Line	Calculation Elements	Traditional Medicaid Fee-For-Service	Medicaid Managed Care "Default & Contract" (excludes GME)
Inlier Payment:		***Data Source and Formulas***	***Data Source and Formulas***
	Calculation of Inlier Payment:		
1	Discharge Case Payment Rate (Without IME for Medicaid Managed Care)	PUB_MA_FFS_Acute_Rate Code 2946_Col 2	PUB_MA_HMO_Acute_Col 1
2.	Per Case Service Intensity Weight for DRG Classification	SIW APR-DRG Table (DOH*)	SIW APR-DRG Table (DOH*)
3.	Case Mix Adjusted Discharge Payment	Line 1 x Line 2	Line 1 x Line 2
4.	Direct Medical Education (DME) Add-On	PUB_MA_FFS_Acute_Rate Code 2589_Col 7	N/A
5.	Capital per Discharge Rates (plus non-comparable/directed payment add-ons where applicable) Note: columns 12 and 13 of the MA HMO publication are effective 4/1/2026 - 3/31/2027 and have special billing guidance in the health plan letter.	PUB_MA_FFS_Acute_Rate Code 2990_Col 8	PUB_MA_HMO_Acute_Col 7 (plus any applicable non-comparable add-ons from Cols 8 - 13)
6.	Inlier DRG Payment	Line 3 + Line 4 + Line 5	Line 3 + Line 5
Alternate Level Of Care (ALC) Payment:			
7.	Calculation Of ALC Payment:		
(a)	Alternate Level of Care (ALC) Price Per Day	PUB_MA_FFS_Acute_Rate Code 2950, 2951_Col 10	PUB_MA_HMO_Acute_Col 15
(b)	Alternate Level of Care (ALC) Days	Medical Record	Medical Record
(c)	Total ALC Payment	Line 7a x Line 7b	Line 7a x Line 7b
Total Payment Amount:			
8.	Total Inlier with ALC Payment at 100%	Line 6 + Line 7c	Line 6 + Line 7c
Medicaid Surcharge Calculation:			
A	Medicaid Surcharge (Indigent Care and Health Care Initiative Surcharge)	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%
B	Medicaid Surcharge Amount	Line 8 x Line A	Line 8 x Line A
C	Payment to Hospital if Provider Signed Authorization for Medicaid Direct Payment of Surcharge to the Pool Administrator.	Line 8	Line 8
D	Payment to Hospital if Provider Did Not Sign Authorization for Medicaid Direct Payments - Hospital Pays Surcharge to the Pool Administrator.	Line 8 + Line B	Line 8 + Line B
	* The SIW APR-DRG Table is available on the DOH public website at:		APR-DRG Weights

Total Transfer Payment cannot exceed the amount that would have been paid if the patient had been discharged (Inlier).			
Line	**Calculation Elements**	**Traditional Medicaid Fee-For-Service**	**Medicaid Managed Care "Default & Contract" (excludes GME)**
Transfer Data:		**Data Source and Formulas**	**Data Source and Formulas**
1.	Transfer Days Determination:		
(a)	Total Number of Days in Stay (inc. ALC)	Medical Record	Medical Record
(b)	Alternate Level of Care (ALC) Days	Medical Record	Medical Record
(c)	Number of Days excluding ALC	Line 1a - 1b	Line 1a - 1b
2.	Is this Case a Transfer?	Your Hospital Data	Your Hospital Data
Do not use this methodology for patients assigned to a DRG specifically designated as a DRG for transfer patient only [i.e., neonate transferred < 5 days (DRGs 580 & 581)].			
Calculation Of Transfer Payment:			
3.	Discharge Case Payment Rate	PUB_MA_FFS_Acute_Rate Code 2946_Col 2	PUB_MA_HMO_Acute_Col 1
4.	Per Case Service Intensity Weight for DRG Classification	SIW APR-DRG Table (DOH*)	SIW APR-DRG Table (DOH*)
5.	Case Mix Adjusted Discharge Payment	Line 3 x Line 4	Line 3 x Line 4
6.	Statewide Average Arithmetic Inlier LOS for DRG	SIW APR-DRG Table (DOH*)	SIW APR-DRG Table (DOH*)
7.	Average Inlier Cost Per Day	Line 5 / Line 6	Line 5 / Line 6
8.	Transfer Adjustment Factor:		
(a)	If Statewide Average Arithmetic Inlier LOS for the DRG = 1, then Transfer Adj. Factor is 100%	100%	100%
	Or	**or**	**or**
(b)	If Statewide Average Arithmetic Inlier LOS for the DRG > 1, then Transfer Adj. Factor is 120%	120%	120%
9.	Transfer DRG Cost Per Day	Line 7 x Line 8a (or 8b)	Line 7 x Line 8a (or 8b)
10.	Case Payment Capital per Diem	PUB_MA_FFS_Acute_Rate Code 2991_Col 9	PUB_MA_HMO_Acute_Col 14
11.	Total Transfer Cost Per Diem	Line 9 + Line 10	Line 9 + Line 10

Line	Calculation Elements	Traditional Medicaid Fee-For-Service	Medicaid Managed Care "Default & Contract" (excludes GME)
Transfer Payment:		**Data Source and Formulas**	**Data Source and Formulas**
12.	Transfer Payment Amount excluding DME	Line 11 x Line 1c	Line 11 x Line 1c
13.	Direct Medical Education (DME) Add-On	PUB_MA_FFS_Acute_Rate Code 2589_Col 7	N/A
14.	Safety Net/ Financially Distressed Hospital & NYC H+H ACR Add-ons Note: columns 12 and 13 of the MA HMO publication are effective 4/1/2026 - 3/31/2027 and have special billing guidance in the health plan letter.	N/A	PUB_MA_HMO_Acute_Col 12 & 13
15.	Transfer Payment Amount Before ALC	Line 12 + Line 13	Line 12 + Line 14
16.	Discharge DRG Test:		
(a)	Inlier DRG Before ALC	Inlier Tab, Line 6	Inlier Tab, Line 6
17.	Total Transfer Payment Before ALC	Lesser of Line 15 or Line 16a	Lesser of Line 15 or Line 16a
18.	Total ALC Payment	Inlier Tab, Line 7c	Inlier Tab, Line 7c
19.	Total Transfer with ALC Payment at 100%	Line 17 + Line 18	Line 17 + Line 18
Medicaid Surcharge Calculation:		**Data Source and Formulas**	**Data Source and Formulas**
A	Medicaid Surcharge (Indigent Care and Health Care Initiative Surcharge)	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%
B	Medicaid Surcharge Amount	Line 19 x Line A	Line 19 x Line A
C	Payment to Hospital if Provider Signed Authorization for Medicaid Direct Payment of Surcharge to the Pool Administrator.	Line 19	Line 19
D	Payment to Hospital if Provider Did Not Sign Authorization for Medicaid Direct Payments - Hospital Pays Surcharge to Pool Administrator.	Line 19 + Line B	Line 19 + Line B

* The SIW APR-DRG Table is available on the DOH public website at: APR-DRG Weights

High Cost Outlier Payment is in addition to the Inlier payment calculated on the Inlier worksheet tab.

Line	Calculation Elements	Traditional Medicaid Fee-For-Service	Medicaid Managed Care "Default & Contract" (excludes GME) [See Stop Loss Insurance footnote]
High Cost Outlier Payment:		**Data Source and Formulas**	**Data Source and Formulas**
1.	Total Inpatient Gross Charges Per Patient UB-92, HCFA 1450	Charge Master	Charge Master
2.	Adjustment to Total Inpatient Gross Charges:		
	a. Telephone and Telegraph	Charge Master	Charge Master
	b. Television and Radio	Charge Master	Charge Master
	c. Private Room Differential	Charge Master	Charge Master
	d. Other Non-Covered	Charge Master	Charge Master
	e. Gross Charges for all ALC Days	Charge Master	Charge Master
	f. Total Adjustments	Sum of Lines 2a thru 2e	Sum of Lines 2a thru 2e
3.	Net Inpatient Gross Charges	Line 1 - Line 2f	Line 1 - Line 2f
4.	High Cost Charge Converter	PUB_MA_FFS_Acute_Col 5	PUB_MA_HMO_Acute_Col 4
5.	Net Inpatient Gross Charges Converted to Costs	Line 3 x Line 4	Line 3 x Line 4
6.	Threshold Calculation:		
	a. APR-DRG Cost Outlier Threshold	Outlier Threshold Table (DOH*)	Outlier Threshold Table (DOH*)
	b. Institution-Specific Adjustment Factor (ISAF/WEF)	PUB_MA_FFS_Acute_Col 4	PUB_MA_HMO_Acute_Col 3
	c. Adjusted Cost Outlier Threshold	Line 6a x Line 6b	Line 6a x Line 6b
7.	High Cost Payment Test:		
	a. Do costs exceed the threshold?	Is Line 5 > 6c?	Is Line 5 > 6c?
	b. Does the case involve a Transfer?	Determination per Your Hospital Data	Determination per Your Hospital Data

Continue With Calculation If Line 7A= "Yes" And The Case Is Not A Transfer.
[High Cost Outlier does not apply to Transfer Cases (other than patients assigned to transfer DRGs) per 86-1.21.]

High Cost Outlier Payment:		**Data Source and Formulas**	**Data Source and Formulas**
8.	High Cost Outlier Payment before Inlier and ALC (100% of costs above adjusted threshold)	Line 5 - Line 6c	Line 5 - Line 6c
9.	Total Inlier with ALC Payment at 100%	Inlier Worksheet Tab, Line 8	Inlier Worksheet Tab, Line 8
10.	Total Payment to Provider at 100%	Line 8 + Line 9	Line 8 + Line 9

Medicaid Surcharge Calculation:		**Data Source and Formulas**	**Data Source and Formulas**
A	Medicaid Surcharge (Indigent Care and Health Care Initiative Surcharge)	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%
B	Medicaid Surcharge Amount	Line 10 x Line A	Line 10 x Line A
C	Payment to Hospital if Provider Signed Authorization for Medicaid Direct Payment of Surcharge to the Pool Administrator.	Line 10	Line 10
D	Payment to Hospital if Provider Did Not Sign Authorization for Medicaid Direct Payments - Hospital Pays Surcharge to Pool Administrator.	Line 10 + Line B	Line 10 + Line B

Note: Policy/interpretation of Section 3.11 of the Medicaid Managed Care model contract: Medicaid Managed Care columns should be used for calculating Stop Loss reimbursement to Managed Care Organizations for high cost outlier payments.

* The SIW APR-DRG Table is available on the DOH public website at: APR-DRG Weights

Line	Calculation Elements	Traditional Medicaid Fee-For-Service	Medicaid Managed Care (excludes DME)
Exempt Unit/Hospital Acute Care Payment:		**Data Source and Formulas**	**Data Source and Formulas**
1.	Exempt Unit/Hospital Stay Days		
	a. Total Number of Days in Stay (inc. ALC)	Medical Record	Medical Record
	b. Alternate Level of Care (ALC) Days	Medical Record	Medical Record
	c. Total Acute Care Days excluding ALC	Line 1a - Line 1b	Line 1a - Line 1b
2.	Exempt Per Diem Rate or Alternate Payment Per Diem (Medicaid Managed Care excluding GME)	PUB_IP_MA_FFS_EU_Applicable EU Rate Code (col 1, 7, 8, 9, 11 or 13). See below for applicable Rate Code key.	PUB_IP_MA_HMO_EU_Applicable EU Rate (col 1, 11, 12, 13, 16 or 18)
3.	Total Exempt Unit/Hospital Acute Care Payment To Provider at 100%	Line 2 x Line 1c	Line 2 x Line 1c
Alternate Level Of Care (ALC) Payment:			
4.	Calculation Of ALC Payment:		
(a)	Alternate Level of Care Billing Rate	PUB_IP_MA_FFS_EU_Applicable EU ALC Rate Code (col 2, 10, 12 or 14). See below for applicable Rate Code key)	PUB_IP_MA_HMO_EU_Applicable EU ALC Rate Code (col 4, 15, 17 or 20)
(b)	Number of ALC Days	Line 1b	Line 1b
(c)	Total ALC Payment	Line 4a x Line 4b	Line 4a x Line 4b
Total Payment Amount:			
5.	Total Exempt Unit/Hospital w/ALC Payment at 100%	Line 3 + Line 4c	Line 3 + Line 4c
Medicaid Surcharge Calculation:		**Data Source and Formulas**	**Data Source and Formulas**
A	Medicaid Surcharge (Indigent Care and Health Care Initiative Surcharge)	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%
B	Medicaid Surcharge Amount	Line 5 x Line A	Line 5 x Line A
C	Payment to Hospital if Provider Signed Authorization for Medicaid Direct Payment of Surcharge to the Pool Administrator.	Line 5	Line 5
D	Payment to Hospital if Provider Did Not Sign Authorization for Medicaid Direct Payments - Hospital Pays Surcharge to Pool Administrator.	Line 5 + Line B	Line 5 + Line B

Rate Code Key:

Exempt Unit Rates: Specialty Hospital (2947, 2949, 2959); Psychiatric Adult Dual Diagnosis (4608); Psychiatric Child Dual Diagnosis (4607); Chemical Dependency - Alcohol & Drug Rehabilitation (2957, 2993); Critical Access Hospital (2999); Medical Rehabiliation (2853, 2948).

ALC Rates: Specialty Hospital (2954, 2955); Chemical Dependency - Alcohol & Drug Rehab (2966, 2967, 3118, 3119);

Line	Calculation Elements	Traditional Medicaid Fee-For-Service	Medicaid Managed Care - age 18 and over (excludes DME)	Medicaid Managed Care - age 17 and under (excludes DME)
Psychiatric Exempt Unit Payment:		**Data Source and Formulas**	**Data Source and Formulas**	**Data Source and Formulas**
1.	Psychiatric Exempt Unit Stay Days			
	a. Total Number of Days in Stay (inc. ALC)	Medical Record	Medical Record	Medical Record
	b. Alternate Level of Care (ALC) Days	Medical Record	Medical Record	Medical Record
	c. Total Acute Care Days excluding ALC	Line 1a - Line 1b	Line 1a - Line 1b	Line 1a - Line 1b
2.	Psych Per Diem Rate or Alternate Payment Per Diem (Medicaid Managed Care excluding DME)	PUB_MA_FFS_EU_Rate Code 2852 (Col 3)	PUB_MA_HMO_EU (Col 5)	PUB_MA_HMO_EU (Col 5a)
3.	Per Case Service Intensity Weight for Psych DRG Classification	*SIW APR-DRG Table (DOH) - Psych	*SIW APR-DRG Table (DOH) - Psych	*SIW APR-DRG Table (DOH) - Psych
4.	Age Adjustment Factor	Age Factor (17 & under =1.3597, 18 & over =1.0000)	Age Factor (1.0000 already included in Line 2 above)	Age Factor (1.3597 already included in Line 2 above)
5.	Mental Retardation Factor (if applicable)	1.0599	1.0599	1.0599
6.	Comorbidity Factor(s)	*Comorbidity Weight Factors (DOH) (If more than 1 exists, use highest weight factor)	*Comorbidity Weight Factors (DOH) (If more than 1 exists, use highest weight factor)	*Comorbidity Weight Factors (DOH) (If more than 1 exists, use highest weight factor)
7.	LOS Scale Factor (indicates which scaling factor is applicable for each day of the stay. Note: day 1 for all readmissions within 30 days is considered day 4 for scaling purposes)	Days 1-4=1.20 Days 5-11=1.00 Days 12-22=0.96 Days 23 & over=0.92	Days 1-4=1.20 Days 5-11=1.00 Days 12-22=0.96 Days 23 & over=0.92	Days 1-4=1.20 Days 5-11=1.00 Days 12-22=0.96 Days 23 & over=0.92
8.	Non-Operating Billing Component (capital, etc)	PUB_MA_FFS_EU_Rate Code 2571 (Col 4) x number of days	PUB_MA_HMO_EU (Col 6) x number of days	PUB_MA_HMO_EU (Col 6) x number of days
9.	Safety Net/Financially Distressed Hospital Add-on Note: column 7 of the MA HMO publication is effective 4/1/2026 - 3/31/2027 and has special billing guidance in the health plan letter.	N/A	PUB_MA_HMO_EU (Col 7) x number of days	PUB_MA_HMO_EU (Col 7) x number of days
10.	Electro Convulsive Therapy (ECT) Component	PUB_MA_FFS_EU_Rate Code 2570 (Col 5) x number of treatments	PUB_MA_HMO_EU (Col 9) x number of treatments	PUB_MA_HMO_EU (Col 9) x number of treatments
11.	Total Payment at 100% (see payment example below)	Repeat for each day of the stay: Line 2 x Line 3 x Line 4 x Line 5 x Line 6 x applicable Line 7 factor. Then, add the totals from Lines 8 and 10	Repeat for each day of the stay: Line 2 x Line 3 x Line 5 x Line 6 x applicable Line 7 factor. Then, add the totals from Lines 8, 9 and 10	Repeat for each day of the stay: Line 2 x Line 3 x Line 5 x Line 6 x applicable Line 7 factor. Then, add the totals from Lines 8, 9 and 10
Alternate Level Of Care (ALC) Payment:				
12.	Calculation Of ALC Payment:			

(a)	Alternate Level of Care Billing Rate	PUB_MA_FFS_EU_Rate Code 2962, 2963 (Col 6)	PUB_MA_HMO_EU (Col 10)	PUB_MA_HMO_EU (Col 10)
(b)	Number of ALC Days	Line 1b	Line 1b	Line 1b
(c)	Total ALC Payment	Line 12a x Line 12b	Line 12a x Line 12b	Line 12a x Line 12b
Total Payment Amount:				
13.	Total Exempt Unit/Hospital w/ALC Payment at 100%	Line 11 + Line 12c	Line 11 + Line 12c	Line 11 + Line 12c

Medicaid Surcharge Calculation:		**Data Source and Formulas**	**Data Source and Formulas**	**Data Source and Formulas**
A	Medicaid Surcharge (Indigent Care and Health Care Initiative Surcharge)	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%	4/1/09 Forward ==> 7.04%
B	Medicaid Surcharge Amount	Line 13 x Line A	Line 13 x Line A	Line 13 x Line A
C	Payment to Hospital if Provider Signed Authorization for Medicaid Direct Payment of Surcharge to the Pool Administrator.	Line 13	Line 13	Line 13
D	Payment to Hospital if Provider Did Not Sign Authorization for Medicaid Direct Payments - Hospital Pays Surcharge to Pool Administrator.	Line 13 + Line B	Line 13 + Line B	Line 13 + Line B

* The SIW APR-DRG Table is available on the DOH public website at: APR-DRG Weights

Rate Code Key: Psychiatric (2852)

FFS Payment Example:			
Principal Diagnosis	APR-DRG 750-1: Schizophrenia SOI-1		0.9444
Patient Age	16 years old		1.3597
Presence of Mental Retardation (limited to one fac	3182, 29901, 75981		1.0599
Comorbidities (use highest factor)	Acute Coronary Syndrome		1.4046
Total Per Diem Adjustment Factor	0.9444 * 1.3597 * 1.0599 * 1.4046		1.9117
Facility operating per diem (adjusted by WEF)	Hospital ABC rate code 2852		$500.00
Total Adjusted Operating Per Diem	$500 * 1.5286		$955.84
Non-Operating Per Diem: Capital + DME			$50.00
ECT with 2 Treatments during the stay (WEF Adju	$244 * 2 treatments		$488.00
Apply variable per diem adjustment for 10 days	Per Diem amount		
Day 1 (adjustment factor = 1.20)	$955.84 * 1.20		$1,147.01
Day 2 (adjustment factor = 1.20)	$955.84 * 1.20		$1,147.01
Day 3 (adjustment factor = 1.20)	$955.84 * 1.20		$1,147.01
Day 4 (adjustment factor = 1.20)	$955.84 * 1.20		$1,147.01
Day 5 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Day 6 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Day 7 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Day 8 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Day 9 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Day 10 (adjustment factor = 1.00)	$955.84 * 1.00		$955.84
Total Operating Per Diem Payment			$10,323.08
Total Non-Operating Per Diem	$50 * 10 days		$500.00
ECT Payment - 2 treatments (WEF Adjusted)			$488.00
Final Total Payment			$11,311.08

Note: Day 1 for all readmissions within 30 days is considered Day 4 for scaling purposes

Medicaid - Traditional And Managed Care
Chemical Dependency Detoxification Payments

Billing Instructions For
Part 816 OASAS Certified Chemical Dependency Detox

Reimbursement for inpatient chemical dependency detox services provided by Office of Alcoholism and Substance Abuse Services (OASAS) certified general hospitals transitioned to a per diem rate methodology effective 12/1/2008. New billing rate codes were established to accurately calculate per diem payments for 2 clinically distinct levels of care: a higher intensity Medically Managed Detox (MMD) level of care, and a lower intensity Medically Supervised Inpatient Withdrawal (MSIW) level of care. The detox rate code payment logic includes recognition of observation days (OBS) to be paid at the higher MMD payment rate, and length of stay (LOS) reductions in payment for stays exceeding 5 days, applicable to both levels of care, as required by statute. Following are the billing instructions effective for services provided 1/1/2010 forward.

Detox Per Diem Rate Code Revisions Effective 1/1/2010:

Effective 1/1/2010, the operating cost component of the MSIW rate of payment was reduced to 75% of the prevailing operating cost component of the MMD rate of payment. However, capital costs in the MSIW rate continue to be included at 100% of the allowable detox capital cost per day. This MSIW operating cost specific reduction in payment, coupled with the requirement that OBS bed days (up to 48 hours) be reimbursed at the higher MMD payment rate, required changes to the initially established detox rate code construct to implement. To assure accurate payment for MSIW stays when OBS days are included in the stay, the following revised and expanded detox per diem rate codes, and related payment logic, became effective for claims with dates of admission 1/1/2010 forward:

1. **Rate Code 4800:** MMD (operating cost) with or without OBS Days
2. **Rate Code 4801:** MSIW (operating cost) without OBS Days
3. **Rate Code 4802:** MSIW (operating cost) with 1 OBS Day
4. **Rate Code 4803:** MSIW (operating cost) with 2 OBS Days
5. **Rate Code 4804:** Inpatient Detox Capital Cost Per Diem **(add-on rate code only)**

Claims are to be submitted on a per discharge basis using the rate code that corresponds to the level of care rendered to the patient on day 3 of the admitted stay, or the level of care determined on the day of admission if the LOS is less than 3 days. Though we recognize there may be instances where a patient transitions through multiple levels of care during a given stay, systems limitations do not allow for the development of more refined billing parameters to address such situations. Day 3 is the first day after the maximum allowable OBS period and is deemed to fairly represent the overall clinical status of the patient's stay for reimbursement purposes. LOS reductions based on the total number of days for the stay continue, with the detox service begin date typically determining the first day for the LOS calculations. If the patient was initially admitted to another unit in the hospital (e.g., Intensive Care Unit or Medical Surgical Unit) to address urgent medical care needs prior to being transferred to the Detox Unit for ongoing care, the admission date to the hospital is the begin date for determining the LOS reductions in payment for the detox unit stay. It is noted that, in such cases, a separate payment for the medical stay (DRG case payment rate) is permissible in addition to payment for the detox unit stay.

Appendix I provides a detailed presentation of the detox per diem billing rate codes and payment logic. **Please note that rate code 4804 is not a billing rate code (i.e., will not be include on the claim form for submission)**, but is necessary from a systems standpoint to be retrieved and added to the calculation for the final payment to be inclusive of capital cost. The schematic presented in Appendix I assumes that the rates posted to the various rate codes are fixed amounts, when in fact they will change from time to time as rates are revised. The programming logic does indeed recognize that detox rate codes 4800-4804 can have different rate amounts that need to be selected and applied based on the dates of service included in the stay, and will select the applicable rate amount based on the service date.

Other Detox Reimbursement Related Issues

Detox Unit Overflow:

Part 816 OASAS certification is specific to hospital site/address location and number of beds approved for the unit. On occasions where the OASAS certified detox unit is at full capacity and another patient in need of detoxification services must, consequently, be admitted to a medical surgical bed at the same location, the hospital is to bill for such "overflow" detox unit patients using the detox per diem rates. Presumably, such overflow admissions to a medical surgical bed will be short term until a bed in the detox unit becomes available. From a clinical perspective, such patients are detoxification unit patients and their treatment plan will follow Part 816 OASAS program regulations. Hence, the detox per diem rates, rather than the hospital's DRG case payment rate, are the appropriate rates to use for determining reimbursement for the inpatient detox service provided such patients.

Detox Scatter Bed Reimbursement for Non-OASAS Certified Hospitals:

Medicaid - Traditional And Managed Care
Chemical Dependency Detoxification Payments

The detox per diem rate methodology applies only to general hospitals certified by OASAS to operate a Part 816 Detoxification Program. As this certification is specific to hospital site/address location, the detox per diem rates are loaded only to the locator code site that corresponds to the OASAS certified site. The per diem rates do not apply to inpatient detoxification services provided in general hospitals that do not have OASAS certification, or to non-certified hospital sites of OASAS certified general hospitals (e.g., hospital entities, such as mergers, that operate multiple acute care inpatient sites at different physical plant locations, not all of which have OASAS certified detox units). Such general medical “scatter bed” inpatient detox services continue to be reimbursed through the DRG rate methodology.

Medicaid - Traditional And Managed Care
Chemical Dependency Detoxification Payments

Appendix I

Inpatient Chemical Dependency Detox Fee-For-Service Rate Codes
Effective for Admissions On and After 1/1/2010

Rate Code Legend:

1. RC 4800 – MMD (operating cost) w/or w/o OBS Days
2. RC 4801 – MSIW (operating cost) w/o OBS Days
3. RC 4802 – MSIW (operating cost) w/1 OBS Day
4. RC 4803 – MSIW (operating cost) w/2 OBS Days
5. RC 4804 – Inpatient Detox Capital Cost Per Diem

Service Description:	LOS (Days):	Payment Logic:
MMD w/or w/o OBS Days	1 – 5	(RC 4800 amount + RC 4804 amount) * Number of Days
	6 – 10	(RC 4800 amount + RC 4804 amount) * 0.5 * Number of Days
	>10	$0.00
MSIW w/o OBS Days	1 – 5	(RC 4801 amount + RC 4804 amount) * Number of Days
	6 – 10	(RC 4801 amount + RC 4804 amount) * 0.5 * Number of Days
	>10	$0.00
MSIW w/1 OBS Day	1	((RC 4802 amount/0.75) + RC 4804 amount) * Number of Days
	2 – 5	(RC 4802 amount + RC 4804 amount) * Number of Days
	6 – 10	(RC 4802 amount + RC 4804 amount) * 0.5 * Number of Days
	>10	$0.00

Medicaid - Traditional And Managed Care
Chemical Dependency Detoxification Payments

MSIW w/2 OBS Days	1 – 2	((RC 4803 amount/0.75) + RC 4804 amount) * Number of Days
	3 – 5	(RC 4803 amount + RC 4804 amount) * Number of Days
	6 – 10	(RC 4803 amount + RC 4804 amount) * 0.5 * Number of Days
	>10	$0.00

Pursuant to the authority vested in the Commissioner of Health by section 2807-c(35) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new section 86-1.21 effective December 1, 2009, to read as follows:

Section 86-1.21. Outlier and transfer cases rates of payment.

(a)(1) 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 Consumer Price Index from the base period used to determine the statewide base price and the rate period.

(2) 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 of total revenue; and
(iv) hospitals with a proportion of outlier to inlier cases greater than 3.0 percent.

(b) 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 (1), (2) and (3) of this subdivision. 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 section 86-1.15(b) of this Subpart by the arithmetic inlier length of stay (LOS) for that DRG, as defined in section 86-1.15(o) of this Subpart, 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.
(1) 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.
(2) A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.
(3) 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.

(4) 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.

Office of Medicaid Management - Medicaid Model Contract Section 3.11
Inpatient Hospital Stop-Loss Insurance for Medicaid Managed Care (MMC) Enrollees

a) The Contractor must obtain stop-loss coverage for inpatient hospital services for MMC Enrollees. A Contractor may elect to purchase stop-loss coverage from New York State. In such cases, the Capitation Rates paid to the Contractor shall be adjusted to reflect the cost of such stop-loss coverage. The cost of such coverage shall be determined by SDOH.
b) Under NYS stop-loss coverage, if the hospital inpatient expenses incurred by the Contractor for an individual MMC Enrollee during any calendar year reaches $100,000, the Contractor shall be compensated for eighty percent (80%) of the cost of hospital inpatient services in excess of this amount up to a maximum of $250,000. Above that amount, the Contractor will be compensated for one hundred percent (100%) of cost. All compensation shall be based on the lower of the Contractor's negotiated hospital rate or Medicaid rates of payment.
(**Note: "**Medicaid rates of payment' interpreted to be the Managed Care rates (not FFS rates.)