perform an assessment of all patients, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third

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month thereafter until the end of the [six-month] twelve-month cost report period referred to in section 86-2.2(e) of this Subpart or if applicable, the six-month cost report identified in subdivision (e) of this section. The direct component of the rate shall be adjusted pursuant to section 86-2.10 of this Subpart, effective the first day of the month of each assessment period, based on the facility's case mix.

(2) Except as identified in paragraph (5), (6) and (7) of this subdivision, for the first three months of operation, the indirect component of the rate shall be equivalent to a blended [base] mean price for the applicable affiliation group as identified in subdivision (d) of section 86-2.10 of this Subpart. The blended [base] mean price shall be established using a proportion of 60 residents in the high case mix index peer group and 40 residents in the low case mix index peer group both as identified in subdivision (d) of 86-2.10 of this Subpart, adjusted by the RIIPAF. Effective on the first day of the fourth month the indirect component shall be the [base] mean price determined using the facility's PRI's and adjusted by the RIIPAF.
(3) the non-comparable component of the rate shall be determined on the basis of generally applicable factors, including but not limited to the following:

(i) satisfactory cost projections;
(ii) allowable actual expenditures;
(iii) an anticipated average utilization of no less than 90 percent.

(4) Rates established pursuant to this subdivision shall also include an adjustment pursuant to subdivision (u) of section 86-2.10 of this Subpart.

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Approval Date July 24, 1996
Effective Date April 1, 1993
(5) **Acquired Immune Deficiency Syndrome (AIDS).**

Except as identified in subparagraph (v) of this paragraph, a facility which is approved as a distinct AIDS facility or has a discrete AIDS unit pursuant to Part 710 of this Title, shall have rates established pursuant to this subdivision as follows:

(i) The direct component of the rate shall be determined in accordance with paragraph (1) of this subdivision provided, however, that the direct [base] mean [price] rate for the first three months of operation shall be determined pursuant to an approved facility’s projection of case mix. The direct component of the rate shall be enhanced by an increment which shall be determined on the basis of the difference between budgeted costs of care and staffing levels for AIDS patients in specific patient classification groups and the costs of care and staffing levels for non-AIDS patients which are classified in the same patient classification groups based on data submitted by a facility. The increment to be included in the facility’s rate pursuant to this subparagraph shall be approved by the commissioner, but in no event shall the increment be greater than 1.0. The direct component of the rate shall also be increased by an occupancy factor of 1.225.

(ii) The indirect component shall be determined in accordance with paragraph (2) of this subdivision provided however, that the indirect [base] mean price for the first three months of operation shall be determined pursuant to an approved facility’s projection of case mix. The indirect component of the rate shall be increased by the AIDS factor as determined pursuant to section 86-2.10(p) of this Subpart.

(iii) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered as a non-comparable cost.
(iv) Rates developed pursuant to this paragraph shall remain in effect until a facility submits twelve-month financial and statistical data pursuant to subdivision (e) of section 86-2.2 of this Subpart.

(v) Notwithstanding the provisions of subparagraph (i), (ii) and (iii) of this paragraph, any facility which prior to April 1, 1991 has a rate approved and certified by the commissioner pursuant to section 2807 of the Public Health Law, which includes AIDS specific adjustments pursuant to this Subpart, or has been approved as an AIDS specific facility by the Public Health Council, and/or has had a certificate of need application approved or conditionally approved pursuant to Part 710 of this Title for the operation of a discrete AIDS unit shall have its rate determined in accordance with the following:

(a) The direct component of the rate shall be based on the statewide ceiling direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to section 86-2.10 of this Subpart and a case mix proxy for AIDS patients established by the subparagraph, and increased by an occupancy factor of 1.225. The case mix proxy for AIDS patients shall be determined as follows:

(1) A facility which was approved based on a written application for establishment and/or construction which indicated that a majority of its AIDS patients would fall into patient classification groups with a case mix index exceeding 0.83 prior to application of any AIDS factors or increments identified in this subdivision shall be assigned a case mix proxy as determined by the following:

(i) For its first three months of operation, the facility shall be assigned a case mix proxy of 2.32.
New York
59(c)
Withdrawn

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59(d)

(ii) The indirect component of the rate for facilities identified in clause (2) of this clause shall be equivalent to the ceiling indirect price per day of the low intensity peer group established pursuant to paragraph (2) of subdivision (d) of section 86-2.10 of this Subpart after application of the RIIPAF as determined pursuant to section 86-2.10 of this Subpart and increased by the indirect AIDS factor as determined pursuant to subdivision (p) of section 86-2.10 of this Subpart.

(4) For purposes of this subparagraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered a non-comparable cost.

(5) Rates developed pursuant to this subparagraph shall remain in effect until a facility submits financial and statistical data pursuant to section 86-2.2(e) of this Subpart, but for a period not to exceed 18 months from the effective date of such rate, or April 1, 1991 whichever is later. If a rate pursuant to subdivision (e) of section 86-2.2 of this Subpart cannot be established within this 18 month period, a facility shall have the operational component of its rate determined pursuant to subparagraphs (i), (ii), and (iii) of this paragraph which will be effective on the first day of the month following the 18 month period referenced in this subclause.
The rates developed pursuant to this section shall remain in effect until a facility submits a twelve-month cost report in accordance with Section 86-2.2(e) of this Subpart for a twelve-month period during which the facility had an overall average utilization of at least 90 percent of bed capacity. This cost report shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the cost report. However, for a facility that did not or does not achieve 90 percent or greater overall average utilization for any year within 5 calendar years from the date of commencing operation, the rates will be recalculated utilizing the facility's most recently available reported allowable costs divided by patient days imputed at 90 percent. Such recalculated rates shall be effective January 1 of the 6th calendar year following the date the facility commenced operations, or April 1, 2006, whichever is later.

All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to Section 86-2.7 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period and computed in accordance with Section [96] 86-2.10 of this Subpart. Except as described in Section 86-2.19(d)(2) of this Subpart, an occupancy rate of not less than 90 percent shall be used when calculating the capital and noncomparable components in rate calculation.

Notwithstanding the provisions of this section, an operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993, but after the date on which the operator began operations shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for purposes of this section in lieu of the twelve-month cost report identified in subdivision (e) of Section 86-2.2 of this Subpart.
(6) **Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI).**

A facility which is approved to operate discrete units for the care of residents under the long-term inpatient rehabilitation for TBI patients shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 increased by a factor of 3.28 and adjusted by the RDIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to subdivision (c) of section 86-2.10 based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to
paragraph (4) of subdivision (c) of section 86-2.10 for TBI residents shall be increased by an increment of 1.49.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) of this Subpart for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIPAF pursuant to 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that opens a discrete unit for the care of patients under the long-term inpatient rehabilitation program for TBI patients, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility’s rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs for personnel required by the Department to operate a TBI unit that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.

(b) For a new facility without a residential health care facility rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.
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59(h)

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u) of this Subpart.

[(iv) The provisions of this paragraph will expire on December 31, 1994.]

(7) Long-term ventilator dependent residents.

A facility which is approved to operate discrete units for the care of long-term ventilator dependent patients as established pursuant to section 415.38 of this Title Appendix 2 of this State Plan shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to section 86-2.10(c)(3)(iii) of this Subpart increased by a factor of 2.89 and adjusted by the RDIPAF pursuant to section 86-2.10 of this Subpart. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to this Subpart based on the facility's case
mix. The case mix index which is used to establish the facility specific mean
direct price per day for each patient classification group pursuant to
paragraph (4) of subdivision (c) of section 86-2.10 for long-term ventilator
dependent residents shall be increased by an increment of 1.15.

(ii) The direct component of the rate shall be equivalent to the mean indirect
price developed pursuant to section 86-2.10(d) for the applicable peer group
established for high intensity case mix identified in paragraph (2) of
subdivision (d) of section 86-2.10, adjusted by the RIPAF pursuant to section
86-2.10(d). The indirect component shall be further adjusted by an
occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that is approved to operate discrete units for the
care of long-term care ventilator residents, the noncomparable
component of the rate shall be equal to the noncomparable component
of the existing residential health care facility’s rate computed pursuant
to subdivision (f) of section 86-2.10 plus approved budgeted costs as
identified in clauses (c) and (d) of this subparagraph plus approved
budgeted costs for personnel required by the Department to operate a
ventilator-dependent unit that would be reported in the functional cost
centers identified in subdivision (f) of section 86-2.10.
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(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10 of this Subpart, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision and include approved budgeted costs identified in clauses (c) and (d) of this subparagraph.

(c) The approved budgeted costs for the central service supply functional cost center as listed in section 86-2.10(c)(1) of this Subpart shall be considered a noncomparable cost reimbursed pursuant to section 86-2.10(f) of this Subpart.

(d) The approved budgeted costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section 86-2.10(f) of this Subpart.

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to 86-2.10(u) of this Subpart.

[(v) The provisions of this paragraph will expire on December 31, 1994.]
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(8) Specialized programs for residents requiring behavioral interventions. A facility which is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions as established by the Department shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 of this Subpart increased by a factor of 2.65 and adjusted by the RDIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to section (c) of this Subpart based on the facility’s case mix. The case mix index which is used to establish the facility’s specific mean direct price per day for each patient classification group pursuant to
paragraph (4) of subdivision (c) of section 86-2.10 for residents requiring behavioral interventions shall be increased by an increment of 1.40.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10 for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIIPAF pursuant to section 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 96-2.10 plus required approved budgeted costs for personnel that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10 of this Subpart.

(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.
(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u).

{(v) The provisions of this paragraph will expire on December 3, 1994.}
86-2.16 Less expensive alternatives.

Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central service or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.
86-2.17 Allowable costs.

(a) To be considered as allowable in determining reimbursement rates, costs shall be properly chargeable to necessary patient care. Except as otherwise provided in this Subpart, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under title XVIII of the Federal Social Security Act (Medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII of the Federal Social Security Act (Medicare) costs or in excess of customary charges to the general public. For purposes of this determination, customary charges to the general public shall equal an average of the applicable charges weighted by patient days. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.
(f) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the director or indirect costs of advertising, public relations or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(j) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner.

(k) Allowable costs shall not include any element of costs as determined by the commissioner to have been created by the sale of a residential health care facility.
Allowable costs shall not include the interest paid to a lender related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

Allowable costs shall be reduced by income earned for Medicare Part B eligible services to the extent that Medicaid has paid for these services.

Allowable costs shall include any fee assessed by the Commissioner on a residential health care facility, for the purpose of providing revenue for the account established pursuant to Chapter 1021 of the Laws of 1981. The reimbursement rate for a facility shall reflect the cost of the annual fee prior to collection of the fee through the rate of reimbursement.

For services provided on and after January 1, 2006, allowable costs shall not include an amount for prescription drugs for residents eligible for both Medicaid and for Part D of Title XVIII of the Social Security Act (Medicare) contingent upon implementation of such provision of the Federal Social Security Care Act in this State.

For rate periods on or after October 1, 2010, residential health care facility Medicaid rates of payment will not include reimbursement for the cost of prescription drugs.
86-2.18 Recoveries of expense.

(a) Operating costs shall be reduced by the costs of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

1. Drugs and supplies sold to other can employees for use outside the residential health care facility;
2. telephone and telegraph services for which a charge is made;
3. discount on purchases;
4. living quarters rented to persons other than employees;
5. meals provided to special nurses or patients' guests;
6. operation of parking facilities for community convenience;
7. lease of office and other space of concessionaires providing services not related to residential health care facility service; and
8. tuitions and other payments for educational service, room and board and other services not directly related to residential health care facility service.

(b) Operating costs shall be reduced by the actual revenue received from services and activities which are provided to employees at less than cost, as a form of fringe benefit. Examples of activities and services covered by this provision include:

1. drugs and supplies sold or provided to employees;
2. living quarters rented or provided to employees; and
3. meals sold or provided to employees.

TN #86-4 Approval Date July 29, 1987
Supersedes TN #82-30 Effective Date January 1, 1986
86-2.19 Depreciation for voluntary and public residential health care facilities.

(a) Reported depreciation based on approved historical cost of buildings, fixed equipment and capital improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities. Useful lives shall be the higher of the reported useful life or those useful lives from the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method of plant and nonmovable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expanded for the purpose for which it was funded.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and nonmovable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law (defined as “facilities” for purposes of this subdivision only) shall conform to the requirements of this Subpart.

(1) In lieu
of depreciation and interest, on the loan-financed portion of the facilities the State Commissioner of Health shall allow debt service on the mortgage loan as set forth in the mortgage prepayment schedule computed by the Medical Care Facilities Finance Agency, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness. Such mortgage repayment schedule may allow for the accelerated repayment of the mortgage indebtedness. Such mortgage repayment schedule may allow for the accelerated repayment of the soft costs, including, but not limited to, mortgage and bone insurance costs, start-up operating costs, underwriter discounts, government agency fees and investment contract fees, included in the approved total project cost.

(2) Effective January 1, 1995 for facilities in an initial period of operation, facilities which have approved discrete units serving specialty populations as defined in paragraphs (5), (6), (7) and (8) of section 86-2.15(b) of this Subpart, which serve AIDS residents, long term ventilator dependent residents, residents requiring behavioral interventions in specialized programs or traumatic brain injured residents who receive long term inpatient rehabilitation, respectively, shall be reimbursed for certain capital expenditures requiring a cash outlay as follows:

(i) Debt service amortization and interest, property insurance and SONYMA annual fees shall be divided by an estimate of patient days in the calculation of the capital component of the specialty population unit rate that is promulgated for the initial period of operation.

(a) An estimate of patient days shall be determined by the department based on a reasonable projection of utilization during the initial period of operation. The reasonable projection of utilization shall be based on prior initial utilization of similarly situated facilities, and information that may have been submitted to the department by the facility as to the anticipated demand for the service.
(b) Initial period of operation is defined as the period commencing on the initial effective date on which the facility is certified by the department to begin operation of the discrete unit(s) identified in paragraph (2) of this subdivision, and ending on the last day of the twelfth month of continuous operation or the beginning date of the initial cost report filed in accordance with subdivision (e) of section 86-2.2 of this Subpart, whichever is shorter.

(ii) The capital component of the facility's rate for the initial period of operation shall be subject to audit for utilization based on actual patient days in the initial period of operation. Such capital component of the rate shall be retrospectively or prospectively adjusted based on such audit.

(e) In the computation of rates for voluntary residential health care facilities which are rented for proprietary interests, the provisions of section 86-2.21 of this Subpart shall apply, except where the realty was previously owned by the voluntary residential health care facility or where the proprietary interest has representation on the board of directors of the voluntary residential health care facility.

(f) (1) In the event that a residential health care facility is sold or leased or is the subject of any other realty transaction, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction has not occurred.

(2) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this subpart shall be deemed to be a non-arms length lease.

(3) Any capital expenditures associated with non-arms length leases shall be approved and certified to if required under the RHCF Certificate of Need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would
have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

[(4) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:

(i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;

(ii) adequate alternate equipment which would serve the purpose are not or were not available at a lower cost; and

(iii) the leasing was based on economic and technical considerations;

(iv) if all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had it retained legal title to the equipment, such as interest, taxes, depreciation, insurance, and maintenance costs.

(v) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental cost for the land shall not be includable in allowable costs.]}

(g) (1) The provisions of subdivision (a) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying facility, all of the following conditions must be met:

(i) A sale or transfer between nonrelated parties must take place
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(ii) The purchaser must assume the seller’s remaining mortgage repayment schedule at the associated fixed rate of interest.
(iii) The difference between the unpaid principal balance of the seller's mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in section 86-2.20 of this Subpart under terms of the first and second mortgage, plus the annual principal debt amortization, exclusive of that portion attributable to the acquisition of land must be less than that which would otherwise be reimbursed pursuant to subdivision (a) of this section and section 86-2.20 of this Subpart if no assumption of the existing first mortgage were made. (This comparison hereinafter referred to as the comparative analysis test.)

(v) For purposes of this subdivision, the loan financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. Equity capital will be considered as first applying to the acquisition of the land, then to the acquisition of the building. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.

(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return on equity in the following manner:
(i) **Principal debt amortization.**

In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage, with the exception of that portion of the indebtedness which is attributable to the acquisition of the land.

(ii) **Interest.**

The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage at a rate which the commissioner finds to be reasonable and is in accordance with the provisions of section 86-2.20 of this Subpart.

(iii) **Return of equity.**

The equity portion of the Medicaid-allowable transfer price, except for that portion which is attributable to the acquisition of the land, shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.
[86-2.20] Interest for all residential health care facilities.

(a) Necessary interest on both current and capital indebtedness is an allowable cost for all residential health care facilities.

(b) To be considered as an allowable cost, debt-generating interest shall be incurred to satisfy a financial need, and interest expense shall be at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained. Financial need for capital indebtedness relating to a specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(c) (1) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusted malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor-restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

(2) For rate years beginning prior to January 1, 1994, investment income reported for the fiscal year ending December 31, 1983, (or for a subsequent fiscal year if that subsequent year’s report is being used by the department to establish the basic rate pursuant to section 86-2.10 of this Subpart) shall reduce the interest expense allowed for reimbursement as follows:

(i) For all residential health care facilities, investment income shall first reduce the interest expense allowed each year for operational cost reimbursement; and

(ii) the amount of any remaining investment income, after application of subparagraph (i), shall reduce the interest expense reimbursed each year as capital cost for residential health care facilities; and
(d) interest on current indebtedness shall be treated and reported as an operating, administrative expense. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.

(e) interest on capital indebtedness, as defined in paragraph 86-2.21(a)(1) of this Subpart, except as provided for in section 86-2.2(c) of this Subpart for rate years beginning January 1, 1986 and thereafter, is an allowable cost if the debt generating the interest is approved by the Commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the Commissioner or the cost of the

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(iii) the amount of any remaining investment income after application of subparagraph (ii), shall not be considered in the computation of the rate.

(3) For rate years beginning on or after January 1, 1994, investment income reported for the same year used to compute capital cost reimbursement for a facility’s rate shall reduce the interest expense allowed for reimbursement, as provided in sub-paragraph (c)(2)(i)-(iii) of this section.

(d) (1) Interest on current indebtedness shall be treated and reported as an operating, administrative expense for rate years beginning prior to January 1, 1994. For rate years beginning on or after January 1, 1994, interest on current indebtedness, reported for the same cost report period used to compute capital cost reimbursement for a facility’s rate, shall be reported as an administrative expense and reimbursed as a non-reimbursable expense. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.

(2) (a) Approval by the Commissioner shall be required for reimbursement of interest expense on current indebtedness incurred on or after January 1, 1994 when such interest expense exceeds the threshold established for that calendar year. The threshold for each calendar year shall be equal to the prime lending rate as published in the first issue of the Wall Street Journal for the calendar year plus 200 basis points (200 points equals 2%) on a loan principal of $270,000 for facilities with 120 or less beds or $270,000 plus an additional $2,250 for each bed over 120 for facilities with more than 120 beds. Approval shall be granted in accordance with the standards set forth in subdivision (b) of this section. Prior approval shall not be required.

* For example, for a home with 100 beds (i.e., less than 120) the threshold would be prime rate +2% applied to $270,000. For a home having 150 beds, the threshold will be the prime rate + 2% applied to $270,000 + $2,250 (30 beds) or $337,500.

(b) New facilities without adequate cost experience whose rates are calculated pursuant to section 86-2.15 of this Subpart shall be exempt from the requirements in subparagraph (a) until January 1st of the first calendar year used as the basis for
computing capital cost reimbursement and for which a cost report is filed subsequent to the cost report described in section 86-2.2(e) of this Subpart. This exemption shall not apply to operating facilities that open new discrete units providing services reimbursed in accordance with the provisions of paragraphs (5), (6) and/or (7) of section 86-2.15(b) of this Subpart or other similar discrete units providing care to residents with special needs that receive a separate and distinct payment rate under section 86-2.15 of this Subpart.

(c) The interest expense threshold for facilities operated by receivers or new operators who are required to file a cost report for the first twelve-month period of operation pursuant to section 86-2.10(k) of this Subpart shall be established for that cost report period in accordance with subparagraph (a) of this paragraph, using the prime lending rate in effect on January 1st of the year in which the cost report period begins.

(e) Interest on capital indebtedness, as defined in paragraph 86-2.2(a)(1) of this Subpart, except as provided for in section 86-2.20(c) of this Subpart for rate years beginning January 1, 1986 and thereafter, is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness [than] being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration [of] to the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness.

(f) Where a public finance authority has established a mortgage rate of interest such that sufficient case flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.
Reserved

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TN #06-18
Supersedes TN #94-04

Approval Date October 10, 2006
Effective Date April 1, 2006
86.2.21 Capital Cost reimbursement for proprietary residential health care facilities.

(a) Definitions.

As used in this section, the following terms shall be defined as follows:

(1) Capital indebtedness.

The term capital indebtedness shall mean all debt obligations of a facility that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment of a facility or evidenced by a note incurred in accordance with subparagraph (ii) of this paragraph;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment (hereinafter called the "authorized purpose"); and

(iii) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility in accordance with standards set forth in section 86-2.21(e)(3)(ii) of this Subpart. Refinancing of capital indebtedness shall be recognized only to the extent of the then unpaid balance of the debt being refinanced.

(2) Commissioner.

The term commissioner shall mean the Commissioner of Health of the State of New York.
(3) **Department.**

The term *department* shall mean the Department of Health of the State of New York.

(4) **Equity.**

The term *equity* shall mean all cash or other assets, net of liabilities, invested by a facility or its operator in land, building and nonmovable equipment, and found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. *Equity* shall not include any change in the book value of a facility resulting from reevaluation of assets or from the amortization of capital indebtedness resulting from payments made pursuant to subdivision (e), paragraph (3) of this section.

(5) **Facility.**

The term *facility* shall mean a proprietary residential health care facility, as the term *residential health care facility* is defined in article 28 of the Public Health Law and in regulations of the department.

(6) **Initial allowed facility cost.**

The term *initial allowed facility cost* shall mean the portion of certified costs approved by the commissioner or, in the case of facilities granted operating certificates prior to April 15, 1973, the costs of the facility as verified by audit to the satisfaction of the commissioner or, in the case of facilities not able to comply with either of the foregoing standards, costs imputed.

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**TN #86-4**

**Approval Date:** July 29, 1987

**Supersedes TN #82-30**

**Effective Date:** January 1, 1986
pursuant to subdivision (g) of this section, in or prior to the first year of useful facility life attributable to the acquisition of land and the construction, acquisition or renovation of building and nonmovable equipment. The commissioner shall disregard any costs relating to prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(7) Useful facility life.

The term useful facility life shall mean a period of 40 years measured from the calendar year in which a facility commences operations as determined by the commissioner.

(8) Rate of return.

The term rate of return shall mean the annual rate of return on equity invested, as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under title XVIII of the Federal Social Security Act.] and said rate for a rate year shall be equal to the yield on thirty year United States Treasury bonds in effect on the second Wednesday of September of the year prior to the rate year.

(9) Capital improvement.

The term capital improvement shall mean any addition to, replacement of, or improvement of a capital item of plant or nonmovable equipment approved by the commissioner as reasonable, necessary and in the public interest.
(10) **Capital improvement cost.**

The term *capital improvement cost* shall mean the actual expenditure or portion thereof attributable to a capital improvement approved by the commissioner as reasonable, necessary and in the public interest.

(11) **Hospital-based residential health care facility.**

The term *hospital-based residential health care facility* shall mean a facility holding a certificate of operation as a residential health care facility which is wholly owned by a hospital as that term is defined in Subpart 86-1 of this Title, and is physically located in a building or buildings, part of which building or buildings are also used for provision of acute care hospital services.

(12) **Effective term.**

The term *effective term* shall mean the number of years and months required, pursuant to the term of the note or mortgage, to fully amortize the principal of debt, predicated upon the regular principal payments required by the mortgage or note, but determined without regard to any provision for making the balance all due and payable at a given date or upon a stated event, and without regard to any provision for acceleration of the debt or any original or subsequent agreement for the suspension or moratorium of principal payments.

(b) Subject to subdivision (f) of this section, the reimbursement rate of every facility certified by the commissioner

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TN #86-4 Approval Date July 29, 1987

Supersedes TN #82-30 Effective Date January 1, 1986
and approved by the State Director of the Budget pursuant to article 28 of the Public Health Law shall, in each year of useful facility life, include a capital cost component determined in accordance with the provisions of subdivision (c), (d) or (e) of this section applicable to the facility in such year.

(c)  (1) The provisions of subdivision (e) of this section shall not apply for the term prescribed by paragraph (3) of this subdivision to any facility which, as of the effective date of this section, is located in and operated from leased space pursuant to a lease:

   (i) which was entered into and approved for reimbursement prior to March 10, 1975; and

   (ii) which the commissioner finds to be bona fide, valid and noncancelable; and

   (iii) the payments, or a portion thereof, made pursuant to such lease are found by the commissioner to have been the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of a facility within the provisions of paragraph (1) of this subdivision shall, for the term prescribed by paragraph (3) of this subdivision, consist of
a payment factor sufficient to reimburse the facility for the total payments required under its lease to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision, and subject to the historical limitations set by the commissioner.

(3) Capital cost reimbursement for leased facilities shall be made pursuant to this subdivision for the balance of the lease term (computed without regard to any future extension or option to renew authorized by the lease) remaining as of the effective date of this subdivision. Upon the expiration of such balance of the lease term provided in an approved lease (as said lease so provides as of August 1, 1977) or such earlier expiration date as may be agreed to by the parties to an approved lease, capital cost reimbursement shall be made pursuant to subdivision (e) of this section notwithstanding any extension or renewal of such lease or the execution of a new lease by or on behalf of the facility, provided, however, that the commissioner may, in his discretion, continue capital cost reimbursement for such leased facilities pursuant to this subdivision, at a rental amount approved by the commissioner prior to such extension or renewal, and not pursuant to subdivision (e), upon his finding that there is a public need.
for such facility at the time and place and under the circumstances proposed and that the continued operation of such facility would be jeopardized by a limitation of reimbursement pursuant to subdivision (e).

(4) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this subpart shall be deemed to be a non-arms length lease.

(5) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, under the hospital certificate of need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

(6) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement shall be included in allowable costs if the following conditions are met:

   (i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area;
(d) The provisions of subdivision (e) of this section shall not apply to hospital-based residential health care facilities. Such facilities will be reimbursed pursuant to capital cost regulations section in Subpart 86-1 Attachment 4.19-D Part I. Such facilities will be reimbursed pursuant to capital cost regulations section in Subpart 86-1 Attachment 4.19-D Part I [of this part].

(e) Subject to the provisions of subdivisions (c), (d) and (f) of this section, the capital cost component for every facility shall consist of the payment factors provided in this subdivision that, in any year of useful facility life, are applicable to the facility.

(2) Interest.

The capital cost component shall, in each year of useful facility life, include a payment for factor sufficient to reimburse, at a rate which the commissioner finds to be reasonable under the circumstances prevailing at the time of the placing of the capital indebtedness, interest on capital indebtedness.

Effective April 23, 2015, for purposes of effectuating a shared saving program, facilities that elect to refinance existing approved debt service, on or after April 23, 2015, medical assistance payments for real property costs will include 50% of the savings attributable to the refinancing. Such refinancing must be approved by the Department. Savings will be calculated each year based upon expenses that correspond only to the refinance portion of the new encumbrance relative to what it would have been absent the refinancing.

(3) Amortization.

(i) Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall, in each year of useful facility life
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life, include a payment factor sufficient to reimburse the amortization component of capital indebtedness pursuant to the terms of the mortgage note or bond.
(ii) The capital indebtedness of a facility, to the extent that the original principal of such debt does not exceed the initial allowed facility cost of the facility shall be recognized as follows:

(a) For capital indebtedness with an effective term of 10 years of less, amortization expense will be recognized for the purpose of reimbursement only, if the schedule of debt amortization is within the limitation set forth in section 86-2.21(e)(5) of this Subpart for each of the years of debt amortization.

(b) For capital indebtedness with an effective term in excess of 10 years, amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the following standards are met:

(1) the debt is incurred for authorized purposes;

(2) the interest rate is reasonable for the time and place in which the capital indebtedness is committed, and for the type of indebtedness associated with the interest rate;
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(3) the amortization schedule is reasonable (amortization must be required in each year of the mortgage in accordance with the established financial practices);

(4) the effective term is consistent with customary commercial practices in the geographic area of the facility; and

(5) the effective term is in accordance with efficient production of services.

c) For capital indebtedness other than first mortgages, the amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the debt, complies with the standards set forth in section 86-2.21(e)(3)(ii)(b) of this Subpart, and the following additional standards:

(1) they must be incurred for the purpose of financing either an approved purchase or construction of a facility; and

(2) the effective term of financing for a capital improvement is reasonable when compared to the estimated useful life of the improvement.

(d) Capital indebtedness for any unauthorized purpose will not be recognized for any reimbursement purpose.
(4) **Return of equity.**

Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall include a payment factor sufficient to return equity. A facility shall be eligible for the return of equity commencing in the first year following the department’s determination, among other factors, that the facility has the ability to meet current capital indebtedness (including principal and interest) over the balance of useful facility life. This shall mean that within the confines of the regulations expressed in this Subpart, capital reimbursement will be sufficient to provide for the remaining amortization of capital indebtedness. The commissioner’s determination shall also take into account such factors as the age, size, location and condition of the facility, and the financial condition of the facility.

(5) **Limitation.**

(i) Annual reimbursement payments for capital cost under paragraphs (3) and (4) of this subdivision shall not at any time result in a cumulative average payment in excess of three and three one-hundredths percent of initial allowed facility cost. For years prior to 1981, actual amortization or depreciation paid by Medicaid will be used in the computation of the limitation. For years prior to Medicaid or in years when Medicaid payments did not include an expense equivalent of depreciation or amortization, a three and three one-hundredths percent payment will be imputed.
(ii) This limitation may be waived by the commissioner where a facility applies to the commissioner for approval to finance an existing mortgage because its recognized amortization expense exceeds the amount of allowable reimbursement for amortization of principal and interest expense (including credit from prior amortization reimbursement). In those instances where the commissioner determines that it would be more expensive to reimburse the debt service that would be incurred if the facility refinanced the remaining principal, than it would be to continue to reimburse the debt service on the existing mortgage, the commissioner may reimburse up to the actual debt service incurred by the facility under the existing mortgage, plus return on equity in accordance with the provisions of paragraph (6) of this subdivision.

(6) **Return on equity.**

The capital cost component for every facility shall include a payment factor sufficient to pay an annual rate of return on average equity, as such average annual equity shall be determined by the commissioner in each year of useful facility life.

(7) **Residual reimbursement.**

After the expiration of useful facility life, the commissioner may approve a payment
factor for any facility for which he determines that continued capital cost reimbursement is appropriate; provided, however, that such payment factor shall not exceed one half of the capital cost reimbursement received by such facility in the final year of useful facility life.

(8) Capital improvement cost reimbursement.

(i) The capital improvement cost shall be reimbursed by adjusting the initial allowed facility cost, capital indebtedness, equity determinations and limitations as stated in paragraph (5) of this subdivision, to include the capital improvement cost.

(ii) Adjustments in accordance with subparagraph (i) of this paragraph shall be made in the following manner:

(a) if the cost of an improvement is $100,000 or more, and certificate of need approval has been granted by the commissioner, then component useful life for the improvement will be permitted. Such component useful life will be equivalent to the estimated asset life in accordance with the Medicare Provider Reimbursement Manual or the remaining useful life of the facility, whichever is less. Where a capital improvement adjusts the expected useful life of the facility beyond the remaining portion of the original useful facility life, the limitation set
forth in section 86-2.21(e)(5) of this Subpart, will be increased to allow for the reimbursement of the amortization component of the debt obtained to finance the improvement.

(b) If the cost of an improvement is less than $100,000, then the cost will be reimbursed over the remaining portion of the expected useful life. In such instances the reimbursement will commence with either the reporting of such costs on an annual certified cost report or, upon submission of a cost report, certified by an independent public accountant, whichever is submitted first. In either event, the reporting of such costs must be accompanied by a sworn statement by the administrator or the chief fiscal officer of the facility to the effect that the improvements made are not part of a number of planned related projects which, in the aggregate, total $100,000 or more.

(c) If the cost of an improvement is less that $100,000 and:

(1) is undertaken as the result of an emergency situation;
(2) affects the health and safety of the patients; and

(3) the facility can demonstrate dire financial condition;

then the limitation set forth in [section 86-2.21(e)(6) of this Subpart] the Limitation subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment will be modified to allow for the reimbursement of the debt service associated with the financing of the approved capital improvement over the effective term of the obligation or five years, whichever is greater. Any contribution to the improvement by the facility and not financed by the debt obligation will be considered an equity contribution and an adjustment to the facility's total capital equity will be made.

(d) If a facility undertakes an authorized improvement without incurring additional debt, then the facility will receive a return on equity and, when a determination has been made in accordance with the [section 86-2.21(e)(4) of this Subpart,] Return of Equity subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment, a return of equity, for the funds invested in the improvement.

[(e) Effective April 1, 2009, any proprietary facility entitled to residual reimbursement, will have the capital cost component of its rate recalculated by the Department to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients, subject to the approval of the Commissioner and all applicable certificate of need requirements. Capital improvements and/or renovation costs that are not related to the provision of nursing facility services are not eligible to be reimbursed in the capital cost component of the nursing home rate.]

(e) Effective April 1, 2011, through March 31, 2012, the capital cost component of the Medicaid rate shall reflect:

(1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and

(2) A reduction in the payment factor for return of equity on real property which is calculated as follows:
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a) If the balance of useful life is currently five years or less, such useful life will be increased by 100 percent.

b) If the balance of useful life is currently six years or more, such useful life will be increased by five years.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

Effective for periods June 1, 2012 through December 31, 2012, the capital cost component of the Medicaid rate will reflect:

1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and

2) A reduction in the payment factor for return of equity on real property which is calculated as follows:

   a) the balance of useful life on January 1, 2012, will be increased by four years.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

Effective for annual periods beginning January 1, 2013, the capital cost component of the Medicaid rate will reflect:

1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and

2) A reduction in the payment factor for return of equity on real property which is calculated as follows:

   a) the balance of useful life on January first of the prior year will be reduced by one year.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

(f) 1) With respect to facilities granted operating certificates prior to March 10, 1975, the Commissioner will modify or
provide exceptions to subdivision (c) or (e) of this section in circumstances where he finds that application of the provisions of either subdivision would result in (i) excessive reimbursement to the facility, or (ii) severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility. In determining severe economic hardship, the commissioner shall consider such factors as debt service required on capital indebtedness, prior withdrawal of assets from the facility, and the financial condition of the facility in general. In such cases where the commissioner makes a finding of severe economic hardship, the capital cost component of the rate shall not exceed the debt service on capital indebtedness.

(2) The commissioner may revise the capital cost component of the reimbursement rate applicable to any facility which he determines is based upon previous error, deceit or any other misrepresentation or misstatement by the facility.

(3) The capital cost component shall not be affected by any sale, lease or transfer occurring after March 10, 1975.

(g) In lieu of determining initial allowed facility cost pursuant to subdivision (a) of this section, the commissioner may estimate the original fair and reasonable cost of the facility with due regard for the fair and reasonable cost of facilities of comparable age, size, location and condition, and impute an initial allowed facility cost to:
(1) every facility for which records on the historical cost or book value of land, building or nonmovable equipment are not available or not verifiable to the satisfaction of the commissioner;

(2) every leased facility which, as of the effective date of this section, is not eligible for reimbursement pursuant to subdivision (c) of this section;

(3) every facility which, after the effective date of this section, ceases to be eligible for reimbursement pursuant to subdivision (c) of this section and becomes eligible for reimbursement pursuant to subdivision (e) of this section; or

(4) every facility whose construction was completed prior to the calendar year in which this section becomes effective and whose initial facility year occurs in or after the calendar year in which this section becomes effective.

(h) In the event that a facility fails to submit information necessary for the implementation of this section, after notification pursuant to subdivision (f) of section 86-2.2 of this Subpart, the capital cost component of the rate shall consist of interest, if reported, and amortization not in excess of the lesser of the amortization payment required under capital indebtedness, or 2 1/2 percent of initial allowed facility cost.

(i) (1) The limitation provision of paragraph (e)(5) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying transaction, all of the following conditions must be met:
(i) A sale or transfer between nonrelated parties must take place.

(ii) The purchaser must assume the seller’s remaining mortgage repayment schedule at the associated fixed rate of interest.

(iii) The difference between the unpaid principal balance of the seller’s mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in this section, under the terms of the first and second mortgage, plus the annual principal debt amortization must be less than that which would otherwise be reimbursed pursuant to this section, if no assumption of the existing first mortgage were made. (This comparison is hereinafter referred to as the comparative analysis test.) For purposes of this subdivision, the loan-financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.
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(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return of equity in the following manner:

(i) **Principal debt amortization.**

   In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage.

(ii) **Interest.**

   The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage as defined by paragraph (e) (2) of this section.

(iii) **Return of equity.**

   The equity portion of the Medicaid-allowable transfer price shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.
The Commissioner shall timely develop and implement a standardized process for assessing the feasibility of capital mortgage refinancing, including a standard formula for determining the net cost benefit of refinancing, inclusive of all transaction and closing costs. On or before September 1, 2003, each residential health care facility established under Section 2808 of the Public Health Law and certified as a provider pursuant to Title XIX of the federal Social Security Act (Medicaid), except for those facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law, shall review its existing capital debt structure using the standard formula to evaluate whether or not a material cost benefit could be derived by refinancing its capital mortgage or mortgages, and shall forward the results of such review to the Commissioner. The Commissioner may request and such facility shall submit descriptions of existing mortgage arrangements and debt service reserve funds as needed to implement paragraph (2) of this subdivision. Facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law shall submit to the Dormitory Authority, the Housing Finance Agency and/or the State of New York Mortgage Agency such information as is required by such agency to evaluate potential refinancing of such capital mortgages.

The Commissioner shall review each facility's submission and make a written determination as to whether or not the facility should refinance its capital mortgage or mortgages, and if so, for what amount, within sixty days of the date of the facility's submission based on the following parameters:

(a) the mortgage refinancing must result in a present value cost benefit that "materially exceeds", as such term is defined by the Commissioner, the amount of all transaction and closing costs associated with the refinancing, including any pre-payment penalties associated with the current mortgage or mortgages. The Commissioner shall do such calculations in a manner consistent with comparable calculations in the State Finance Law;

(b) mortgages may be refinanced for a term greater than the remaining term of the existing debt within certain limits, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;

(c) mortgages may be refinanced utilizing variable rate mortgage loans, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph. In such cases, for purposes of determining the reimbursable capital interest expense included in the capital cost component of rates of payment determined pursuant to this section, the average interest rate over the life of the refinanced mortgage shall not exceed the interest rate in effect on the previous mortgage debt immediately prior to the refinancing.
not-for-profit and governmental residential health care facilities may utilize taxable mortgage loans to refinance their existing debts, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;

moneys contained in facility debt service reserve funds may be considered in the evaluation of amounts necessary to be refinanced, but only to the extent such moneys total more than the debt service reserves needed to establish the successor capital mortgage financing;

in no event shall funded depreciation accounts, or building funds accumulated through donor-restricted contributions or unrestricted contributions, gifts, bequests or legacies, be considered in the evaluation of amounts necessary to be refinanced; and

notwithstanding any inconsistent provision of law or regulation to the contrary, the principal amount, including all transaction and closing costs and any pre-payment penalties associated with the previous mortgage or mortgages, that is thereby deemed necessary to be refinanced by the Commissioner, as approved by the Public Authorities Control Board and the United States Department of Housing and Urban Development where appropriate, shall be considered the final approved mortgage amount for capital cost reimbursement under the relevant provisions of this section.

Notwithstanding any inconsistent provision of law or regulation to the contrary, the capital cost component of rates of payment for services provided for the period beginning October 1, 2003 through March 31, 2004 for residential health care facilities that have been identified by the commissioner as refinancing candidates pursuant to paragraph (2) of this subdivision shall reflect capital interest costs equivalent to the lower of the prevailing market borrowing rates available on or about July 1, 2003, for refinancing capital mortgages for their remaining term plus two hundred basis points, or the existing rate being paid by the facility on its capital mortgage or mortgages as of that date. The Commissioner shall determine, in consultation with mortgage financing experts, the prevailing market borrowing rates available
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to not-for-profit and governmental residential health care facilities to refinance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to refinance capital mortgages on a taxable fixed rate basis, for this purpose. Exceptions to this policy shall be provided by the Commissioner to each such facility that demonstrates, prior to December 1, 2003, or thirty days after receipt of the Commissioner’s written determination specified in paragraph (2) of this subdivision, whichever occurs later, that:

(a) it has initiated or completed the process of refinancing the mortgage or mortgages in question, in which case the capital cost component of rates of payment shall be timely revised to reflect capital interest costs associated with a refinanced mortgage that conforms to the standards in paragraph (2) of this subdivision. For this purpose, a facility that has applied for approval by the Commissioner, the State Hospital Review and Planning Council and/or Public Health Council to refinance its existing mortgage debt as part of a larger project involving facility replacement, expansion, renovation or change of ownership is considered to have initiated the process of refinancing; or

(b) it can not refinance its capital mortgage or mortgages to achieve the relevant present value cost benefit specified in subparagraphs (a) and (b) of paragraph (2) of this subdivision due to a “lock out” or similar provision in its current mortgage agreement that prevents re-financing; due to some other type of genuine refinancing obstacle, such as an inability of the facility to obtain credit approval from a lender or mortgage insurer, or due to an intervening change in credit market conditions or other relevant circumstances. In which case the capital cost component of rates of payment shall continue to reflect capital interest costs associated with the existing mortgage or mortgages, together with reasonable costs incurred in connections with the facility’s attempt to refinance its existing mortgage debt.
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(4) Each residential health care facility established under the New York State Nursing Home Companies Law and designated as an acquired immune deficiency syndrome (AIDS) facility or having a discrete AIDS unit approved by the Commissioner of Health shall refinance its capital mortgage on or before August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, and shall forward the results of such refinancing to the Commissioner of Health; provided however, no such residential health care facility shall be required to refinance its capital mortgage if the Department of Health, in consultation with the Dormitory Authority of the State of New York, determines that such refinancing could not be accomplished on an economic basis or is otherwise not feasible. Notwithstanding any inconsistent provision of law or regulation to the contrary, in the event that any such residential health care facility does not refinance its capital mortgage and the Department of Health has not made a determination that a refinancing was not economic or feasible, then the capital cost component of rates of payment determined pursuant to Article 28 of the New York State Public Health Law for such facilities beginning August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, shall reflect the capital interest cost equivalent to the lower of: (i) the prevailing market borrowing rates available for refinancing capital mortgages for their remaining term on or about August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later; or (ii) the existing rate being paid by the facility on its capital mortgage or mortgages as of such date. The Commissioner of Health shall determine, in consultation with the Dormitory Authority of the State of New York, the prevailing market borrowing rates available to residential health care facilities to refinance capital mortgages.
Effective July 1, 2012, the capital cost component of the rate for eligible residential health care facilities will be adjusted to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with the federal regulations set forth in 42 CFR 483.70(a)(8). Facilities that submit a request to the Commissioner and meet at least three of the following criteria, using financial information obtained from the facility’s latest cost report and more recent financial information provided by the facility, shall be eligible for such capital rate adjustment:

(i) Operating losses;

(ii) Negative unrestricted fund balances;

(iii) Documentation demonstrating the inability of the facility to obtain credit, at current market rates, without the reimbursement treatment accorded pursuant to this section;

(iv) Negative working capital;

(v) Less than 30 days of cash expense on hand;

(vi) More than 30 days of revenue in accounts receivable;

(vii) Cash flow statements and budget projections demonstrating material deterioration in fiscal stability of facility.

Eligible facilities will also be required to:

1) File the required certificate of need information with the Department of Health and obtain any required certificate of need approvals.

2) Provide information documenting the costs of the sprinkler project and that such costs are necessary to achieve compliance with the federal regulations set forth in 42 CFR 483.70(a)(8).
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3) Submit to the Commissioner, for review and approval, a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule will be provided to the Commissioner at least 60 days prior to the due date of the first debt service payment (or such shorter timeframe as the Commissioner may authorize).

4) Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account may only be used solely for the purpose of satisfying such debt service payments.
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86-2.22 Movable equipment.

(a) Necessary and reasonable expenses related to movable equipment (depreciation computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years-digits method, interest on indebtedness, lease, etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

(b) An arms length lease purchase agreement with a nonrelated lessor involving equipment entered into on or after October 23, 1992 which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(1) The lease transfers title of the equipment to the lessee during the lease term.

(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the equipment.
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(4) The present value of the minimum lease payments (payments to be made during
the lease term including bargain purchase option, guaranteed residual value and
penalties for failure to renew) equals at least 90 percent of the fair market value of
the leased property. This provision is not applicable if the lease begins in the last
25 percent of the useful life of the equipment. Present value is computed using the
lessee’s incremental borrowing rate, unless the interest rate implicit in the lease is
known and is less than the lessee’s incremental borrowing rate, in which case the
interest rate implicit in the lease is used.

(c) If a lease is established as a virtual purchase under subdivision (b) of this section, the
rental charge is includable in capital-related costs as the lesser of the annual rent or the
annual costs of ownership which shall be limited to depreciation and interest. When the
cost of ownership becomes less than the annual rent, the rental charge shall be
includable in capital-related costs. The aggregate rental or lease costs included in
capital-related costs may not exceed the costs of ownership that would have been
included in capital-related costs over the useful life of the asset had the provider
received legal title to the asset.

(d) If a facility enters into a sale and leaseback agreement involving equipment on or after
October 23, 1992, the amounts to be included in capital-related costs are the lesser of
the annual rent or the annual costs of ownership. When the cost of ownership becomes
less than the annual rent, the rental charge shall be includable in capital-related costs.
The aggregate rental or lease costs included in capital-related costs may not exceed the
cost of ownership which shall be limited to depreciation and interest that would have
been included in capital-related costs over the useful life of the asset had the provider
retained legal title to the asset.
86-2.23 Research.

(a) All research costs shall be excluded from allowable costs in computing reimbursement rate.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understanding, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.
86.2.24 Educational activities.

The costs of educational activities, less tuition and supporting grants, shall be included in the calculation of the basic rate, provided such activities are directly related to patient care services.
86-2.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law or regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full-time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.
86-2.26 COST OF RELATED ORGANIZATIONS.

(a) A RELATED ORGANIZATION shall be defined as any entity which the residential health care facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association or material interest exists in an entity which supplies goods and/or services to the residential health care facility, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption.

(b) The costs of goods and/or services furnished to a residential health care facility by a related organization are includable in the computation of the basic rate at the lower of the cost in the related organization, or the market price of comparable goods and/or services available in the residential health care facility’s region within the course of normal business operations.

(c) If the residential health care facility has incurred any costs in connection with a related organization, the final payment rate shall include the costs of such goods and/or services.

(d) A special purpose organization shall be defined as an organization which is established to conduct certain of the provider’s patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the
(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the facility or used at its discretion or direction;

(ii) the facility has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the facility.
86-2.27 Termination of service.

The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notifications shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-2.7 of this Subpart.
86-2.28 Return on investment.

(a) For rate year 1993, in computing the allowable cost of a proprietary residential health care facility, there will be included, after subtracting for current and noncurrent time deposits and equivalents, investments and construction in progress, a reasonable return on average equity capital [excluding capital invested in land, plant, fixed equipment and capital improvements thereto.] invested for necessary and proper operation for patient care activities of residential health care facility and related organizations, as defined in section 86-2.26(a) of this Subpart. For purposes of this section, average equity capital shall mean the difference between total assets less total liabilities averaged over the applicable cost report period, including assets and liabilities attributable to land, plant, fixed equipment and capital improvements thereto. It shall also include the average equity capital of related organizations proportionate with the percentage of a related organization’s business with the residential health care facility, as calculated in the annual report forms filed in accordance with section 86-2.2 of this Subpart.

(b) The allowable average equity capital shall be further adjusted by subtracting the equity, as that term is defined in section 86-2.21(a)(4) of this Subpart, upon which a return is calculated pursuant to section 86-2.21(e)(6) of this Subpart. The return on investment for rate year January 1, 1993 shall be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ended December 31, 1991, or other applicable cost report period used to determine the capital component of the 1993 rate, in accordance with section 86-2.21 of this Subpart. The return on investment for subsequent
rate year shall be based upon the annual cost report used by the department to determine the capital component of the rate in accordance with section 86-2.21 of this Subpart. The percentage to be used in computing the return on investment shall be [that percentage determined annually by the commissioner and shall be] equal to the twenty-six week United States Treasury Bill rate in effect on the second Wednesday of September of the year prior to the rate year.
86-2.29 Payments to receivers.

- Section deleted from State Plan.

TN #86-4 Approval Date July 29, 1987
Supersedes TN #82-30 Effective Date January 1, 1986
Reserved

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TN #86-4
Supersedes TN #82-30

Approval Date July 29, 1987
Effective Date January 1, 1986
86-2.30 Residential Health Care Facilities Patient Assessment for Certified Rates.

(a) For the purpose of determining reimbursement rates effective January 1, 1986, and thereafter, for governmental payments each residential health care facility shall, on an annual basis or more often as determined by the department, pursuant to this subpart, assess all patients to determine case mix intensity using the patient review criteria and standards promulgated and published by the department (Patient Review Instrument [PRI] and Instructions: Patient Review Instrument) and specified in appendix 7 infra.

(b) (1) The patient review form (PRI) shall be submitted according to a written schedule determined by the department. Such written schedule shall be established by the Commissioner of Health with notice to residential health care facilities. Extension of the time for filing may be granted upon application received prior to the due date of the Patient Review Forms and only in circumstances where the residential health care facilities establishes, by documentary evidence, that the patient review forms cannot be submitted by the due date for reasons beyond the control of the facility.
(2) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the requirements of this section. Compliance with the assessment requirements of this section, shall include, but not be limited to, the timely filing of properly certified patient review forms (PRI) which are complete and accurate. Failure of a residential health care facility to file the patient review form (PRI) pursuant to the written schedule established pursuant to this subdivision, shall subject the residential health care facility to a rate reduction set forth in section 86-2.2 of this Subpart.

(c) The operator of a residential health care facility shall ensure:

(1) that the patient review form (PRI) is completed for all patients of the facility pursuant to subdivision (a) of this section.

(2) that the patient review form (PRI) is completed by a registered professional nurse who is qualified by experience and demonstrated competency in long term care and who has successfully completed a training program in patient case mix assessment approved by the department to

TN #92-4 Approval Date December 30, 1994
Supersedes TN #86-4 Effective Date March 11, 1992
train individuals in the completion of the patient review form (PRI) for the purposes of establishing a facility’s case mix financial reimbursement; and

[(3) notwithstanding paragraph (2) of this subdivision, an operator of a free-standing health-related facility may substitute no more than two licensed practical nurses who are qualified by experience and demonstrated competence in long-term care and who have successfully completed a training program in patient case mix assessment for the purposes of establishing a facility’s case mix financial reimbursement for meeting the required number of assessors pursuant to subdivision (d) of this section. Such substitution may occur only in the instance that a free-standing health-related facility does not employ a sufficient number of staff registered nurses to meet the required number of assessors pursuant to subdivision (d) of this section; and

(4)] (3) that the patient review form (PRI) is certified by the operator and the nurse assessor responsible for completion of the patient review form (PRI). (The form of the certification required shall be as prescribed in the report form provided by the department.)
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(d) In order to maximize reliability and accuracy, a limited number of personnel for each residential health care facility may be responsible for completion of the patient review form (PRI) during each assessment period. The maximum number of personnel which may be responsible for residential health care facility is as follows:

<table>
<thead>
<tr>
<th>Bed Size of Facility</th>
<th>Number of Responsible Assessors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100</td>
<td>Two</td>
</tr>
<tr>
<td>101 to 200</td>
<td>Three</td>
</tr>
<tr>
<td>201 to 300</td>
<td>Four</td>
</tr>
<tr>
<td>301 to 400</td>
<td>Five</td>
</tr>
<tr>
<td>401+</td>
<td>Five plus one additional assessor for each additional 100 beds or part thereof</td>
</tr>
</tbody>
</table>

(e) (1) The Department shall monitor and review each residential health care facility’s performance and its patient assessment function as described in this section through the following activities which may include but shall not be limited to:

(i) Analysis of patient case mix profiles and statistical data:

(ii) Review of information provided by the residential health care facility; and
(iii) On-site inspections.

(2) The purpose of the department's monitoring and review shall be to determine whether the residential health care facility is complying with the assessment requirements contained in this section.

(3) The patient review form (PRI) and any underlying books, records, and/or documentation which formed the basis for the completion of such form shall be subject to review by the department.

(4) The department shall acknowledge, in writing, receipt of the residential health care facilities patient review forms (PRI). In the event that any information or data that the facility has submitted is inaccurate or incorrect, the facility shall correct such information or data in the following manner:

(i) The facility shall submit to the department, within five days of receipt of the department's written acknowledgement provided for in this paragraph, such corrections on a form which meets the same certification requirements as the document being corrected. Once receipt of corrected data is acknowledged in writing by the department, a residential health care facility may not correct or amend the patient review for (PRI) or submit any additional information for the assessment period.
(5) The department, in order to ensure accuracy of the patient review form (PRI), may also conduct timely on-site observations and/or interviews of patients/residents and review of their medical records. When an additional on-site review is performed by the department as a result of controverted items found during the initial on-site review, the facility shall be afforded an on-site conference prior to the conclusion of such additional on-site review. Upon completion of a department on-site review pursuant to this subdivision, the department, in order to ensure accuracy of the patient review form (PRI), shall correct, where necessary, a residential health care facility’s assessment of its patient case mix intensity. The department’s on-site determination shall be considered final for purposes of assessing the residential health care facility’s case mix intensity for that assessment period and notwithstanding section 2.14 of this Subpart, the residential health care facility may not correct or amend the patient form (PRI) or submit any additional information after department reviewers have concluded the on-site review. The residential health care facility shall be notified in writing regarding the department determination of any controverted items.

TN #86-4 Approval Date July 29, 1987
Supersedes TN #85-6 Effective Date January 1, 1986
(f) (1) If the department determines pursuant to this section, that a residential health care facility is not performing its case mix intensity assessment function in a timely and/or accurate manner, as required by subdivision (b) of this section, the department shall, in writing:

   (i) Notify the residential health care facility; and

   (ii) Require the residential health care facility to perform its patient case mix assessment function through written agreement with a person or entity approved by the department for the completion of the patient review form (PRI) for the purpose of establishing a residential health care facilities case mix reimbursement.

   (iii) Any patient case mix assessment performed pursuant to subparagraph (ii) of the paragraph shall also be subject to department monitoring and review pursuant to this section.

(2) The department shall determine that a residential health care facility is not performing its case-mix intensity assessment function in an accurate manner where there exists inaccuracies in its case-mix assessment which results in a statistically significant modification of the residential health care facility's reimbursement.
(3) The cost of written agreements required by paragraph (1) of this subdivision shall not be considered an allowable cost for determining reimbursement rates pursuant to this Subpart.

(4) Certification.

Operators of residential health care facilities completing the department’s patient review form (PRI) through written agreement with a department approved non-residential health care facility person or entity shall have such form certified by such person or entity in lieu of a facility registered professional nurse as required by paragraph (2) of subdivision (c) of this section.

(g) Reconsiderations.

(1) Any residential health care facility after one year from the date it has been notified in writing by the department that it must enter into a written agreement pursuant to paragraph (1) of subdivision (f) of this section, may request, in writing, that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(2) The department shall not rescind its withdrawal of a residential health care facility's patient case mix assessment function unless the residential health care...
facility satisfies the department that the residential health care facility has the capability to comply with the requirements of the department’s patient case mix assessment process which shall include the capability to accurately complete the patient review form (PRI).

(3) The department shall give written notice of its decision and shall, if negative, give a statement of the reasons for its refusal to rescind its withdrawal of the residential health care facility’s patient case mix assessment function.

(4) Any residential health care facility after six months from the date it receives a written department decision pursuant to paragraph (3) of this subdivision, may again request in writing that the department rescind its withdrawal of the residential health care facility’s patient case mix assessment function.

[(h) The provisions of this section shall expire on April 30, 1989.]
Residential health care facilities [with 80 or more beds] shall submit the data contained in the PRI using an electronic medium including but not limited to magnetic computer tape, floppy disk or an electronic telecommunication system consistent with the technical specifications established by the department.

[(i)] (1) The electronically produced data shall be accompanied by a certification statement executed by the operator or a person authorized to sign on the operator’s behalf in a format provided or approved by the department.

[(ii)] (2) Facilities [required or those electing to submit PRI data in this format] shall have an additional ten days from the time specified pursuant to subdivision (b) of this section to file the required information.

[(iii)] (3) Adjustments to certified rates made pursuant to section 86-2.11 of this Subpart shall be certified by the Commissioner of Health within 90 days from the date upon which a facility’s rate was last certified pursuant to this Subpart or within 90 days from the latest scheduled PRI submission date pursuant to section 86-2.11 of this Subpart, whichever is later. Such ninety day time frames shall not apply in any instance where a facility has been notified that its submitted PRI data is inaccurate or incorrect pursuant to paragraph (e)(4) of [subdivision (e) of section 86-2.30 of] this [Subpart] section until such data has been corrected to the satisfaction of the commissioner, or if an additional on-site review has been deemed necessary pursuant to paragraph (e)(5) of [subdivision (e) of section 86-2.30 of] this [Subpart] section.
2.31 Recalibration.

(a) For rate periods commencing on or after January 1, 1987, notwithstanding any other provisions of this Subpart, the Direct Component of facility rates, determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart, shall be reduced by 3.035 percent to reflect a recalibration adjustment based on the change in the aggregate statewide case mix index attributable to factors other than changes in patient population or condition.

(b) The reduction in the Direct Component of facility rates as defined in subdivision (a) of this section shall be implemented on or about July 1, 1987 and shall be applied retroactive to January 1, 1987.
(b) For rate years 1992 and thereafter, notwithstanding any other provision of this Subpart and subject to the provisions of paragraph (1) of this subdivision and subdivision (c) of this section, payment rates shall be adjusted in accordance with this subdivision to reflect a percentage recalibration adjustment based on the change in each facility’s case mix which has been determined by the department to be due to factors other than changes in patient population or condition. Such payment rate adjustments shall be implemented utilizing the direct component of facility rates for such rate years determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(1) The percentage recalibration adjustment provided for in this subdivision shall not be less than 0% nor greater than one hundred fifty percent of the statewide weighted average percentage recalibration adjustment obtained by utilizing the facility-specific percentage recalibration adjustments as determined pursuant to this subdivision.

(2) The percentage recalibration adjustment shall be calculated as follows for each facility:

   (i) A statewide distribution of patients in each patient classification group shall be determined by utilizing the patient data for the assessment of all patients obtained in the patient assessment period March 1, 1985 through September 30, 1985 (the 1985 period) conducted pursuant to section 86-2.30 of this Subpart.

   (ii) The statewide distribution of patients in each patient classification group shall be further segregated by the following length of stay (LOS) groups:

   (a) less than or equal to 90 days

   (b) greater than 90 days but less than or equal to 1 year

   (c) greater than 1 year but less than or equal to 2 years

   (d) greater than 2 years but less than or equal to 3 years
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(e) greater than 3 years but less than or equal to 4 years

(f) greater than 4 years but less than or equal to 5 years

(g) greater than 5 years

(iii) A statewide average initial case mix index for each LOS group for the 1985 period shall be calculated by multiplying the initial distribution of patients in each patient classification group within each LOS group times the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the total number of patients in all patient classification groups within each LOS group.

(iv) For each facility, a 1985 distribution of patients in each patient classification group and a 1985 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data for the assessment of all patients obtained in the 1985 period, conducted pursuant to section 86-2.30 of this Subpart. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988 or if the facility has the lesser of ten cases or twenty percent of its patients in the distributions as determined in this subparagraph for the 1985 period, or if the facility had undergone the appointment of a receiver or the establishment of a new operator.
subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the distribution of patients to be used for the purposes of this subparagraph shall be that distribution pertaining to the earliest full patient assessment period conducted pursuant to section 86-2.30 of this Subpart subsequent to the 1985 period or subsequent to the effective date of the appointment of a receiver or the change in operator (the “substituted 1985 period”), and such distribution shall be deemed the facility’s “substituted 1985 distribution” of patients for the calculations in subparagraphs (vi) and (vii) of this paragraph. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that have been identified by the department as also having been included in the patient assessment period July 1, 1988 through December 31, 1988.

(v) For each facility, a 1988 distribution of patients in each patient classification group and a 1988 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data obtained in the patient assessment period July 1, 1988 through December 31, 1988. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that were admitted to the facility in which they are presently residing before October 1, 1985 and have been identified by the department as also having been included in the patient assessments during the 1985 period. In the event a facility commenced operations after the
patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988 or if the facility had the lesser of ten cases or twenty percent of its patients in the distributions for the 1985 period as determined pursuant to subparagraph (iv) of this paragraph, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the facility’s substituted 1985 period, as defined in subparagraph (iv) of this paragraph, shall be used in lieu of the 1985 period for the purposes of this subparagraph, and the only patients to be included shall be patients that were admitted to the facility in which they are presently residing before the end date of the facility’s substituted 1985 period and have been identified by the department as also having been included in the patient assessments during the substituted 1985 period.

(vi) A percentage increase in case mix attributable to LOS shall, for each facility, be determined as follows:

(a) A 1985 aggregate case mix index shall be determined by multiplying the facility’s 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, within each LOS group, determined pursuant to subparagraph (iv) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility’s total number of patients in all LOS groups, as determined pursuant to subparagraph (iv) of this paragraph.
(b) A 1988 LOS adjusted case mix index shall be determined by multiplying the facility's 1988 distribution of patient within each LOS group determined pursuant to subparagraph (v) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 aggregate case mix index shall be subtracted from the 1988 LOS adjusted case mix index and the result divided by the 1985 aggregate case mix index to arrive at the percentage increase in case mix attributable to LOS.

(vii) An actual percentage increase in case mix shall, for each facility, be determined as follows:

(a) A 1985 actual case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, in each patient classification group as determined pursuant to subparagraph (iv) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility’s total number of patients in all patient classification groups, as determined pursuant to subparagraph (iv) of this paragraph.
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108(m)

(b) A 1988 actual case mix index shall be determined by multiplying the facility's 1988 distribution of patients in each patient classification group, as determined pursuant to subparagraph (v) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 actual case mix index shall be subtracted from the 1988 actual case mix index and the result divided by the 1985 actual case mix index to arrive at an actual percentage increase in case mix.

(viii) Except as provided in subparagraph (ix) of this paragraph, a percentage recalibration adjustment shall be determined by annualizing* the result obtained by subtracting the percentage increase in case mix attributable to LOS determined pursuant to subparagraph (vi) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph.

(ix) If a facility undergoes the appointment of a receiver or the establishment of a new operator on or after January 1, 1992 and files a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which is used in the calculation of a revised payment rate, or for new facilities who receive an initial operating certificate on or after January 1, 1992, the percentage recalibration adjustment provided for in this subdivision shall be 0% for such revised payment rate or for such new facilities.

* The three-year effect of improved coding was annualized by taking the cube root of the three year accumulation factor.
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108(n)

(3) The operating portion of each residential health care facility's rate of payment, as defined pursuant to paragraph (7) of subdivision (a) of Section 86-2.10 of this Subpart, shall be reduced by a per diem recalibration adjustment which shall be determined as follows:

(i) The percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of this subdivision shall be applied to the direct component of the rate determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart, to arrive at each facility's per diem recalibration adjustment in 1983 base year dollars.

(ii) Each facility's per diem recalibration adjustment in 1983 base year dollars shall then be trended to the rate year by the applicable roll factor as defined in paragraph (8) of subdivision (a) of Section 86-2.10 of this Subpart.

(c) For a residential health care facility receiving a percentage recalibration adjustment greater than zero percent, as determined in subdivision (b) of this section, the percentage recalibration adjustment may be modified when conditions set forth in section 86-2.31(c)(1) are met. Additionally, a facility shall submit a modification request as an appeal application within the time limit set forth in section 86-2.13(a) of this Subpart.
(ii) A facility shall document that the percentage change in the facility's reported case mix index (CMI) from the annual rate period 1985 through 1988, such percentage reduced by the percentage recalibration adjustment as determined by subdivision (b) of this section, is at least ten percent.* The percentage change in the facility's reported CMI, for purposes of this subparagraph, shall utilize the CMI calculated from the facility's patient data obtained during the patient assessment period, March 1, 1985 through September 30, 1985, to the patient assessment period July 1, 1988 through December 31, 1988, conducted pursuant to section 86-2.30 of this Subpart, and shall be calculated by subtracting from the reported 1988 CMI, the reported 1985 CMI and the result divided by the reported 1985 CMI.

(iii) (a) Except as provided in clause (b) of this subparagraph, a facility shall document that the percentage change in direct care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision (c) of section 86-2.10 of this Subpart, is at least ten percent. The percentage change in direct care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported direct care cost, the 1985 annual reported direct care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987, and 1988, and the result divided by the trended 1985 direct care cost. The annual reported direct care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation. **

* This means that the increase in reported case mix from 1985 to 1988, after subtracting out the recalibration adjustment for the facility, must be at least ten percent for the facility to qualify to possibly get a reduction in its recalibration adjustment.

** This refers to the allocation of the accumulated facility costs as reported via the RHCF cost reports into other cost centers that utilize their services. The purpose of the step-down process is to finally consolidate reimbursable costs into the four components of the RHCF reimbursement rate for rate setting purposes. For example, costs reported under patient-specific services such as transportation, nursing administration and therapies, among others, are finally allocated to the costs contained in the direct portion of the rate.
New York
108(p)

(b) In the event a facility's facility-specific cost based direct price per day exceeds the facility-specific ceiling direct price per day, as determined pursuant to section 86-2.10(c)(4) of this Subpart, for the annual rate period 1988, such excess percentage shall be used to determine a credit to be added to the facility's percentage change in direct care cost over trend as determined in clause (a) of this subparagraph for the purposes of meeting the required percentage change in direct care cost over trend identified in clause (a) of this subparagraph. The amount of the credit shall be equal to such excess percentage if the facility documents that its percentage change in indirect care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision(d) of section 86-2.10 of this Subpart, does not exceed its percentage change in direct care cost over trend for this period, as determined in clause (a) of this subparagraph, and if the facility cannot so document, the credit identified in this clause shall be reduced (but not be less than 0%) by the extent to which the percentage change in indirect care cost over trend exceeds the percentage change in direct care cost over trend. The percentage change in indirect care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported indirect care cost, the 1985 annual reported indirect care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 indirect care cost. The annual reported indirect care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation.

(iv) Documentation shall be included in an appeal filed by the facility to the department that supports the reasons for the direct care cost increase which shall be based on increases in staffing levels and/or range and/or types of patient services. Increased direct care cost resulting
solely from an increase in the bed complement of a facility shall not constitute sufficient justification for granting a modification pursuant to this subdivision.

(2) For a facility meeting all conditions specified in paragraph (1) of this subdivision, the modified percentage recalibration adjustment shall be determined as follows.

(i) The modification to the percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage change in the facility’s reported CMI reduced by the percentage recalibration adjustment, as determined in subparagraph (ii) of paragraph (1) of this subdivision, from the percentage change in direct care cost over trend, as determined in subparagraph (iii) of paragraph (1) of this subdivision.

(ii) The modified percentage recalibration adjustment shall be equal to the result obtained by subtracting the modification to the percentage recalibration adjustment, as determined in subparagraph (i) of this paragraph, from the percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of subdivision (b) of this section.

(iii) The modified percentage recalibration adjustment, as determined in subparagraph (ii) of this paragraph, shall not be less than 0%.
APPLICATION OF 1992 RECALIBRATION APPEAL CRITERIA
EXAMPLE

ASSUMPTIONS
1. Reported CMI Change, 1985-1988 24.44%
2. Recalibration % (Annualized) 7.40%
3. Real CMI Change, 1985-1988 17.04% (1-2)
5. Indirect Cost-Over-Trend, 1985-1988 10.50%
6. % Facility Above Direct Ceiling 20.9%

APPLICATION OF CRITERIA
• Real CMI Change (17.04%) meets 10% requirement
• Direct Cost-Over-Trend (8.71%) does not meet the 10% requirement.

However, since this facility is above ceiling on direct costs, a credit amount is determined, to be added to the direct cost growth of 8.71%.

CALCULATION OF CREDIT
• Excess of indirect Cost-Over-Trend compared to direct cost:
  10.50% - 8.71% = 1.79%
• Credit Amount: 20.9% - 1.79% = 19.11%
• Direct Cost-Over-Trend: 8.71% + 19.11% = 27.82%

CALCULATION OF MODIFIED RECALIBRATION

Since the revised value of direct cost growth with the credit (27.82%) exceeds the 10% requirement, facility qualifies for a modification, subject to appropriate documentation showing that direct care cost increases were due to increases in staffing levels or range/types of services.

Modification Value = 27.82% - 17.04% = 10.78%
(Dir. cost) - (real CMI change)
This is then annualized, giving 3.47%

Modified Recalibration Adjustment = 7.40% - 3.47% = 3.93%
Nursing facilities (NF) shall receive prospective 1994 rate enhancements to their rates of payment, effective November 3, 1994 through December 31, 1994. An amount not to exceed $111 million shall be distributed to all eligible nursing facilities through 1994 prospective rate enhancements to their rates of payment. Eligible facilities shall be those facilities that sought timely relief for such rate enhancements. Such amount shall be allocated to each eligible NF based upon its reported change in patient case mix as determined by the total number of patients properly assessed and reported by the facility pursuant to 86-2.30, in excess of that reimbursed for the same base period, 1989-1991. The facility’s allocated share of the prospective payment enhancement shall be converted to a per diem adjustment by dividing this amount by its volume of Medicaid days for the period November 3, 1994 through December 31, 1994.
Reserved

TN  #91-24            Approval Date  October 23, 1992
Supersedes TN  #87-7    Effective Date  April 1, 1991
New York  
110(a)

86-2.33 Dementia Pilot Demonstration Projects.

(a) Payment rates shall be adjusted by the addition of a per diem amount as determined by the commissioner pursuant to this section for residential health care facilities participating in pilot demonstration projects for the development of additional knowledge and experience in the area of dementia care and to improve the quality of care and treatment of patients with dementia.

(b) The adjustment to payment rates provided for in this section shall be made for qualifying residential health care facilities (RHCFs) applying for and receiving the approval of the commissioner for participation in such projects. Acceptable uses of such adjustment shall include but shall not be limited to:

(1) increasing the availability of programs and resources for dementia patients;

(2) training staff to manage behavior or promote effective care of dementia patients;

(3) arranging the environment in ways that produce positive outcomes for dementia patients; and/or

(4) maintaining and promoting autonomy and decision-making on the part of dementia patients.

(c) Individual facilities or groups of facilities may participate in pilot demonstration projects pursuant to this subdivision.
EXPLANATION OF DEMENTIA PILOT PROJECT RATE ADJUSTMENT

The per diem for dementia care pilot demonstration projects is calculated by dividing the total award for each facility by the duration (i.e., years) of the project to determine the annual expenditure. This annual expenditure is then divided by the annualized Medicaid patient days reported by the facility to arrive at the per diem add-on.

New York
110(a)(1)

March 30, 1990
TN #88-34 Approval Date March 30, 1990
Supersedes TN ------- Effective Date January 1, 1989
Effective January 1, 2000, enhancements to the Medicaid reimbursement rates of hospice-operated nursing homes will be provided to enable them to study and analyze several issues pertaining to operations of such a nursing home. This demonstration will provide additional knowledge and experience and will collect information concerning alternative methodologies for reimbursement, delivery of medical services or eligibility of medical assistance in such facilities.

The hospice-operated nursing home will conduct a demonstration to address several patient care related issues including:

1) insuring appropriate placement and use of resources for residents in hospice-operated nursing homes;

2) training staff to promote effective care of terminally ill residents; and

3) maintaining and promoting autonomy and decision making on the part of the residents in hospice-operated nursing facilities.
Effective for dates of service beginning on April 1, 2002 and ending on December 31, 2004, Medicaid rates of payment to non-public nursing homes shall be adjusted pursuant to a competitive process to fund projects intended to improve the quality of care for nursing home residents. This competitive process will follow the Request for Proposal procurement process, as mandated by the NYS Office of the State Comptroller.

Such eligible projects may include:

(a) an increase in direct care staff, either facility wide or targeted at a particular area of care or shift;

(b) increased training and education of direct care staff, including allowing direct care staff to increase their level of licensure relevant to nursing home care;

(c) efforts to decrease staff turn-over; and

(d) other efforts related to the recruitment and retention of direct care staff that will effect the quality of care at such facility.

The evaluation of each submitted proposal will be based on the following criteria:

(1) proposal demonstrates that the project will improve the quality of care in a cost effective manner;

(2) proposal provides evidence that the project can be successfully implemented;

(3) proposal provides evidence that the quality of care will be improved by improving or increasing the training, education and retention of direct care staff;

(4) proposal provides a detailed budget with a cost effective approach;

(5) proposal demonstrates financial need; and

(6) proposal provides a written labor union concurrence from the relevant bargaining agent for the projects where a collective bargaining agreement exists covering occupations in which training is proposed.

A proposal may be rejected if the submitting facility has significant non-compliance in areas that affect resident health and safety.

Submitted proposals will be ranked based on the results of the review and evaluation process. Proposals achieving a predetermined minimum score will receive an initial award determined by multiplying the score, expressed as percentage, by the project amount requested. Available funds will be distributed as follows:

<table>
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<tr>
<th>TN</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#02-23</td>
<td>September 16, 2002</td>
<td>April 1, 2002</td>
</tr>
</tbody>
</table>
New York
110(a)(4)

(a) If the total amount initially awarded for all nursing homes equals the total funding available, each nursing home will receive its initial award.

(b) If the total amount initially awarded for all nursing homes exceeds the total funding available, each initial award will be reduced on a proportional basis such that the sum of all final awards does not exceed the total funds available.

(c) If the total amount initially awarded for all nursing homes is less than the total funding available, each nursing home will receive its initial award. Remaining funds will be distributed proportionally based on each nursing home’s initial award to the total of all initial awards.

Nursing homes receiving awards shall submit an annual progress report that describes and evaluates the quality improvements achieved through this project. Significant changes from the approved project or budget may result in a revision to the nursing home’s award. Funding may be discontinued if it is determined that the goal of the project is not being met. The Department of Health shall have the right to audit the nursing home’s financial records to determine that the funds granted for this project have been used for the specific purposes defined in the approved proposal and shall recoup any funds determined to have been used for purposes other than specified in the approved proposal.

The Department of Health will not issue any new requests for proposals after December 31, 2004, and all awards for subsequent annual periods will be distributed on the same proportional basis as the most recent available distribution. Funds may be utilized for any of uses listed in this Section and the Department of Health shall have the right to audit to determine that the funds have been used accordingly, and recoup any funds determined to have been used otherwise.

Resultant adjustments to Medicaid rates of payment shall not, in aggregate, exceed 62.5 million dollars for the rate period beginning April 1, 2002 and ending December 31, 2002, and for each annual period thereafter beginning January 1, 2003 and ending December 31, 2004, and shall not exceed, in aggregate, 46.875 million dollars for the period July 1, 2005 through December 31, 2005, and [31.25] 78.125 million dollars [on an annualized basis.] for the period January 1, 2006 through [June 30, 2007] December 31, 2006, and 62.5 million dollars for the period January 1, 2007 through June 30, 2007. Award amounts shall be included as a reimbursable
New York
110(a)(4)(i)

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. These adjustments shall not be subject to subsequent adjustment or reconciliation to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.
Section 86-2.34 Affiliation changes.

(a) A hospital based residential health care facility as defined in section 86-2.10(a)(13) of this Subpart whose affiliated hospital closes its acute care beds shall notify the department within 30 days of actual complete closure of such beds. Such residential health care facility shall have its affiliation status changed to freestanding effective as of the date of actual complete closure.

(b) For purposes of establishing the allowable indirect component of the rate pursuant to subdivision (d) of section 86-2.10 of this Subpart, a hospital based residential health care facility whose affiliation changes to freestanding under circumstances described in subdivision (a) of this section may apply to the department at the same time notice of closure is given pursuant to subdivision (a) of this section for a three year phase in of its freestanding affiliation for reimbursement purposes effective the beginning of the next calendar year following actual complete closure of its acute care beds.

(1) For the rate effective January 1 of the calendar year following actual complete closure of the affiliated hospital’s acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .75 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .25.

(2) For the rate effective January 1 of the second calendar year following actual complete closure of the affiliated hospital’s acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .50 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .50.

(3) For the rate effective January 1 of the third calendar year following actual complete closure of the affiliated hospital’s acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital based peer group by .25 and the product of multiplying the mean indirect price per day of the appropriate freestanding peer group by .75.

(c) For purposes of establishing the factor determined pursuant to section 86-2.12(a) of this Subpart, a hospital based residential health care facility whose affiliation changes to freestanding under circumstances described in subdivision (a) of this section and has applied for a three year phase in of the freestanding indirect component pursuant to subdivision (b) of this section shall continue to be classified as hospital based for a period of three calendar years following the actual complete closure of the affiliated hospital’s acute care beds.

(d) A hospital based residential health care facility whose affiliation changed to freestanding under the circumstances described in subdivision (a) of this section that fails to notify the department within 30 days from the date of actual complete closure of the acute care beds shall not be eligible for the provisions of subdivision (b) and subdivision (c) of this section.
Such facilities shall be designated freestanding, for rate calculation purposes, pursuant to this Subpart retroactive to the date of actual complete closure of the acute care beds of the affiliated hospital.

Attachment 4.19-D
Part I

New York
110-c

February 27, 1990

Supersedes TN  

Effective Date  October 1, 1988

Approval Date  February 27, 1990

TN  #88-47
86-2.36 Scheduled short term care.

(a) Residential health care facilities which provide scheduled short term care for residents shall be paid a per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for the facility as established pursuant to this Subpart.

(b) The requirements of sections 86-2.11 and 86-2.30 relating to resident assessments (PRI) and the submission of case mix information to the Department shall not apply to scheduled short term care.

Clarifying Information:

1. Scheduled short term care is care provided to individuals who are determined to need nursing facility care but are being cared for by someone in the community, and who do not participate in a Home and Community Based Waiver program.

2. All federal nursing facility statutory and regulatory requirements, including those related to admission, discharge and transfer, continue to apply to scheduled short term care services.

3. Individuals may receive no more than 30 days of scheduled short term care for a given admission, and no more than a total of 42 days of scheduled short term care during a given year.

4. If an individual receives services in the nursing facility for a time period exceeding the maximum limits specified in (3), the admission will be considered as a normal nursing facility admission for state and federal regulatory purposes, and the reimbursement for such services will be according to the standard state nursing facility rate-setting methodology contained in this Part of the plan.
Pay for Performance Incentive

(a) The commissioner shall make rate adjustments, effective May 1, 2008, and thereafter, to certain residential health care facilities who demonstrate to the satisfaction of the Commissioner that they can meet or exceed defined quality measures.

(b) Initial awards shall be based on a residential health care facility’s performance for pressure ulcer quality of care for chronic care residents.

(c) The Commissioner shall make two sets of awards as follows:

An award shall be made for the best performers for the evaluation period. Best performers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the four quarters average score for the period January 1, 2007 through December 31, 2007.

An award shall be made to residential health care facilities with the best improvement in pressure ulcer care between a base and evaluation period. Best improvers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the base and the evaluation periods four quarters average score. The base period score shall be based on the period July 1, 2006 through June 30, 2007; the evaluation score shall be based on the period July 1, 2007 through June 30, 2008. Facilities in the bottom quarter percentile of all eligible residential health care facilities for this evaluation period shall not be eligible for such an award if, even after their improvement in pressure ulcer care, they still remain in the bottom quarter percentile of all eligible residential health care facilities; and

Residential health care facilities that qualify are eligible to receive an award in both categories of awards.

(d) The evaluation period for the award for best performers shall be January 1, 2007 through December 31, 2007. The base period for the award for best improvement shall be July 1, 2006 through June 30, 2007, which shall be compared to the period July 1, 2007 through June 30, 2008.

(e) The following factors shall be considered by the Commissioner in making awards pursuant to this section:

The quality measure of pressure ulcer shall be risk adjusted using such patient health factors to include but not be limited to, coma, malnutrition, diseases and conditions related to pressure ulcer, low body mass index, and plegia (paraplegia or hemiplegia);
New York
110(d)(2)

Pressure ulcer rates shall be considered only for chronic care residential health care facility residents.

In order to be eligible to be considered for a rate enhancement, a residential health care facility must have averaged more than one prevented pressure ulcer per quarter of the evaluation period identified in paragraph (d) of this section as calculated by comparing the actual number of residents with a pressure ulcer to the expected number of residents with a pressure ulcer based on the facility's risk adjusted pressure ulcer rate developed pursuant to this subdivision; and

Any residential health care facility receiving a written deficiency for substandard quality of care, as defined in federal regulation 42 C.F.R. §488.301, during the evaluation periods contained in this section shall be excluded from receiving an award under this section.

(f) Rate adjustments made pursuant to this section for residential health care facilities receiving monetary awards shall be made proportionately based on each eligible facility's percent of Medicaid patient days to the total Medicaid patient days for all eligible facilities. Such days of care are as reported in the latest RHCF-4 cost reports for patients eligible for medical assistance.

Residential health care facilities chosen to receive rate enhancements pursuant to this section shall, prior to the rate enhancement, inform the Commissioner in writing as to their proposed use of the additional monies to further improve quality and care of patients in the residential health care facility.

(g) A total of $3,000,000 will be paid as rate adjustments.
New York
110(d)(3)

Computation of a Price for the Operating Component of the Rate for Non-specialty Facilities and the Non-capital Component of the Rate for Specialty Facilities

a) Effective January 1, 2012, the operating component of rates of payment for non-specialty residential health care facilities (RHCFs) shall be a price and shall consist of the sum of the following components:

1) \[((50\% \text{ of the statewide direct price for all non-specialty facilities} + 50\% \text{ of the peer group direct price}) \times (\text{direct WEF adjustment}) \times (\text{case mix adjustment}))+((50\% \text{ of the statewide indirect price for all non-specialty facilities} + 50\% \text{ of the peer group indirect price}) \times (\text{indirect WEF adjustment})) + \text{non comparable component} + \text{applicable rate add-ons}\n
b) For purposes of calculating the direct and indirect price component of the rates, peer group shall mean:

1) all non-specialty facilities (NSF)
2) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more (NSHB/NS300+)
3) non-specialty freestanding facilities with certified bed capacities of less than 300 beds (NS300-)

c) Specialty facilities shall mean:

1) AIDS facilities or discrete AIDS units within facilities;
2) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons;
3) discrete units providing specialized programs for residents requiring behavioral interventions;
4) discrete units for long-term ventilator dependent residents; and
5) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.
6) discrete units for residents with Neurodegenerative diseases; Amyotrophic Lateral Sclerosis and Huntington as is defined in Attachment 4.19-D Part I Huntington's disease.

TN #16-0009 Approval Date January 30, 2017
Supersedes TN #11-0023-A Effective Date November 1, 2016
d) The direct component of the price shall consist of a blended rate to be determined as follows:
1) For NSHB/NS300+ the direct component of the price shall consist of a blended rate equal to:
   
   i) 50% of the statewide direct NSF price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-speciality facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, and
   
   ii) 50% of the direct NSHB/NS300+ price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-speciality hospital-based facilities and all non-speciality freestanding facilities with certified bed capacities of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

2) For NS300- the direct component of the price shall consist of a blended rate equal to:
   
   i) 50% of the statewide direct NSF price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-speciality facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, and
   
   ii) 50% of the direct NS300- price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-speciality facilities with certified bed capacities of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

3) Pursuant to the methodology described above, the direct component of the price for each peer group shall be as follows:
### Direct Component of the Price

**Medicare Ineligible Price, Medicare Part D Eligible Price**

(NSHB/NS300+ Peer Group)

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Direct NSF Price (a)</th>
<th>50% of Direct NSF Price (b)</th>
<th>Direct NSHB/NS300+ Price (c)</th>
<th>50% of Direct NSHB/NS300 + Price (d)</th>
<th>Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2012</td>
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<td>$52.90</td>
<td>$117.48</td>
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### Direct Component of the Price

**Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price**

(NSHB/NS300 + Peer Group)

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Direct NSF Price (a)</th>
<th>50% of Direct NSF Price (b)</th>
<th>Direct NSHB/NS300+ Price (c)</th>
<th>50% of Direct NSHB/NS300 + Price (d)</th>
<th>Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)</th>
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<tr>
<td>January 1, 2012</td>
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**TN #18-0049**

Approval Date September 04, 2018

Supersedes TN #18-0044

Effective Date May 17, 2018
### Direct Component of the Price

#### Medicare Ineligible Price, Medicare Part D Eligible Price

(NS300- Peer Group)

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Direct NSF Price (a)</th>
<th>50% of Direct NSF Price (b)</th>
<th>Direct NS300-Price (c)</th>
<th>50% of Direct NS300-Price (d)</th>
<th>Total Direct Component of Price for NS300- Peer Group (b)+(d)</th>
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<tr>
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### Direct Component of the Price

#### Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price

(NS300- Peer Group)

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Direct NSF Price (a)</th>
<th>50% of Direct NSF Price (b)</th>
<th>Direct NS300-Price (c)</th>
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As used in this subdivision, Medicare Ineligible Price shall mean the price applicable to Medicaid patients that are not Medicare eligible, Medicare Part B Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B eligible, Medicare Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part D eligible, and Medicare Part B and Part D eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B and Part D eligible.
4) The allowable costs percent reduction for the direct component shall be as follows:

<table>
<thead>
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<th>Effective Date</th>
<th>Allowable Cost Percent Reduction</th>
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<tr>
<td>January 1, 2013</td>
<td>14.963800%</td>
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<td>10.305120%</td>
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<td>9.893250%</td>
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<td>January 1, 2017</td>
<td>9.485290%</td>
</tr>
</tbody>
</table>

e) Allowable costs for the direct price component shall be the costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, as extracted by the Commissioner on December 21, 2010, or from the most recent cost report available on that day, after first deducting costs attributable to specialty units and the hospital and capital costs.

1) For the purposes of calculating the Medicare Ineligible Price and the Medicare Part D Eligible Price the costs identified shall be reduced by the costs of prescription drugs as reported on the facility's 2007 cost report.

2) For the purposes of calculating the Medicare Part B Eligible Price and the Medicare Part B Eligible Price and Medicare Part D Eligible Price the costs identified shall be reduced by the costs of prescription drugs as reported on the facility's 2007 cost report and the revenue offsets associated with Medicare Part B Eligible Patients as reported by Medicare.

i) Nursing administration (013);
ii) Activities (014);
iii) Social services (021);
iv) Transportation (022); - non-medical transportation only effective April 1, 2016
v) Physical therapy (039) (including associated overhead);
vii) Speech/hearing therapy (041) (including associated overhead);
viii) Central service supply (043);
ix) Residential health care facility (051); and
x) Pharmacy (042) (excluding the costs allocated to non comparables).
f) The direct component of the price shall be adjusted by a wage equalization factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 certified cost report (RHCF-4), or extracted from a hospital-based facility's 2009 certified cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) as extracted by the Commissioner on October 31, 2011, after first deducting costs attributable to specialty units and the hospital, for the 2009 calendar year. The WEF adjustment shall consist of 50% of a facility-specific direct WEF and 50% of a regional direct WEF.

1) The facility-specific direct WEF shall be calculated as follows:

\[
\frac{1}{\left(\frac{\text{Facility-Specific Wage Ratio}}{\text{Wage Index}}\right) + \text{Facility-Specific Non-Wage Ratio}}
\]

i) The Facility-Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to direct cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses from such cost centers.

ii) The Wage Index shall be calculated by dividing facility-specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.

2) A regional direct WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered for determining in which WEF region a facility is located.
# New York 110(d)(10)

<table>
<thead>
<tr>
<th>Region</th>
<th>Consisting of the counties of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Region</td>
<td>Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady and Schoharie</td>
</tr>
<tr>
<td>Binghamton Region</td>
<td>Broome and Tioga</td>
</tr>
<tr>
<td>Central Rural Region</td>
<td>Cayuga, Cortland, Seneca, Tompkins and Yates</td>
</tr>
<tr>
<td>Elmira Region</td>
<td>Chemung, Schuyler and Steuben</td>
</tr>
<tr>
<td>Erie Region</td>
<td>Cattaraugus, Chautauqua, Erie, Niagara and Orleans</td>
</tr>
<tr>
<td>Glens Falls Region</td>
<td>Essex, Warren and Washington</td>
</tr>
<tr>
<td>Long Island Region</td>
<td>Nassau and Suffolk</td>
</tr>
<tr>
<td>New York City Region</td>
<td>Bronx, Kings, New York, Queens and Richmond</td>
</tr>
<tr>
<td>Northern Rural Region</td>
<td>Clinton, Franklin, Hamilton and St. Lawrence</td>
</tr>
<tr>
<td>Orange Region</td>
<td>Chenango, Delaware, Orange, Otsego, Sullivan and Ulster</td>
</tr>
<tr>
<td>Poughkeepsie Region</td>
<td>Dutchess and Putnam</td>
</tr>
<tr>
<td>Rochester Region</td>
<td>Livingston, Monroe, Ontario and Wayne</td>
</tr>
<tr>
<td>Syracuse Region</td>
<td>Madison and Onondaga</td>
</tr>
<tr>
<td>Utica Region</td>
<td>Herkimer, Jefferson, Lewis, Oneida and Oswego</td>
</tr>
<tr>
<td>Westchester Region</td>
<td>Rockland and Westchester</td>
</tr>
<tr>
<td>Western Rural Region</td>
<td>Allegany, Genesee, and Wyoming</td>
</tr>
</tbody>
</table>

3) The regional direct WEF shall be calculated for each of the 16 regions as follows:

\[
\frac{1}{\left(\frac{\text{Regional Wage Ratio}}{\text{Regional Wage Index}}\right) + \left(\frac{\text{Regional Non-Wage Ratio}}{}\right)}
\]
New York 110(d)(11)

i) The Regional Wage Ratio shall be calculated by dividing total salaries and fringes related to direct costs in the region from cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses in the region from such cost centers.

ii) The Regional Wage Index shall be calculated by dividing labor costs per hour in the region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

4) The regional direct WEF adjustment to the direct component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

g) The direct component of the price shall be subject to a case mix adjustment in accordance with the following:

1) The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services and revised to reflect New York State wage and fringe benefits and based on Medicaid-only patient data.
2) New York State wages shall be used to determine the weight of each RUG. The cost for each RUG shall be calculated using the relative resources for RNs, LPNs, aides, therapists, and therapy aides and the 1995-97 federal time study. The minutes from the federal time study are multiplied by the NY average dollar per hour to determine the fiscal resources need to care for that patient type. This amount shall be multiplied by the number of patients in that RUG. RUG weights shall be assigned based on the distance from the statewide average. The RUGS III weights shall be increased by the following amounts for the following categories of residents:

i) thirty minutes of certified nurse aide time for the impaired cognition A category.

ii) forty minutes of certified nurse aide time for the impaired cognition B category, and

iii) twenty-five minutes of certified nurse aide time for the reduced physical functions B category.

3) The case mix adjustment for the direct component of the price effective January 1, 2012, shall be calculated as follows:

i) For NSHB/NS300+ the case mix adjustment shall be calculated by dividing the Medicaid-only case mix derived from data for January 2011 for each such facility by the all-payer case mix for the base year 2007. The all-payer case mix for base year 2007 shall be a blend of:

   (a) 50% of the case mix for all non-specialty facilities, and

   (b) 50% of the case mix for all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more; or

ii) For NS300- the case mix adjustment shall be calculated by dividing the Medicaid-only case mix derived from data for January 2011 for each such facility by the all-payer case mix for the base year 2007. The all-payer case mix for base year 2007 shall be a blend of:

   (a) 50% of the case mix for all non-specialty facilities, and

   (b) 50% of the case mix for non-specialty freestanding facilities with certified bed capacities of less than 300 beds.
## Calculation of 2007 All Payer Base Year Case Mix

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Case Mix Total (Count x Weight)</th>
<th>Total Patient Days</th>
<th>Weighted Average Case Mix (Case Mix Total/ Patient Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSHB/NS300+</td>
<td>12,385,293</td>
<td>13,623,548</td>
<td>0.9091</td>
</tr>
<tr>
<td>NS300-</td>
<td>22,137,438</td>
<td>24,403,182</td>
<td>0.9072</td>
</tr>
<tr>
<td>Statewide/All Non-Specialty Facilities</td>
<td>34,522,731</td>
<td>38,026,730</td>
<td>0.9079</td>
</tr>
</tbody>
</table>

\[ \text{2007 Base Year Case Mix} = \frac{\text{NSHB/NS300+}}{2} + \frac{\text{Statewide}}{2} \]

\[ = 0.9085 \]

\[ \text{2007 Base Year Case Mix} = \frac{\text{NS300-}}{2} + \frac{\text{Statewide}}{2} \]

\[ = 0.9075 \]

\* Count is defined as the number of patients in each Resource Utilization Group and weight is calculated and defined as described above in paragraph g(1) and g(2).

4) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period (e.g., July 1, 2012, case mix adjustment will use January 2012 case mix data, and January 1, 2013, case mix adjustment will use July 2012 case mix data).
New York
110(d)(14)

5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient shall be equal to the base year case mix of the peer group applicable to such facility.

6) The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of Medicaid Inspector General.

h) The indirect component of the price shall consist of a blended rate to be determined as follows:

1) For NSHB/NS300+ the indirect component of the price shall consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which shall be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

ii) 50% of the indirect NSHB/NS300+ price which shall be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty hospital-based facilities and all non-specialty freestanding facilities with certified bed capacity of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or

2) For NS300- the indirect component of the price shall consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which shall be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

ii) 50% of the indirect NS300- prices which shall be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities with certified bed capacity of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.
3) Pursuant to the methodology described above, the indirect component of the price for each peer group shall be as follows:

### Indirect Component of the Price (NSHB/NS300+) Peer Group

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Indirect NSF Price (a)</th>
<th>50% of Indirect NSF Price (b)</th>
<th>Indirect NSHB/NS300 Price (c)</th>
<th>50% of Indirect NSHB/NS300 + Price (d)</th>
<th>Total Indirect Component of Price for NSHB/NS300+ Peer Group (b)+(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2012</td>
<td>$53.15</td>
<td>$26.58</td>
<td>$61.54</td>
<td>$30.77</td>
<td>$57.35</td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>$56.18</td>
<td>$28.09</td>
<td>$65.04</td>
<td>$32.52</td>
<td>$60.61</td>
</tr>
<tr>
<td>January 1, 2014</td>
<td>$58.57</td>
<td>$29.29</td>
<td>$67.82</td>
<td>$33.91</td>
<td>$63.20</td>
</tr>
<tr>
<td>January 1, 2015</td>
<td>$59.26</td>
<td>$29.63</td>
<td>$68.61</td>
<td>$34.31</td>
<td>$63.94</td>
</tr>
<tr>
<td>January 1, 2016</td>
<td>$59.53</td>
<td>$29.77</td>
<td>$68.92</td>
<td>$34.46</td>
<td>$64.23</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>$59.80</td>
<td>$29.90</td>
<td>$69.23</td>
<td>$34.62</td>
<td>$64.52</td>
</tr>
</tbody>
</table>

### Indirect Component of the Price (NS300-) Peer Group

<table>
<thead>
<tr>
<th>Effective Date of Prices</th>
<th>Indirect NSF Price (a)</th>
<th>50% of Indirect NSF Price (b)</th>
<th>Indirect NS300 Price (c)</th>
<th>50% of Indirect NS300- Price (d)</th>
<th>Total Indirect Component of Price for NS300- Peer Group (b)+(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2012</td>
<td>$53.15</td>
<td>$26.58</td>
<td>$48.49</td>
<td>$24.25</td>
<td>$50.82</td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>$56.18</td>
<td>$28.09</td>
<td>$51.25</td>
<td>$25.63</td>
<td>$53.72</td>
</tr>
<tr>
<td>January 1, 2014</td>
<td>$58.57</td>
<td>$29.29</td>
<td>$53.44</td>
<td>$26.72</td>
<td>$56.01</td>
</tr>
<tr>
<td>January 1, 2015</td>
<td>$59.26</td>
<td>$29.63</td>
<td>$54.06</td>
<td>$27.03</td>
<td>$56.66</td>
</tr>
<tr>
<td>January 1, 2016</td>
<td>$59.53</td>
<td>$29.77</td>
<td>$54.31</td>
<td>$27.16</td>
<td>$56.92</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>$59.80</td>
<td>$29.90</td>
<td>$54.55</td>
<td>$27.28</td>
<td>$57.18</td>
</tr>
</tbody>
</table>
New York
110(d)(16)

4) The allowable costs percent reduction for the indirect component shall be the same as the allowable cost reduction used for the direct component and shown in paragraph C of the subdivision 4) of this section.

i) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 certified cost report (RHCF-4), or extracted from a hospital-based facility's 2007 certified cost report (RHCF-2) and the institutional cost report of its related hospital, as extracted by the Commissioner on December 21, 2010, after first deducting costs attributable to specialty units, and the hospital; and capital costs:

1) Fiscal Services (004);
2) Administrative Services (005);
3) Plant Operations and Maintenance (006) with the exception of utilities and real estate occupancy taxes;
4) Grounds (007);
5) Security (008);
6) Laundry and Linen (009);
7) Housekeeping (010);
8) Patient Food Services (011);
9) Cafeteria (012);
10) Non-Physician Education (015);
11) Medical Education (016);
12) Housing (018); and
13) Medical Records (019).
New York
110(d)(17)

i) The indirect component of the price shall be adjusted by a wage equalization factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported by each facility’s 2009 certified cost report ((RHCF-4), or extracted from a hospital-based facility’s 2009 certified cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) as extracted by the Commissioner on October 31, 2011 after first deducting costs attributable to specialty units and the hospital. The WEF adjustment shall consist of 50% of a facility-specific indirect WEF and 50% of a regional indirect WEF.

1) The facility-specific indirect WEF shall be calculated as follows:

\[
\frac{1}{(\text{Facility-Specific Wage Ratio} / \text{Wage Index}) + \text{Facility-Specific Non-Wage Ratio}}
\]

i) The Facility-Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to indirect cost centers for fiscal services (004), administrative services (005), plant operation and maintenance (006), grounds (007), security (008), laundry and linen (009), housekeeping (010), patient food service (011), cafeteria (012), non physician education (015), medical education (016), housing (018) and medical records (019), by total indirect operating expenses from such cost centers.

ii) The Wage Index shall be calculated by dividing facility-specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.

2) A regional indirect WEF shall be calculated using the 16 regions as defined for the regional WEF in paragraph e) subsection 2 of this section. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located.
3) The regional indirect WEF shall be calculated for each of the 16 regions as follows:

\[ \frac{1}{((\text{Regional Wage Ratio} / \text{Regional Wage Index}) + (\text{Regional Non-Wage Ratio}))} \]

i) The Regional Indirect Wage Ratio shall be calculated by dividing total salaries and fringes related to indirect costs centers in the region for Fiscal Services (004), Administrative Services (005), Plant Operation and Maintenance (006), Grounds (007), Security (008), Laundry and Linen (009), Housekeeping (010), Patient Food Service (011), Cafeteria (012), Non Physician Education (015), medical education (016), housing (018) and Medical Records (019) for such indirect cost centers by total indirect operating expenses in the region from such cost centers.

ii) The Wage Index shall be calculated by dividing labor costs per hour in the Region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

4) The regional indirect WEF adjustment to the indirect component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

k) The non-comparable component of the price shall be calculated using allowable operating costs and statistical data as reported in each non-specialty facility's certified cost report for the 2007 calendar year, as extracted by the Commissioner on December 21, 2010, divided by total 2007 patient days.
Allowable costs for the non-comparable component of the price shall include costs reported in the following functional cost centers on the facility's annual certified cost report (RHCF-4), or extracted from a hospital-based facility's annual certified cost report (RHCF-2) and the institutional cost report of its related hospital, as extracted by the Commissioner on December 21, 2010, after first deducting costs attributable to specialty units, and the hospital; and capital costs:

1) Laboratory services (031);
2) ECG (032);
3) EEG (033);
4) Radiology (034);
5) Inhalation Therapy (035);
6) Podiatry (036);
7) Dental (037);
8) Psychiatric (038);
9) Speech and Hearing Therapy – (Hearing Therapy Only including associated overhead) (041);
10) Medical Directors Office (017);
11) Medical Staff Services (044);
12) Utilization review (020);
13) Other ancillary services (045, 046, 047);
14) Costs of utilities associated with plant operations and maintenance; and
15) Pharmacy costs pertaining to administrative overhead and costs of non-prescription drugs and supplies.
m) The non-comparable component of the price for facilities for which 2007 cost report data is unavailable or insufficient to calculate the non-comparable component as described above shall initially receive a non-comparable rate which is calculated using the most recently available certified cost report which is most proximate to 2007 and the total patient days which relate to such report and if no such report is available, the regional average non comparable price shall be utilized until such time as a certified cost report is available.

n) Per Diem Adjustments for Dementia, Bariatric, or Traumatic Brain-Injured Patients. If applicable, and as updated pursuant to the case mix adjustments described above, the operating component of the price shall be adjusted to reflect:

1) A per diem add-on in the amount of $8 for each dementia patient, defined as one who A) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (B) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B, or C or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

2) A per diem add-on in the amount of $17 for each bariatric patient, defined as one whose body mass index is greater than thirty-five.

3) A per diem add-on in the amount of $36 for each traumatic brain-injured patient, defined as one requiring extended care as a result of that injury.

o) [Reserved.] Effective for services provided on and after June 20, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, will receive a per diem adjustment. The adjustment is equal to the difference between (1) such facility's allowable operating cost, as described previously in this section, for 2010 extracted by the Commissioner on January 10, 2012 divided by 2010 total resident days, and (2) the daily weighted average non-capital component of the rate, calculated using 2010 Medicaid days, in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year as described previously in this section. Such per diem adjustment shall not result in a total operating rate that exceeds allowable total operating costs per day.

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TN #12-23 Approval Date September 19, 2012
Supersedes TN #11-23-A Effective Date June 20, 2012
Effective May 10, 2018 and thereafter, the fee-for-service rate of reimbursement for inpatient services for a residential health care facility located in a county with a population of more than seventy-two thousand but less than seventy-five thousand persons, based on the 2010 federal census, and operating between one hundred and one hundred thirty beds, will be increased by 17% of the base operating and capital components of the inpatient services rate calculated for that facility. Residential health care facility fee-for-services rates can be found on the Department of Health website at:

https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/
Effective on or after May 17, 2018, the Department of Health shall adjust Medicaid service payments in response to a New York State Supreme Court decision in the Matter of The Bronx-Lebanon Highbridge Woodycrest Center. The adjustment shall be a lump sum payment of $4,314,009. This payment is intended to satisfy the judgment in the aforementioned court decision. This payment will be made in SFY 2019.

TN #18-0050 Approval Date August 6, 2018
Supersedes TN #NEW Effective Date May 17, 2018
The New York State Nursing Home Quality Pool (NHQP) is an annual budget-neutral pool of $50 million dollars. The intent of the NHQP is to incentivize Medicaid-certified nursing facilities across New York State to improve the quality of care for their residents, and to reward facilities for quality based on their performance. The set of measures used to evaluate nursing homes are part of the Nursing Home Quality Initiative (NHQI). The performances of facilities in the NHQI determine the distribution of the funds in the NHQP.

For the calendar year [2017] 2018, the Commissioner will calculate a score and quintile ranking based on data from the [2016] 2017 calendar year (January 1, 2016 2017 through December 31, 2016 2017), for each non-specialty facility. The score will be calculated based on measurement components comprised of Quality, Compliance, and Efficiency Measures. These measurement components and their resulting score and quintile ranking will be referred to as the Nursing Home Quality Initiative. From the NHQI, the Commissioner will exclude specialty facilities consisting of non-Medicaid facilities, Special Focus Facilities as designated by the Centers for Medicare and Medicaid Services (CMS), Continuing Care Retirement Communities, Transitional Care Units, specialty facilities, and specialty units within facilities. Specialty facilities and specialty units shall include AIDS facilities or discrete AIDS units within facilities, facilities or discrete units within facilities for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons, facilities or discrete units within facilities that provide specialized programs for residents requiring behavioral interventions, facilities or discrete units within facilities for long-term ventilator dependent residents, facilities or discrete units within facilities that provide services solely to children, and neurodegenerative facilities or discrete neurodegenerative units within facilities. The score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures.

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner)</td>
<td>CMS</td>
</tr>
<tr>
<td>2 Percent of Long Stay Residents Who Received the Pneumococcal Vaccine</td>
<td>CMS</td>
</tr>
<tr>
<td>3 Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine</td>
<td>CMS</td>
</tr>
<tr>
<td>4 Percent of Long Stay Residents Experiencing One or More Falls with Major Injury</td>
<td>CMS</td>
</tr>
<tr>
<td>5 Percent of Long Stay Residents Who have Depressive Symptoms</td>
<td>CMS</td>
</tr>
<tr>
<td>6 Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder</td>
<td>CMS</td>
</tr>
<tr>
<td>7 Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)</td>
<td>CMS</td>
</tr>
</tbody>
</table>

TN #18-0002 Approval Date July 18, 2018
Supersedes TN #17-0036 Effective Date April 1, 2018
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Percent of Long Stay Antipsychotic Use in Persons with Dementia</td>
<td>Pharmacy Quality Alliance (PQA)</td>
</tr>
<tr>
<td>9</td>
<td>Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner)</td>
<td>CMS</td>
</tr>
<tr>
<td>10</td>
<td>Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased</td>
<td>CMS</td>
</tr>
<tr>
<td>11</td>
<td>Percent of Long Stay Residents with a Urinary Tract Infection</td>
<td>CMS</td>
</tr>
<tr>
<td>12</td>
<td>Percent of Employees Vaccinated for Influenza</td>
<td>NYS DOH</td>
</tr>
<tr>
<td>13</td>
<td>Percent of Contract/Agency Staff Used</td>
<td>NYS DOH</td>
</tr>
<tr>
<td>14</td>
<td>Rate of Staffing Hours per Day</td>
<td>NYS DOH</td>
</tr>
</tbody>
</table>

**Compliance Measures**

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>15</td>
<td>CMS Five-Star Quality Rating for Health Inspections as of April 1, [2017] 2018 (By Region)</td>
<td>CMS</td>
</tr>
<tr>
<td>16</td>
<td>Timely Submission and Certification of Complete [2016] 2017 New York State Nursing Home Cost Report to the Commissioner</td>
<td>NYS DOH</td>
</tr>
<tr>
<td>17</td>
<td>Timely Submission of Employee Influenza Immunization Data for the September 1, [2016] 2017 - March 31, [2017] 2018 Influenza Season by the deadline of May 1, [2017] 2018</td>
<td>NYS DOH</td>
</tr>
</tbody>
</table>

**Efficiency Measure**

<table>
<thead>
<tr>
<th></th>
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<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1, [2016] 2017 - December 31, [2016] 2017 (As Risk Adjusted by the Commissioner)</td>
<td>NYS DOH</td>
</tr>
</tbody>
</table>

The maximum points a facility may receive for the Quality Component is 70. The applicable percentages or ratings for each of the 14 measures will be determined for each facility. Two measures will be awarded points based on threshold values. The remaining 12 measures will be ranked and grouped by quintile with points awarded as follows:

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quintile</td>
<td>5</td>
</tr>
<tr>
<td>2nd Quintile</td>
<td>3</td>
</tr>
<tr>
<td>3rd Quintile</td>
<td>1</td>
</tr>
<tr>
<td>4th Quintile</td>
<td>0</td>
</tr>
<tr>
<td>5th Quintile</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** The following quality measures will not be ranked into quintiles and points will be awarded based on threshold values:

- Percent of employees vaccinated for influenza: facilities will be awarded five points if the rate is 85% or higher, and zero points if the rate is less than 85%.
- Percent of contract/agency staff used: facilities will be awarded five points if the rate is less than 10%, and zero points if the rate is 10% or higher.

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**TN ** #18-0002                      ** Approval Date ** July 18, 2018

**Supersedes TN  #17-0036**                      ** Effective Date ** April 1, 2018
[Addition of New Measure to Quality Component]

[Rate of Staffing Hours per Day]

This measure will replace the CMS Five-Star Quality Rating for Staffing. NYS DOH will calculate an annualized adjusted rate of staffing hours per resident per day. For this measure, staff are defined as RNs, LPNs, and Aides. The observed staffing hours will be taken from the 2015 nursing home cost reports. The expected staffing hours will be determined using Resource Utilization Group data on the 2015 MDS 3.0 and the CMS 1995-1997 Staff Time Measurement Study. The observed-to-expected staffing hours will be adjusted using the statewide distribution and the formula adapted from the CMS Five-Star Quality Rating for Staffing at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf. The formula below will be used:

\[
\frac{\text{Hours worked reported from cost reports}}{\text{# of residents from MDS 3.0}} \div 365 \text{ days} \\
\div \frac{\text{(RUG distribution from MDS 3.0*hours from CMS time study)}}{\text{# of residents from MDS 3.0}} \div 365 \text{ days}
\]

Awarding for Improvement

Nursing homes will be awarded improvement points from previous years’ performance in selected measures in the Quality Component only. One improvement point will be awarded for a nursing home that improves in its quintile for a specific quality measure, compared to its quintile in the previous year for that quality measure. Nursing homes that obtain the top quintile in a quality measure will not receive an improvement point because maximum points per measure cannot exceed five. The [three] two quality measures below will not be eligible to receive improvement points:

- Percent of Employees Vaccinated for Influenza (based on threshold)
New York
110(d)(22.2)

- Percent of Contract/Agency Staff Used (based on threshold)

The remaining 12 quality measures that are eligible for improvement points are listed below:
- Percent of Long Stay High Risk Residents With Pressure Ulcers
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- Percent of Long Stay Residents Who have Depressive Symptoms
- Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder
- Percent of Long Stay Residents Who Lose Too Much Weight
- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain
- Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
- Percent of Long Stay Residents with a Urinary Tract Infection
- Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
- Percent of Long Stay Antipsychotic Use in Persons with Dementia
- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine
- Rate of Staffing Hours per Day

The grid below illustrates the method of awarding improvement points.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintiles</td>
<td>1 (best) 2 3 4 5</td>
</tr>
<tr>
<td>1 (best)</td>
<td>5 5 5 5 5</td>
</tr>
<tr>
<td>2</td>
<td>3 3 4 4 4</td>
</tr>
<tr>
<td>3</td>
<td>1 1 1 2 2</td>
</tr>
<tr>
<td>4</td>
<td>0 0 0 0 1</td>
</tr>
<tr>
<td>5</td>
<td>0 0 0 0 0</td>
</tr>
</tbody>
</table>

For example, if [2016] 2017 NHQI performance is in the third quintile, and [2017] 2018 NHQI performance is in the second quintile, the facility will receive four points for the measure. This is three points for attaining the second quintile and one point for improvement from the previous year’s third quintile.

Risk Adjustment of Quality Measures
The following quality measures will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors:

- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain: the covariate includes cognitive skills for daily decision making on the prior assessment.
- Percent of Long Stay High Risk Residents with Pressure Ulcers: The covariates include gender, age, healed pressure ulcer since the prior assessment, BMI, prognosis of less than six months of life expected, diabetes, heart failure, deep vein thrombosis, anemia, renal failure, hip fracture, bowel incontinence, cancer, paraplegia, and quadriplegia.
Percent of Long Stay Residents who Lose Too Much Weight: The covariates include age, hospice care, cancer, renal failure, prognosis of less than six months of life expected.

For these three measures the risk adjusted methodology includes the calculation of the observed rate; that is the facility’s numerator-compliant population divided by the facility’s denominator.

The expected rate is the rate the facility would have had if the facility’s patient mix was identical to the patient mix of the state. The expected rate is determined through the risk-adjusted model and follows the CMS methodology found in the MDS 3.0 Quality Measures User’s Manual, Appendix A-1.

The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate.

Reduction of Points Base: When a quality measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home’s total score will be the sum of its points divided by the base. This reduction can happen in the following scenarios:

- When nursing homes do not have enough cost report data to calculate a percent of contract/agency staff used or the rate of staffing hours per day; or
- When a quality measure has a denominator of less than 30
The maximum points a facility may receive for the Compliance Component is 20 points. Points shall be awarded as follows:

<table>
<thead>
<tr>
<th>Scoring for Compliance Measures</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Five-Star Quality Rating for Health Inspections (By Region)</strong></td>
<td></td>
</tr>
<tr>
<td>5 Stars</td>
<td>10</td>
</tr>
<tr>
<td>4 Stars</td>
<td>7</td>
</tr>
<tr>
<td>3 Stars</td>
<td>4</td>
</tr>
<tr>
<td>2 Stars</td>
<td>2</td>
</tr>
<tr>
<td>1 Star</td>
<td>0</td>
</tr>
<tr>
<td><strong>Timely Submission and Certification of Complete [2016] 2017 New York State Nursing Home Cost Report to the Commissioner</strong></td>
<td>5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points)</td>
</tr>
<tr>
<td><strong>Timely Submission of Employee Influenza Immunization Data</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 for the May 1, [2017] 2018 deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero points)</td>
</tr>
</tbody>
</table>

**CMS Five-Star Quality Rating for Health Inspections**

The CMS Five-Star Quality Rating for Health Inspections as of April 1, [2017] 2018 will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS’ methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

**Metropolitan Area Regional Offices (MARO):** Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

**Central New York Regional Offices (CNYRO):** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.


TN #18-0002 Approval Date July 18, 2018
Supersedes TN #17-0036 Effective Date April 1, 2018

Reduction of Points Base: When a compliance measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home’s total score will be the sum of its points divided by the base. This reduction can happen when a facility does not have a CMS Five-Star Quality Rating for Health Inspections.

The maximum points a facility may receive for the Efficiency Component is 10 points. The rates of potentially avoidable hospitalizations will be determined for each facility and each such rate will be ranked and grouped by quintile with points awarded as follows:

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quintile</td>
<td>10</td>
</tr>
<tr>
<td>2nd Quintile</td>
<td>8</td>
</tr>
<tr>
<td>3rd Quintile</td>
<td>6</td>
</tr>
<tr>
<td>4th Quintile</td>
<td>2</td>
</tr>
<tr>
<td>5th Quintile</td>
<td>0</td>
</tr>
</tbody>
</table>

The Efficiency Measure will be risk adjusted [using the following] for certain conditions chosen from a pool of covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, [race/ethnicity, payor, prior hospitalization (hospitalization less than or equal to 90 days before the long stay episode began), pneumonia, urinary tract infection,] shortness of breath, falls with injury, pressure ulcer, activities of daily living, renal disease, cognitive impairment, dementia, diabetes, parenteral nutrition, rheumatologic disease, gastrointestinal disease, multi-drug-resistant infection, indwelling catheter, wound infection, deep vein thrombosis, cancer, feeding tube, [septicemia, antibiotic-resistant infection,] coronary artery disease, liver disease, paralysis, peripheral vascular disease, and [Charison Index*] malnutrition.

[*The Charlson Index is a score based on several comorbidities following CMS specifications. In the statistical model, the Charlson Index is separated into the following three groups: Low (a score of less than or equal to 1), Mid (2-4), and High (5 and greater). The comorbidities were determined using (1) any MDS assessment during the resident’s long stay episode, or (2) a hospitalization record up to 12 months before the resident’s long stay episode began, or (3) a hospitalization record up to three days after the resident’s long stay episode ended. The comorbidities used to create the Charlson Index include the following: myocardial infarction, congestive heart failure, peripheral vascular disease, cebrovascular disease, dementia, chronic pulmonary disease, rheumatologic disease, peptic ulcer disease, mild liver disease, diabetes with complications, diabetes without complications, paraplegia and hemiplegia, renal disease, cancer/leukemia, moderate or severe liver disease, metastatic carcinoma, and AIDS/HIV.*]
A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in SPARCS. The following primary [ICD-9 and] ICD-10[*] diagnoses on the SPARCS hospital record are potentially avoidable:

<table>
<thead>
<tr>
<th>Potentially Avoidable Hospitalization Condition</th>
<th>[ICD-9 codes]</th>
<th>ICD-10 codes</th>
</tr>
</thead>
</table>
Anemia | D500, D501, D508, D509, D510, D511, D513, D518, D520, D521, D528, D529, D530, D531, D532, D538, D539, D62, D638

Reduction of Points Base: When the number of long stay residents that contribute to the denominator of the potentially avoidable hospitalization measure is less than 30, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base.

The following rate adjustments, which will be applicable to the [2017] 2018 calendar year, will be made to fund the NHQP and to make payments based upon the scores calculated from the NHQI as described above.

- Each non-specialty facility will be subject to a Medicaid rate reduction to fund the NHQI, which will be calculated as follows:

- For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's [2016] 2017 cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days. If a facility fails to submit a timely filed [2016] 2017 cost report, the most recent cost report will be used.

- The total scores as calculated above for each such facility will be ranked and grouped by quintile. Each of the top three quintiles will be allocated a share of the $50 million NHQI and each such facility within such top three quintiles will receive a payment. Such payments will be paid as a per diem adjustment for the [2017] 2018 calendar year. Such shares and payments will be calculated as follows:
## Distribution of NHQI Payments

<table>
<thead>
<tr>
<th>Facilities Grouped by Quintile</th>
<th>A Facility’s Medicaid Revenue Multiplied by Award Factor</th>
<th>B Share of $50 Million NHQI Allocated to Facility</th>
<th>C Facility Per Diem Quality Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Quintile</strong></td>
<td>Each facility’s [2016] 2017 Medicaid days multiplied by [2017] 2018 Medicaid Rate as of January 1, [2017] 2018 = Total Medicaid Revenue multiplied by an award factor of 3</td>
<td>Each facility’s column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million</td>
<td>Each facility’s column B divided by the facility’s [2016] 2017 Medicaid days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd Quintile</strong></td>
<td>Each facility’s [2016] 2017 Medicaid days multiplied by [2017] 2018 Medicaid Rate as of January 1, [2017] 2018 = Total Medicaid Revenue multiplied by an award factor of 2.25</td>
<td>Each facility’s column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million</td>
<td>Each facility’s column B divided by the facility’s [2016] 2017 Medicaid days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3rd Quintile</strong></td>
<td>Each facility’s [2016] 2017 Medicaid days multiplied by [2017] 2018 Medicaid Rate as of January 1, [2017] 2018 = Total Medicaid Revenue multiplied by an award factor of 1.5</td>
<td>Each facility’s column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million</td>
<td>Each facility’s column B divided by the facility’s [2016] 2017 Medicaid days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Sum of Total Medicaid Revenue for all facilities</td>
<td>Sum of quality pool funds: $50 million</td>
<td>--</td>
</tr>
</tbody>
</table>

[Payments made pursuant to this program will be subject to this rate adjustment and will be reconciled using actual Medicaid claims data.]
The following facilities will not be eligible for 2018 payments and the scores of such facilities will not be included in determining the share of the NHQP payments:

- A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the time period of July 1, 2016 through June 30, 2017. Deficiencies will be reassessed on October 1, 2018 to allow a three-month window (after the June 30, 2017 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, 2017 and September 30, 2017. Any new J/K/L deficiencies between July 1, 2017 and September 30, 2017 will not be included in the 2018 NHQI.
Effective May 17, 2018, and every January 1 thereafter, low quality performing residential health care facilities will have their rates reduced as described in this section based on the most recent two years of Nursing Home Quality Initiative (NHOI) data. A low quality performing facility is one that was ranked in the lowest two quintiles for the second most recent year, and ranked in the lowest quintile for the most recent year. In the rate year immediately following the two-year measurement period, a low quality performing facility’s computed Medicaid rate will be reduced by 2 percent. Financially distressed providers will be excluded from this penalty.
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 the specialty and non-specialty Nursing Home rate.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>$11.00</td>
<td>$13.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Nassau, Suffolk, &amp; Westchester counties</td>
<td>$10.00</td>
<td>$11.00</td>
<td>$12.00</td>
<td>$13.00</td>
<td>$14.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Remainder of the State</td>
<td>$9.70</td>
<td>$10.40</td>
<td>$11.10</td>
<td>$11.80</td>
<td>$12.50</td>
<td>$12.50</td>
</tr>
</tbody>
</table>

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 nursing facility providers. If a facility does not submit a survey, the minimum wage add-on will be calculated based on the facility’s Residential Health Care Facility (RHCF) 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.
   a. Survey data will be collected for facility specific wage data.
   b. Facilities will report by wage bands, the total count of FTEs and total hours paid to all employees (contracted and non-contracted staff) earning less than the statutory minimum wage applicable for each region.
   c. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
   d. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the facility has reported total hours paid. To this result, the facility’s average fringe benefit percentage is applied and added to the costs.

ii. Minimum wage cost development based on the RHCF 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.
3. The facility specific cost amount will be adjusted by a factor calculated by dividing the facility’s average dollar per hour under minimum wage by the regional average. The resulting amount will be divided by patient days to arrive at a rate per diem add on, which will be applied to only Medicaid days for purposes of Medicaid reimbursement.

4. In subsequent years until the minimum wage is completely implemented statewide, the Department will survey facilities utilizing the methodology employed in year one. If a facility fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the personnel wage data reported on the Facility’s latest available RHCF cost report. If a facility fails to submit both the survey and the RHCF cost report, its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the nursing home rate, the minimum wage add-on will be excluded from the rate.

5. **Minimum Wage Reconciliation** - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the reconciliation survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the reconciliation survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider’s minimum wage add-on for the calendar year covered by the survey will be recouped.

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.

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**TN #17-0007**  
Approval Date January 10, 2018  
Supersedes TN #16-0024  
Effective Date January 1, 2017
Nursing Home Advanced Training Incentive Payments

Advanced Training Incentive Payments to Eligible Facilities. Effective June 1, 2015, the state will annually distribute $46 million to eligible nursing facilities in State Fiscal Year 2016 and in 2017. The purpose of these incentive payments is to reduce avoidable hospital admissions for nursing home residents. New York will incentivize and encourage facilities to develop training programs aimed at early detection of patient decline. Such programs will allow frontline caregivers to provide staff with the training/tools needed to identify resident characteristics that may signify clinical complications. A comprehensive training program will lead to consistent staff assignment to ensure that families and residents can rely on highly trained caregivers to provide effective, high quality, individualized care.

Patient decline detection programs will assist caregivers with identifying residents who are exhibiting warning signs for worsening clinical conditions and allow for rapid intervention to avoid the decline and possible hospitalization. The goal of such training programs will be to reign in the high costs of avoidable hospitalizations, improving the quality of life for New York’s nursing home residents. This initiative will reward eligible nursing home providers who are those that have shown a commitment to giving direct care staff the tools to help lower resident hospitalization rates.

The annual amount will be distributed proportionally to each eligible facility based on its relative share of Medicaid bed days to total Medicaid bed days of all such eligible facilities. Incentive payments will be paid in two lump sum adjustments to supplement nursing facility rates. 75% will be paid in the October - December quarter and the 25% will be paid in the January - March quarter.

To be eligible for this incentive payment, in each state fiscal year a facility must:

1) Provide a training program to direct care staff that has been reviewed and approved by the Department to assist direct care staff identify changes in a resident’s physical, mental, or functional status that could lead to hospitalization. The training program will be subject to Department of Health oversight; and

2) Have a direct care staff retention rate above the statewide median; and

3) Not be excluded from participating in this program.

Attachment 4.19-D
Part I

New York
110(d)(29)

March 9, 2016
Approval Date

Supersedes TN # NEW

June 1, 2015
Effective Date
Nursing Home Advanced Training Incentive Payments (cont’d)

Excluded Facilities are:

- Hospital based nursing facilities; and
- Nursing Facilities that have been approved to receive Vital Access Provider (VAP) payments during the same state fiscal year the incentive payment is available.

Calculation Statewide Median and Staff Retention Percentage: Data from Schedule P (Staff Turnover) of the most recently filed Cost Report will be used to measure staff turnover and retention rates for direct care staff. For the 2016 payment, the State will use the 2014 cost report. For the 2017 payment, the state will use 2015 cost report. The staff retention percentage will be equal to the number of employees retained as of December 31, who were employed on January 1 of the same year by the number of staff as of January 1 of that year.

\[
\frac{\text{# of Employees Retained as of December 31, 20XX, who were Employed on January 1, 20XX}}{\text{# of Staff as of January 1, 20XX}} = \text{Staff Retention \%}
\]

XX = 2014 or 2015 cost report as applicable.

A statewide staff retention median was derived by sorting the provider percentages from high to low and selecting the percentage in the middle of the range.

Restorative (Intensive) Care in a Nursing Home

Effective December 1, 2016 NYSDOH will implement a Restorative Care Unit Program to reduce hospital admissions and readmissions from residential health care facilities through the establishment of restorative care units. These restorative care units will provide higher-intensity treatment services to residents who are at risk of hospitalization upon an acute change in condition and seeks to improve the capacity of nursing facilities to identify and treat higher acuity patients with multiple co-morbidities as effectively as possible in place, rather than through admission to an acute care facility. Eligible facilities are required to institute new programs through which residents normally transported to hospital will be cared for in the nursing facility through the use of more intensive nursing home units.

The targeted population receiving restorative care unit services are participating in the restorative care program, post hospital admission and have an overall goal of discharging to the community.

Rate payments will be provided, semi-annually, to eligible residential health care facilities which meet the criteria of providing intensive treatments to nursing home residents in the facility and thereby avoid hospitalization. The rate adjustment is intended to:

TN #16-0051 Approval Date September 14, 2017
Supersedes TN #15-0047 Effective Date December 1, 2016
New York
110(d)(29.2)

- Enhance quality of care
- Provide immediate intensive care in a nursing home setting
- Improve the cost effectiveness through the avoidance of hospital admission

Eligible residential health care providers, the amount of the semi-annual payment, and the duration of each rate adjustment period shall be listed in the table which follows. The total adjustment amount for each period shown below will be paid semi-annually during each period in equal installments. The temporary payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the six months.

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 may result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's payment period adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology.

Additional payments have been approved for the following providers in the amounts and for the effective periods listed.

**Nursing Homes:**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Gross Medicaid Rate Adjustment</th>
<th>Rate Period Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Hill Nursing Center</td>
<td>$3,000,000</td>
<td>12/01/2016 – 03/31/2017</td>
</tr>
<tr>
<td></td>
<td>$1,500,000</td>
<td>04/01/2017 – 09/30/2017</td>
</tr>
<tr>
<td></td>
<td>$1,500,000</td>
<td>10/01/2017 – 03/31/2018</td>
</tr>
<tr>
<td></td>
<td>$1,500,000</td>
<td>04/01/2018 – 09/30/2018</td>
</tr>
<tr>
<td></td>
<td>$1,500,000</td>
<td>10/01/2018 – 03/31/2019</td>
</tr>
</tbody>
</table>

---

Approval Date September 14, 2017
Effective Date December 1, 2016
Provider Assessments.

For purposes of determining rates of payment for residential health care facilities beginning July 1, 1992 for beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act, a state assessment of 1.2% of residential health care facility gross revenues received during the period April 1, 1992 through March 31, 1994, and as may be extended by statute, shall be a reimbursable cost to be included in calculating rates of payment. The state assessment of 1.2% of RHCF gross revenues shall be in effect from April 1, 1992 through March 31, 1994, and as may be extended by statute, an additional state assessment of 3.8% of facility gross revenues shall be a reimbursable cost to be included in calculating rates of payment.

Effective for the period April 1, 1996 through April 30, 1996, the further additional assessment will be reduced from 3.8% to 1.9% of each facility’s cash receipts from all patient care services and other operating income, for a total state assessment of 3.1% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective on or after May 1, 1996, rates of payment will be adjusted to allow costs associated with a total state assessment of 5.4% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates based on a reconciliation of actual assessment payments to estimated payments.  

1The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.
Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which will be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities will be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, April 1, 2005 through March 31, 2013,[ and] April 1, 2013 through March 31, 2015, [and] April 1, 2015 through March 31, 2017 and April 1, 2017 through March 31, 2019, the total reimbursable state assessment on each residential health care facility’s gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), will be 6%, 5%, and 6% thereafter, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments. The reimbursable portion of the provider’s cost for the assessment will only be Medicaid’s share of the assessment; which is determined by the appropriate assessment percentage multiplied by Medicaid revenues.

TN #17-0035  Approval Date September 27, 2017
Supersedes TN #15-0027  Effective Date April 1, 2017
New York
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Appendix 13 - Patient Categories and Case Mix Indices Under the Resource Utilization Group (RUG-II) Classification System

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Case Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Care A</td>
<td>1.51</td>
</tr>
<tr>
<td>Special Care B</td>
<td>1.74</td>
</tr>
<tr>
<td>Heavy Rehabilitation A</td>
<td>1.57</td>
</tr>
<tr>
<td>Heavy Rehabilitation B</td>
<td>1.79</td>
</tr>
<tr>
<td>Clinically Complex A</td>
<td>0.70</td>
</tr>
<tr>
<td>Clinically Complex B</td>
<td>1.18</td>
</tr>
<tr>
<td>Clinically Complex C</td>
<td>1.32</td>
</tr>
<tr>
<td>Clinically Complex D</td>
<td>1.64</td>
</tr>
<tr>
<td>Severe Behavioral A</td>
<td>0.69</td>
</tr>
<tr>
<td>Severe Behavioral B</td>
<td>1.03</td>
</tr>
<tr>
<td>Severe Behavioral C</td>
<td>1.25</td>
</tr>
<tr>
<td>Reduced Physical Functioning A</td>
<td>0.55</td>
</tr>
<tr>
<td>Reduced Physical Functioning B</td>
<td>0.83</td>
</tr>
<tr>
<td>Reduced Physical Functioning C</td>
<td>1.03</td>
</tr>
<tr>
<td>Reduced Physical Functioning D</td>
<td>1.17</td>
</tr>
<tr>
<td>Reduced Physical Functioning E</td>
<td>1.41</td>
</tr>
</tbody>
</table>
New York

Appendix 13(a) - Schedule of Allowances for Operators, Administrators, and Assistant Administrators Effective for the Base Year Ending 12/31/83

<table>
<thead>
<tr>
<th>BEDS</th>
<th>TOTAL ALLOWANCE</th>
<th>INDIVIDUAL ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-40</td>
<td>$20,690</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>23,280</td>
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</tr>
<tr>
<td>50</td>
<td>25,870</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>28,460</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>31,050</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>33,640</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>36,230</td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>38,820</td>
<td>$36,970</td>
</tr>
<tr>
<td>80</td>
<td>41,410</td>
<td>37,930</td>
</tr>
<tr>
<td>85</td>
<td>44,000</td>
<td>38,890</td>
</tr>
<tr>
<td>90</td>
<td>46,590</td>
<td>39,850</td>
</tr>
<tr>
<td>95</td>
<td>49,180</td>
<td>40,810</td>
</tr>
<tr>
<td>100</td>
<td>51,770</td>
<td>41,770</td>
</tr>
<tr>
<td>110</td>
<td>54,360</td>
<td>42,730</td>
</tr>
<tr>
<td>120</td>
<td>56,950</td>
<td>43,690</td>
</tr>
<tr>
<td>130</td>
<td>59,540</td>
<td>44,650</td>
</tr>
<tr>
<td>140</td>
<td>62,130</td>
<td>45,610</td>
</tr>
<tr>
<td>150</td>
<td>64,720</td>
<td>46,570</td>
</tr>
<tr>
<td>160</td>
<td>67,310</td>
<td>47,530</td>
</tr>
<tr>
<td>170</td>
<td>69,900</td>
<td>48,490</td>
</tr>
<tr>
<td>180</td>
<td>72,490</td>
<td>49,450</td>
</tr>
<tr>
<td>190</td>
<td>75,080</td>
<td>50,410</td>
</tr>
<tr>
<td>200</td>
<td>77,670</td>
<td>51,370</td>
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<tr>
<td>210</td>
<td>80,260</td>
<td>52,330</td>
</tr>
<tr>
<td>220</td>
<td>82,850</td>
<td>53,290</td>
</tr>
<tr>
<td>230</td>
<td>85,440</td>
<td>54,250</td>
</tr>
<tr>
<td>240</td>
<td>88,030</td>
<td>55,210</td>
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<tr>
<td>250</td>
<td>90,620</td>
<td>56,170</td>
</tr>
<tr>
<td>260</td>
<td>93,210</td>
<td>57,130</td>
</tr>
<tr>
<td>270</td>
<td>95,800</td>
<td>58,090</td>
</tr>
<tr>
<td>280</td>
<td>98,390</td>
<td>59,050</td>
</tr>
<tr>
<td>290</td>
<td>100,980</td>
<td>60,010</td>
</tr>
<tr>
<td>300</td>
<td>103,570</td>
<td>60,970</td>
</tr>
<tr>
<td>310</td>
<td>106,160</td>
<td>61,930</td>
</tr>
<tr>
<td>320</td>
<td>108,750</td>
<td>62,890</td>
</tr>
</tbody>
</table>

To determine the salary allowance for facilities with bed capacities not listed above, use the following amounts:

**TN #87-7**
**Approval Date February 21, 1989**
**Supersedes TN #86-4**
**Effective Date January 1, 1987**
### New York

<table>
<thead>
<tr>
<th>Total Beds</th>
<th>Total Bed Cost</th>
<th>Individual Bed Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>41-100</td>
<td>$518 per bed</td>
<td></td>
</tr>
<tr>
<td>101-100</td>
<td>$192 per bed</td>
<td></td>
</tr>
<tr>
<td>101 &amp; over</td>
<td>259 per bed</td>
<td></td>
</tr>
<tr>
<td>101 &amp; over</td>
<td>96 per bed</td>
<td></td>
</tr>
</tbody>
</table>

Maximum: 79,707

- TN #87-7
- Supersedes TN #86-4

**Approval Date**: February 21, 1989

**Effective Date**: January 1, 1987
### Counties and Regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties in region</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBANY</td>
<td>Albany, Columbia, Greene, Montgomery, Rensselaer,</td>
</tr>
<tr>
<td></td>
<td>Saratoga, Schenectady, Schoharie, Fulton</td>
</tr>
<tr>
<td>BINGHAMTON</td>
<td>Broome, Tioga</td>
</tr>
<tr>
<td>ERIE</td>
<td>Cattaraugus, Chautauqua, Erie, Niagara, Orleans</td>
</tr>
<tr>
<td>ELMIRA</td>
<td>Chemung, Steuben, Schuyler</td>
</tr>
<tr>
<td>GLENS FALLS</td>
<td>Essex, Warren, Washington</td>
</tr>
<tr>
<td>LONG ISLAND</td>
<td>Nassau, Suffolk</td>
</tr>
<tr>
<td>ORANGE</td>
<td>Chenango, Delaware, Orange, Otsego, Sullivan, Ulster</td>
</tr>
<tr>
<td>NEW YORK CITY</td>
<td>Bronx, Kings, Queens, Richmond, New York</td>
</tr>
<tr>
<td>POUGHKEEPSIE</td>
<td>Dutchess, Putnam</td>
</tr>
<tr>
<td>ROCHESTER</td>
<td>Livingston, Monroe, Ontario, Wayne</td>
</tr>
<tr>
<td>CENTRAL RURAL</td>
<td>Cayuga, Cortland, Seneca, Tompkins, Yates</td>
</tr>
<tr>
<td>SYRACUSE</td>
<td>Madison, Onondaga</td>
</tr>
<tr>
<td>UTICA</td>
<td>Herkimer, Jefferson, Lewis, Oneida, Oswego</td>
</tr>
<tr>
<td>WESTCHESTER</td>
<td>Rockland, Westchester</td>
</tr>
<tr>
<td>NORTHERN RURAL</td>
<td>Clinton, Franklin, Hamilton, St. Lawrence</td>
</tr>
<tr>
<td>WESTERN RURAL</td>
<td>Allegany, Genesee, Wyoming</td>
</tr>
</tbody>
</table>

**TN #91-4**

*Approval Date: July 2, 1993*

*Effective Date: January 1, 1991*
NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

1. USING THESE INSTRUCTIONS: These instructions and the training manual should be read before completing the PRI. These instructions should be kept with the PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE PRI ACCURATELY.

2. ANSWER ALL QUESTIONS: Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number should be entered: /9/6/2/1/0/. If there are unused boxes, they should be on the left side of the number as shown in the example.

3. QUALIFIERS: Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered yes. These qualifiers take the following forms:
   ◦ TIME PERIOD - The time period for the questions is the past four weeks, unless stated otherwise. For patients who have been in the facility less than four weeks (that is, new admissions or readmissions), use the time from admission to PRI completion as the time frame.
   ◦ FREQUENCY - The frequency specifies how often something needs to occur to meet the qualifier. For example, respiratory care needs to occur daily for four weeks or the PRI cannot be checked for this patient as receiving this care.
   ◦ DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered “yes” for the patient.
   ◦ EXCLUSIONS - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from respiratory care.

4. ACTIVITIES OF DAILY LIVING: The approach to measuring ADLs is slightly different from the other PRI questions. Measure the ADLs according to how the activity was completed 60% or more of the time during the past four weeks. Read the specific instructions for ADLs to understand the CHANGED CONDITION RULE and other details. PERFORMANCE: Measure what the patient does, rather than what the patient might be capable of doing.

5. CORRECTIONS: Cross out any responses which you wish to change and re-enter clearly to the right of the original response. Example: /3/ 4.

6. Use pen, not pencil.

TN       #99-34                     Approval Date  December 30, 1999
Supersedes TN       #91-25               Effective Date  July 1, 1999
INSTRUCTIONS: PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the 8 character identifier (7 numbers followed by the letter “N”) stated on the facility’s operating certificate. The last character “N” indicates Nursing Facility.

2. SOCIAL SECURITY NUMBER: Your PRIs can not be processed unless this question is accurately entered. Do not leave this question blank, do not enter zero if there is no social security number. Only use the Social Security number that has been specifically designated for the patient and not the spouse of the patient. Only use the number that has been assigned by the federal Social Security Administration. If there is no such number for a patient, a NEW SYSTEM has been developed to enable all facilities in the State to assign a unique ID number to those patients without a Social Security number. If a patient was assigned a computer generated number by the Department, that number should no longer be used. If the patient has no Social Security number, use this method: Enter the first three (3) letters of the patient’s last name (starting to the far left), and then enter the six digits of the patient’s date of birth. Omit the century in the birth date, which will either be a “19” or “18” as in 1930 or 1896. As an example, if a patient named Cheryl Brant has no social security number and was born on May 18, 1913, you would enter: /B/R/A/0/5/0/8/1/3 on the PRI.

3. RESIDENT IS LOCATED: Former HRF Area of Former SNF Area. This question has been revised to reflect the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87). It is imperative that nursing facilities formerly deemed “dual level” complete this section properly.

4. PATIENT NAME: Enter the patient’s name, last name first, in the boxes provided. Enter up to the first 10 letters of the patient’s last name.

6. MEDICAL RECORD NUMBER: Enter the unique number assigned by the facility to identify each patient. It is not the Medicaid, Medicare or Social Security number unless that is the number used by the facility to identify each of its patients.

7. ROOM NUMBER: Enter the numbers and/or letters which identify the patient’s room in the facility.

8. UNIT NUMBER: Enter the one or the two digit number (01-12) assigned by your facility to each nursing unit for the purpose of this data collection.

11. DATE OF INITIAL ADMISSION: Enter the month, day and year the patient (1) entered the present nursing facility. Use the date of the patient’s first admission and not the most recent. If the patient were transferred from another facility, it would be an initial admission to your facility. As another example, consider a patient that was admitted to a hospital from your facility and subsequently loses bed hold. If this patient is eventually readmitted to your facility at the original level of care, use the original admission date to complete this item.

12. MEDICAID NUMBER: Enter these numbers if patient has the coverage available, whether
New York
PRI-3

13. **MEDICARE NUMBER:** or not the coverage is being used. If not, enter only one zero in far right box.

14. **PRIMARY PAYOR:** Enter the one source of coverage which pays for most of the patient’s current nursing home stay. Code “Other” only if the primary payor is not Medicaid or Medicare. (Do not code “Other” for a patient with Medicaid coverage supplemented by Medicare Part B Code Medicaid.) Medicaid pending is to be coded as “Medicaid”, if there is no other primary coverage being used for the patients present stay.

15A. **REASON FOR PRI COMPLETION:** Select the one reason why the PRI is being completed. Responses 3, 4, and 5 under Utilization Review have been eliminated.

**REIMBURSEMENT ASSESSMENT CYCLE:**

Indicate whether this assessment is being completed as a part of a full facility assessment or as part of a quality assessment cycle for new admissions only.

1. **Biannual Full Facility Cycle** - The data collection during which all the patients residing in the facility are assessed. These PRI assessments include patients who were assessed during your previous PRI data collection and any new admissions.

2. **Quarterly New Admission Cycle** - The “new admission only data collection,” involving only patients who were not assessed at their present level of care during your previous full facility data collection are reviewed. This specific PRI data collection occurs three months after your full facility PRI data collection. A new admission may be a new patient from the hospital, community or another nursing facility; or was hospitalized during your previous full facility assessment (regardless of bedhold).

15B. **WAS A PRI SUBMITTED BY YOUR FACILITY FOR THIS PATIENT DURING A PREVIOUS FULL FACILITY AND/ OR NEW ADMIT CYCLE:** Review your facility’s records to determine whether a PRI for reimbursement purposes was ever completed for this patient.

II. **MEDICAL EVENTS**

16. **DECUBITUS LEVEL:** Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

   **Documentation** - For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components:

   • A description of the patient’s decubitus
   • Circumstance or medical condition which led to the decubitus.
   • An active treatment plan.

   December 30, 1999  ____________________________
   Approval Date  ____________________________
   ____________________________
   Effective Date  ____________________________

   __________  Approval Date  _______
   Supersedes TN  ________
   ________  Effective Date  ________
   #99-34  ________  July 1, 1999  ________
   #91-25  ________
New York
PRI-4

Definition LEVELS:

#0 No reddened skin or breakdown
#1 Reddened skin, potential breakdown.
#2 Blushed skin, dusty colored, superficial layer of broken or blistered skin.
#3 Subcutaneous skin is broken down.
#4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.
#5 Patient is a level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a “YES” to be answered for any of these conditions, all of the following qualifiers must be met:

Time Period - Condition must have existed during the past four weeks. (The only exception is to use the past twelve weeks for question 17H, urinary tract infection.

Documentation - Written support exists that the patient has the condition.

Definitions - See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>EXAMPLES OF CAUSES</th>
<th>EXAMPLES OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>17A. COMATOSE:</td>
<td>Brain insult</td>
<td>Total ADL care</td>
</tr>
<tr>
<td></td>
<td>Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days</td>
<td>Intake and output</td>
</tr>
<tr>
<td></td>
<td>Hepatic encephalopathy</td>
<td>Parenteral feeding</td>
</tr>
<tr>
<td></td>
<td>Cerebral vascular accident</td>
<td></td>
</tr>
<tr>
<td>17B. DEHYDRATION:</td>
<td>Fever</td>
<td>Intake &amp; output</td>
</tr>
<tr>
<td></td>
<td>Excessive loss of body fluids requiring immediate medical treatment and ADL care.</td>
<td>Electrolyte lab tests</td>
</tr>
<tr>
<td></td>
<td>Acute Urinary tract infections</td>
<td>Parenteral hydration</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>Nasal Feedings</td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unstable diabetes</td>
<td></td>
</tr>
<tr>
<td>17C. INTERNAL BLEEDING:</td>
<td>Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention</td>
<td>Critical monitoring of vital signs</td>
</tr>
<tr>
<td></td>
<td>Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.</td>
<td>Transfusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of blood pressure elevators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plasma expanders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood likely to be needed every 60 day</td>
</tr>
</tbody>
</table>

TN #99-34 Approval Date December 30, 1999
Supersedes TN #91-25 Effective Date July 1, 1999
### 17D. STASIS ULCER:
Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.

#### Examples of Causes
- Severe edema
- Diabetes
- PVD

#### Examples of Treatments
- Sterile dressing
- Compresses
- Whirlpool
- Leg elevation

### 17E. TERMINALLY ILL:
Professional prognosis (judgement) is that patient is rapidly deteriorating and will likely die within three months.

#### End stages of:
- Carcinoma
- Renal disease
- Cardiac disease

#### Examples of Treatments
- ADL Care
- Social/emotional support

### 17F. CONTRACTURES:
Shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to spasticity, paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.

To qualify as “YES” on the PRI the following qualifiers must be met:

1. The contracture must be documented by a physician, physical therapist or occupational therapist.

2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis.

There does not need to be an active treatment plan to enter “YES” to contractures.
### 17G. DIABETES MELLITUS:
A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.

**Examples of Causes:**
- Destruction/malfunction of the pancreas
- Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus
- Exclude if symptoms are present, but the lab values are negative

**Examples of Treatments:**
- Special diet
- Oral agents
- Insulin
- Exercise
- Antibiotics
- Fluids

---

### 17H. URINARY TRACT INFECTION:
During the past twelve weeks symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q. 29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (e.g., mentally confused or incontinent patients).

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**TN #99-34**            **Approval Date** December 30, 1999
**Supersedes TN #91-25** **Effective Date** July 1, 1999
### New York

**PRI-7**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Examples of Causes</th>
<th>Examples of Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17I. HIV Infection</strong>&lt;br&gt;<strong>Symptomatic:</strong> HIV (Human Immunodeficiency Virus)&lt;br&gt;Infection, Symptomatic: Includes Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection AND a positive finding is documented AND the patient has had symptoms, documented by a physician, nurse practitioner (in conformance with a written practice agreement with a physician), or physician assistant as related to the HIV infection. Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>17J. Accident:</strong> An event resulting in serious bodily harm, such as a fracture, a laceration which requires closure, a second or third degree burn or an injury requiring admission to a hospital. To qualify as “YES” on the PRI the following qualifier must be met: 1. During the past six months serious bodily harm occurred as the result of one or more accidents.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Supersedes TN #91-25**

**Effective Date** July 1, 1999
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**DEFINITION**

17K. **VENTILATOR DEPENDENT:** A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.

All services shall be provided in accordance with Sections 416.13, 711.5 and 713.21 of Chapter V of Title 10 of the *Official Compilation of Codes Rules and Regulations* of the State of New York.

**EXAMPLES OF CAUSES**

**EXAMPLES OF TREATMENTS**

### 18. MEDICAL TREATMENTS:

For a “YES” to be answered for any of these, the following qualifiers must be met:

**Time Period** - Treatment must have been given during the past four weeks in conformance with the frequency requirements cited below and is still be required. For medical treatments having a daily frequency requirement, treatment must be provided every day of the four week period, except for residents newly admitted during the period. For residents newly admitted during the four week period, treatments required daily must have been provided each day from admission to the end of the four week period and documentation must support the seriousness of the condition and the probability that treatment will continue for at least four weeks.

**Frequency** - As specified in the chart below. (The only exception is to use the past twelve weeks for question 18L, catheter.)

**Documentation** - Physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order specifies that treatment should be given and includes frequency as cited below, where appropriate.

**Exclusions** - See chart on next page.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>DEFINITION</td>
<td>SPECIFIC FREQUENCY</td>
<td>EXCLUSIONS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td><strong>18A. TRACHEOSTOMY CARE:</strong> Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.</td>
<td>Daily</td>
<td>Self-care patients</td>
</tr>
<tr>
<td><strong>18b. SUCTIONING:</strong> Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.</td>
<td>Daily</td>
<td>Any tracheostomy Suctioning</td>
</tr>
<tr>
<td><strong>18C. OXYGEN THERAPY:</strong> Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (e.g., cardiopulmonary condition).</td>
<td>Daily</td>
<td>Inhalators Oxygen in room, but not in use</td>
</tr>
<tr>
<td><strong>18D. RESPIRATORY CARE:</strong> Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.</td>
<td>Daily</td>
<td>Suctioning</td>
</tr>
<tr>
<td><strong>18E. NASAL GASTRIC FEEDING:</strong> Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.</td>
<td>None</td>
<td>None Gastrostomy not applicable</td>
</tr>
<tr>
<td><strong>18F. PARENTERAL FEEDING:</strong> Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (e.g., comatose, damaged stomach).</td>
<td>None</td>
<td>None Gastrostomy not applicable</td>
</tr>
<tr>
<td><strong>18G. WOUND CARE:</strong> Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers.</td>
<td>Care has been provided or is professionally judged to be needed for at least 3 consecutive weeks</td>
<td>Decubiti Stasis ulcers Skin tears Feeding tubes</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>SPECIFIC FREQUENCY</th>
<th>EXCLUSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18H. CHEMOTHERAPY:</strong> Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician, nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant when the physician assistant’s order is appropriately cosigned. (Patient may have to go to a hospital for treatment.)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>18I. TRANSFUSIONS:</strong> Introduction of whole blood or blood components directly into the blood stream. (Patients may have to go to a hospital for treatment.)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>18J. DIALYSIS:</strong> The process of separating components, as in kidney dialysis (e.g., renal failures, leukemia, blood dyscrasia). Patient may have to go to a hospital for treatment.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>18K. BOWEL AND/ OR BLADDER REHABILITATION:</strong> The goal of this treatment to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (i.e., usually not longer than six weeks). NOT all patients at level 5 under Toileting Q.22 may be a “YES” with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:</td>
<td>Very specific And unique for each patient</td>
<td>Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions</td>
</tr>
</tbody>
</table>

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**DEFINITION** | **SPECIFIC FREQUENCY** | **EXCLUSIONS**
---|---|---
**Bladder rehabilitation:** Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental and physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.

**Bowel rehabilitation:** A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (e.g., bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.

**18L CATHETER:** During the past twelve weeks, an indwelling or external catheter has been needed. Indwelling catheter has been used for any duration during the past twelve weeks. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past twelve weeks. A physician order is required for an indwelling catheter; for an external catheter a physician order is not required.

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## DEFINITION

**18M. PHYSICAL RESTRAINTS:**
A physical device used to restrict resident movement. Physical restraints include belts, vests, cuffs, mitts, jackets harnesses and geriatric chairs.

## SPECIFIC FREQUENCY

At least two continuous Daytime hours for at least 14 days during the past four weeks.

## EXCLUSIONS

Exclude all of following:

- Medication use for the sole purpose of modifying residents behavior
- Application only at night
- Application for less than two continuous daytime hours for 14 days
- Devices which residents can release/remove such as, Velcro seatbelts on wheelchairs
- Residents who are bed bound
- Side rails, locked doors/gates, domes

To Qualify as “YES” on the PRI the following qualifiers must be met:

1. The restraint must have been applied for at least two continuous daytime hours for at least 14 days during the past four weeks. Daytime includes the time from when the resident gets up in the morning to when the resident goes to bed at night.

2. An assessment of need for the physical restraint must be written by an M.D. or R.N.

3. The comprehensive care plan based on the assessment must include a written physician’s order and specific nursing interventions regarding use of the physical restraint.

**NEW ADMISSIONS:** If a patient is a new admission and will require the use of a physical restraint for at least two continuous daytime hours for at least 14 days as specified by the physician order, then enter “YES” on the PRI.

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<thead>
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III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING

Use the following qualifiers in answering each ADL question:

**Time Period** - Past four weeks.

**Frequency** - Assess how the patient completed each ADL 60% or more of the time performed (since ADL status may fluctuate during the day or over the past four weeks.)

**CHANGED CONDITION RULE:** When a patient’s ADL has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.

**Definitions** -

- **SUPERVISION** means verbal encouragement and observation, not physical hands-on care.
- **ASSISTANCE** means physical hands-on care.
- **INTERMITTENT** means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.
- **CONSTANT** means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

Note how these terms are used together in the ADLs. For example there is intermittent supervision and intermittent assistance.

**CLARIFICATION OF ADL RESPONSES**

19. **EATING:**

- #3 “Requires continual help...” means that the patient requires a staff person’s continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

- #5 “Tube or parenteral feeding...” means that all food and drink is given by nursing staff through the means specified.

20. **MOBILITY:**

- #3 “Walks with constant supervision and/or assistance...” may be required if the patient cannot

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maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 “Requires two people...” may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient needs the help of two people to transfer.

#5 “Bedfast...” may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 “Continent....Requires no or intermittent supervision” and #2 “...and/or assistance” can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 “Continent...Requires constant supervision/total assistance...” refers to a patient who may not be able to balance him/herself and transfer, has contractures, has fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 “Incontinent...Does not use a bathroom” refers to a patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 “Incontinent...Taken to a Bathroom...” refers to a patient who is on a formal toileting schedule, as documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A Patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel incontinence.
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Example 2:

The patient requires intermittent supervision for bowel function (level 2) and is taken to the toilet every two hours as part of a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

IV. BEHAVIORS - VERBAL DISRUPTION; PHYSICAL AGGRESSION; DISRUPTIVE, INFANTILE/SOCIALLY INAPPROPRIATE BEHAVIOR; AND HALLUCINATIONS

The following qualifiers must be met:

Time Period - Past four weeks.

Frequency - As stated in the responses to each behavioral question.

Documentation - To qualify a patient as LEVEL 4 or to qualify the patient as a “YES” to HALLUCINATIONS, the following conditions must be met:

- Active treatment plan for the behavioral problem must be in current use.

- Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. The problem addressed by this assessment must still be exhibited by the patient.
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PRI-16

Definitions - The terms used on the PRI should be interpreted only as they are defined below:

- **PATIENT'S BEHAVIOR:** Measure it as displayed with the behavior modification and treatment plan in effect during the past four weeks.

- **DISRUPTION:** Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.

- **NONDISRUPTION:** Verbal outbursts and/or physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.

- **UNPREDICTABLE BEHAVIOR:** The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern.

- **PREDICTABLE BEHAVIOR:** Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and can plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

**CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS**

23. **VERBAL DISRUPTION:** Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.

24. **PHYSICAL AGGRESSION:** Note that the definition states “with intent for injury.”

25. **DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:**
Note that the definition states this behavior is physical and creates disruption. EXCLUDE the following behaviors:

- Verbal outbursts
- Social withdrawal
- Hoarding
- Paranoia

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26. **HALLUCINATIONS:** For a “YES” response, the hallucinations must occur at least once per week during the past four weeks, in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment.

V. **SPECIALIZED SERVICES**

27. **PHYSICAL AND OCCUPATIONAL THERAPIES:**

° For each therapy these three types of information will be entered on the PRI; “Level”, “Days” and “Time” (hour and minutes).

° For a patient not receiving a therapy at all, the “Level” will always be entered in the answer key as #1 (“does not receive”), the “Days” will be entered 0 (zero) and the “Time” will be 0 (zero).

° Use the chart on the following page to understand the qualifiers for each of the three types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART THAT FOLLOWS FOR THE SPECIFIC QUALIFIERS.
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27. **LEVEL QUESTION:** **QUALIFIERS (see level 4 below)**

<table>
<thead>
<tr>
<th>QUALIFIERS FOR LEVEL</th>
<th>MAINTENANCE THERAPY= LEVEL 2</th>
<th>RESTORATIVE THERAPY= LEVEL 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL/ADL ABILITY</td>
<td>None. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement.</td>
<td>There is positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.</td>
</tr>
<tr>
<td>PHYSICIAN ORDER, NURSE PRACTITIONER ORDER (IN CONFORMANCE WITH A WRITTEN PRACTICE AGREEMENT WITH A PHYSICIAN), OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER</td>
<td>Yes</td>
<td>Yes, monthly</td>
</tr>
<tr>
<td>PROGRAM DESIGN AND EVALUATION QUALIFIER</td>
<td>Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.</td>
<td>Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.</td>
</tr>
<tr>
<td>TIME PERIOD QUALIFIER</td>
<td>Treatments have been provided during the past four weeks.</td>
<td>Treatments have been provided during the past four weeks.</td>
</tr>
</tbody>
</table>

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27. **LEVEL QUESTION:** **QUALIFIERS (see level 4 below)**

<table>
<thead>
<tr>
<th>QUALIFIERS FOR LEVEL</th>
<th>MAINTENANCE THERAPY= LEVEL 2</th>
<th>RESTORATIVE THERAPY= LEVEL 3</th>
</tr>
</thead>
</table>
| NEW ADMISSION QUALIFIER | Not Applicable | New admissions of less than four weeks can be marked for restorative therapy if:
- There is a physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order for therapy and patient is receiving it.
- The licensed therapist has documented in the care/plan that therapy is needed for at least 4 weeks.
- A new admission includes readmission to a residential health care facility.

* After completion of the “Level” question, proceed to the separate “Days” and “Time” qualifiers on the next page.

** QUALIFIERS NOT MET = LEVEL 4
ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS FOR LEVELS 2 OR 3 IS NOT MET.

27. **DAYS AND TIME PER WEEK QUESTION: QUALIFIERS**

<table>
<thead>
<tr>
<th>QUALIFIERS FOR DAYS AND TIME*</th>
<th>MAINTENANCE THERAPY (i.e., level 2 or 4 under “Level” question)</th>
<th>RESTORATIVE THERAPY (i.e., If level 3 or 4 under “Level” question)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF THERAPY SESSION</td>
<td>Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).</td>
<td>Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).</td>
</tr>
</tbody>
</table>

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| SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY) | A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy. | A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides). |

* QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THE QUALIFIERS UNDER EACH LEVEL OF THERAPY.

28. **NUMBER OF PHYSICIAN VISITS:** Enter “0” (zero) unless the patient needs qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or a physician assistant visits that meet the physician, nurse practitioner, or physician assistant visit qualifiers.

   o **PATIENT TYPE/NEED QUALIFIERS:** The patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).

   o **PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT VISIT QUALIFIER:** If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits during the past four weeks that meet the following qualifications:

      o A visit qualifies only if there is physician, nurse practitioner, or physician assistant documentation that she/he has personally examined the patient to address the pertinent medical problem. The physician, nurse practitioner, or physician assistant must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (e.g., change medications, renew treatment orders, nursing orders, order lab tests).

      o Do not include phone calls as a visit nor visits which could have been accomplished over the phone.

      o A visit qualifies whether it is on-site or off-site, as long as the patient is not an inpatient in a hospital/other facility.

29. **MEDIICATIONS**

   A. **Monthly average number for all medications ordered:** Enter the monthly average number of different medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months determine the monthly

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average number of medications ordered based on the number of months since admission. The average should include the total number of ordered medications whether or not they were administered: (PRN medications; injectables, ointments, creams, ophthalmics, short-term antibiotic regimens and over-the-counter medications, etc.)

B. Monthly average number of psychoactive medications ordered: Enter the monthly average number of psychoactive medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months, determine the monthly average psychoactive medications ordered based on the number of months since admission. The average should include all ordered psychoactive medications whether or not they were actually administered.

A “psychoactive” medication is defined as a medication that is intended to affect mental and/or physical processes, namely to sedate, stimulate, or otherwise change mood, thinking or behavior.

The following are classes of psychoactive medications with several examples listed in each:

- Antidepressants - Amitriptyline (Elavil); Imipramine (Tofranil); Doxepin (Sinequan); Tranylcpromine (Parnate); Phenelzine (Nardil)
- Anticholinergics - Benztropine (Cogentin); Trihexyphenidyl (Artane)
- Antihistamines - Diphenhydramine (Benadryl); Hydroxyzine (Atarax)
- Anxiolytics - Chlordiazepoxide (Librium); Diazepam (Valium)
- Cerebral Stimulants - Methylphenidate (Ritalin); Amphetamines (Benzedrine)
- Neuroleptics - Phenothiazines; Thiothixene (Navane); Haloperidol (Haldol); Chlorpromazine (Thorazine); Thioridazine (Mellaril)
- Somnifacients - Barbituates (Nembutal); Temazepam (Restoril); Glutethimide (Doriden); Flurazepam (Dalmane)

VI. DIAGNOSIS

30. PRIMARY MEDICAL PROBLEM: Follow the guideline stated below when answering this question.

- NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks. A review of the medical record for nursing and physician, nurse practitioner, or physician assistant notes during the past four weeks may be necessary.

- JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.
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- **ICD-9** Refer to the ICD-9 Codes for Common Diagnoses attached at the end of these instructions for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.

- **NO ICD-9 NUMBER:** Enter “0” (zero) in the far right box if no ICD-9 number can be found for the patient’s primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

- **NOTE:** If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042.044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV infection.

### 31. QUALIFIED ASSESSOR NUMBER:

The qualified assessor who is attesting to the accuracy of the assessment must sign the completed form and enter the assessor Identification Number which was assigned at an approved N.Y.S. Department of Health Training Program.

Since the PRI is completed and submitted for the purposes of a reimbursement assessment cycle, the certified assessor must have actually completed the patient assessment, utilizing medical records and/or observations or interviews of the patient. This should be indicated by checking the YES box.

### 38. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups.

1. **WHITE**: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.
2. **WHITE/HISPANIC**: A person who meets the definition of both White and Hispanic (See Hispanic Below)
3. **BLACK**: A person having origins in any of the Black racial groups of Africa.
4. **BLACK/HISPANIC**: A person who meets the definition of both black and Hispanic (see below).
5. **ASIAN OR PACIFIC ISLANDER**: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
6. **ASIAN OR PACIFIC ISLAND/HISPANIC**: A person who meets the definition of both Asian or Pacific Islander and Hispanic (see below).
New York
PRI-23

7. **AMERICAN INDIAN or ALASKAN NATIVE:** A person having origins in any of the original peoples of North American and who maintains tribal affiliation or community recognition.

8. **AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC:** A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. **OTHER:** Other groups not included in previous categories.

**HISPANIC:** A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.
I. ADMINISTRATIVE DATA

1 OPERATING CERTIFICATE NUMBER

2 SOCIAL SECURITY NUMBER

3 RESIDENT IS LOCATED:
   1 = Former HRF Area
   2 = Former SNF Area

4 PATIENT NAME (PLEASE PRINT)

5 DATE OF PRI COMPLETION [19]

6 MEDICAL RECORD NUMBER

7 ROOM NUMBER

8 UNIT NUMBER (Assigned by RUG II Project)

9 DATE OF BIRTH

10 SEX
   1 = Male
   2 = Female

II. MEDICAL EVENTS

16 DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS

17 MEDICAL CONDITIONS: DURING THE PAST FOUR WEEKS, READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS: 1 = Yes 2 = No
   A. Comatose
   B. Dehydration
   C. Internal Bleeding
   D. Stasis Ulcer
   E. Terminally Ill
   F. Contractures
   G. Diabetes Mellitus
   H. Urinary Tract Infection
   I. HIV Infection Symptomatic
   J. Accident
   K. Ventilator Dependent
   L. Chemotherapy
   M. Dialysis
   N. Dialysis
   O. Transfusion
   P. Respiratory Care
   Q. Suctioning

18 MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR QUALIFIERS: 1 = Yes 2 = No
   A. Trachestomy Care / Suctioning
   B. Suctioning - General
   C. Oxygen
   D. Respiratory Care
   E. Nasal Gastric Feeding
   F. Parenteral Feeding
   G. Wound Care
   H. Chemotherapy
   I. Transfusion
   J. Dialysis
   K. Bowel and Bladder Rehabilitation
   L. Catheter (Indwelling or External)
   M. Physical Therapy (Daytime Only)
   N. Physical Therapy (Indwelling or External)

Supersedes TN 89-4

Approval Date July 11, 1994

Effective Date April 1, 1991
### III. ACTIVITIES OF DAILY LIVING (ADLs)

#### 19 EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEIPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE)

- **1** = Feeds self without supervision or physical assistance. May use adaptive equipment.
- **2** = Requires intermittent supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, butting bread or opening milk can.
- **3** = Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
- **4** = Totally fed by hand; patient does not manually participate.
- **5** = Tube or parenteral feeding for primary intake of food (Not just for supplemental nourishments)

#### 20 MOBILITY: HOW THE PATIENT MOVES ABOUT

- **1** = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
- **2** = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
- **3** = Walks with constant one-to-one supervision and/or constant physical assistance.
- **4** = Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
- **5** = Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

#### 21 TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING (EXCLUDES TRANSFERS TO/FROM BATH AND TOILET)

- **1** = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
- **2** = Requires intermittent supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
- **3** = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
- **4** = Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
- **5** = Cannot and is not gotten out of bed.

#### 22 TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES

- **1** = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
- **2** = Requires intermittent supervision for safety or encouragement, or minor physical assistance (for example, clothes adjustment or washing hands).
- **3** = Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (i.e., colostomy, ileostomy, urinary catheter).
- **4** = Incontinent of bowel and/or bladder and is not taken to a bathroom.
- **5** = Incontinent of bowel and/or bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

### IV. BEHAVIORS

#### 23 VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC

- **1** = None during the past four weeks. (May have verbal outbursts which are not disruptive.)
- **2** = Verbal disruption one to three times during the past four weeks.
- **3** = Short-lived disruption at least once per week during the past four weeks or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing).
- **4** = Unpredictable, recurring verbal disruption at least once per week for no foretold reason.
- **5** = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

#### 24 PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY, DANGEROUS MANEUVERS WITH WHEELCHAIR

- **1** = None during the past four weeks.
- **2** = Unpredictable aggression during the past four weeks (whether mild or extreme), but not at least once per week.
- **3** = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
- **4** = Unpredictable, recurring aggression at least once per week during the past four weeks for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
- **5** = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

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**TN 91-25**

**Approval Date** July 11, 1994

**Effective Date** April 1, 1991
25 DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES DISRUPTION WITH OTHERS (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESelf TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.
1 = No infantile or socially inappropriate behavior, whether or not disruptive, during the past four weeks.
2 = Displays this behavior, but is not disruptive to others, (for example, rocking in place).
3 = Disruptive behavior during the past four weeks, but not at least once per week.
4 = Disruptive behavior at least once per week during the past four weeks.
5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26 HALLUCINATIONS: EXPERIENCED AT LEAST ONCE PER WEEK DURING THE PAST FOUR WEEKS. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.
1 = Yes
2 = No
3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

V. SPECIALIZED SERVICES

27 PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) PER WEEK.

A. Physical Therapy (P.T.)

B. Occupational Therapy (O.T.)

LEVEL
1 = Does not receive.
2 = Maintenance Program - Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3 = Restorative Therapy - Requires and is currently receiving physical and/or occupational therapy for four or more consecutive weeks.
4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, restorative therapy given or to be given for only two weeks.)

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) PER WEEK THAT EACH THERAPY IS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28 NUMBER OF PHYSICIAN VISITS: ENTER ONLY THE NUMBER OF VISITS DURING THE PAST FOUR WEEKS THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. EXCLUDE VISITS BY PSYCHIATRISTS.

29 MEDICATIONS
A. Monthly average number of medications ordered.
B. Monthly average number of psychoactive medications ordered.

DIAGNOSIS

30 PRIMARY PROBLEM: THE MEDICAL CONDITION (ICD-9 CODE) REQUIRING THE LARGEST AMOUNT OF NURSING TIME. THIS MAY NOT BE THE ADMISSION DIAGNOSIS BY THE PHYSICIAN.

ICD-9 Code of medical problem...

If code cannot be located, print medical name here:
### RACE/ETHNIC GROUP

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>1</td>
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<td>2</td>
<td>White/Hispanic</td>
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<td>8</td>
<td>American Indian or Alaskan Native/Hispanic</td>
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<td>9</td>
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**TN 91-25**  
**Approval Date** July 11, 1994  
**Effective Date** April 1, 1991  
**Supersedes TN 89-4**
Specialized programs for residents requiring behavioral interventions.

(a) General.

(1) Specialized programs for residents requiring behavioral interventions ("the program") shall mean a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning.

(2) The program shall serve residents who are a danger to self or others and who display violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. This behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(3) The program shall be located in a nursing unit which is specifically designated for this purpose and physically separate from other facility residents. The unit shall be designed in accordance with the provisions as set forth in Subpart 713-2 of this Title.

(4) The facility shall have a written agreement with an inpatient psychiatric facility licensed under the Mental Hygiene Law to provide for inpatient admissions and consultative services as needed.

(5) In addition to the implementation of the quality assessment and assurance plan for this program as required by section 415.27 of this Part, the facility shall participate with the commissioner or his or her designee in a review of the program and resident outcomes. The factors to be reviewed shall include but not be limited to a review of admissions, the care and services provided, continued stays, and discharge planning. The facility shall furnish records, reports and data in a format as requested by the commissioner or his or her designee and shall make available for participation in the review, as necessary, members of the interdisciplinary resident care team.

(b) Admission.

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September 8, 1998

Supersedes TN NEW

January 1, 1994 March 16, 1994
New York

2

(1) The facility shall develop written admission criteria which are applied to each prospective resident. As a minimum, for residents admitted to the program, there shall be documented evidence in the resident’s medical record that:

(i) the resident’s behavior is dangerous to him or herself or to others;

(ii) the resident’s behavior has been assessed according to severity and intensity;

(iii) within 30 days prior to the date of application to the program, the resident has displayed:

(a) verbal aggression which constitutes a clear threat of violence towards others or self; or

(b) physical aggression which is assaultive or combative and causes or is likely to cause harm to others or self; or

(c) persistently regressive or socially inappropriate behavior which causes actual harm.

(iv) various alternative interventions have been tried and found to be unsuccessful;

(v) the resident cannot be managed in a less restrictive setting; and

(vi) the prospective resident has the ability to benefit from such a program.

(2) Prior to admission, the facility shall fully inform the resident and the resident’s designated representative both orally and in writing about the program plan and the policies and procedures governing resident care in this unit. Such policies and procedures shall at a minimum include a statement that the resident’s right to leave or be discharged from the program shall be consistent with the rights of other residents in the facility.

(c) Assessment and Care Planning.

(1) The interdisciplinary team shall have determined preliminary approaches and interventions to the severe behavior and recorded them in the resident care plan prior to admission to the unit.

(2) Each resident’s care plan shall include care and services which are therapeutically beneficial for the resident and selected by the resident

TN  #94-04 Approval Date September 8, 1998
Supersedes TN  NEW Effective Date January 1, 1994 March 16, 1994
when able and as appropriate. The care plan shall be prepared by the interdisciplinary team, as described in section 415.11 of this Part, which shall include psychiatrist, psychologist, or social worker participation as appropriate to the needs of the resident.

(3) Based on the resident’s response to therapeutic interventions, the care plan including the discharge plan shall be reviewed and modified, as needed, but at least once a month.

(d) Discharge.

(1) A proposed discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident and his or her family, as appropriate, and any outside agency or resource that will be involved with the resident following discharge.

(2) When the interdisciplinary team determines that discharge of a resident to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the resident, family and caregiver in the transition to the new setting. Program staff shall be available post-discharge to act as a continuing resource for the resident, family or caregiver.

(3) The resident shall be discharged to a less restrictive setting when he or she no longer meets the admission criteria for this program as stated in subdivision (b) of this section.

(4) A resident discharged to an acute care facility shall be accompanied by a member of the program’s direct care staff during transfer. He or she shall be given priority readmission status to the program as his or her condition may warrant.

(5) There shall be a written transfer agreement with any nursing home of origin which allows for priority readmission to such transferring facility when a resident is capable of a safe discharge.

(e) Resident services and staffing requirements.

(1) The program shall consist of a variety of medical, behavioral, counseling, recreational, exercise, and other services to help the resident control or redirect his or her behavior through interventions carried out in a therapeutic environment provided on-site.

(2) There shall be dedicated staffing in sufficient numbers to provide for the direct services in the unit and to allow for small group activities and for one-on-one care.

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(3) The unit shall be managed by a program coordinator who is a licensed or certified health care professional with previous formal education, training and experience in the administration of a program concerned with the care and management of individuals with severe behavioral problems. The program coordinator shall be responsible for the operation and oversight of the program. Other responsibilities of the program coordinator shall include:

(i) the planning for and coordination of direct care and services;

(ii) developing and implementing inservice and continuing education programs, in collaboration with the interdisciplinary team, for all staff in contact with or working with these residents;

(iii) participation in the facility's decisions regarding resident care and services that affect the operation of the unit; and

(iv) ensuring the development and implementation of a program plan and policies and procedures specific to this program.

(4) A physician who has specialized training and experience in the care of individuals with severe behavioral or neuropsychiatric conditions shall be responsible for the medical direction and medical oversight of this program and shall assist with the development and evaluation of policies and procedures governing the provision of medical services in this unit.

(5) A qualified specialist in psychiatry who has clinical experience in behavioral medicine and experience working with individuals who are neurologically impaired shall be available on staff or a consulting basis to the residents and to the program.

(6) A clinical psychologist with at least one year of training in neuropsychology shall be available on staff or a consulting basis to the residents and to the program.

(7) A social worker with experience associated with severe behavioral conditions shall be available either on staff or a consulting basis to work with the residents, staff and family as needed.

(8) Other than the program coordinator, there shall be at least one registered professional nurse deployed on each shift in this unit who has training and experience in caring for individuals with severe behaviors.

(9) A full-time therapeutic recreation specialist shall be responsible
for the therapeutic recreation program.

(10) The facility shall ensure that all staff assigned to the direct care of the residents have pertinent experience or have received training in the care and management of individuals with severe behaviors.

(11) The facility shall ensure that educational programs are conducted for staff not providing direct care but who come in contact with these residents on a regular basis such as housekeeping and dietary aides. The programs shall familiarize staff with the program and the residents.

Volume: 10C
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of New York

Methods and Standards for Establishing Payment Rates

Intermediate Care Facilities for the Mentally Retarded

TN #99-07 Approval Date June 6, 2001
Supersedes TN NEW Effective Date January 1, 1999 April 1, 1999 July 1, 1999
Rate setting and financial reporting for intermediate care facilities for persons with developmental disabilities (ICF/DD). This section is effective [January 1, 1999] January 1, 2003 for under thirty one bed non-state operated facilities classified as Region II and III facilities, [April 1, 1999] April 1, 2003 for all under thirty one bed State operated facilities, and [July 1, 1999] July 1, 2003 for under thirty one bed non-state operated facilities classified as Region I facilities.

(a) Definitions applicable to this section.

(1) Intermediate Care Facilities for the Developmentally Disabled.

For the purpose of this section: “Provider” shall mean the individual, corporation, partnership or other organization to which the OMRDD has issued an operating certificate, to operate a facility, or a State owned developmental center and to which the New York State Department of Health has issued a Medicaid provider agreement for such facility. For the purpose of this section: “Facility” shall mean

(i) (a) that program and site for which OMRDD has issued an operating certificate to operate as an intermediate care facility for the developmentally disabled or

(b) a development center which consists of institutional beds, including those beds in Small Resident Units operated by a Developmental Disabilities Services Office (DDSO), but excluding those beds in Small Residential Units operated by a DDSO whose developmental center has closed or is schedule to close, and

(ii) for which the New York State Department of Health has issued a Medicaid provider agreement.

(2) For the purposes of this section:

(i) A Region I facility is a facility which is located in Region I (other than a facility located in Region I which has been designated or elected to a Region II and III reporting cycle), or a facility which is located in Region II or III which has been designated or elected to a Region I reporting cycle in accordance with 14 NYCRR subpart 635-4.

(ii) A Region II or III facility is a facility which is located in Region II or III (other than a facility located in Region II or III which has been designated or elected to a Region I reporting cycle), or a facility which is located in Region I which has been designated or elected to a Region II or III reporting cycle in accordance with 14 NYCRR subpart 635-4.

(3) Region - The geographic regions are:

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<td>March 11, 2004</td>
<td>January 1, 2003</td>
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New York

(i) Region I (NYC) is New York City and includes the counties of New York, Bronx, Kings, Queens, and Richmond.

(ii) Region II (NYC Suburban) includes the counties of Putnam, Rockland, Nassau, Suffolk and Westchester.

(iii) Region III (Upstate New York) includes all other counties in New York State.

(4) Newly certified facility is an under thirty-one bed facility which has been in operation for less than five four full years as of the start of a rate cycle, or an over thirty bed facility which has been in operation for less than two full years as of the start of a rate cycle.

(5) Operating costs are allowable costs which are non-capital in nature and which are allowable as specified in paragraph s (f)(1) and (2) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary. For purposes of this section, this includes day treatment, day service, transportation and regional FTE add-ons.

(6) Capital Costs are allowable costs as specified in paragraph (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary.

(7) Reimbursable Costs are allowable costs, either operating or capital, adjusted per the application of this section, and prior to the application of the trend factor.

(8) Total reimbursable costs are reimbursable costs trended, as appropriate, per the application of subdivision (g) of this section.

(b) Reporting requirements. Each provider shall submit reports in accordance with the requirements of 14 NYCRR subpart 635-4.

(c) Rate setting.

(1) Units of service.

(i) A unit of service is the unit of measure denoting lodging and services rendered to one consumer between the census-taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One unit of service shall be counted if the consumer is discharged on the same day the consumer is admitted, providing there was an expectation that the admission would have at least a 24-hour duration.

(ii) Reserve bed days determined in accordance with 18 NYCRR section 505.9 and subdivision (i) of this section are units of service.

TN #03-36 Approval Date March 11, 2004
Supersedes TN #00-47 #99-07 Effective Date January 1, 2003
(2) **Rate cycle.**

(i) For facilities of over thirty beds, the rate cycle is comprised of two twelve month rate periods.

(ii) For facilities of under thirty-one beds the rate cycle is comprised of [three twelve month rate periods except that the rate cycles beginning January 1, 1999, April 1, 1999 and July 1, 1999 shall consist of four twelve month rate periods] a base period and subsequent period or periods. 

[(iii) This rate cycle is divided into a base period and a subsequent period or periods.]

(a) The base period is the first twelve month period of the rate cycle.

(1) The base period for under thirty one bed non-state operated facilities is from January 1 to December 31 for Region II or III facilities. The first base period for non-state operated facilities begins January 1, 1988 for over thirty bed Region II or III facilities. The [first] base period for non-state operated under thirty one bed facilities begins [January 1, 1999] January 1, 2003 for under thirty-one bed Region II or III facilities.

(2) The base period for under thirty one bed non-state operated facilities is from July 1 to June 30 for region I facilities. The first base period for non-state operated facilities begins July 1, 1988 for over thirty bed Region I facilities [, and July 1, 1999]. The base period for non-state operated facilities begins July 1, 2003 for under thirty-one bed Region I facilities.

(3) For state operated facilities of under 31 beds, regardless of region, the [first] base period shall be [April 1, 1999 to March 31, 2000] April 1, 2003 to March 31, 2004 and shall remain April 1 to March 31 for every rate cycle thereafter. For state operated facilities of more than 30 beds and developmental centers, regardless of region, the first base period shall be April 1, 1988 to March 31, 1989 and shall remain April 1 to March 31 for every rate cycle thereafter.

(b) The subsequent period for over thirty bed facilities is the second twelve month period of the rate cycle. The subsequent periods for under thirty-one bed facilities are the [second and third] subsequent twelve month periods of the rate cycle. [For the rate cycles beginning January 1, 1999, April 1, 1999 and July 1, 1999 there shall be additional]
subsequent period of January 1, 2002 to December 31, 2002; April 1, 2002 to March 31, 2003; and July 1, 2002 to June 30, 2003 for under 31 bed facilities.

(1) The subsequent period for non-state operated facilities is from January 1 to December 31 for Region II or III facilities. The first subsequent period begins January 1, 1989 for non-state operated over thirty bed Region II or III facilities. The first subsequent period for non-state operated facilities begins [January 1, 2000] January 1, 2004 for under thirty-one bed Region II or III facilities.

(2) The subsequent period for non-state operated facilities is from July 1 to June 30 for Region I facilities. The first subsequent period for non-state operated facilities begins July 1, 1989 for over thirty bed Region I facilities. The first subsequent period for non-state operated facilities begins [July 1, 2000] July 1, 2004 for under thirty-one bed Region I facilities.

(3) For state operated facilities of less than 31 beds, regardless of region, the first subsequent period begins [April 1, 2000] April 1, 2004 and shall remain April to March for every rate cycle thereafter. For developmental centers and state operated facilities over 30 beds, regardless of region, the first subsequent period shall be April 1, 1989 to March 31, 1990 and shall remain April 1 to March 31 for every rate cycle thereafter.

(3) Computation of Rates (General).

(i) All rates shall not be final unless approved by the Director of the Division of the Budget.

(ii) The commissioner may make adjustments to rates calculated in accordance with this section based upon the allowability of costs as determined by subdivision (f) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary. In addition, costs may be reallocated and adjusted following a desk audit of cost reports.
(a) The desk audit will examine the allocation of costs and OMRDD will reallocate unidentified and improperly classified costs, if any, to appropriate cost categories.

(b) The desk audit will examine base year costs against both the prior and subsequent years’ costs. OMRDD will determine if costs are recurring, or are atypical and/or expended only in the base year.

(1) If OMRDD determines that base year costs for a facility are recurring, for the base periods beginning January 1, 2003, April 1, 2003 or July 1, 2003, the methodology described in this section will apply.

(2) If OMRDD determines that base year costs for a facility are atypical and/or were expended only in the base year, OMRDD will expand the desk audit. OMRDD may make adjustments to base year costs so that such costs represent typical and recurring costs.

(3) For a facility whose base year costs are subject to an expanded desk audit per subclause (b)(2) of this subparagraph, OMRDD shall continue the rate in effect on December 31, 2002, March 31, 2003 or June 30, 2003, and, if applicable, trended to 2003 or 2003-2004 dollars, until OMRDD completes the desk audit. For Region II and III facilities, OMRDD shall notify the provider by December 1, 2002 if the December 31, 2002 rate shall continue. For Region I facilities, OMRDD shall notify the provider by June 1, 2003 if the June 30, 2003 rate shall continue. For all State operated facilities, OMRDD shall notify the provider by March 1, 2003 if the March 31, 2003 rate shall continue. Upon OMRDD’s completion of the expanded desk audit, for the base periods beginning January 1, 2003, April 1, 2003 or July 1, 2003, the methodology described in this section will apply.
(c) **Administrative review of expanded desk audits shall be in accordance with subdivision 635-4.6(b) of 14 NYCRR**

The commissioner may also make adjustments based on errors which occurred in the computation of the rate, changes in certified capacity, changes in payment for real property which have the prior approval of the commissioner and the Director of the Division of the Budget, or changes based upon previously determined final audit findings. If a facility has undergone a change in certified capacity, the commissioner may:

(a) request the facility to submit a budget report subject to 14 NYCRR subpart 635-4; or

(b) request the facility to submit incremental/decremental cost data which is associated with the capacity change.

(c) Utilizing the submitted incremental/decremental data or budget report, OMRDD shall make the appropriate upward or downward adjustment in a facility's rate; or

(d) continue the then existing rate for the remainder of the subject rate period in those instances where the commissioner has determined that the facility is operating at a loss for the rate period in question and adjusting the current rate would further increase such loss, or the facility is operating at a surplus for the rate period in question and adjusting the rate would further increase such surplus.

[(iii)] [(iv)] Rate adjustments as described in subparagraph (ii) of this paragraph will be limited to those adjustments which will result in an annual increase or decrease in reimbursement of $1,000 or more.

[(iv)] [(v)] Notwithstanding any other provisions of this section, for over thirty bed facilities the reimbursable operating costs contained in the rates shall be computed as follows.

(a) For over thirty bed facilities other than developmental centers, OMRDD shall determine the total reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, and day training services) included in the payment rate in effect on December 31, March 31 or June 30 of the immediately preceding rate period applicable to that facility.

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**TN #03-36** Approval Date March 11, 2004
Supersedes TN NEW Effective Date January 1, 2003
The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor calculated in subdivision (g) of this section and may be adjusted for appropriate appeals. Education and related services will be updated in accordance with clause (4)(ix)[(c)](f) of this subdivision. To determine the capital cost portion of the subsequent period rate, OMRDD shall review the component relating to capital costs for substantial material changes and, if said changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, make corresponding adjustments in computing the subsequent period rate.

(b) (i) For developmental centers, the statewide average rate for the period from April 1 to March 31 shall be calculated as follows. The total reimbursable operating costs contained in the payment rate in effect on the preceding March 31, with the exception of education and related service costs, after the adjustment for the latest available
projected number of client days, shall be increased by the trend factor described in subdivision (g) and increased by an amount for education and related services in accordance with clause 4(ix)(c)(f). In addition, if substantial, material changes that conform to the requirements of subdivision (h) are projected for the rate year these changes may be incorporated into the computation of the April 1 to March 31 period rate without an appeal being filed. OMRDD shall perform a rate year end volume variance adjustment to the April 1 to March 31 period rate for developmental centers by taking into account recalculated operating costs based upon a fixed to variable ratio of 64 percent fixed/36 percent variable, and actual client days.

(ii) In addition, to encourage the closure of developmental centers, the commissioner will allow the net variable costs associated with the planned reduction of the developmental centers to become part of the operating costs of remaining like facilities. Net variable costs are total variable costs less the sum of that portion of the variable costs that become part of the operating costs of new state operated programs and services and the projected personal service attrition savings, as determined using historical attrition trends over the preceding three years, that occur at the developmental centers. The commissioner will allow reimbursement of these net variable costs as part of a plan to close the developmental centers. This incentive plan would provide for the reimbursement in total of net variable costs in the developmental centers without adjustment or offsets.

(a) For each rate period, the net variable cost will be calculated based on the number of reduced beds planned for that rate period. 100 percent reimbursement of the net variable cost will be allowed for that rate period.

(b) Under this incentive plan eligible costs will be limited to personal service costs including fringe benefits and overhead and other than personal service costs excluding capital costs.

(c) To determine the capital cost portion of the rate, OMRDD shall review the component relating to capital costs for substantial material changes and if said changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, make corresponding adjustments in computing the subsequent period rate.
The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

(a) \[ \text{trended reimbursable operating costs} + \text{untrended reimbursable operating costs} + \text{reimbursable capital costs} = \text{total reimbursable costs}. \]

(b) \[ \frac{\text{total reimbursable costs}}{\text{units of service}} = \text{the rate}. \]

If OMRDD is unable to compute a rate for a newly certified facility, it may establish an interim rate which shall be the regional average for other facilities.

(a) OMRDD shall replace the interim rate retroactively to the starting date of such interim rate by a rate developed from the initial budget report submitted by the facility.

(b) The rate developed from the initial budget report shall be subject to all the requirements of this section, and shall be effective for the remainder of the then current rate period.

Since July 1, 1996, providers have been responsible for any necessary transportation to and from physician, dentist, and other clinical services, and any other transportation appropriate to the consumer’s participation in community-based out of residence activities planned for or sponsored by the facility. Nothing herein shall be interpreted as precluding the accessing of separate Medicaid claiming for emergency/nonemergency ambulance services (as defined in 18 NYCRR 505.10) necessitated by the consumer’s medical condition.

To encourage the closure of developmental centers, the commissioner will consider proposals to allow the variable costs associated with the closed facility or facilities to become part of the operating expenses of new or existing state operated under 31 bed facilities. The commissioner will allow a reasonable incentive plan for the reimbursement of the increased costs in the state operated under 31 bed facilities if it is coupled with the closure of a developmental center. An incentive plan would provide for the reimbursement in total of increased costs in the state operated under 31 bed facilities without adjustment or offsets.

(i) 100 percent reimbursement of the increased cost for at least one full rate period, but less than two full rate periods.
(ii) 75 percent reimbursement of the increased cost for the second full rate period.

(iii) 50 percent reimbursement of the increased cost for the third full rate period.

(iv) 25 percent reimbursement of the increase cost for the fourth full rate period.

(b) 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.

(i) In order to have the cost of former developmental center employees included in the incentive plan, the state operated facility applying for a rate adjustment must hire such employee within twelve months of the official closing date of the developmental center.

(ii) Salaries and fringe benefit amounts paid to eligible employees by the facility cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that facility's payroll.

(c) Incentive plan applications from provider shall be made in writing to the commissioner.

(i) The application shall identify the employees, their job titles, salary levels, date hired and B/DDSO.

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 under 31 bed facilities. 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 and ending on the date of actual closure. Also variable costs associated with the planned conversion of beds which is at least 10 percent change in the facility census will be allowed. The commissioner will allow a reasonable incentive for the reimbursement of the increased costs in the state operated under 31 bed facilities during the transition and/or conversion period. An incentive plan would provide for the reimbursement in total of increased costs in the state operated under 31 bed facilities without adjustments or offsets.

Approval Date  March 11, 2004
Effective Date  January 1, 2003
(a) The commissioner will allow the following reimbursement for approved proposals:

(i) 75 percent reimbursement of the increased costs incurred during the transitional closure period. On the effective date of closure, reimbursement of increased costs will be considered under subsection (c)(3)(viii).

(ii) 75 percent reimbursement of the increased costs incurred during the conversion period. The conversion period will be for at least one full rate period but less than two full rate periods. If during the conversion period, an official announcement of closure occurs, the reimbursement of increased costs may be considered under (c)(3)(ix)(a)(i).

(b) 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 developmental center.

(i) In order to have the cost of former developmental center's employee included in the incentive plan, the facility applying for a rate adjustment must hire such employee during the transitional and conversion periods.

(ii) Salaries and fringe benefit amounts paid to eligible employees by the facility cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that facility's payroll.

(c) Incentive plan applications from the provider shall be filed in accordance with (c)(3)(viii)(c).

(4) Computation of the base period rate.

(i) For each facility the commissioner shall establish rates in accordance with the certified capacity as stated in a facility’s provider agreement.

(ii) Base period rates for over thirty bed facilities and developmental centers shall be computed on the basis of a full 12-month cost report submitted by the provider for the 12-month period beginning 24 months prior to the effective date of the base period, and subject to the cost category screens described herein. For a newly certified over thirty bed facility, OMRDD

TN #99-07 Approval Date June 6, 2001
Supersedes TN #97-08 Effective Date January 1, 1999 April 1, 1999 July 1, 1999
shall use budget data, as submitted pursuant to NYCRR subpart 635-4 or 681.12 (which ever is applicable).

(iii) The [initial] base period rate for under thirty-one bed Region II and III non-state operated facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning January 1, [1994] 1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision. The [initial] base period rate for under thirty-one bed Region I non-state operated facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning July 1, [1994] 1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision. For state operated facilities of under thirty-one beds, regardless of region, the initial base period shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning April 1, [1994] 1999 and adjusted in accordance with subparagraph (3)(ii) of this subdivision. Thereafter the base period rates for under thirty-one bed facilities shall be computed on the basis of a full twelve month cost report submitted by the provider for the twelve month period beginning [36] 48 months prior to the effective date of the base period. [However, there shall be no base period rate for the rate periods beginning January 1, 2002, April 1, 2002 and July 1, 2002.] For a newly certified under thirty-one bed facility, OMRDD shall use the budget data submitted pursuant to NYCRR subpart 635-4 or 681.12 (which ever is applicable).

(iv) For a newly certified facility, the initial base period rate shall be determined pursuant to subparagraph (vii) of this paragraph. For under thirty-one bed facilities the units of service are determined by multiplying the certified capacity of the facility by 365 days. For over thirty bed facilities, units of service are the certified capacity of the facility multiplied by 365 days multiplied by 99 percent. A facility's submitted budget costs may be adjusted based on a comparison to the actual costs of other existing facilities operated by the provider in order to determine the costs of an efficient and economic operation. If the provider does not operate other facilities, the submitted budget costs may be adjusted based on a comparison to the average costs of other facilities in the same region.

(v) For facilities which are not newly certified facilities, the initial base period rate shall be determined pursuant to subparagraph (vii) of this paragraph. For under thirty-one bed facilities the units of service are determined by multiplying the certified capacity of the facility by 365 days. For over thirty bed facilities, units of service are the higher of the certified capacity of the facility multiplied by 365 days multiplied by 99 percent, or the actual reported units of service.

(vi) As appropriate, OMRDD shall apply trend factors to each facility's reimbursable operating costs, except for education and related services.
The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

(a) trended reimbursable operating costs + untrended reimbursable operating costs + reimbursable capital costs = total reimbursable costs.

(b) total reimbursable costs / units of service = the rate.

For [under thirty-one bed] all facilities there shall be a day [treatment] program services add-on [such] so that facilities which have day [treatment] program services included in their [operating costs] rate shall be reimbursed [in their base period rate. For day treatment services, a facility shall be reimbursed at a varying funding level, for a maximum of 225 days per year. The facility will be reimbursed at the lower of either the actual costs per the cost report (or for budget costs for newly certified facilities) or the calculated per diem fee for day treatment services pursuant to 14 NYCRR section 690.7 of this Title in effect for the appropriate fee period.] as follows for these services. The add-on shall reflect service needs as well as the efficiency and economy of operation.

For all facilities there shall be a day services add-on such that facilities which have the following day services included in their operating costs shall be reimbursed as follows for these services.

(a) For sheltered workshop services, effective July 1, 1995, the facility will receive a reimbursable cost of $9,899 per annum for each program participant. For program participants to whom the conditions set forth in subparagraph [(x)(ix) of this paragraph apply, the facility will receive a reimbursable cost of $9,499 per annum for each program participant.

(b) For day training [services] programs effective July 1, 1995, the facility will receive a reimbursable cost of $11,033 per annum for each program participant. For program participants to whom the conditions set forth in subparagraph [(x)(ix) of this paragraph apply, the facility will receive a reimbursable cost of $10,633 per annum for each program participant.
Upon an agency’s application, if an agency applies to OMRDD prior to January 1, 2003 and for participants receiving services in day training facilities where the Developmental Disability Profile average score for the site exceeds 348 for the adaptive score and exceeds 10 for the health score, the amount of reimbursement the add-on shall be determined by a budget review. The amount of reimbursement the add-on received by the ICF/DD for such day training services shall reflect individual service needs as well as efficiency and economy of service provision. Effective January 1, 2003, for any facility to which this subclause applies the add-on will be equal to the reimbursement that was in the facility’s rate on December 21, 2002, and that was applicable to day training services described in this subclause.

The costs of day program services delivered in a certified Day treatment facility (see Part 690 of 14 NYCRR) may not be included as an add-on to the ICF/DD rate.

Effective January 1, 2003, a provider may request that a day services add-on be included in the facility’s rate. The day program services add-on for all day program services shall be either the day program services reimbursement included in the rate on December 31, 2002 and adjusted for actual service delivery; or the lower of:

1. the actual costs per the cost report, or
2. the budget costs
3. The costs in subclauses (1) and (2) of this clause are subject to a desk audit. Administrative review of these desk audits shall be in accordance with subdivision 635-6(h) if 14 NYCRR.

Effective June 1, 1995, the facility will be reimbursed for education and related services in accordance with Title 8 NYCRR. These costs shall not be trended.

Effective July 1, 1997 an under thirty-one bed facility may submit to the commissioner a request for a transportation add-on for the transportation of
persons to and from an outpatient service certified pursuant to Article 28 of the Public Health Law for certain persons if:

(a) in order to meet a person’s active treatment needs the person’s Individual Program Plan requires a day service (comprising regular attendance at a sheltered workshop or a day training service) in combination with visits to the outpatient service described above, and

(b) prior to July 1, 1996, transportation to and from the outpatient service was not included in the rate for the operator of the outpatient service, and

(c) prior to July 1, 1996, the rate approved by the local social services district was billed separately by a transportation vendor for transportation to and from the outpatient service, and

(d) the vendor ceased billing for transportation of persons residing in the facility to and from the outpatient service.

[(xi)] (x) The transportation add-on shall be a reimbursable cost added to a facility’s rate subject to the conditions set forth in subparagraph [(x)](ix) of this paragraph. The transportation add-on shall be calculated using payment/rate data based on local social service district approved Medicaid payment rates made to transportation vendors as of June 30, 1996. A weighted transportation average shall be calculated for each facility by dividing the aggregate transportation payments by the aggregate day service transportation round trips for all persons described in subparagraph [(x)](ix) of this paragraph.

(a) The weighted transportation average for each facility shall be ranked among all day treatment facilities state wide pursuant to the methodology for calculating the transportation component add-on for day treatment facilities described in NYCRR Part 690 subclauses 690.7(e)(3)(vii)(a)(1) through and including (a)(3).

(b) The modified weighted transportation average shall be multiplied by the total to and from day service transportation units of service to determine reimbursable transportation costs.

(5) Computation of the subsequent period rate.

(i) The reimbursable operating costs contained in the subsequent period rates shall be computed as follows. OMRDD shall determine the total
reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, day training services) included in the payment rate in effect on December 31, March 31, or June 30 of the immediately preceding rate period applicable to that facility. The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor described in subdivision (g) of this section and may be adjusted for appropriate appeals. Education and related services will be updated in accordance with clause (4)(ix)(c)(f) of this subdivision. OMRDD will determine the capital cost portion of the subsequent period rate by reviewing the component relating to capital costs for substantial material changes. If such changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, OMRDD will make corresponding adjustments in computing the subsequent period rate.

(ii) The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

(a) trended reimbursable operating costs + untrended reimbursable operating costs + reimbursable capital costs = total reimbursable costs.

(b) total reimbursable costs / units of service = the rate.

(iii) For a newly certified facility which begins to provide services that fall within a subsequent period, the initial rate shall be calculated as though it were a base period rate.

(d) Cost category screens and reimbursement for under thirty-one bed facilities.

In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used. The regional screens corresponding to the actual geographic location of the facility will be applied.

(1) Administration screens and reimbursement.

(i) Screens.

(a) Administrative screen values shall be equal to the sum of the total reimbursable administrative costs and the total reimbursable administrative fringe benefits, less the value of the efficiency adjustment, included in the rate effective on the last day of the

TN    #03-36                Approval Date March 11, 2004
Supersedes TN #00-47 #99-07 Effective Date January 1, 2003
immediately preceding rate period. This amount shall be detrended to the base period.

(b) For facilities, without a screen as determined in clause (a) of this subparagraph, operated by a provider which does operate other facilities, an agency administrative percentage based on the current reimbursement of those other facilities shall be applied.

(c) For facilities without a screen as determined in clauses (a) and (b) of this subparagraph, operated by a provider which operates other OMRDD certified residential programs, an agency administrative percentage based on the current reimbursement of the other OMRDD certified residential programs shall be applied.

(d) For facilities without a screen as determined in clauses (a) – (c) of this subparagraph, operated by a provider which does not operate any other OMRDD certified residential programs, a regional average administrative percentage based on the current reimbursement of facilities operated by other providers shall be applied.

(e) For facilities without a screen value as determined per clause (a) of this subparagraph, the administrative screen value shall be equal to the percentages derived from clause (b), (c), or (d) of this paragraph times the reimbursable operating costs other than administration. This value shall be detrended to the base year.

(ii) Reimbursable administration costs shall be the lesser of administrative base year costs/ budget costs, or the screen value as determined in subparagraph (i) of this paragraph.

(2) Direct care screens and reimbursement.

(i) Screen.

The direct care screen value shall be the direct care FTEs multiplied by the regional salary.

(a) Direct care FTEs shall be calculated utilizing the facility specific disability increment plus bed size increment. The term disability increment shall mean the process of developing facility specific direct care FTEs based upon aggregate consumer disability characteristics as described in 14 NYCRR subdivision 690.7(g) [of this Title] and reported on the Developmental Disabilities Profile (DDP). The disability increment methodology will only be calculated if at least 50 percent of the DDP scores are available. If less than 50 percent of the DDP scores are
available, the direct care FTEs calculated shall be based upon bed size increment alone. The disability increment using the DDP scores is calculated as follows: 0.063 FTEs times the facility mean direct care score plus 0.008 FTEs times the facility mean behavior score plus 0.062 FTEs times the facility standard deviation direct care score minus 0.019 FTEs times the facility standard deviation behavior score. The direct score is computed for each consumer from the DDP adaptive and health/medical scores as follows: 7.962 plus 0.156 times the adaptive score plus 1.611 times the health/medical score. The bed size increments are as follows:

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New York
15

June 6, 2001

Approval Date ________________

January 1, 1999 April 1, 1999 July 1, 1999

Supersedes TN #88-12 Effective Date

Attachment 4.19-D
Part II ICF/ DD
(b) Direct care regional salaries.

Region

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Note: The above values are in base year dollars.

(ii) Reimbursable direct care costs shall be the lesser of the base year costs/budget costs or the screen values established by the subparagraph (i) of this paragraph.

(3) Support personal service screens and reimbursement.

(i) Screen.

The support screen value shall be the support FTEs multiplied by the regional salary.

(a) Support FTE screen values for the budget-based facilities:

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<th>Bed size</th>
<th>Support FTE value</th>
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Attachment 4.19-D
Part II ICF/DD

New York
16

(b) Direct care regional salaries.

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</table>

March 11, 2004

TN #03-36 Approval Date ______
Supersedes TN #99-07 #88-12 Effective Date January 1, 2003
(b) Support FTE screen values for cost-based facilities are based on the base year cost report.

(c) Support regional salaries.

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>29,375</td>
</tr>
<tr>
<td>II</td>
<td>29,522</td>
</tr>
<tr>
<td>III</td>
<td>25,005</td>
</tr>
</tbody>
</table>

Note: The above values are in base year dollars.

(ii) Reimbursable support personal service costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph.

(4) Clinical screens and reimbursement.

(i) For facilities which are not newly certified, the clinical screen shall be the [value contained in the base year cost report] the appropriate clinical regional salary multiplied by the base year cost report clinical FTEs. Clinical regional salaries are:

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>56,510</td>
</tr>
<tr>
<td>II</td>
<td>53,584</td>
</tr>
<tr>
<td>III</td>
<td>40,414</td>
</tr>
</tbody>
</table>

Note: The above values are in base year dollars.
(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the reimbursable clinical costs will be the clinical FTEs approved and reimbursed in the rate effective on the last day of the immediately preceding rate period multiplied by the lesser of:

(a) the clinical average salary reimbursed in the rate on the last day of the immediately preceding rate period detrended to the base year; or

(b) the appropriate clinical regional salary listed in subparagraph (i) of this paragraph.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, OMRDD will consider budgeted FTEs and average salaries, reviewed and adjusted if necessary through a desk audit process and multiplied by the base year average reimbursed clinical salary of the other facilities operated by the provider. If the provider does not operate any other facilities then a base year regional average reimbursed clinical salary will be utilized.] The reimbursable clinical costs shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

(a) the desk audited budgeted clinical average salary, detrended to the base year; or

(b) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.
For facilities which are not newly certified the reimbursable clinical costs shall be the base year clinical costs. For newly certified facilities the reimbursable costs shall be the lesser of the clinical budget year costs or the screen values established in subparagraph (ii) or (iii) of this paragraph. base year cost report clinical FTEs multiplied by the lesser of:

(a) the base year cost report clinical average salary; or

(b) The appropriate clinical regional clinical salary listed in subparagraph (i) of this paragraph.

(5) Fringe benefit screens and reimbursement.

(i) For every new rate cycle, OMRDD shall compute a facility-specific fringe benefit percentage. This percentage shall be determined by summing the direct care, clinical and support fringe benefit costs from the base year budget or cost report and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) from the base year budget or cost report.

(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen shall equal the fringe benefit percentage contained in the rate effective on the last day of the immediately preceding rate period.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen (as calculated in subparagraph (i) above) shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage screen shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage screen shall equal the regional average percentage reimbursed to other facilities.

(iv) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percent established in subparagraphs (i), (ii) or (iii) of this paragraph multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(6) Support OTPS (other than personal service) screens and reimbursement.

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Region I</th>
<th>Region II</th>
<th>Region III</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>51,314</td>
<td>41,999</td>
<td>39,150</td>
</tr>
<tr>
<td>5</td>
<td>64,142</td>
<td>52,499</td>
<td>48,938</td>
</tr>
<tr>
<td>6</td>
<td>76,970</td>
<td>62,999</td>
<td>58,725</td>
</tr>
<tr>
<td>7</td>
<td>89,799</td>
<td>73,499</td>
<td>68,513</td>
</tr>
<tr>
<td>8</td>
<td>102,627</td>
<td>83,999</td>
<td>78,300</td>
</tr>
</tbody>
</table>

TN #03-36 Approval Date March 11, 2004
Supersedes TN #99-07 #95-27 Effective Date January 1, 2003
**New York**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>115,456</td>
<td>94,498</td>
</tr>
<tr>
<td>10</td>
<td>128,284</td>
<td>104,998</td>
</tr>
<tr>
<td>11</td>
<td>141,112</td>
<td>115,498</td>
</tr>
<tr>
<td>12</td>
<td>153,941</td>
<td>125,998</td>
</tr>
<tr>
<td>13</td>
<td>166,769</td>
<td>136,498</td>
</tr>
<tr>
<td>14</td>
<td>179,598</td>
<td>146,998</td>
</tr>
<tr>
<td>15</td>
<td>192,426</td>
<td>157,497</td>
</tr>
<tr>
<td>16</td>
<td>205,254</td>
<td>167,997</td>
</tr>
<tr>
<td>17</td>
<td>218,083</td>
<td>178,497</td>
</tr>
<tr>
<td>18</td>
<td>230,911</td>
<td>188,997</td>
</tr>
<tr>
<td>19</td>
<td>243,740</td>
<td>199,497</td>
</tr>
<tr>
<td>20</td>
<td>256,568</td>
<td>209,997</td>
</tr>
<tr>
<td>21</td>
<td>269,396</td>
<td>220,496</td>
</tr>
<tr>
<td>22</td>
<td>282,225</td>
<td>230,995</td>
</tr>
<tr>
<td>23</td>
<td>295,053</td>
<td>241,496</td>
</tr>
<tr>
<td>24</td>
<td>307,882</td>
<td>251,995</td>
</tr>
<tr>
<td>25</td>
<td>320,710</td>
<td>262,495</td>
</tr>
<tr>
<td>26</td>
<td>333,538</td>
<td>272,995</td>
</tr>
<tr>
<td>27</td>
<td>346,367</td>
<td>283,495</td>
</tr>
<tr>
<td>28</td>
<td>359,195</td>
<td>293,995</td>
</tr>
<tr>
<td>29</td>
<td>372,024</td>
<td>304,495</td>
</tr>
<tr>
<td>30</td>
<td>384,852</td>
<td>314,995</td>
</tr>
</tbody>
</table>

(i) The facility’s support OTPS screen is determined by multiplying the certified capacity by the appropriate regional per bed value.

(ii) Support OTPS regional per bed values:

<table>
<thead>
<tr>
<th>Region</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>$16,097</td>
</tr>
<tr>
<td>II</td>
<td>13,085</td>
</tr>
<tr>
<td>III</td>
<td>16,418</td>
</tr>
</tbody>
</table>

Note: The above values are in base year dollars.

[(iii) Reimbursable support OTPS costs shall be the lesser of the base year costs/ budget costs, or the screen values established in subparagraph (i) of this paragraph.

(7) Utility costs will not be included within the support OTPS screen. The reimbursable utility costs shall be the base year costs or budget costs.

[(8) OMRDD shall include in reimbursable costs a regional FTE add-on calculated by multiplying FTEs established per subparagraph (2)(i)(a) of this paragraph by the following dollar amounts:

| Region One | $624.00 |
| Region Two | $623.35 |
| Region Three | $556.87 |

Note: The above values are in base year dollars.]
(e) **Cost Category Screens and reimbursement for over thirty bed facilities.**

In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used.

(1) **Direct care, mid-level supervision, and clinical personal service cost category screens:**

   (i) For every new rate cycle, OMRDD shall develop values by applying a maximum statewide salary amount to a facility's applicable consumer specific staffing standards. Refer to paragraphs (5)-(8) of this subdivision.

   (ii) These standards shall reflect the severity of disabilities of the population residing at the facility as determined by the procedures outlined in paragraphs (5)-(7) of this subdivision; the number of beds in the facility; whether or not a facility provides on site day program services; and the persons the facility provides services to (i.e., adults, children or both).

   (iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In absence of such an election, the standard shall be determined by the facility's actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(2) **Administrative and support cost category screens:**

   (i) OMRDD shall develop values for every new rate cycle by application of a statewide maximum allowable cost.

   (ii) The personal service costs shall be determined by applying a maximum statewide salary amount to the allowable staffing level contained in this subdivision.

   (iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In the absence of such an election, the standard shall be
determined by the facility’s actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(3) Fringe benefit cost category screens:

(i) For every new rate cycle, OMRDD shall compute a facility-specific fringe benefit percentage. This percentage shall be determined by computing the total fringe benefit cost from the base year budget or cost report and dividing this total by the total personal service cost (exclusive of contracted personal service) from the base year budget or cost report. For every rate cycle after April 1, 1984, this percentage shall be the lower of the previous rate cycle’s cost-based fringe benefit percentage plus one percent or a new percentage computed in accordance with the immediately preceding sentence. If a facility’s previous rate is based upon a budget, it is not subject to the aforementioned one-percent fringe benefit limitation.

(ii) To determine the fringe benefit component of the rate, the facility-specific fringe benefit percentage shall be multiplied by the total reimbursable personal service dollars exclusive of contracted personal services.

(iii) For newly certified facilities, the fringe benefit percentage allowed shall not exceed the average allowed for existing facilities (regardless of size) currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage allowed shall not exceed the fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage allowed shall not exceed the regional average for other facilities.

(iv) Any increase in the fringe benefit percentage due to Federal or State laws, rules or regulations shall not be subject to the percent increase limitation described in subparagraph (i) of this paragraph.

(v) If a newly certified facility whose base period rate was determined from total reimbursable budget costs, submits a cost report for the subsequent period in accordance with 14 NYCRR subpart 635-4 [of this Title], a new fringe benefit percentage shall be computed by dividing these costs by the total personal service costs (exclusive of contracted services) as submitted in the new cost report. This percentage shall be subject to the limitations of subparagraphs (i) and (ii) of this paragraph.

(4) Other than Personal Service (OTPS) and Overhead shall be combined into one cost category screen.
New York
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(i) The Other than Personal Service cost category screen will be based on a per bed amount effective at the beginning of each new rate cycle (see paragraph (8) of this subdivision.)

(ii) The Overhead cost category screen will be a percentage of reimbursable personal service and fringe benefits (see paragraph (8) of this subdivision). This screen will be compared to reported cost or budget costs (agency administration, personal service, OTPS, fringe benefits and capital costs) to determine reimbursable costs.

(iii) Costs associated with transportation to and from physician, dentist and other clinical services shall be included in the Other than Personal Service screen and subject to the limitations contained therein.
(5) **Over thirty bed facility staffing standards, algorithm and screens.** FTE factors to determine staff allocations for consumers with differing day programs, who reside in over thirty bed facilities.

<table>
<thead>
<tr>
<th>Current Willow-brook ratios</th>
<th>Ratios with offsets for adults with outside day program</th>
<th>Ratios with offsets for children with outside day program</th>
<th>On site day program consumer requiring 1:1</th>
<th>31-bed facility children on-site day program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
</tr>
<tr>
<td>1:4</td>
<td>0.9917 FTE</td>
<td>1:4 0.9442 FTE</td>
<td>3.5417 FTE</td>
<td>1:4 0.9917</td>
</tr>
<tr>
<td>1:6</td>
<td>0.7083 FTE</td>
<td>1:6 0.6399 FTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:16</td>
<td>0.3541 FTE</td>
<td>1:16 0.3285 FTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
</tr>
<tr>
<td>0.1771 FTE</td>
<td>0.1599 FTE</td>
<td>0.1692 FTE</td>
<td>0.1771 FTE</td>
<td>0.1771 FTE</td>
</tr>
<tr>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
</tr>
<tr>
<td>0.3333 FTE</td>
<td>0.2934 FTE</td>
<td>0.3147 FTE</td>
<td>See below</td>
<td>0.4878 FTE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>60+ bed facility children on-site day program</th>
<th>100+ bed facility children on-site day program</th>
<th>31-bed facility adults on-site day program</th>
<th>60-bed facility adults on-site day program</th>
<th>100+ bed facility adults on-site day program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
<td>Direct Care</td>
</tr>
<tr>
<td>1:4</td>
<td>0.9917 FTE</td>
<td>1:4 0.9917 FTE</td>
<td>1:4 0.9917 FTE</td>
<td>1:4 0.9917 FTE</td>
</tr>
<tr>
<td>1:6</td>
<td>0.7083 FTE</td>
<td>1:6 0.7083 FTE</td>
<td>1:6 0.7083 FTE</td>
<td>1:6 0.7083 FTE</td>
</tr>
<tr>
<td>1:16</td>
<td>0.3541 FTE</td>
<td>1:16 0.3541 FTE</td>
<td>1:16 0.3541 FTE</td>
<td>1:16 0.3541 FTE</td>
</tr>
<tr>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
<td>Mid-level supervision</td>
</tr>
<tr>
<td>0.1771 FTE</td>
<td>0.1771 FTE</td>
<td>0.1771 FTE</td>
<td>0.1771 FTE</td>
<td>0.1771 FTE</td>
</tr>
<tr>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
<td>General clinical</td>
</tr>
<tr>
<td>0.4350 FTE</td>
<td>0.3883 FTE</td>
<td>0.4046 FTE</td>
<td>0.3651 FTE</td>
<td>0.3518 FTE</td>
</tr>
</tbody>
</table>

**TN #99-07**
**Approval Date**  
June 6, 2001

**Supersedes TN #88-12**
**Effective Date**  
January 1, 1999 April 1, 1999 July 1, 1999
(6) For the purposes of developing an economy of scale, the following FTE offsets shall be applied against the clinical ratios listed in paragraph (5) of this subdivision:

(i) For children, bed sizes 32-59, a straight deduction of 0.00182 will be computed per 1-bed increase from the 0.4878 at 31 beds.

(ii) For children, bed sizes 61-99, a straight deduction of 0.00119 will be computed per 1-bed increase from the 0.4350 at 60 beds.

(iii) For adults, bed sizes 32-59, a straight deduction of 0.00136 will be computed per 1-bed increase from 0.4046 at 31 beds.

(iv) For adults, bed sizes 61-99, a straight deduction of 0.00034 will be computed per 1-bed increase from 0.3651 at 60 beds.

(7) An assessment of consumer level of disability for the purposes of designating direct care staffing levels, as listed in paragraph (5) of this subdivision, shall be completed utilizing the following criteria.

<table>
<thead>
<tr>
<th>Direct Care Shift</th>
<th>Ratio (Shift)</th>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day or Evening</td>
<td>1:4</td>
<td>0.25000</td>
<td>1) All children age 21 and under</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) All nonambulatory consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>nonambulatory or wheelchair only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) All multiply handicapped consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(blind or deaf or tube-fed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4) All nonself-preserving consumers</td>
</tr>
<tr>
<td></td>
<td>1:16</td>
<td>0.06250</td>
<td>All consumers over age 22 who:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) walk freely</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) have a mental level moderate or above</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) are toilet-trained</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4) do not need help eating or dressing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5) have no serious behavior problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6) do not have any mild behavior problems in the following categories:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) assaults others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) self-abusive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) destroys property</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d) runs away</td>
</tr>
</tbody>
</table>
New York
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7) have some speech and comprehension

1:6 0.16666 All others not in above categories

Night 1:12 0.08333 All consumers

(8) Cost center screens for over thirty bed facilities.

(i) From July 1 to June 30, the cost center screens shall be:

(a) Salaries.

Cost area

Administration and support $21,751
Direct care and mid-level supervision 20,814
Clinical 34,824

(b) Other cost center screens.

Cost area

OTPS/bed $9,190
Overhead 7.29%
Administration and support FTE 0.6284/bed

(ii) From January 1 to December 31 the cost center screens shall be:

(a) Salaries.

Cost area

Administration and support $19,413
Direct care and mid-level supervision 19,956
Clinical 31,931

(b) Other cost center screens.

Cost Area

OTPS/bed $9,180
Overhead 6.76%
Administration and Support FTE 0.56/bed
(vi) April 1 to March 31 the cost center screens shall be:

(a) Salaries

<table>
<thead>
<tr>
<th>Cost Area</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration and Support</td>
<td>$21,560</td>
</tr>
<tr>
<td>Direct Care and Mid-level Supervision</td>
<td>20,643</td>
</tr>
<tr>
<td>Clinical</td>
<td>34,495</td>
</tr>
</tbody>
</table>

(b) Other Cost Center Screens

<table>
<thead>
<tr>
<th>Cost Area</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTPS/Bed</td>
<td>$9,121</td>
</tr>
<tr>
<td>Overhead</td>
<td>6.34%</td>
</tr>
<tr>
<td>Administration and Support FTE</td>
<td>.6288 FTE/Bed</td>
</tr>
</tbody>
</table>
(f) **Allowable costs.**

To be considered allowable, costs must be properly chargeable to necessary consumer care rendered in accordance with the requirements of this Part.

(1) **Allowable costs (general).**

(i) Except where specific rules concerning allowability of costs are stated herein, or in subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, or subdivision (k) Glossary, the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, shall be used to determine the allowability of costs. HIM-15 is published by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) and is available from:

Health Care Financing Administration  
Division of Publications Management-SSL-12-15  
7500 Security Boulevard  
Baltimore, MD 21244-1850

It may be reviewed in person during regular business hours at the NYS Department of State, 41 State Street, Albany, NY 12207; or, by appointment, at the NYS Office of Mental Retardation and Developmental Disabilities, Division of Revenue Management, 44 Holland Avenue, Albany, NY 12229-0001.

(ii) Where [specific] rules stated herein, in subdivision (j) General Rules for Capital Costs and Costs of related Party Transactions, subdivision (k) Glossary or in HIM-15, are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to consumer care and generally accepted accounting principles.

(iii) Expenses of portions of expenses reported by a facility that are not reasonably related to the efficient and economical provision of care in accordance with the requirements of this Part, because of either the nature or the amount of the item, shall not be allowed.

(iv) Costs which are not properly related to consumer care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators or employees of the facility, shall not be allowed.

(v) The OMRDD shall reduce a facility’s base year costs/budget costs by the costs of such services and activities that are not chargeable to the care of the consumers in accordance with this subdivision.

**TN #00-47 Approval Date August 3, 2001**

**Supersedes TN #99-07 Effective Date October 1, 2000 January 1, 2001**
(a) In the event that the commissioner determines that it is not practical to establish the costs of such services and activities, the income derived therefrom shall be substituted as the basis for reductions of the facility's reported or estimated costs.

(b) Examples of sources of such income include, but are not limited to:

(1) supplies and drugs sold by the facility for use by nonresidents;
(2) telephone and telegraph services for which a charge is made;
(3) discount on purchases;
(4) employees' rental of living quarters;
(5) cafeterias;
(6) meals provided to staff or a consumer's guests for which there is a charge;
(7) operating parking facilities for community convenience; and
(8) lease of office and other space by concessionaires providing services not related to intermediate care facility services.

(vi) Costs for any interest expense related to funding expenses in excess of an approved rate, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed. OMRDD will not pay interest on the final dollar settlement resulting from the retrospective impact of the rate appeals.

(vii) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

[(viii) Costs of related organizations, other than costs incurred pursuant to a lease, rent or purchase of real property, may be an allowable cost subject to the following:]
(a) A related organization means and entity of which the facility is in control or by which the facility is controlled including the organizations and persons listed in clauses (3)(iii)(g)-(f) of this subdivision, either directly or indirectly, or where an association of common interest exists in an entity which supplies goods and/or services to the facility.

(b) The costs of goods and/or services furnished to a facility, within the course of normal business operations, by a related organization, are allowable at the cost to the related organization, or the market price of comparable goods and/or services available in the facility’s region whichever is lower.

[(ix)](viii) Restricted funds are funds expended by the facility, which include grants, gifts, and income from endowments, whether cash or otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Except as provided for in [clauses (3)(iv)(d) and (e)] subparagraphs (3)(iii) and (iv) of this subdivision, restricted funds are to be deducted from the designated costs when determining allowable costs. The commissioner may waive the provisions of this subparagraph at his discretion only in those instances where the provider makes a reasonable showing that the imposition of requirements of this subparagraph would cause undue financial harm to the existence of the facility.

[(x)] (ix) Only that portion of the dues paid to any professional association which has been demonstrated to be attributable to expenditures other than for lobbying or political contributions shall be allowed.

[(xi)] (x) A monetary value assigned to services provided by a religious order for services rendered to an owner and operator of a facility shall be considered allowable subject to review by the OMRDD for reasonableness.

[(xii)] (xi) Funded depreciation.

(a) Applicability.

This subparagraph shall apply to all facilities except those governed by [clause (3)(iv)(d) or (e)] subparagraphs (3)(iii) or (iv) of this subdivision and those for which the provider is receiving or has a commitment to receive HUD funding. This section shall apply to facilities which were governed by [clause (3) (iv)(d) or (e)] subparagraphs (3)(iii) or (iv), but which are no longer governed by either such section because the provider has repaid the entire principal owed on the real property of the facility.
(b) Effective April 1, 1986, for any rate period during which the reimbursement attributable to depreciation on a facility’s real property, excluding equipment, exceeds the provider’s principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such differences in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by this paragraph, the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation accounts with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider’s equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the facility.

(c) OMRDD will not reimburse interest expense incurred to meet funded depreciation, pursuant to this subparagraph and [clauses (3)(iv)(d) and (e)] subparagraphs (3)(iii) and (iv) of this subdivision.

(2) Allowable costs (operating).

(i) Interest on working capital indebtedness in accordance with standards listed in [subparagraph (3)(vii) of this] subdivision (j) General Rules for Capital-Costs and Costs of Related Party Transactions and subdivision (k) Glossary and subject to the limitations of paragraph (d)(1) or (e)(4) of this section will be considered allowable. In the event that a loan is not in accordance with the standards listed above, then the approval of the commissioner is required.

(ii) Effective April 16, 1992, costs incurred as a result of the provider of services assessment charged pursuant to section 43.04 of the Mental Hygiene Law in the amount of 2.4 percent of the 3 percent assessment charged on cash receipts shall be included in the rate.

(iii) Effective April 4, 1996, costs in excess of 0.6 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 1999, costs in excess of 0.3 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 2000, the assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be a reimbursable expense.
(iv) Allowable operating costs shall also include, but not be limited to, personal service, fringe benefits, OTPS, utility, administration costs, as well as day treatment, day services, and transportation costs, and regional FTE add-ons.

(v) Liability for compensated absences determined and accrued in accordance with generally accepted accounting principles for governments as promulgated by the Governmental Accounting Standards Board shall be considered an allowable cost.

(3) Allowable costs (capital).

(i) Start-up costs are those costs which are incurred from the period the provider receives approval pursuant to 14 NYCRR Part 620 for a facility to become an intermediate care facility to the date the first consumer is admitted. However, costs incurred during the period from the first admission to the effective date of the initial provider agreement shall not be considered as start-up costs.

(a) OMRDD may, at the discretion of the commissioner, reimburse a provider for all allowable start-up costs incurred in the preparation of the provider during that six-month period prior to the date of the first consumer admission. A provider may apply to the commissioner for an extension of the six-month reimbursable start-up period, provided that the provider 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 consumer admission.

(b) Allowable start-up costs may include, but not be limited to:

1. personal service expenses;
2. utility expenses;
3. taxes;
4. insurance expenses;
5. employee training expenses;
6. housekeeping expenses;
(7) repair and maintenance expenses; and

(8) administrative expenses.

(c) Any costs that are properly identifiable as organization costs, or capitalizable as construction costs, shall be classified as such and excluded from start-up costs.

(d) If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred account and shall be amortized from the date of the first consumer admission. However, if a provider intends to prepare only portions of its facility (e.g., preparation of a floor or wing), start-up costs shall be capitalized and amortized separately. In either case, unless reimbursed as described in [subparagraph (iv) of this paragraph] paragraph (3) of subdivision (j) of the ICF/DD section of this Plan, start-up costs shall be amortized over a period not to exceed 60 months from the date of the first consumer admission.

(ii) Any cost of the sale, purchase, alteration, construction, rehabilitation and/or renovation of a physical plant or interest in real property manifested by cooperative shares shall be considered allowable up to the amount approved by the commissioner and the director of the Division of the Budget.

(g) [(ii)] (ii) For any transaction resulting in a change of ownership, the valuation of the assets shall be limited to the lesser of the allowable acquisition cost of the assets to the first owner of record who has received Medicaid payment for the assets in question on or after August 1, 1982, minus and paid depreciation (i.e., seller's net book value) or the acquisition cost of the asset to the new owner.

[(b) Costs including legal fees, accounting and administrative costs, travel costs, and the costs of the feasibility studies (attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger) for which any payment has previously been made under Medicaid, shall not be allowable for reimbursement.

(iii) A facility's annual rental payments for real property and maintenance charges associated with cooperative shares may be considered an allowable cost subject to the following conditions:
(a) The lease, or in the case of cooperative shares, the subscription agreement, is reviewed by and acceptable to OMRDD and any other State agency which must by law or regulation review and approve reimbursement rates.

(b) The lease agreement must be considered an “arm’s-length transaction” not involving an affiliate, controlling person, immediate family or principal stockholder. The “arms-length transaction” requirement may be waived by the commissioner upon application for those corporations holding title to the intermediate care facility’s physical plant, created pursuant to the Not-for-Profit Corporation Law with the approval of the commissioner.

(c) For the purposes of this section, affiliate means:

1. with respect to a partnership, each partner thereof;
2. with respect to a corporation, each officer, director, principal stockholder and controlling person thereof;
3. with respect to a natural person, each member of said person’s immediate family, or each partnership and each partner of such person, or each corporation in which said person or any affiliate of said person is an officer, director, principal stockholder or controlling person.

(d) For the purposes of this section, controlling person of any corporation, partnership or other entity means any person who by reason of a direct or indirect ownership interest whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the direction of the management policies of said corporation, partnership or other entity. Neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a facility, shall by reason of his or her official position be deemed a controlling person of any corporation, partnership or other entity; nor shall any person who serves as an officer, administrator or other employee of any corporation, partnership or other entity, or as a member of a board of directors or trustees of any corporation, be deemed to be a controlling.
person of such corporation, partnership or other entity solely as a result of such position or his or her official actions in such position.

(e) For the purposes of this section, immediate family means brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent or child of such person, whether such relationship arises by reason of birth, marriage or adoption.

(f) For the purposes of this section, principal stockholder of a corporation means any person who beneficially owns, holds or has the power to vote, 10 percent or more of any class of securities issued by said corporation.

(g) The rental amount is comparable to similar leases for properties with similar functions in the same geographic area.

(h) If the criteria in this paragraph are not met, reimbursement for lease costs will be the lower of lease costs or the amount determined in accordance with subparagraphs (iv) and (vii) of this paragraph.

(i) Existing leases shall be approved during the original term of the lease. However, lease options to renew shall not be exercised without review and approval of the parties listed in clause (a) of this subparagraph. Such review and decision shall occur more than 30 days before the last date the option may be exercised, the date of which the facility has notified OMRDD in accordance with clause (j) of this subparagraph.

(j) Effective January 1, 1983, requests for approval of lease renewals must be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease renewal option.

(iv) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life of buildings, fixed equipment and/or capital improvements or acquisition of an interest in real property manifested by cooperative shares. For the purpose of this section:

(a) Unless an exception is made by the commissioner, the useful life shall be the higher of the reported useful life or those from the Estimated Useful Lives of Depreciable Hospital Assets (1983 edition), published by the American Hospital Association, and
available by writing to the American Hospital Association, 840 Lake Shore Drive, Chicago, IL 60611. In certain instances, a useful life that is based upon historical experience as shown by documentary evidence and approved by OMRDD may be allowed.

(b) The depreciation method used shall be the straight-line method.

(c) In the event that the historical cost of the facility cannot be adequately determined by the commissioner, an appraisal value shall be the basis for depreciation. The appraisal of the historical cost of assets shall produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level and in a bona fide market as of the date of acquisition. Such appraisal shall be conducted by an appraiser approved by OMRDD and pursuant to a method approved by OMRDD.

(d) (iii) Notwithstanding subparagraph (f)(1)[(ix)](viii) of this paragraph, in the case of any provider which has been notified by OMRDD on or after April 1, 1986 that there is a preliminary reservation of State aid funds for a capital grant pursuant to Mental Hygiene Law, section 41.18(c) or [section] 41.23, the basis for computing depreciation on the facility which is the subject of the capital grant shall include the facility’s depreciable project costs which were funded with such capital grant, provided that the provider is not receiving and does not have a commitment to receive HUD funding for the facility, and has not repaid the entire principal owed on the real property of the facility. If the depreciable project costs are adjusted after audit, the basis for computing depreciation on the facility will be changed to such adjusted depreciable project costs. Upon full repayment of principal, the basis for depreciation for the facility will cease to include the amount of the capital grant. Any provider which receives such a capital grant shall enter into certain assurances with the OMRDD whereby the provider agrees that:

(a) The difference between depreciation in the rate attributable to the facility’s depreciable project costs (other than depreciation attributable to the provider’s equity in the facility’s real property at the time such property is put into use as a facility) and the principal...
which is repaid shall be deposited in a secure investment approved by the commissioner.

(b) Withdrawals from such investment shall be made only for the purpose of repayment of indebtedness owed on the real property of the facility. **With the commissioner's approval based on cost savings, a provider may use withdrawals from such investment for repayment of indebtedness owed on the real property of another facility which received a capital grant under this subparagraph or under subparagraph (ix) of this paragraph, or if there is no such other facility which is mortgaged, for the repayment of indebtedness owned on the real property of another facility which is mortgaged under the same mortgage as the facility.**

(c) Each withdrawal must be approved by the commissioner.

(d) If the provider ceases to operate the facility as an intermediate care facility for the developmentally disabled, or as any facility certified by OMRDD, it will repay to OMRDD the balance on deposit in the secure investment at the time of such cessation, including interest earned on the investment.

(e) Depreciable project costs shall mean those acquisition and construction costs of a facility which have been approved, either before or after audit, by the New York State Office of the State Comptroller or by OMRDD or by OMRDD's designee. Such costs shall include the cost of land.

(f) HUD funding shall mean lower income housing assistance under section 8 of the United State Housing Act of 1937, as amended 42 U.S.C. section 1437(f) and/or a loan or loans pursuant to section 202 of the Housing Act of 1959, as amended 12 U.S.C. section 1701(q).

(iv) Notwithstanding subparagraph (f)(1)(viii) of this paragraph, any provider which has been notified by OMRDD before April 1, 1986 that there is a preliminary reservation of State aid funds for a capital grant pursuant to Mental Hygiene Law, section 41.18(c) or section 41.23, which is not receiving and has no commitment to receive HUD funding for the facility which is the subject of the capital grant, may apply to the commissioner to have the basis for computing depreciation on the facility include the facility's depreciable project cots which were funded with the capital grant. Such application must be submitted to the commissioner on or before September 30, 1986 on the forms prescribed by the commissioner. Such application shall be granted at the discretion of the commissioner upon a showing that inclusion in the depreciation basis of the facility's depreciable projects which were funded with the capital grant is necessary.
to the financial viability of the facility and will not impede the facility’s efficient and economical operation. If the commissioner approves such application, the facility’s rate shall be revised retroactive to April 1, 1986 to include in the depreciation basis the facility’s depreciable project costs which were funded with the capital grant, and the provider shall enter into certain assurances described in subparagraph (iii) of this paragraph. Upon full repayment of principal, the basis for depreciation for the facility will cease to include the amount of the capital grant. If the depreciable project costs are adjusted after audit, the basis for computing depreciation on the facility will be changed to such adjusted depreciation project costs.

(v) Effective April 29, 2005, for non State operated facilities, costs incurred as a result of requests for criminal history record information under section 16.33 of the New York State Mental Hygiene Law and section 845-b of the New York State Executive Law shall be allowable costs and shall be considered part of the rate.
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Advance refunding costs incurred in connection with the refunding of bonds, and determined in accordance with generally accepted accounting principles, shall be an allowable cost.

(g) Trend factors.
(1) As appropriate, OMRDD shall apply trend factors to each facility's total reimbursable operating costs as determined by subdivision (c)-(f) and as submitted on the budget or cost reports required by section (a)(1)(i) and (ii) respectively. Except for educational and related services as defined at (3)(viii)(b)(3), such trend factors shall be applied to only reimbursable operating costs, with capital costs and start-up costs added to this result to compute the final rate.

(i) For all facilities, effective on the first day of the applicable fiscal cycle the trend factor utilized shall be that figure developed by the New York State Office of Mental Retardation and Developmental Disabilities.

(2) Effective January 1, 2006, for all facilities, in addition to the trend factor identified in subparagraph (1)(i), a variable adjustment within a range of zero percent to three percent [may] shall be applied to the rate. This variable adjustment shall be that figure developed by the New York State Office of Mental Retardation and Developmental Disabilities from a review of the provider’s application and historical expenditures for fringe benefits as a result of an initiative aimed at improving the recruitment and retention of the facility’s lower paid employees, e.g., health care.
Where appropriate, the commissioner shall use some combination in whole or in part of the yearly components to project cost data into the appropriate rate period.

(h) Appeals to rates.

(1) The commissioner will consider only the following appeals for adjustment to the rates which would result in an annual increase of $1,000 or more in a facility’s allowable costs, and are:

(i) needed because of changes in the statistical information used to calculate a facility's staffing or utilization standards; or

(ii) requests for relief from the standards contained in subdivision (d) or (e) of this section which were applied to costs used in calculating the base period and subsequent period rates.

(iii) Appeals for adjustments needed because of material errors in the information submitted by the facility which OMRDD used to establish the rate, or material errors in the rate computation.

(iv) Appeals for significant increases or decreases in a facility's overall base period operating costs due to implementation of new programs, changes in staff or service, changes in the characteristics or number of individuals, changes in a lease agreement so as not to involve a related party, capital renovations, expansions or replacements which have been either mandated or approved by the commissioner and, except in life-threatening situations, approved in advance by the appropriate State agencies.

(2) Notification of first level appeal.

(i) In order to appeal to a rate in accordance with subparagraphs (1)(ii-iii) of this subdivision, the facility must send to OMRDD an appeal application by certified mail, return receipt requested, either within 90 days of the facility receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later.
(ii) In order to appeal a rate in accordance with subparagraphs (1)(i and iv) of this subdivision, the facility must send to OMRDD, within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.

(3) First level rate appeal applications shall be made in writing to the commissioner.

(i) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and OMRDD may request such additional documentation as it deems necessary.

(ii) Actions on first level rate appeal applications will be processed without unjustifiable delay.

(4) The burden of proof on the first level appeal shall be on the facility to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation.

(5) A rate revised by OMRDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.

(6) At no point in the first level appeal process shall the facility have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process OMRDD shall notify the facility of any proposed revised rate or denial of same by certified mail, return receipt requested. OMRDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with 14 NYCRR section 602.9 [of this Title] in the event that the proposed revised rate fails to grant some or all of the relief requested.

(7) If OMRDD approves the revision to the rate and State Division of the Budget denies the revision, the facility shall have no further right to administrative review pursuant to this section.

(8) Any rate revised in accordance with this subdivision shall be effective according to the dates indicated in the rate appeal notification.

(9) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with this subdivision, shall be restricted to the specific purpose set forth in the appeal decision.

(10) Second level appeals to rates.
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(i) OMRDD’s denial of the first level appeal of any or all of the relief requested in the appeals provided for in paragraph (1) of this subdivision shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.

(ii) Second level appeals shall be brought and determined in accordance with the applicable provisions of 14 NYCRR Part 602.

(i) Reserve bed days for overnight absences for hospitalization or leaves of absence in facilities.

(1) Payment.

(i) Payment for overnight absences due to hospitalization shall be in accordance with 18 NYCRR section 505.9.

(ii) Payment for overnight absences due to leaves of absence shall be in accordance with 18 NYCRR section 505.9 and the following additional requirements.

(a) A leave of absence due to visits with relatives or friends, must not be medically or programmatically contraindicated.

(b) In the case of a leave of absence due to medically acceptable therapeutic leave or rehabilitative plans of care, the plan of care must be documented.

(c) Leaves of absence covered under the bed reservation program must be provided for in the consumer’s individual program plan as designated by the interdisciplinary team.

(d) Such planning should most appropriately take place during the development and monitoring process of the individual program plan during the quarterly and annual reviews. A consumer’s assigned bed cannot be reserved if another person is occupying that bed.

(2) Reporting.

(i) Each facility shall maintain an absence register for each consumer who is absent overnight.
(ii) The facility shall record the duration and purpose of each absence and make an annotation indicating whether or not the consumer’s bed was reserved.

(iii) Each month the facility shall complete a report summarizing all consumer absences and submit the report to OMRDD. The facility shall submit the report to the consumer’s sponsoring local social services district within ten working days following the end of the month. This report shall reflect the information contained in each consumer’s absence register.

(iv) The facility shall report reserve bed absences in the form and format as prescribed by the commissioner.

(j) General Rules for Capital Costs and Costs of Related Party Transactions

(1) Determination of Whether Transaction is Between Related Parties

(i) Where a transaction is not presumed to be between related parties under subparagraphs (ii) or (iv) below, OMRDD will determine whether the transaction is between related parties.

(a) Such determination shall be made on a case-by-case basis.

(b) Such determination shall be based on whether the facts and circumstances of the transaction, and the parties’ situation and history, indicate that the party from whom the provider or consumer obtained the real property, equipment, goods, services or property is a related party.

(c) If a transaction is between a provider or consumer and a party not presumed to be a related party (under subparagraphs (ii) or (iv) below), OMRDD never-the-less can determine that the transaction is between related parties (using the criteria in subparagraph (i)(b) above), where the party transacting with the provider or consumer directly or indirectly obtained the real property, equipment, goods, services or property in question from someone or an organization presumed to be related to the provider or consumer (under subparagraphs (ii) or (iv) below).

(ii) The existence of any of the conditions in clauses (a) through (f) below will create a presumption that the transaction is between a provider and a related party.

(a) The provider is a partnership and the other party to the transaction is a partner of the provider.
(b) The provider is a corporation and the other party to the transaction is an officer, director, trustee, principal stockholder or controlling party of the provider.

(c) The provider is a corporation and the other party to the transaction is a corporation, where someone is an officer, director, trustee, principal stockholder or controlling party of both corporations.

(d) The provider is a natural person and the other party to the transaction is either:

(1) a member of the provider’s immediate family;

(2) a partnership in which the provider is a partner;

(3) a co-partner of the provider;

(4) a corporation in which the provider is an officer, director, trustee principal stockholder or controlling party;

(5) a corporation in which a member of the provider’s immediate family is an officer, director, trustee, principal stockholder or controlling party;

(6) a corporation in which any partnership in which the provider is a partner is a principal stockholder;

(7) a corporation in which a co-partner of the provider is an officer, director, trustee, principal stockholder or controlling party, or

(8) a corporation in which another corporation is a principal stockholder, where the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(e) The provider is an unincorporated association and the other party to the transaction is either:

(1) someone who is a member of the provider;

(2) someone, a member of whose immediate family is a member of the provider;
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(3) a partnership in which one partner is a member of the provider;

(4) a corporation in which a member of the provider is an officer, director, trustee, principal stockholder or controlling party;

(5) a corporation in which a member of the provider has an immediate family member who is an officer, director, trustee, principal stockholder or controlling party;

(6) a corporation in which any partnership, in which a member of the provider is a partner, is a principal stockholder;

(7) a corporation in which a co-partner of a member of the provider is an officer, director, trustee, principal stockholder or controlling party, or

(8) a corporation in which another corporation is a principal stockholder, where a member of the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(f) The other party to the transaction is a special purpose organization.

(iii) A provider may overcome a presumption that the transaction is between related parties by clearly demonstrating that:

(a) The other party to the transaction in question is a bona fide separate organization;

(b) A substantial part of the other party’s business activity of the type carried on with the provider is transacted with other organizations or those not related to the provider and the other party by common ownership or control and there is an open, competitive market for the type of real property, equipment, goods, services or property furnished by the other party;

(c) The real property, equipment, goods, services or properties are those which commonly are obtained by organizations such as the provider from other organizations and are not a basic element of care ordinarily furnished directly to consumers by such programs, and
(d) The charge to the provider is comparable to the charge for such real property, equipment, goods, services or property in the open market and no more than the charge made under comparable circumstances to others by the other party to the transaction for such real property, equipment, goods, services or property.

(iv) The existence of any of the conditions in clauses (a) through (e) below will create a presumption that the transaction is between a consumer and a related party.

(a) The other party to the transaction is a member of the consumer's immediate family.

(b) The other party to the transaction is a partnership in which the consumer or a member of the consumer's immediate family is a partner.

(c) The other party to the transaction is a corporation in which the consumer or a member of the consumer's immediate family is an officer, director, trustee, principal stockholder or controlling party.

(d) The other party to the transaction is a corporation in which:

(1) any partnership, in which the consumer or a member of the consumer's immediate family is a partner, is a principal stockholder, or

(2) another corporation is a principal stockholder, where the consumer or a member of the consumer's immediate family is an officer, director, trustee, principal stockholder or controlling party of such other corporation.

(e) The other party to the transaction is an unincorporated association which has as a member either:

(1) the consumer;

(2) a member of the consumer's immediate family;

(3) a partnership in which the consumer or a member of the consumer's immediate family is a partner;

(4) a corporation in which the consumer or a member of the consumer's immediate family is an officer, director, trustee.
principal stockholder or controlling party;

(5) a corporation in which any partnership, in which the consumer or a member of the consumer’s immediate family is a partner, is a principal stockholder, or

(6) a corporation in which another corporation is a principal stockholder, where the consumer or a member of the consumer’s immediate family is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(2) Leases for Real Property

(i) In order for lease costs to be considered for allowability, the provider or consumer must submit the lease to OMRDD for approval. In deciding whether to approve a lease, OMRDD shall consider whether the lease is in the best interests of the programs and the persons it serves and whether the lease in any way violates public policy. In deciding whether to approve an amount for rent, OMRDD shall consider whether the provider’s rate, fee or price, as a whole, including the amount of rent to be approved, would result in a payment which is consistent with efficiency and economy.

(ii) If an approved lease or approved proprietary lease is between the provider or consumer and a party which is not a related party, allowable lease costs shall be the lesser of contract rent or fair market rental.

(iii) If an approved lease or approved proprietary lease is between the provider or consumer and a related party, allowable lease costs shall be the least of:

(a) contract rent,
(b) fair market rental, or
(c) the landlord’s net cost (see subdivision (k), glossary)

(iv) The Commissioner may waive the limitations on allowable costs as state in subparagraph (iii) above upon a showing that such limitations would jeopardize the opening or continued operation of the program or services and that the negotiations for the lease or proprietary lease were conducted as though the parties were not related.

(v) The commissioner may, upon application from a provider, allow lease costs in an

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principal stockholder or controlling party;

(5) a corporation in which any partnership, in which the consumer or a member of the consumer’s immediate family is a partner, is a principal stockholder, or

(6) a corporation in which another corporation is a principal stockholder, where the consumer or a member of the consumer’s immediate family is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(2) Leases for Real Property

(i) In order for lease costs to be considered for allowability, the provider or consumer must submit the lease to OMRDD for approval. In deciding whether to approve a lease, OMRDD shall consider whether the lease is in the best interests of the programs and the persons it serves and whether the lease in any way violates public policy. In deciding whether to approve an amount for rent, OMRDD shall consider whether the provider’s rate, fee or price, as a whole, including the amount of rent to be approved, would result in a payment which is consistent with efficiency and economy.

(ii) If an approved lease or approved proprietary lease is between the provider or consumer and a party which is not a related party, allowable lease costs shall be the lesser of contract rent or fair market rental.

(iii) If an approved lease or approved proprietary lease is between the provider or consumer and a related party, allowable lease costs shall be the least of:

(a) contract rent,
(b) fair market rental, or
(c) the landlord’s net cost (see subdivision (k), glossary)

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(v) The commissioner may, upon application from a provider, allow lease costs in an

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<th>Effective Date</th>
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<tr>
<td>#00-47</td>
<td>August 3, 2001</td>
<td>NEW</td>
<td>October 1, 2000 January 1, 2001</td>
</tr>
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</table>
amount equal to contract rent and greater than fair market rent if the following conditions are met. The commissioner will allow such lease costs only for as long as it is necessary for the provider to relocate the program or services located on the lease property.

(a) the lease is a renewal which is not pursuant to an option to renew;

(b) the lease is a renewal of a lease for an existing program or services, and

(c) the provider has shown that:

(1) the provider has made diligent efforts to negotiate a lease renewal for fair market rent or less;

(2) the provider has been unable to negotiate a lease renewal for less than the current rent;

(3) the parties to the lease renewal are not related;

(4) allowance of lease costs in the amount of contract rent is necessary to ensure the continued operation of the program of services.

(vi) From October 1, 2000 until January 1, 2001, allowable costs under leases between related parties in effect on September 1, 1984 shall be determined in accordance with the State Plan in effect on September 30, 2000. On and after January 1, 2001, allowable costs under leases between related parties in effect on September 1, 1984 shall be determined in accordance with subparagraph (iii) above.

(vii) Contract rent incurred pursuant to an approved lease or approved proprietary lease which is renewed pursuant to an option to renew is allowable.

(viii) Costs incurred pursuant to an approved lease or approved proprietary lease which is renewed other than pursuant to an option to renew shall be allowable as follows:

(a) If the lease is between parties who are not related, allowable costs are determined in accordance with subparagraph (ii) above.

(b) If the lease is between parties who are related, allowable costs are determined in accordance with subparagraph (iii) above.
(c) OMRDD shall decide whether to approve any such renewal at least 30 days before the last day the lease may be renewed, if the provider or consumer has notified OMRDD in accordance with subclause (d) below.

(d) Whenever possible, the provider or consumer shall submit to OMRDD a request for approval of lease renewals at least 120 days prior to the last date for renewing the lease.

(3) Costs of Ownership of Real Property

(i) Unless specifically otherwise provided for in this part of the Plan, costs of ownership of real property shall be allowable in the amount of depreciation, interest and costs attributable to the negotiation or settlement of sale or purchase of real property, or in the amount of costs related to loans from the Dormitory Authority of the State of New York.

(ii) Depreciation is based upon the historical cost and useful life of buildings, fixed equipment and/or capital improvements.

(iii) Historical cost shall be determined as follows:

(a) The historical cost of any real property which is transferred, purchased, altered, constructed, rehabilitated and/or renovated shall be equal to the amount approved by the OMRDD and the Division of the Budget. In deciding whether to approve any such cost, OMRDD shall consider whether the provider's reimbursement as a whole for the services in question, including the cost of purchase, transfer, construction, alteration, rehabilitation and/or renovation to be approved, would result in payment which is consistent with efficiency and economy. In no event shall OMRDD or the Division of Budget approve an historical cost which exceeds the lesser of fair market value or the provider's or consumer's actual cost.

(b) The historical cost of any real property which is transferred or purchased from a party related to the provider or consumer is the lesser of fair market value or the acquisition cost of the real property to the transferor or the seller.

(c) The historical cost of any real property which is altered, constructed, rehabilitated and/or renovated by a party related to the provider or consumer is the lesser of:

(1) the fair market value of such alteration, construction, rehabilitation or renovation, or

(2) the related party's cost of the alteration, construction, rehabilitation or renovation.
or renovation.

(iv) Where the previous owner of the real property had the costs of such property funded, in whole or in part, by the State of New York, the historical cost of the property shall be the least of:

(a) the acquisition cost of the property to the new owner;
(b) the seller's net book value (see subdivision (k), glossary), or
(c) fair market value.

(v) If the previous owner is related to the provider or consumer purchasing the property, any amount paid by the State to the provider or consumer for rent equal to depreciation on the property shall be counted as paid depreciation and as funding for the costs of of such property.

(vi) If the seller or transferor of the real property to the provider or consumer is not a party related to the provider or consumer, but any prior owner of the property in question is a party related to the provider or consumer, and the sale or transfer from the prior related party occurs within five years of the sale or transfer to the provider or consumer, the transaction shall be deemed to be between the provider or consumer and the prior owner related to the provider or consumer.

(vii) If OMRDD cannot determine the historical cost of real property, OMRDD shall use an appraisal value as the basis for depreciation. The appraisal value shall be based upon an appraisal which is done by OMRDD or by an appraiser approved by OMRDD, which uses an appraisal methodology which is generally accepted within the profession and which is factually correct in all significant matters. OMRDD shall approve an appraiser if one of the following tests is met:

(a) the appraiser is a New York State certified or licensed appraiser, or
(b) no licensed or certified appraiser is available in the geographic area in which the property is located; the appraiser is recommended by another State agency and, in OMRDD’s opinion, the appraiser has the professional experience and qualifications to do the appraisal in question.

(viii) The commissioner may allow an alternative historical cost of ownership of real property obtained from a related party.

(a) The commissioner may allow such alternative historical cost if
the provider or consumer demonstrates that allowing such alternative historical cost would make property available to consumers or providers which would not otherwise be available;

such alternative historical cost is substantially less than the cost which would be allowed under this subpart for property which is obtained from an unrelated party and which is of similar function and value to OMRDD and to the provider or consumer;

the seller or transferor has owned the property in question for at least five years, and

the fair market value of such property is greater than the seller's cost.

Such alternative historical cost may be greater than the cost of the property to the transferor or seller, but shall not be greater than the lesser of:

the acquisition cost of the property to the provider or consumer, or

the cost of the property to the seller or transferor, increased by one-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for New York – Northeastern New Jersey (All items), as reported by the United States Department of Labor, Bureau of Labor Statistics.

The commissioner may allow an alternative historical cost only for transfers, purchases, alteration, construction, renovation or rehabilitation, the terms of which were agreed to after October 1, 2000.

The useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the Estimated Useful Lives of Depreciable Hospital Assets (current edition).
The provider or consumer shall use the straight-line method of depreciation.

(xi) **Interest costs.**

(a) Interest costs shall be allowable if the following criteria are met:

(1) The interest rate is not in excess of the amount a prudent borrower would pay at the time the loan was incurred.

(2) The loan agreement is entered into between the provider or consumer and a party not related to the provider or consumer. The commissioner may waive this provision based on a demonstration of need for the services and cost savings resulting from the transaction.

(3) If the interest expense results from either start-up costs and/or the initial financing of the capital indebtedness, the capital indebtedness shall represent all or part of the current OMRDD and Division of the Budget approved value of the property, after subtracting any equity contributions such as, but not limited to, grants applied to the property.

(4) In the case of interest expense, or a portion of interest expense, resulting from the refinancing of the capital indebtedness, the refinancing has the prior approval of the commissioner and the Division of the Budget, and the interest is in the amount associated with the outstanding principal balance prior to refinancing.

(b) Interest expense resulting from the inclusion of the reasonable closing costs, such as, but not limited to, attorney's fees, recording costs and points, is allowable in the initial financing and start-up costs, and in the refinancing of the capital indebtedness.

(c) Interest income generated from the provider's revenues for the operation of the services shall be used to offset interest expense incurred during the same reporting period. Notwithstanding the foregoing, a provider is not required to use the following to offset...
interest expense: income earned on qualified pension funds, income from gifts or grants which are donor-restricted, income earned on funded depreciation accounts or secure investments for depreciable project costs above principal repayments.

(xii) Where any real property for which previous Medicaid payment has been made is transferred by sale, purchase, acquisition or merger (other than as a result of a receivership under New York Mental Hygiene Law, section 16.27), the costs (including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies) attributable to the negotiation or settlement of sale or purchase are not allowable.

(xiii) Costs related to Dormitory Authority loans shall be allowable as follows:

(a) The cost of principal and interest payments on loans from the Dormitory Authority 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, are allowable; provided that the reimbursement of such costs is an allowance in lieu of reimbursement of interest and depreciation associated with the property, and in lieu of reimbursement of the underlying allowable costs, which may include allowable start-up costs, for which the Dormitory Authority loan is received. A provider which receives a Dormitory Authority loan shall not have the option of having included, in the calculation of its rate, fee or price, the loan’s underlying costs instead of the loan principal and interest payments.

(b) Operational period fees imposed by OMRDD and annual administrative fees imposed by the dormitory Authority in connection with Dormitory Authority mortgage loans shall be allowable costs.

(c) Interest payments on Dormitory Authority loans pursuant to this subparagraph (xiii) for capital indebtedness and start-up costs will be considered allowable where interest expense results from capital indebtedness and start-up costs in an amount equal to the OMRDD and Division of Budget approved value of the loan.

(d) Interest payments on Dormitory Authority loans pursuant to the provisions of subparagraph (xiii) are allowable in excess of the amount associated with the outstanding principal balance prior to refinancing, if the purpose of the debt is to acquire assets to be used for care of the persons served by the program or services and all other applicable requirements of this Plan are met.

(4) Costs of Co-operate (see subdivision (k), glossary) Ownership of Real Estate

(i) If an agreement to purchase membership or ownership interest in a co-operative, which agreement has been approved by OMRDD and the New York State Division of Budget, is
agreement has been approved by OMRDD and the New York State Division of Budget, is between the provider or a consumer and a party which is not a related party, allowable costs shall be the lesser of the actual purchase price or the price of a membership or ownership interest in a co-operative for real estate with similar functions in the same geographic area.

(ii) If an agreement to purchase membership or ownership interest in a co-operative, which agreement has been approved by OMRDD and the New York State Division of Budget, is between the provider or a consumer and a related party, allowable costs for such purchase shall be the least of:

(a) the actual purchase price.

(b) the price of membership or ownership interest in a co-operative with similar functions in the same geographic area, or

(c) the co-operative’s costs attributable to the provider or consumer.

(iii) The allowable cost of purchasing membership or ownership interest in a co-operative shall be amortized over fifteen years, or the term of the mortgage given by the provider or consumer, whichever is greater.

(5) **Moveable Equipment and Personal Property**

(i) Costs of ownership of moveable equipment and personal property shall be allowable in the amount of depreciation and interest if the purchase is made through a multiple bid process. Depreciation shall be based upon the historical cost and useful life.

(a) If the equipment or personal property is purchased from a party not related to the provider or consumer, the historical cost shall be the lesser of the actual cost of purchasing the equipment or personal property or the fair market value of such equipment or personal property.

(b) If the equipment or personal property is purchased from a party related to the provider or the consumer, the historical cost shall be the least of:

   (1) actual acquisition cost,

   (2) fair market value, or

   (3) the seller’s cost

(c) The useful life is the higher of the reported useful life or the useful life as reported in the Estimated Useful Lives of Depreciable Hospital Assets (current edition), published by the American Hospital Association. A provider or consumer may
OMRDD shall base such approval upon historical experience and documentary evidence.

(d) The provider or consumer shall use the straight-line, double declining balance or sum-of-the-years’ digits depreciation method. Once selected, the depreciation method shall remain constant for the useful life of the asset.

(ii) Costs of leasing moveable equipment and personal property shall be allowable as follows:

(a) If lease payments are made to a party which is not a related party, allowable costs shall be the lesser of:

1. actual lease payments,
2. fair market rental.

(b) If lease payments are made to a related party, allowable costs shall be the least of:

1. actual lease payments,
2. fair market rental, or
3. allowable depreciation, the associated interest expense, if any, and other related expenses, including, but not limited to, maintenance costs.

(6) Costs Applicable to Goods, Services or Property Not Covered Elsewhere in this Section.

(i) Costs applicable to goods, services, or property not covered elsewhere in the ICF/DD portion of this Plan and furnished to the provider or consumer by a related party shall be allowable at the lesser of:

(a) the cost to the related part, or

(b) the price of comparable goods, services or properties that could be obtained elsewhere.

(ii) Interest on working capital indebtedness in accordance with subparagraph (xi) of paragraph (3) of the ICF/DD portion of this Plan are allowable. In the event that a loan is not in accordance with the standards listed in subparagraph (xi), the need for such loan shall be demonstrated in writing to the commissioner, and the express written approval of the commissioner is required.
(k) **Glossary**

(1) **Approved lease** - A lease approved by OMRDD and the New York State Division of the Budget.

(2) **Approved proprietary lease** - A proprietary lease approved by OMRDD and the New York State Division of Budget.

(3) **Common ownership** - An individual or individuals possessing significant ownership or equity in the provider and the organization serving the provider.

(4) **Consumer** - Anyone with a diagnosis of developmental disability who receives services from OMRDD or from a provider, or anyone to whom OMRDD provides funds (other than payment from competitive employment with OMRDD) to purchase services from a provider or to purchase other goods, services or property.

(5) **Control** - The power, directly or indirectly, to significantly influence or direct the actions or policies of someone or an organization.

(6) **Controlling party** - An organization or someone who, by reason of a direct or indirect ownership interest (whether of record or beneficial), has the ability, acting either alone or in concert with others with ownership interest, to direct or exert a controlling influence on the management policies of the provider. Except as otherwise provided in this section, neither the commissioner, nor any employee of the OMRDD, nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a program, shall by reason of his or her official position be deemed a controlling party of the provider; nor shall anyone who serves as an administrator or other employee of a provider be deemed to be a controlling party of such provider solely as a result of such position or his or her official actions in such position.

(7) **Contract rent** - The amount of rent stated in the lease or proprietary lease as rent, additional rent, maintenance, special assessments, or any other additional charges, costs, expenses, liabilities and obligations. Notwithstanding the foregoing, a contract rent shall not include an amount greater than the amount approved by OMRDD and the Division of Budget.

(8) **Co-operative** - A corporation or organization formed for the purpose of co-operative ownership of real estate.

(9) **Co-partner** - A partner in a partnership of which the provider is also a partner.

(10) **Dormitory Authority** - The Dormitory Authority of the State of New York as successor to the Facilities Development Corporation and the Dormitory Authority of the State of New York as the Successor to the Medical Care Facilities Finance Agency.
(11) **Fair market rental** - The rental that the property would most probably command on open market as indicated by rentals being paid and asked for comparable properties in the same geographic area as of the date of the appraisal.

(12) **Fair market value** -

(i) In the case of goods and services, the price of comparable goods and services that could be obtained elsewhere.

(ii) In the case of real property, the most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller each acting prudently and knowledgeably, and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:

(a) buyer and seller are typically motivated;

(b) both parties are well-informed or well-advised, and acting in what they consider their own best interest;

(c) a reasonable time is allowed for exposure in the open market;

(d) payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto, and

(e) the price represents the normal consideration for the property sold unaffected by special or creative financing or sales concessions granted by anyone associated with the sale.

(13) **Immediate family** - Brother, sister, grandparent, grandchild, first cousin, aunt, uncle, spouse, parent or child of an individual, whether such relationship arises by reason of birth, marriage or adoption.

(14) **Landlords net cost** - The amount equal to depreciation (subject to the limitation in section (j)), the associated interest expense on capital indebtedness, if any, and other expenses approved by OMRDD. OMRDD shall approve such other expenses if they are reasonable in an amount and directly related to owning and maintaining the property in question. The types of other expenses directly related to owning and maintaining the property in question include, but are not limited to, real estate taxes, water and sewer charges, heat and utilities, maintenance costs, legal and accounting fees, lawn care, snow removal, rubbish and insurance.
removal, rubbish and insurance.

(15) **Option to renew a lease** - An option, stated in a lease, to renew the lease at a specific amount of rent and term of renewal, where such rent and term of renewal were stated in the original lease at the time the parties entered into the original lease, and were not negotiated by the parties subsequent to the signing of the original lease.

(16) **Organization** - A corporation, partnership or unincorporated association.

(17) **Principal stockholder** - Someone or an organization beneficially owning, holding or having the power to vote, 10 percent or more of any class of securities issued by a corporation.

(18) **Proprietary lease** - A lease between a co-operative, as lessor, and a person or organization with membership or ownership interest in the co-operative, as lessee.

(19) **Provider** - Someone or an organization licensed or otherwise approved by OMRDD to provide goods, services or property to consumers.

(20) **Related Party** - Someone or an organization which to a significant extent is associated or affiliated with the consumer or provider by common ownership or control, or which to a significant extent has control of, or is controlled by, the consumer or provider, by common ownership or control.

(21) **Seller’s new book value** - The allowable acquisition cost of the asset(s) to the first owner of record who has received payment from the State of New York for the asset(s), minus any paid depreciation.

(22) **Special purpose organization** - For the purpose of this subpart is:

(a) an organization which the provider controls through the contracts or other legal documents that give the provider the authority to direct the organization’s activities, management and policies;

(b) an organization, the activities of which the provider is, for all practical purposes, the sole beneficiary. The provider will be considered the organization’s sole beneficiary if one or more of the three following circumstances exist:

(1) the provider has assigned certain of its functions to the organization and the organization is operating primarily for the benefit of the provider;

(2) the provider has transferred some of its resources to the organization.
and substantially all of the organization's resources are held for the benefit of the provider; or

(3) the organization has solicited funds in the name of and with the express or implied approval of the provider, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the provider or used at its discretion or direction; or

(c) an organization which was created for the sole purpose of benefiting the provider, where the provider of such organization has been in operation for less than one year. The organization will be considered to be created for the sole purpose of benefitting the provider if the organization's or provider's certificate of incorporation, by-laws, partnership agreement or other governing rule state one or more of the following:

(1) the provider must assign certain of its functions to the organization and the organization must operate primarily for the benefit of the provider;

(2) the provider must transfer some of its resources to the organization, and substantially all of the organization's resources must be held for the benefit of the provider; or

(3) the organization shall solicit funds in the name of and with the express or implied approval of the provider, where substantially all the funds to be solicited by the organization will be intended by the contributor or otherwise required to be transferred to the provider or used at its discretion or direction.
(I) Adjustments.

Effective January 1, 2005 for Region II and III voluntary operated facilities, effective April 1, 2005 for all state operated facilities, and effective July 1, 2005 for voluntary operated Region I facilities, there shall be an efficiency adjustment for under-31 bed facilities as described herein and applied as a reduction to reimbursable operating costs.

(1) A determination shall be made as to whether each provider has a per bed surplus or loss for all its under-31 bed facilities.

(i) Surplus/loss shall equal operating revenue minus operating costs.

(a) For purposes of this efficiency adjustment, operating revenue and costs are net of day treatment, day service, transportation and regional FTE add-ons.

(b) Revenue for determining the surplus/loss calculations for all facilities in all regions is from the rate effective July 1, 2004.

(c) Costs for determining the surplus/loss calculations are from the 2001 or 2001-2002 cost reporting year, trended to 2004 or 2004-2005 dollars.

(ii) The value of the surplus/loss is divided by the total number of beds in all of the provider’s under-31 bed facilities to determine the provider’s per bed surplus/loss value.

(2) Regional ranking of the per bed surplus/loss.

(i) Within each of the three regions, the per bed surplus/loss values are ranked and identified in descending order.

(ii) Within each region, the ranking is divided into five groups:

<table>
<thead>
<tr>
<th>Region 1</th>
<th>Surplus/ Loss Range (Per Bed)</th>
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<tbody>
<tr>
<td>Efficiency Group 5</td>
<td>$17,498 to $4,289</td>
</tr>
<tr>
<td>Efficiency Group 4</td>
<td>$4,288 to $523</td>
</tr>
<tr>
<td>Efficiency Group 3</td>
<td>$522 to ($2,986)</td>
</tr>
<tr>
<td>Efficiency Group 2</td>
<td>($2,987) to ($7,465)</td>
</tr>
<tr>
<td>Efficiency Group 1</td>
<td>($7,466) to ($42,035)</td>
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<table>
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<tr>
<th>Region II</th>
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<td>Efficiency Group 5</td>
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<tr>
<td>Efficiency Group 4</td>
<td>$6,353 to $4,081</td>
</tr>
<tr>
<td>Efficiency Group 3</td>
<td>$4,080 to $873</td>
</tr>
<tr>
<td>Efficiency Group 2</td>
<td>$872 to ($5,343)</td>
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<td>Efficiency Group 1</td>
<td>($5,344) to ($16,087)</td>
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<thead>
<tr>
<th>Region III</th>
<th>Surplus/ Loss Range (Per Bed)</th>
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</thead>
<tbody>
<tr>
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<td>$7,215 to $2,207</td>
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<tr>
<td>Efficiency Group 3</td>
<td>$2,206 to ($1,049)</td>
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<tr>
<td>Efficiency Group 2</td>
<td>($1,050) to ($6,440)</td>
</tr>
<tr>
<td>Efficiency Group 1</td>
<td>($6,441) to ($15,631)</td>
</tr>
</tbody>
</table>

(3) Each of the five groups within each region is assigned an ordinal weight.

- Group 5=5
- Group 4=4
- Group 3=3
- Group 2=2
- Group 1=1

(4) Determination of total adjustment per facility.

(i) The number of beds in the facility is multiplied by its assigned ordinal weight and the result is multiplied by $334.

(ii) The facility's reimbursable operating costs are reduced by the amount determined in subparagraph (i) of this paragraph.

(5) Reallocation of costs.

The following changes to cost allocations for all under-31 bed facilities are effective January 1, 2005 for voluntary operated Region II and III facilities, effective April 1, 2005 for all state operated facilities, and effective July 1, 2005 for voluntary operated Region I facilities.

(i) General insurance costs are reallocated from base year administration OTPS costs to base year support OTPS costs.

(ii) Property and casualty insurance costs are removed from base year administration OTPS costs. Property and casualty insurance costs from the appropriate cost report period are included in capital costs.

(iii) Expensed equipment costs from the base year cost report are included in Support OTPS costs. Expensed equipment costs are not included in capital costs.

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Supersedes TN NEW Effective Date January 1, 2005
Effective April 1, 2013, the methodology described in the Rate Setting and Financial Reporting for Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) section in this Attachment for government operated facilities will be terminated, with the exception of those sections outlined in Paragraph (m), which follows. The new methods and standards for establishing payment rates are described in Paragraph (m) of this section.

(m) Effective April 1, 2013, rate setting for Intermediate Care Facilities for the Developmentally Disabled operated by New York State will be governed by this section of Part II of Attachment 4.19-D. These facilities are Developmental Centers and Community-based State Operated Intermediate Care Facilities for the Developmentally Disabled (SOICF/DDs). The Developmental Centers’ rate is an all inclusive rate. The rate for Community-based SOICF/DDs include services being provided in the ICF/DD with the addition of Day Services and Tax Assessment components which will be added to the calculated rate as set forth in paragraphs (6) and (7).

(1) **Reporting Requirements.** The State will report cost in accordance with Generally Accepted Accounting principles in a complete Consolidated Fiscal Report (CFR) format.

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

(i) **Allowable Operating Costs** - Are all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of ICF/DDs. Necessary and proper costs are costs which are common and accepted occurrences in the field of intermediate care facilities for the developmentally disabled. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). This will include allowable program administration, direct care, support, clinical, fringe benefits, and indirect personal service/non-personal service.

(ii) **Allowable Capital Costs** - Are all necessary capital costs incurred to provide covered services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). This will include allowable lease/rental and ancillary payments; depreciation of equipment, vehicles, leasehold improvements and real property; financing expenditures associated with the purchase of equipment, vehicles and real property, and related expenditures and leasehold improvements.

(iii) **Base Period** - is the CFR period from which the Initial Period rate will be calculated.

(iv) **Base Period CFR** - is the CFR from three years prior to the initial rate period.

(v) **Beginning Census/Capacity** - is the beginning census/capacity on March 31st immediately prior to the beginning of the rate period.

(vi) **Capital Costs** - Costs that are related to the acquisition and/or long term use of land, buildings, construction, and equipment.

(vii) **Certified Capacity (Community-based SOICF/DDs)** - represents the total capacity of the Community-based SOICF/DDs in the Operating Certificates.

(viii) **Census (Developmental Centers)** - is the number of individuals in all Developmental Centers on a given day.

(ix) **Consolidated Fiscal Report (CFR)** - is the reporting tool utilized by all government and non-government providers to communicate annual costs incurred as a result of operating OPWDD programs and services, along with related utilization and staffing statistics.
Depreciation - is the allowable cost based on historical costs and useful life of buildings, fixed equipment, capital improvements and/or acquisition of real property. The useful life shall be based on “The Estimated Useful Life of Depreciable Hospital Assets (2008 edition).” The depreciation method used shall be straight-line method.

Facility - the site or physical building where actual services are provided.

Financing Expenditures - interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property.

Historic Utilization Factor – For Community-based SOICF/DDs, the historic utilization factor shall be the number of reported units of service for all individuals residing in Community-based SOICF/DDs in the base period, divided by the maximum possible units of service. The maximum possible units of service shall be the product of the certified capacity for all Community-based SOICF/DDs on March 31 immediately prior to the first day of the base period and the number of days in the base period. For developmental centers, the historic utilization factor shall be the number of reported units of service for all individuals residing in all Developmental Centers in the base period who were not projected to move to the community during that base period, divided by the maximum possible units of service for such individuals. The maximum possible units of service for such individuals shall be the product of the number of individuals residing in all Developmental Centers on March 31 immediately prior to the first day of the base period who were not projected to move to the community during the base period and the number of days in the base period.

Individual – a person who resides in a Developmental Center or a Community Based SOICF/DD.

Initial Period – is the first 12 months of the two-year rate cycle. Costs will be calculated by using the CFR from three years prior to the rate period.

Lease/Rental and Ancillary Payments – a facility's annual rental payments for real property and ancillary outlays associated with the property, such as utilities and maintenance.

Operating Costs for Developmental Centers – are all allowable operating costs with the exception of Tax Assessment and Capital.

Operating Costs for Community Based State Operated ICF/DDs – are all allowable operating costs with the exception of Tax Assessment, Day Services and Capital.

Phase Factor - represents the projection of time during the rate period individuals will live in a Developmental Center prior to moving to the community. The phase factor is 60%.

Projected Units of Service Developmental Centers - is determined by multiplying the number of anticipated individuals moving to the community in the rate period by the calendar days in the rate period multiplied by the phase factor, and adding that value to the product of the number of individuals anticipated to remain in the Developmental Center for the entire rate period multiplied by the calendar days in the rate period multiplied by the historic utilization factor.

Projected Units of Service-Community SOICF/DDs – is determined by multiplying the certified capacity on March 31 immediately prior to the rate period by the number of calendar days in the rate period by the historic utilization factor.

Rate Period – is the annual time period that rates are effective, i.e. April 1st through March 31st.

Rate Cycle – the rate cycle is a 24 month period that consists of two rate periods beginning on April 1st of each year.

Reimbursable Costs – are the allowable costs calculated from the base period CFR.

Staffing Ratio - is the calculated ratio between individuals and staff in the base period CFR.

Subsequent Period – is the second 12 months of the rate cycle.

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March 28, 2013

Approval Date

Supersedes TN

Effective Date

NEW

April 1, 2013
(xxvii) **Trend Factor** - is a percentage applied to all applicable operating costs that represent inflations in the costs of goods and services as described in (m)(5).

(xxviii) **Unit of Service** - is the unit of measure denoting lodging and services rendered to one individual between the census taking hours of the facility on two successive days. The day of admission but not the day of discharge will be counted as a unit of service. Also, one unit of service will be counted if the individual is discharged on the same day he/she is admitted, providing there was an expectation that the admission would have at least 24-hour duration. Reserved bed days under Attachment 4.19-C are included in the units of service.

(3) **Computation of Rates (General).**

(i) There will be one Statewide rate for all Developmental Centers and one Statewide rate for all Community-based SOICF/DDs.

(ii) New York State will make an adjustment to the rate resulting from any final audit findings or reviews.

(iii) Developmental Center costs include any necessary transportation to and from physician, dentist, and other clinical services as well as any other transportation appropriate to the individual’s participation in community-based activities planned for or sponsored by the facility. Developmental Center costs do not include emergency/nonemergency ambulance services which were separately billed to Medicaid.

(iv) The rate for the initial period will be computed on the basis of a full 12-month base period CFR, adjusted in accordance with (m)(3)(ii). If a facility closes or is no longer used as an ICF/DD during or subsequent to the base year, all costs and statistics for that facility will be removed from the base period before calculating the initial period rate. The computation of the base period staffing ratio using the end of year census/certified capacity is effective for the first rate cycle. The State will submit a State Plan Amendment to establish the staffing ratio that will be effective for the 2015-17 rate cycle.

(v) For a Community-based SOICF/DD that has been in operation less than four full years as the start of the initial period, the initial period rate will be the Statewide rate for Community-Based SOICF/DDs in effect during such initial period, and the subsequent period rate will be the Statewide rate for Community-Based SOICF/DDs in effect during such subsequent period, until the beginning of the next rate cycle.

(4) **Reimbursable Costs for the Initial Period of the 24-month Rate Cycle.**

(i) Program Administration Reimbursement is the Administration directly related to the provision of the service.

A per person average staffing ratio will be calculated using the direct personal service from the base period CFR-4. The total Program Administration FTE’s (full time equivalents) is divided by the ending census (Developmental Centers)/certified capacity (Community-based SOICF/DD) from the base period CFR which will result in a Program Administration staffing ratio.

(a) An average Program Administration salary will be calculated by dividing the direct personal service from the base period CFR-4 total annual salary of all Program Administration employees by the total
Program Administration FTE’s.

(b) The Program Administration staffing ratio is then multiplied by the census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) of the March 31st date immediately prior to the beginning of the rate period. The product of this calculation is the total number of Program Administration FTE’s.

(c) The calculated average Program Administration salary is then multiplied by the calculated Program Administration FTE’s. The product of this calculation is the total Program Administration salary cost.

(d) The result of paragraph (4)(i)(c) is then trended in accordance with paragraph (5) of this section, then divided by the total projected units of service on March 31st immediately prior to the beginning of the rate period to arrive at the Program Administration salary cost per diem.

(ii) **Direct Care Reimbursement.**

A per person average staffing ratio will be calculated using the direct personal service from the base period CFR-4. The total Direct Care FTE’s is divided by the ending census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) from the base period CFR which will result in a Direct Care staffing ratio.

(a) An average Direct Care salary is calculated by dividing the direct personal service from the base period CFR-4 total annual salary of all Direct Care employees by the total Direct Care FTE’s.

(b) The Direct Care staffing ratio is multiplied by the census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) of the March 31st date immediately prior to the beginning of the rate period. The product of this calculation is the total number of Direct Care FTE’s.

(c) The calculated average Direct Care salary is multiplied by the calculated Direct Care FTE’s. The product of this calculation is the total Direct Care salary cost.

(d) The result of paragraph (4)(ii)(c) is then trended in accordance with paragraph (5) of this section, then divided by the total projected units of service on March 31st immediately prior to the beginning of the rate period to arrive at the Direct Care salary per diem.

(iii) **Support Reimbursement.**

A per person average staffing ratio will be calculated using the direct personal service from the base period CFR-4. The total Support FTE’s is divided by the ending census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) from the base period CFR which will result in a Support staffing ratio.

(a) An average Support salary is calculated by dividing the direct personal service from the base period CFR-4 total annual salary of all Support employees by the total Support FTE’s.
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(b) The Support staffing ratio is then multiplied by the census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) of the March 31st immediately prior to the beginning of the rate period. The product of this calculation is the total number of Support FTE's.

(c) The calculated average Support salary is multiplied by the calculated Support FTE's. The product of this calculation is the total Support salary cost.

(d) The result of paragraph (4)(iii)(c) is trended in accordance with paragraph (5) of this section, then divided by the total projected units of service on March 31st immediately prior to the beginning of the rate period to arrive at the Support salary per diem.

(iv) Clinical Reimbursement.

A per person average Clinical staffing ratio will be calculated using the direct personal service from the base period CFR-4. The total Clinical FTE's is divided by the ending census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) from the base period CFR which will result in the Clinical staffing ratio.

(a) An average Clinical salary is calculated by dividing the direct personal service from the base period CFR-4 total annual salary of all Clinical employees by the total Clinical FTE's.

(b) The Clinical staffing ratio is multiplied by the census (Developmental Centers)/certified capacity (Community-based SOICF/DDs) of the March 31st date immediately prior to the beginning of the rate period. The product of this calculation is the total number of Clinical FTE's.

(c) The calculated average salary is then multiplied by the calculated Clinical FTE's. The product of this calculation is the total Clinical salary cost.

(d) The result of Paragraph (4)(iv)(c) is trended in accordance with Paragraph (5) of this section, then divided by the total projected units of service on March 31st immediately prior to the beginning of the rate period to arrive at the Clinical salary cost per diem.

(v) Fringe Benefits are calculated by multiplying the sum of trended allowable Personal Service dollars calculated in (m)(4)(i) through (m)(4)(iv) by the budgeted fringe factor of 55.48%. The result is divided by the total projected units of service as on March 31st immediately prior to the beginning of the rate period to arrive at the fringe per diem. Fringe benefit related accruals will also be included. Accruals are calculated as change between the end of the current benefit period and the next benefit period, for this period the accrual would be .25%. The computation of the base year fringe benefits is effective for the first rate cycle. The State will submit a State Plan Amendment to establish the fringe benefits factor that will be effective for the 2015-17 rate cycles.

(vi) Indirect Personal Service and Non-Personal Service Costs are calculated as follows:

(a) The Total Personal Service dollars from the base period CFR-1 less the total Direct Personal Service dollars from the base period CFR-4 results in the Indirect Personal Service dollars.
(b) The Indirect Personal Service amount is then multiplied by the fringe benefit percentage.

(c) The Indirect Personal Service dollars with associated fringe is added to Non-Personal Service dollars from the base period CFR. The product is Total Indirect Personal Service dollars and Non-Personal Service dollars.

(d) Total Indirect Personal Service and Non-Personal Service dollars are divided by the ending census/capacity on the base period CFR resulting in a per-person annual Non-Personal Service dollar amount.

(e) The per-person annual Non-Personal Service amount is multiplied by the beginning census/certified capacity, giving the annual Indirect Non-Personal Service dollars.

(f) The result of paragraph (4)(vi)(e) is trended in accordance with Paragraph (5) of this section, then divided by the total projected units of service on March 31st immediately prior to the beginning of the rate period to arrive at the Indirect Non-Personal Service cost per diem.

(vii) Sum products of paragraphs (4)(i)(d), (4)(ii)(d), (4)(iii)(d), (4)(iv)(d), (4)(v), and (4)(vi)(f) of this section to arrive at the total trended operating cost per diem.

(5) Trend Factors.

(i) The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.BLS.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.

(ii) Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.

(iii) A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate period.

(6) Day Service add-on for Community-based SOICF/ DDs. To reimburse Community-based SOICF/DDs that obtain day services from State and Voluntary providers, the State will calculate an interim amount that will approximate the costs Community-based SOICF/DDs will incur to obtain these services for the individuals they serve, and this interim amount will be reconciled to the actual rate year costs incurred. The interim amount included in the rate will be calculated as stated below:

(i) The Day Services from the base period CFR will be added to an approximate payment to be made to the day services providers for the individuals residing in Community-based SOICF/DDs and attending Day Services.
(ii) The result of paragraph (6)(i) is trended in accordance with paragraph (5) of this section, then divided by the total units of service as projected on March 31st immediately prior to the beginning of the rate period to arrive at the Day Services per diem.

(iii) The Day Services reconciliation to final rate - New York State will pay for SOICF Day Services at the same rate established by OWPDD under the comprehensive home and community based services waiver for the day habilitation program operated by the same provider and in the same location as such day services. Subsequent to the rate period OPWDD will determine the actual billings for day services for each individual and reconcile the interim amount in (II) to the amount of actual billings.

(7) **Tax Assessment costs** in the amount of a 5.5 percent assessment uniformly imposed on all SOICF/DD services of all such providers will be included in the rate.

(8) **Capital Add-on Cost**

   (i) The Capital add-on will be calculated using the Base Period CFR.

   (ii) Capital costs are calculated by adding Base Period CFR Total Equipment and Total Property-Provider Paid.

   (iii) The result of paragraph (8)(ii) of this section is divided by total projected units of service on March 31st immediately prior to beginning of rate period to arrive at the Capital cost per diem.

(9) **Total Per Diem** will be the sum products of paragraphs (4)(vii), (6)(ii), (7), and (8)(iii) of this section.

(10) **Computation of the Subsequent Period Rate**.

   (i) The reimbursable costs contained in the subsequent period rate will be computed as follows:

   (a) New York State will update the census (Developmental Center) and certified capacity (Community-based SOICF/DDs) based on the number of individuals in the facility as of March 31st of the immediately preceding rate period. Once these updates have been made OPWDD will increase the costs by the trend factor as described in Paragraph (5) of this section.

   (b) An adjustment will be made to reflect the capital in the CFR three years prior to the rate period. The first full year after an institution is closed OPWDD will remove all related capital.

   (ii) The computation of the subsequent period rate can also be represented by the following formula:

   \[
   \text{Trended Reimbursable Operating costs} + \text{Trended Adjusted Day Service costs} + \text{Adjusted Reimbursable Capital costs} + \text{Tax Assessment} = \text{Total Reimbursable Costs.}
   \]

(11) **Upper Payment Limit Assurance**.

TN #12-03 Approval Date March 28, 2013
Supersedes TN ___ NEW__ Effective Date April 1, 2013
So that CMS may monitor the reasonableness of the methodology set forth in paragraph (4) on an ongoing basis, the State will report to CMS on a quarterly basis the current quarter’s average salaries and the number of individuals that have been placed in the community that quarter. The State will also report to CMS annually beginning census information and the number of individuals who actually moved from Developmental Centers to the community and the State’s anticipated placements for the next year.

When the cost data for each rate period is finalized, the State will calculate the aggregate upper payment limit in accordance with applicable federal law, regulations, and official guidance from CMS for all Developmental Centers and Community-based SOICF/DDs, and will provide CMS with its upper payment limit calculation. The State anticipates it will finalize the cost data for each rate period by completing a CFR in the normal course of business within 18 months of the end of the rate period. If the total payments received and expected to be received under this section (m) for all Developmental Centers and Community-based SOICF/DDs exceed the upper payment limit for such rate period as calculated by the State and accepted by CMS, the State will treat any overage as an overpayment the federal share of which will be refunded.
Effective July 1, 2011, the methodology described in the Rate Setting and Financial Reporting for under thirty-one bed Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DDs) section in this Attachment for voluntary operated facilities will be terminated, with the exception of those sections outlined in this section (n). The methods and standards effective July 1, 2011 for establishing payment rates for under thirty-one bed voluntary operated ICF/DDs are described in this section (n). Rates for ICF/DD services delivered on dates after June 30, 2011 and before July 1, 2014 shall be determined in accordance with this section (n).

(1) Definitions (applicable to this section):

**Allowable Capital Costs** - All necessary costs incurred to provide covered services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (PRM-15). This will include allowable lease/rental and ancillary payments; depreciation of equipment, vehicles, leasehold improvements and real property; and bonding, principal, interest and financing expenditures associated with the purchase of equipment, vehicles and real property, and related expenditures and leasehold improvements.

**Allowable Operating Costs** - All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of ICF/DDs. Necessary and proper costs are costs which are common and accepted occurrences in the field of ICF/DDs. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (PRM-15), which will include allowable Administration, OTPS, Clinical, Direct Care, Support, Fringe Benefits and Utilities.

**Base Period** - The period from July 1, 1999 to June 30, 2000 for Region I facilities and January 1, 1999 to December 31, 1999 for Region II and Region III facilities.

**Capital Costs** - Costs that are related to the acquisition and/or long term use of land, buildings, construction and equipment.

**Certified Capacity** - Represents the total capacity of the ICF/DD in the provider’s operating certificate as of the first day of the rate period.

**Consolidated Fiscal Report (CFR)** - A reporting tool prepared in accordance with Generally Accepted Accounting Principles and utilized by all New York State (NYS) government and non-government providers to communicate their annual costs incurred as a result of operating Office of People with Developmental Disabilities (OPWDD) programs and services, along with related utilization and staffing statistics.
Cost Component Category - The following cost component categories are utilized when establishing rates: Administration, OTPS, Clinical, Direct Care, Support, Fringe Benefits, Utilities, Day Services, Efficiency Adjustments, Capital and a Provider Assessment.

Depreciation - The allowable cost based on historical costs and useful life of buildings, fixed equipment, capital improvements and/or acquisition of real property. The useful life will be based on “The Estimated Useful Life of Depreciable Hospital Assets (2008 edition).” The depreciation method used will be the straight line method.

De-trend - The process of deflating dollars to represent those dollars in a prior period, using the applicable trend factors.

DDP Score - A Developmental Disabilities Profile (DDP) score is an index which measures an individual's disabilities in various domains, such as Medical, Behavior, Adaptive, and Clinical Service needs.

Disability Increment - The methodology for developing facility-specific Direct Care full-time equivalents (FTEs) using aggregate and measurable consumer disability characteristics.

Facility - The site or physical building where actual services are provided.

ICF/DD - An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) that has a certified capacity of under thirty-one beds and that is not operated by the State.

Individual - A person who resides in an ICF/DD.

Lease/Rental and Ancillary Payments - A facility's annual rental payments for real property and ancillary outlays associated with the property, such as utilities and maintenance.

Maximum Units of Service - Maximum units of service are equal to the certified capacity multiplied by the number of days in the rate period.
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**Newly Certified Facility** - A Region I facility which opened after July 1, 2008, or a Region II or III facility which opened after January 1, 2008.

**Operating Certificate** - The authority and documentation issued by OPWDD permitting a provider to operate a residential facility for the care and treatment of persons with developmental disabilities. Each physical ICF/DD location is assigned a unique operating certificate.

**Pass-Through Costs** - Allowable costs that are not subjected to screen values.

**Provider** - A voluntary agency that has been issued a Medicaid provider agreement for an ICF/DD. A provider may operate multiple ICF/DDs.

**Provider Rate** - The provider-specific rate resulting from implementation of the reimbursement methodology. The provider rate is unique for each provider.

**Provider Assessment** - An assessment in the amount of 5.5% uniformly imposed on all providers of ICF/DD services.

**Rate Period** - The time period for which rates are effective.

**Reimbursable Costs** - Allowable and pass through costs that have prevailed after being subjected to screen values.


**Re-based Period** - The period from July 1, 2008 to June 30, 2009 for Region I facilities, and January 1, 2008 to December 31, 2008 for Region II and III facilities.

**Regions**

i. **Region I:**

A facility which is located in the counties of New York, Bronx, Kings, Queens, and Richmond.

The cost report period and rate period for Region I is July 1st to June 30th. A provider located in Region I may request to report on the Region II and III period.
ii. **Region II:**

A facility which is located in the counties of Putnam, Rockland, Nassau, Suffolk, and Westchester.

The cost report period and rate period for Region II is January 1st to December 31st. A provider located in Region II may request to report on the Region I period.

iii. **Region III:**

A facility which is located in any other county in New York State, not specified in Region I or Region II.

The cost report period and rate period for Region III is January 1st to December 31st. A provider located in Region III may request to report on the Region I period.

**Screen Values** - A dollar figure, represented in base period dollars, which actual costs are measured against in determining reimbursable costs.

**Trend Factor** - A percentage applied to all applicable costs that represent inflation in the costs of goods and services.

**Unit of Service** - A unit of service is equal to one day that an individual resides in an ICF/DD. Maximum units of service are equal to the certified capacity times the number of days in the rate period.

(2) **General Overview of the Methodology:**

i. The methodology first de-trends costs from the re-based period to the base period using the trend factors in paragraph (6)(i)(a); compares these amounts to screen values as described in paragraph (3) to determine the lower of cost or screen; compares these results to the costs as of June 30, 2011, as per paragraph (4); establishes reimbursable operating costs; then trends those costs up to the rate period; and incorporates costs for Day Service, Capital and a Provider Assessment. The methodology results in one per diem rate for each provider operating one or more ICF/DDs.

ii. **Provider Rate** = (Reimbursable Operating Costs + Day Services + Efficiency Adjustments + Capital + Provider Assessment) / Maximum Units of Service

The facility-specific efficiency adjustments are listed in the Supplemental Detail Schedule in Appendix A.
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(3) Establishing Screen Values and Reimbursable Operating Costs

i. Administration Screen Value and Reimbursable Costs

(a) **Administration Screen Value** is equal to 85% of the provider’s administration screen value as of June 30, 2011.

The facility-specific administration screens are listed in the Supplemental Detail Schedule in Appendix A.

(b) **Reimbursable Administration Costs** are the lesser of:

1. The administrative costs as reported on the re-based CFR, de-trended to the base period; or
2. Screen value as described in paragraph (3)(i)(a).

ii. Other than Personal Service (OTPS) Screen Value and Reimbursable Costs

(a) **OTPS Screen Value** is calculated by multiplying the per bed value for the facility’s region, by the certified capacity.

(b) OTPS regional per bed value (in base period dollars) are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Per Bed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region I</td>
<td>$16,097</td>
</tr>
<tr>
<td>Region II</td>
<td>$13,085</td>
</tr>
<tr>
<td>Region III</td>
<td>$16,418</td>
</tr>
</tbody>
</table>

(c) **Reimbursable OTPS Costs** are the lesser of:

1. OTPS costs, as reported on the re-based CFR, de-trended to the base period; or
2. Screen values as described in paragraph (3)(ii)(a).

(d) **Expensed Equipment and General Insurance** – Costs as reported on the re-based CFR, de-trended to the base period, are pass-through costs and will not be subject to a screen value.
iii. **Personal Service (PS) Clinical Screen Value and Reimbursable Costs**

(a) **PS Clinical Screen Value** is calculated by multiplying the base period PS Clinical salary for the facility's region, by the Clinical FTEs reported on the re-based CFR, Personal Services and Contracted Direct Care and Clinical Personal Services Schedules. The contracted clinical FTEs are calculated as follows: (clinical contracted personal service dollars, deflated to the base period) divided by (the base period PS Clinical salary for the facility's region adjusted to include the facilities fringe benefit percentage described in paragraph (3)(vi)(a)).

(b) PS Clinical regional salaries (in base period dollars) are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>$56,510</td>
</tr>
<tr>
<td>II</td>
<td>$53,584</td>
</tr>
<tr>
<td>III</td>
<td>$40,414</td>
</tr>
</tbody>
</table>

(c) **Reimbursable PS Clinical Costs** are the lesser of:

1. PS Clinical costs, as reported on the re-based CFR, Personal Services and Contracted Direct Care and Clinical Personal Services Schedules, de-trended to the base period; or

2. Screen value as described in paragraph (3)(iii)(a).

iv. **Personal Service (PS) Direct Care Screen Value and Reimbursable Costs**

(a) **PS Direct Care Screen Values** are calculated by multiplying the base period PS Direct Care salary for the facility's region, by the calculated Direct Care FTEs as described in paragraph (3)(iv)(c).

(b) Direct Care regional salaries (in base period dollars) are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>$29,375</td>
</tr>
<tr>
<td>II</td>
<td>$29,522</td>
</tr>
<tr>
<td>III</td>
<td>$25,005</td>
</tr>
</tbody>
</table>

(c) Direct Care FTEs are calculated by utilizing the facility-specific disability increment plus bed size increment.

1. The disability increment is only calculated if at least 50% of the DDP scores for individuals that resided in the facility during the re-based
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period are available. If less than 50% of the DDP scores are available, the direct care FTEs are based on bed size increment alone.

2. The disability increment using the DDP scores is calculated as follows:

\[(0.063 \text{ FTEs} \times \text{the facility-specific mean direct care score}) + (0.008 \text{ FTEs} \times \text{the facility-specific mean behavior score}) + (0.062 \text{ FTEs} \times \text{the facility standard deviation direct care score}) - (0.019 \text{ FTEs} \times \text{the facility standard deviation behavior score})\]

3. Direct care score is calculated for each individual from the DDP Adaptive and Health/Medical scores as follows:

\[7.962 + (0.156 \times \text{the Adaptive score}) + 1.611 \times \text{the Health/Medical score}\]
### Bed Size Increments

<table>
<thead>
<tr>
<th>Bed Size</th>
<th>Bed Size Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
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<td>5</td>
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<td>29</td>
<td>33.205</td>
</tr>
<tr>
<td>30</td>
<td>34.145</td>
</tr>
</tbody>
</table>

**(d)** Reimbursable PS Direct Care Costs are the lesser of:

1. PS Direct Care costs, as reported on the re-based CFR, Personal Services and Contracted Direct Care and Clinical Personal Services Schedules, de-trended to the base period; or

2. Screen values as described in paragraph (3)(iv)(a).
v. **Personal Service (PS) Support Screen Value and Reimbursable Costs**

(a) **PS Support Screen Value** is calculated by multiplying the salary for the facility's region by Support FTEs in the re-based CFR, Personal Services Schedule.

(b) Support regional salaries (in base period dollars) are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>$29,375</td>
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</tbody>
</table>

(c) **Reimbursable PS Support Costs** are the lesser of:

1. PS Support Costs, as reported on the re-based CFR, Personal Services Schedule, de-trended to the base period; or

2. Screen values as described in paragraph (3)(v)(a).

vi. **Fringe Benefit Percentage and Reimbursable Costs**

(a) For each facility, a **Fringe Benefit Percentage** is calculated by dividing the sum of the PS Direct Care, PS Clinical, and PS Support fringe benefits costs, as reported on the re-based CFR de-trended; plus the addition of certain facility specific reimbursable fringe costs incurred subsequent to the re-based CFR, de-trended; by the sum of the PS Direct Care, PS Clinical, and PS Support costs (exclusive of contracted Personal Service) as reported on the re-based CFR, de-trended.

\[
\text{Fringe Benefit \%} = \frac{\text{de-trended PS Direct Care} + \text{PS Clinical} + \text{PS Support fringe benefits costs} + \text{certain facility specific reimbursable fringe costs incurred subsequent to the re-based CFR, de-trended}}{\text{de-trended total PS Direct Care} + \text{PS Clinical} + \text{PS Support costs, exclusive of contracted Personal Service}}
\]

The facility-specific reimbursable fringe costs incurred subsequent to the re-based CFR (HCA IV-VI) are listed in the Supplemental Detail Schedule in Appendix A.

(b) **Reimbursable Fringe Benefit Costs** are calculated by multiplying the facility-specific fringe benefit percentage, as described in paragraph (3)(vi)(a), by the total PS Direct Care, PS Clinical, and PS Support reimbursable costs, exclusive of contracted Personal Service.
vii. **Utilities Reimbursable Costs**

(a) **Reimbursable Utility Costs** will be equal to the sum of all utilities costs reported on the re-based CFR, Program/Site Data Schedule, de-trended.

(b) All utilities costs are pass-through costs and will not be subjected to a screen value.

(4) **Comparison of Costs** – The rationale of the cost comparison is to prevent providers from experiencing decreases exceeding 10% of the June 30, 2011 costs or increases above their June 30, 2011 costs. If the re-based costs fall within 90% - 100% of the June 30, 2011 costs, OPWDD will proceed calculating the provider rate using the re-based costs. The methodology for the comparison of costs is as follows:

The sum of each provider’s re-based, de-trended, reimbursable operating costs as described in paragraphs (3)(i)(b), (3)(ii)(c), (3)(iii)(c), (3)(iv)(d), (3)(v)(c), (3)(vi)(b), and (3)(vii)(a) of this section less the efficiency adjustment are compared to the reimbursable operating costs in the provider's rates less the efficiency adjustment as of June 30, 2011. As a result of this comparison, one of these conditions will prevail in calculating the provider rate:

i. If the re-based, de-trended, reimbursable operating costs are *between* 90% and 100% of the June 30, 2011 de-trended reimbursable operating costs, the re-based, de-trended, reimbursable operating costs prevail in calculating the provider rate;

ii. If the re-based, de-trended reimbursable operating costs fall *below* 90% of the June 30, 2011 de-trended reimbursable operating costs, an adjustment will be made to bring the provider’s re-based, de-trended reimbursable operating costs up to 90% of the provider’s June 30, 2011 de-trended reimbursable operating costs, and prevail in calculating the provider rate; or

iii. If the re-based de-trended reimbursable operating costs are *higher than* the June 30, 2011 de-trended reimbursable operating costs, then the June 30, 2011 de-trended reimbursable operating costs will prevail, less the administrative 15% reduction, in calculating the provider rate.

(5) **Day Services** – ICF/DDs are reimbursed for individuals who participate in day service programs/activities provided by State and voluntary providers.
The facility-specific day services are listed in the Supplemental Detail Schedule in Appendix A.

(6) Trend Factors

(i) Once the reimbursable costs for all of the appropriate cost component categories have been established as per paragraphs (4)(i), (4)(ii), or (4)(iii) of this section, each cost component category is then trended up to the rate period.

(a) The trend factors from the base period to June 30, 2014 are as follows:

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<th>Calendar Year From</th>
<th>Calendar Year To</th>
<th>Fiscal Year From</th>
<th>Fiscal Year To</th>
<th>Trend Factor % Change</th>
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<td>FY 2011/2012</td>
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<tr>
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<td>CY 2012</td>
<td>FY 2011/2012</td>
<td>FY 2012/2013</td>
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<tr>
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<td>CY 2013</td>
<td>FY 2012/2013</td>
<td>FY 2013/2014</td>
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<td>CY 2014</td>
<td>FY 2013/2014</td>
<td>FY 2014/2015</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

(7) Capital – The rate will include capital if the provider has been approved for capital reimbursement. Providers requesting the incorporation of property reimbursement in an ICF/DD rate must get the reimbursement level prior approved by OPWDD. Providers are reimbursed for capital according to depreciation, amortization, lease and capital indebtedness schedules that are developed as part of an OPWDD prior property approval process. OPWDD’s prior property review process includes an assessment that assets and leases are within fair market value and that capital interest costs are at market rates. Property reimbursement schedules, developed as part of the prior approval process, delineate by rate period the exact amount of approved capital reimbursement including the expiration date for that reimbursement. Useful asset lives utilized in the depreciation and amortization schedules are in accordance with the Provider Reimbursement Manual (PRM-15).
The facility-specific property reimbursement levels are listed in the Supplemental Detail Schedule in Appendix A.

In addition to the capital reimbursement described above, allowable equipment and vehicle related costs will be updated annually based on the costs reported on the CFR from two years prior. (e.g., the January 1, 2012 cost update will be based on the January 1, 2010 through December 31, 2010 CFR.)

(8) **Provider Assessment** - The provider assessment on ICF/IID services rendered to Medicaid recipients shall be considered an allowable cost and reimbursed through Medicaid service rates of payment.

(9) **Existing Facilities** - Rates for ICF/DDs that are not newly certified facilities will be calculated in accordance with paragraphs (3), (4), (5), (6), (7), (8), and (11) of this section.

**Newly Certified Facilities** - For newly certified facilities, OPWDD will request a budget from the provider. A desk audit process will compare budgeted average salaries, OTPS, Administration and Fringe with those reimbursed in other ICF/DDs operated by the provider. If the provider does not operate other ICF/DDs, OPWDD will desk audit against regional ICF/DD averages. The budgeted dollars for all of the cost component categories are subject to the screen values as per paragraph (3) of this section. Rates for newly certified facilities will continue to be calculated as described in paragraphs (5), (6), (7), (8), and (11) of this section.

(10) **Computation of the Provider Rate** - The provider rate will be the sum of the trended cost component categories of the provider's facility rates, aggregated as one provider agency rate, as described in paragraph (4), with the addition of the provider assessment, as described in paragraph (8), divided by the maximum units of service.

(11) **Rate Appeals** - A provider may appeal for an adjustment to its rate that would result in an annual increase of $5,000 or more in the provider's allowable costs and that is needed because of bed vacancies. The appeal request must be made within one year of the close of the rate period in which the bed vacancies occurred. OPWDD will only grant the appeal if the provider has demonstrated that the vacancies were unavoidable. No amount granted on appeal will exceed the provider's ICF/DD program loss.

(12) **Adjustments** - A provider may request a rate revision based on rate computation errors by notifying OPWDD either within 90 days of the provider receiving the rate or within 90 days of the beginning of the period in question, whichever is later. Adjustments to rates will be limited to those adjustments which will result in an annual increase or
decrease of $5,000 or more in the provider’s allowable cost. For changes in certified capacity, the operating portion and units of service used to calculate the provider’s rate will be prorated up or down in the same ratio as the change in capacity.

(13) Supplemental Schedule - Refer to the Supplemental Schedule in Appendix A beginning on the next page.
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<th>Provider</th>
<th>Op Cert</th>
<th>Admin Screen 6/30/11</th>
<th>Admin Screen 7/1/11</th>
<th>Efficiency Adj 6/30/11</th>
<th>Efficiency Adj 7/1/11</th>
<th>Day Services 6/30/11</th>
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<td>(10,171)</td>
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### APPENDIX A

#### Supplemental Detail Schedule

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# APPENDIX A

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TN 11-85
Supersedes TN NEW

Approval Date November 6, 2014
Effective Date July 1, 2011


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## APPENDIX A

### Supplemental Detail Schedule

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## APPENDIX A

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TN 11-85
Supersedes TN NEW

Approval Date November 6, 2014
Effective Date July 1, 2011


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## APPENDIX A

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## APPENDIX A

### Supplemental Detail Schedule

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# Supplemental Detail Schedule

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### APPENDIX A

**Supplemental Detail Schedule**

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Methods and Standards for Establishing Payment Rates

Out of State Services

[Skilled Nursing and Intermediate Care Facilities (SNF’s and ICF’s)]

Nursing Facilities

New York State reimburses [SNF/ICF] nursing facility services provided in accordance with rates negotiated by the [recipient's district of fiscal responsibility or directly] State and the facility. The rate negotiated is based on the approved Medicaid rate established by the facility's home state. Where ancillary services for the necessary care of the recipient are not included in the home state's Medicaid rate, the rate approved by New York State may be augmented to include the additional services. All out-of-state rates, except those equal to or less than the facility's home state Medicaid rate must be approved by both the State Department of Social Services and the Division of the Budget. In those instances where the proposed rate is not approved, an alternative rate is negotiated and re-submitted to the Division of the Budget. Only one rate for a level or type of care will be established for a given out-of-state facility and will be applicable to all local districts. The implementation of a single locator code for all out-of-state billings precludes the potential for different rates being paid to the same facility on behalf of different local districts.
DEFINITION OF A CLAIM BY TYPE OF SERVICE

A claim is defined as a request for reimbursement for medical services rendered to an eligible Medicaid recipient.

Claims must be submitted on acceptable claim forms.

1) **Claim Form A** - used by Practitioners (physicians, podiatrists, private duty nurses, therapists, clinical psychologists), Clinics (Outpatient and Free-Standing), Dental providers, (private practicing, schools and clinics), Laboratories, HMO’s Referred Ambulatory, Home Health, Personal Care Services, Transportation and Eye Care providers.

2) **Practitioner Claim Form** - used by Physicians.

3) **Claim Form B** - used by Skilled Nursing Facilities, Health Related Facilities, Child Care Agencies and Intermediate Care Facilities.

4) **Claim Form C** - used by Hearing Aid dealers and Durable Medical Supplies, Equipment and Appliances vendors.

5) **UBF-1-81** - used by Inpatient Hospital providers.

6) **Pharmacy Claim Form** - used by pharmacy providers.

7) **Child Health Assurance Program Claims and report Form** - used by physicians and clinics to bill for services rendered under the CHAP (EPSDT) program.

8) **Universal Physician Claim Form** - (New York State’s modification of the HCFA-1500) (when implemented will be used by physicians).
Claims are submitted either using the approved rate for each service or billing on a fee-for-service basis.

**Providers which submit claims on a fee-for-service basis include:**

- Physicians/CHAP physicians
- Podiatrists
- Private Duty Nurses
- Therapists
- Clinical Psychologists
- Pharmacies
- Dentists (private practice, dental school)
- Laboratories
- Eye Care
- Referred Ambulatory
- Transportation
- Durable Medical Supplies, Equipment, Appliances
- Hearing Aid Dealers

**Providers which submit claims based on a rate include:**

- Outpatient Clinics
- Free Standing Clinics
- Inpatient Hospital
- Skilled Nursing Facilities
- Health Related Facilities
- HMO
- Home Health Agencies (including Long Term Home Health)
- Personal Care Services
- Child Care Agencies
- Intermediate Care Facilities/MR
1. **Frequency of Data Exchanges**

433.138(d)(1) **State Wage Information Collection Agency (SWICA) and SSA Wage and Earnings File.**

Matches with the SWICA in NYS are performed daily and quarterly. Matches with SSA Wage and Earnings files occur monthly.

433.138(d)(3) **State Title IV-A Agency.**

In New York State, all potentially employable recipients are matched with an employee file from the Department of Labor. Since these recipients and their resources are carried on a single eligibility file, a data exchange is not needed.

433.138(d)(4)(i) **State Worker’s Compensation.**

A match with Worker’s Compensation is performed on an annual basis.

433.138(d)(4)(ii) **Department of Motor Vehicle Accident File.**

This is conducted on an annual basis.

433.138(e) **Diagnosis and Trauma Code Edit**

The Department uses diagnosis and trauma codes and provider entered accident indicator codes on a monthly basis to determine the legal liability of third parties.
Follow-up Requirements

433.138(g)(1)(i) **SWICA, SSA Wage and Earning Files and Title IV-A Data Exchanges.**

Districts are required to follow-up on information obtained during initial application and redetermination so that it can be used for claims processing and/or recoveries within 60 days of the district first becoming aware of it.

433.138(g)(2)(i) **Health Insurance Information and Worker’s Compensation.**

The Department has issued an Administrative Directive to all local district eligibility and Third Party Workers that establishes procedures for identifying third party resources and requires entering the information on the data base within 60 days so it can be used for claims processing.

433.138(d)(4)(ii) **Department of Motor Vehicle.**

If the match identifies a Medicaid recipient who was involved in an auto accident, a questionnaire is sent to the recipient to determine if any medical services were necessary as a result of the accident. Questions are also asked about insurance coverage.

If a positive response is received, it is sent to the local district which has fiscal responsibility for the recipient. The local district is instructed to investigate the potential liability and pursue recoveries when necessary. If medical services are still being provided as a result of the accident, the coverage is added to MMIS to affect claims processing.

433.138(e) **Diagnosis and Trauma Code Follow-up.**

The Department has been editing claims using diagnosis and trauma codes as well as provider entered accident indicator codes since MMIS was implemented. Through this experience, which has included extensive analysis by local district staff, the Department has developed an efficient program to pursue potential liability for accident/casualty cases.
433.138(e) Diagnosis and Trauma Code Follow-up (cont.)

On a monthly basis, claims that meet the criteria using trauma diagnosis codes and accident indicators are selected and are used to generate questionnaires to both the recipient and the medical provider for further information concerning the accident. If the questionnaires are not returned, a follow-up letter is sent to the provider and/or recipient. If either questionnaire is returned indicating the potential for a third party to pay for medical expenses, the questionnaire is forwarded to the local district that has fiscal responsibility for the recipient. After the local district has investigated the potential resource a lien is filed if a third party is found to be liable. In any event the Department is to be notified of the outcome of the local district investigation.

The information will only be added to the data base where a provision for medical coverage is involved and it is expected that the recipient will require additional medical services past the date of accident.
1. **Providers Compliance with 433.139(b)(3)(ii)(C).**

Compliance with these billing requirements is determined through third party edits in MMIS. If the Medicaid recipient is covered by insurance that is furnished through medical support enforcement carried out by the State IV-D agency, the claim is denied if the specific medical service is covered by the insurance and the provider fails to indicate that the third party was billed by making a positive entry in the other insurance payment field on the claim form.

2&3. **Threshold Amount 433.139(F)(2) and (3).**

New York State will continue to pursue third party reimbursement through cost avoidance in the first instance by requiring providers to pursue third party resources prior to submitting claims to Medicaid. However, upon discovering insurance which was previously unknown or not utilized, the State will elect not to pursue any potential recovery below threshold amounts periodically established to represent a cost effective return for particular classes of cases. Claims may be accumulated for a period not to exceed two years, for purposes of recovery.

Specific exceptions to this policy include but are not restricted to the following:

- Where accumulated amounts of claims per individual, carrier or provider provide a cost effective basis to submit claims for reimbursement.

- The deterrent effect of recovery is felt to outweigh the administrative cost of claims submission.

- Special audit situations which warrant a recovery based on the specific merits of the case.

- Technological advances which allow computer techniques to be utilized to provide an efficient submission procedure.
## State Plan Under Title XIX of the Social Security Act

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
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<tr>
<td>1906 of the Act</td>
<td>State Method on Cost Effectiveness of Employer-Based Group Health Plans</td>
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The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district or Department of Health staff obtain information about the insurance policy and the individual applying for the premium payment. If the average Medicaid payment is known for certain demographics (e.g., sex, age, location), cost effectiveness for paying the premium can be easily determined by comparing that cost to the cost of a premium for the same demographics.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district or Department of Health staff.

The following points should be considered at the time of determination and redetermination for coverage provided through employer-based group health plans.

1. Assess the types of medical services covered by the health insurance policies.
2. Has there been a high utilization of medical services by the applicant/recipient (A/R)? Request the applicant/recipient to bring to the interview all medical bills (paid and unpaid), statements of insurance benefit payments and premium notice for the past year. Determine the total amount paid by all parties for the medical services.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. Can the past utilization of medical expenses be expected to continue or increase?

   During the interview, inquire if any acute or chronic medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization.

   Due to the client’s age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected?

5. For policies in force, what are the maximum benefit levels of the policy?

   - Have the maximum benefit levels been met, rendering the A/R ineligible for benefits?

   - If so, is the maximum benefit recurring? Will it be reinstituted on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?

   - If there will be benefits or recurring benefits that will pertain to the A/R’s potential medical expenses, how do these benefits compare to the cost of the premium?

6. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.

7. Compare the cost of premium to the cost of all medical services received by the applicant/recipient in the previous year (see #2). Using this comparison and the other factors related to anticipated future utilization (3 through 6) decide whether or not it is cost beneficial to maintain the policy. That is, does the cost of the premium payment and cost-sharing amounts appear likely to be less than Medicaid expenditures for an equivalent set of services?

**NOTE:** For those districts that use the [Health Insurance Automated Decision Tree] “Health Insurance Cost Appraisal Program (HICAP)” make sure that the premium payment used in the calculation is the Medicaid portion of the premium payment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(l) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(l) of the Social Security Act.

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<th>#09-58</th>
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<tr>
<td>Supersedes TN</td>
<td>NEW</td>
<td>Effective Date</td>
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Sanctions for Psychiatric Hospitals

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan; or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Income and Eligibility Verification System Procedures
Requests to Other State Agencies

[New York State does not routinely match or request information from any other State in order to verify Medicaid eligibility.]

New York State routinely matches its Medicaid recipient/applicant files against:

1) New York State employee payroll file;

2) Death Certificates filed with the New York State Department of Health; and

3) Public Assistance Reporting Information System (PARIS), a system that matches data from federal and state public assistance programs.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

New York will mail an ID card to any address indicated by the otherwise eligible client. This includes Post Office boxes as well as residential addresses or other addresses of convenience.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Established by Chapter 752 of the Laws of 1990 by adding Article 29-c of the Public Health Law. Establishes in statute the right of a competent adult to appoint a health care agent to make decisions about healthcare treatment for the adult in the event the adult no longer has the capacity to make such decisions.

The law confers no new rights regarding the provision or rejection of any specific health care treatment and affirms existing laws and policies which limit individual conduct, including those laws and policies against homicide, suicide, assisted suicide and mercy killing.

The following are definitions that are applicable:

“Adult” means any person who is eighteen years of age or older, or is the parent of a child, or has married.

“Capacity to make health care decisions” means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.

“Health Care” means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.

“Health Care Agent” or “Agent” means an adult to whom authority to make health care decisions is delegated under a health care proxy.

“Health Care Decision” means any decision to consent or refuse to consent to health care.

“Health Care Proxy” means a document delegating the authority to make health care decisions, executed in accordance with the requirements of this law.

New York

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attachment 4.34-a

TN #91-81

Approval Date January 15, 1992

Supersedes TN New

Effective Date December 1, 1991
Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

New York State will use the factors described at §488.404(b)(1) to determine the seriousness of deficiencies.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

**Termination of Provider Agreement:** Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

Will use the criteria and notice requirements specified in the regulation.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[ ] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[X] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Appointment of Temporary Management (Alternative)

New York State provides under §2806-b of the Public Health Law pertaining to caretakers and §2810 of the Public Health Law pertaining to receivers, for management of a facility to assure resident health and safety and an orderly closure or correction of requirements. These receivers and caretakers must pass a character and competence review.

The caretaker/receiver remedy described above is being submitted as an alternative remedy. It is more stringent than OBRA '87 requirements for facilities with care problems so serious as to warrant new management imposed by the state and that control not be returned to the same operator. Our experience has demonstrated great success in gaining court support for the appointment of caretakers or receivers under our current provisions. In instances of immediate jeopardy, §2806-b(c) calls for the caretaker to be appointed under the provisions specified in §2810(2). This procedure allows the state’s request for a caretaker appointment to be before a Supreme Court judge 5 days after notice of the caretaker action is given to the provider. The notice is given immediately upon the state decision that a caretaker is necessary.

Over the last 10 years, 25 facilities have had receivers utilized on a voluntary or involuntary basis to resolve care issues.
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[ ] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN #95-33
Supersedes TN NEW
Approval Date March 7, 1997
Effective Date July 1, 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

**Civil Money Penalty:** Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[ ] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[ ] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of Residents: Transfer of Residents with Closure of Facility: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[ ] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[X] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

In Emergency Cases, Closure of Facility and/or Transfer of Residents

Section 2806 of the Public Health Law gives the Commissioner the authority to revoke or suspend a facility's operating certificate and/or transfer residents. Rather than subject residents to unnecessary transfer, Section 2806-b of the Public Health Law is utilized to seek emergency appointment by a court of a caretaker on a temporary basis, to protect the interests of the residents while legal action is taken to revoke the operating certificate of the facility and place the facility in receivership and ultimately under a new operator.
Enforcement of Compliance for Nursing Facilities

**Directed Plan of Correction:** Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[ ] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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**Approval Date** March 7, 1997

**Effective Date** July 1, 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Directed Inservice Training: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

[X] Specified Remedy

(Will use the criteria and notice requirements specified in the regulation).

[ ] Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

**Additional Remedies:** Describe the criteria (as required at §1919(h)(2)(A) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, category 3 as described as 42 CFR 488.408).

**STATE CIVIL MONEY PENALTIES IMPOSED AS A CATEGORY 2 ENFORCEMENT REMEDY**

New York provides under Section 12 of the Public Health law a civil money penalty system which allows fining facilities for each occurrence of a deficiency. A facility may be fined up to $2,000 for the one time occurrence of any violation of state requirements even if that violation has been corrected. It provides us with the flexibility to evaluate the deficiencies cited, to determine the existence of poor performing facilities, and to fine or not to fine a facility which has corrected the deficiencies, based on the severity and repetitiveness of the violation. Any facility with deficiencies identified with a scope and severity in box (D-L) on the remedy grid will be screened to determine whether a fine will be recommended. Effective October 1, 1990, 10 NYCRR Part 415 was revised and mirrors 42 CFR Part 483 of the federal nursing home requirements in most areas exceeding requirements in some sections. Since the requirements are analogous, compliance with state regulations that might be achieved as a result of utilizing this remedy should also result in a comparable outcome related to the federal requirements also.

State fines will be assessed at a higher level for facilities identified at subsequent surveys with repetitive violations as an incentive to maintain compliance. In some cases a portion of the state fine may be suspended contingent on maintaining compliance with selected regulatory groupings for a specified period of time. Failure to comply with that provision would result in the collection of the suspended fine as well as assuming a new fine for those violations.

This remedy encourages facilities not to allow deficiencies to recur and discourages initial deficiencies, as facilities understand that they cannot allow deficiencies to occur and avoid a penalty by correction within 30 days.

Funds collected by the state from imposition of a penalty are not applied to maintain operation of a facility pending correction or closure or to costs of relocation or to lost resident funds. Facilities in such a situation are monitored by the state to assure that operations are maintained. The Department requires operator(s) to provide a final account of residents’ monies. In addition, Public Health Law Section 2810(3) provides a mechanism for non-interest bearing payments to receivers who take over deficient facilities. The receiver must repay such loans.

**TN #95-33**  
**Approval Date** March 7, 1997  
**Supersedes TN** NEW  
**Effective Date** July 1, 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Information disclosed by the New York State Nursing Home Nurse Aide Registry in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv)

- Individuals’ certification number
- Date of recertification, if applicable
- Last home address of record
- Date of birth
- Date of conviction of patient abuse, neglect, mistreatment of patients, or misappropriation of resident’s property, if any.

TN  #92-05
Supersetes TN  NEW
Approval Date  April 29, 1992
Effective Date  January 1, 1992
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

New York State Nursing Home Nurse Aide Registry information included on the registry in addition to the information required by 42 CFR 483.156(c)

Maiden name and other surnames used (ASI)

Address of nurse aide when certified/recertified

Date of Birth

Social Security Number

Name/Date of state approved training and competency programs successfully completed

Certification number of nurse aide

Most recent recertification date of nurse aide

Nursing home employer at time of certification/recertification

Date of conviction(s), for patient abuse, neglect, mistreatment of patients, or misappropriation of resident property, if any.
DEFINITION OF SPECIALIZED SERVICES

1) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, result[s] in [the continuous and aggressive implementation of] an individualized plan of care that demands hospitalization.

The care plan must require one or more of the following:

a. [Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and, as appropriate, other professionals.] Hospital level assessment or diagnosis of recent behavioral change;

b. [Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and] Intensive observation, protection, assistance, or supervision from the professional staff of a hospital;

c. [Is directed toward diagnosing and reducing the resident’s behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time]. Introduction or change in medication or other somatic treatment that needs frequent round the clock monitoring by professional staff.

The plan must be developed and supervised by an interdisciplinary team which includes a physician, qualified mental health professional and, as appropriate, other professionals.

The plan must be directed toward diagnosing and reducing the resident’s behavioral symptoms that necessitated hospitalization, so as to improve his or her independent functioning to a level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

2) For mental retardation, specialized services means the services specified by the State which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of Section 483.440(a)(1).
New York

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CATEGORICAL DETERMINATIONS

Categories for which the State Mental health or mental retardation authority may make an advance group determination that Nursing Facility (NF) services are needed are:

1) **Convalescent care from an acute physical illness which:**
   
   (i) Required hospitalization; and
   
   (ii) Does not meet all the criteria for an exempt hospital discharge, which is not subject to preadmission screening as specified in Section 483.106(b)(2).

2) **Terminal illness**, as defined for hospice purposes in Section 418.3 of this chapter.

3) **Severe physical illness** such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson’s disease, Huntington’s disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

4) **Very brief and finite stays** of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with Mental Illness (MI) or Mental Retardation (MR) is expected to return following the brief NF stay.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

- Health Facility Memorandums – The Health Department's medium for issuing items in the New York State Official Compilation of Codes, Rules and Regulations, and written information on policy and procedures of concern to certified health facilities.

- Bureau of Long Term Care Staff conduct seminars and training for facility providers.

- The Health Department contracts with private vendors to present programs to providers.

- The survey process includes surveyors meeting with the facility's resident council.

- Ongoing communication occurs between the Bureau of Long Term Care and the State Ombudsman Office.

- Bureau of Long Term Care Staff meet with the provider associations regarding specific issues on policies and regulations.

- Bureau of Long Term Care Staff are available by telephone to answer specific provider questions.
The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

See Supplement 1A
Complaint Program Overview

The Department maintains a Patient Abuse Investigation program for investigation of complaints of physical abuse, mistreatment, and neglect. A General Complaint program is maintained for the investigation of complaints involving systemic problems in RHCFs. Complaints involving misappropriation of resident funds are investigated under the General Complaint Program.

The patient abuse reporting legislation was enacted to protect Residential Health Care Facility (RHCF) patients from abuse. The original statute became effective on September 1, 1977, and mandated the immediate reporting of RHCF patient abuse, mistreatment or neglect by certain licensed health care professionals and encouraged reports from all sources.

On September 1, 1980, the statute was amended to require all RHCF employees and licensed health care personnel to make such reports.

The administration of the patient abuse reporting program is the responsibility of the Office of Health Systems Management’s Bureau of Long Term Care Services. Following is a brief overview of the administrative procedures associated with the program.

- Reports may be made anytime, night or day, via the Office of Health Systems Management’s Hotline. The telephone number for each Office of Health Systems Management Area Office is displayed on the Hotline poster in every RHCF. An emergency contact number for evenings, weekends and holidays (518-445-9989) is also listed. Collect calls are accepted on all numbers.

- Each report to the Office of Health Systems Management is referred to the Deputy Attorney General for Medicaid Fraud Control for possible criminal investigation and to the Local District Attorney if a prior request for such information has been made by the District Attorney. Thirteen (13) such referral arrangements are currently honored. (August 1994)

- Each report is investigated on-site by Office of Health Systems Management Staff within 48 hours. A full investigation is conducted. This may include multiple visits to the residential health care facility, interviews of all involved, and a review of pertinent facility and patient records.

- The investigation results are compiled by the Office of Health Systems Management’s Area Offices and forwarded to the Commissioner of Health’s Designee for review.
• The Commissioner of Health's Designee renders a findings that either sustains the allegation of abuse or finds the allegation unsustained. If the allegation is unsustained, all records related to the report are expunged in accordance with the statute and the accused, the facility administrator and all officials previously contacted are notified of the determination. If an allegation is sustained, the accused is notified by certified mail that he/she may request a fair hearing and that as a result of the sustained finding he/she may be liable for a fine up to $2,000. The administrator of the facility is also notified of the sustained finding.

• The request for a fair hearing must be made in writing within 30 days of receipt of the finding of the Commissioner of Health's Designee. All fair hearings are scheduled and conducted by the Department of Health’s Division of Legal Affairs. The purpose of the hearing is to determine whether the record of the report of the written determination of the sustained finding should be amended or expunged on the grounds that the record is inaccurate or the determination is not supported by the evidence. The burden of proof in such a hearing is on the Office of Health Systems Management. The hearing will determine whether or not the sustained finding will be upheld, and if so, whether or not a fine is to be assessed. In the case of a licensed person, a referral will be made to the appropriate licensing board, and in the case of a certified nurse aide, a referral would be made to the RHCF Nurse Aide Registry.

• 10NYCRR 415.26j requires RHCFs to establish and implement policies and procedures for the receipt, review and investigation of allegations of misappropriation of resident property by the individuals in the employ of and/or whose services are utilized by the facility. This is to be done regardless of the monetary value of the property.

• An investigation is required to be made no later than 48 hours after the receipt of the allegation. The facility must maintain a log regarding the receipt, review, investigation, and disposition of every allegation including the name of the complainant and resident, a description of the personal property involved, and the staff designated to conduct the review and investigation.

• Under the General Complaint program, the Department investigates complaints of inadequate response by RHCFs to allegations of misappropriation of resident property. These complaints may be made to the Office of Health Systems Management Hotline as indicated above.
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• The RHCF is required to notify the resident and complainant in writing as to the findings upon disposition of the allegation and to notify the appropriate police agency when the results of the investigation indicate that there is reasonable cause to believe that a resident’s personal property valued at more than two hundred fifty dollars has been misappropriated. The RHCF may elect to make such notification when the personal property is valued at less than that amount.

• The RHCF is required to monitor all such referrals at least quarterly and to notify the New York State Department of Health within 72 hours of receipt of notice that such referral resulted in the conviction of an individual who was involved in the misappropriation of resident property.

• Upon receipt of notice of a conviction involving misappropriation of resident property by a nurse aide, the Department provides the individual with an opportunity to dispute the allegations and conviction. Report is then made to the New York State Nurse Aide Registry.

• Upon receipt of notice of a conviction involving misappropriation of resident property involving a licensed professional, a referral is made to the appropriate licensing authority. The licensing authority takes appropriate action after satisfying the individual’s due process rights.

• When a referral to the Registry is made of a sustained finding of physical abuse, mistreatment or neglect, or a conviction for misappropriation of resident property, the individual is given an opportunity to provide a brief statement, not exceeding 150 words, disputing the findings provided that this does not name any residents or the complainant.
Upon receipt of a written request, the New York State RHCF Nurse Aide Registry provides the following information:

Verification that an individual is a certified nurse aide,

The certification number,

The date of certification/recertification,

Copies of any final findings of resident abuse, mistreatment or neglect by a nurse aide and any statement from the nurse aid disputing the findings.

A report of a criminal conviction for resident abuse, mistreatment, neglect or misappropriation of resident property and the date of conviction.

This information is also available by telephone to RHCFs, nurse aide agencies/employment organizations, and nurse aide registries maintained by other states.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

New York State utilizes the flexible survey schedule which assigns nursing home surveys on a variable interval basis according to facility performance. Poor facilities are surveyed more often, whereas good facilities are surveyed less often. Facilities are surveyed in accordance with the Federal Surveillance process at 6-10 month, 10-13 month and 12-15 month intervals. These wide intervals makes it difficult for nursing homes to predict a general survey date, thus enabling the State to conduct surveys on a surprise basis. The flexible survey schedule ensures the average survey cycle is no more than twelve months.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Bureau of Long Term Care Services evaluates and fosters statewide consistency of the surveillance process. Area Office surveyors are trained to consistently apply federal decision making criteria contained in TASK 6 of Appendix P, Survey Protocol for Long Term Care Facilities. Statements of deficiencies are routinely reviewed by Area Office supervisory staff.

The Central Office Quality Improvement Unit reviews Statements of Deficiencies to ensure statewide uniformity. Area Office Long Term Care Program Directors are informed verbally and in writing of the results of these reviews.

Quality Improvement staff also conduct onsite reviews of the surveillance process. Surveyors performance in regard to consistent application of the survey process is evaluated and feedback is provided to individuals and supervisors.

The Bureau of Long Term Care Services staff respond to code interpretation and surveillance questions from the area offices. These questions and answers are sent to all offices to ensure consistency of code interpretation and application of the survey process.

Various improvement measures to foster consistency are in effect including regularly scheduled meetings with Long Term Care Program Directors from the 6 area offices and workgroups of surveillance staff who are participating in the development of tools to measure and reduce inconsistencies.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Complaints received by the Area Offices are screened by the Long Term Care Program Director and Team Leader. Based on severity, the complaint is categorized as a 340 (patient abuse or neglect) or a general complaint. If the complaint is determined to be a 340, it is investigated within 48 hours. (See Supplement 1A). General complaints may result in an onsite visit or be investigated at the next surveillance visit. The substance of the general complaint will determine when the onsite visit is completed.

Based on the type, number and severity of the complaints received, the Area Office may conduct a focus survey to determine the facility's compliance with the regulations. Monitoring visits may also be conducted to ensure the facility is progressing toward compliance. In addition, prior to the recertification survey all complaints are reviewed in order for surveyors to investigate and determine compliance with all applicable regulations.
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Citation

1902(a)(68) of the Act, P.L. 109-171 (section 6032)

Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities’ compliance with these requirements.

(1) Definitions.

(A) An “entity” includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an “entity” (e.g., a state mental
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity’s responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An “employee” includes any officer or employee of the entity.

(C) A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity needs not create an employee handbook if none already exists.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State’s provider enrollment agreements.

(5) The State will implement this State Plan amendment on 01/01/07 (date).

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.
Oversight will primarily be the responsibility of the Office of the Medicaid Inspector General, which will incorporate criteria to address these mandates into its periodic audits and investigations.

Under proposed regulatory provisions, each covered provider and entity, as defined in section 4.42(a)(1)(A) above, shall be required to submit to the Office of the Medicaid Inspector General on or before October 1, 2007, and on or before January 1, every year thereafter, a certification that it maintains the written policies, and any employee handbook, required under the above mandates and that they have been properly adopted and published by the provider entity, and disseminated among employees, contractors and agents. The written policies and any employee handbook shall be retained for a period of six years from the latter of the due date or the actual date of submission of the certification.

The Office of the Medicaid Inspector General will review the certifications of the entity, and will also review the written policies and any employee handbook maintained by the entity during audits, for compliance with the Social Security Act, and any additional requirements of which entities are notified. Failure to timely submit the required certifications, or to bring the written policies and any employee handbook into compliance upon reasonable notice from the Medicaid Inspector General, may be considered an unacceptable practice and subject the entity to sanctions and/or penalties. CMS may, at its discretion, independently determine compliance through audits of entities or other means.

In addition, the Medicaid Inspector General will request participation from other state agencies responsible for regulatory oversight and will strongly recommend inclusion of this periodic review during such agencies’ routine audits and investigations. These agencies will include:

- Department of Law: Medicaid Fraud Control Unit
- Office of Mental Health
- Department of Health: Offices of Health Systems Management, Professional Medicaid Conduct
- State Education Department: Office of Professions
- Office of Alcoholism and Substance Abuse Services
- Office of Mental Retardation and Developmental Disabilities
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Non discrimination

Currently approved methods of administration under the Civil Rights requirements are on file in the Regional Office.

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

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TN #74-2
Supersedes TN
Approval Date December 31, 1974
Effective Date January 1, 1974
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

NONDISCRIMINATION ON THE BASIS OF HANDICAP

METHODS OF ADMINISTRATION

1. The Affirmative Action Officer of the New York State Department of Social Services is primarily responsible for insuring compliance with the 45 CFR Part 84 Non-discrimination on the Basis of Handicap Regulations and Section 504 of the Rehabilitation Act of 1973 throughout the Department itself and for all agencies, institutions, organizations and vendors which provide services or benefits. The Bureau of Local Agency Manpower is responsible for compliance with the regulations for the fifty-eight local social service districts.

2. (a) The New York State Department of Social Services has issued a memorandum to all Department employees regarding the regulations. In addition the regulations will be included in the orientation program for all new employees.

   (b) The Department has issued an Administrative Directive to all local social service districts informing them of the provisions of the regulations and instructing them to notify all agencies, institutions, organization vendors which provide services as well as instruct them to file the Assurance of Compliance if they haven’t done so. In addition the Directive instructs local service districts to inform all applicants and recipients for any of the programs they administer of the provisions of the regulations.

   (c) The Department has published a display advertisement in a number of newspapers throughout the State indicating that the Department complies with the provisions of the regulations.

3. (a) The Affirmative Action Officer will conduct regular reviews of Department practices and policies to assure the individual is being discriminated against on the handicap.

   (b) The Bureau of Local Agency Manpower will conduct reviews of the local social service districts to insure that they are complying with the provisions of the regulations both in employability and equal availability services.