Summary of Express Terms

General Summary for 86-8.1 through 86-8.12

The amendments to Part 86 of Title 10 (Health) NYCRR are required to update the Ambulatory Patient Groups (APGs) methodology, implemented on December 1, 2008, which governs reimbursement for certain ambulatory care fee-for-service (FFS) Medicaid services. APGs group procedures and medical visits that share similar characteristics and resource utilization patterns so as to pay for services based on relative intensity.

86-8.1 – Scope of services and effective dates

Section 86-8.1 of Title 10 (Health) NYCRR defines the categories of facilities subject to APGs and the time frames for implementation. The revision to subdivision (a) clarifies that ambulatory services provided by diagnostic and treatment centers and ambulatory surgery services provided by free-standing ambulatory surgery centers will be reimbursed on APGs commencing September 1, 2009. The revision to subdivision (b) deletes language that prohibits APG payments to out-of-state facilities.

86-8.2 – Definitions

The proposed amendments to section 86-8.2 of Title 10 (Health) NYCRR provide revised definitions for “discounting”, “packaging”, and “visit”. Additionally, two new subdivisions, (p-1) and (p-2), are proposed to be created to define what constitutes an episode payment and when it is appropriate to use.

86-8.6 - Rates for new facilities during the transition period

The proposed revision to section 86-8.6 of Title 10 (Health) NYCRR stipulates that the operating component of rates shall reflect:

- for general hospital outpatient clinics, effective for the period December 1, 2008 through November 30, 2009, 75% of the historical 2007 average payment per visit as calculated by the department, and 25% of APG rates as computed in accordance with this Subpart, and effective December 1, 2009 through December 31, 2010, 50% of the historical 2007 average payment per visit as calculated by the department, and 50% of APG rates as computed in accordance with this Subpart;

- for diagnostic and treatment centers, effective for the period September 1, 2009 through 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 computed in accordance with this Subpart, and effective for the period December 1, 2009 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 computed in accordance with this Subpart;

- for free-standing ambulatory surgery centers, effective for the period September 1, 2009 through 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 Subpart, and for the period 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;

86-8.10 Exclusions from payment

The proposed amendment to section 86-8.10 of Title 10 (Health) NYCRR removes the following APGs from the list of services that are not eligible for reimbursement pursuant to this subpart: APG 094 - Cardiac Rehabilitation; APG 371 – Level 1 orthodontics; and APG 372 level II Orthodontics.

86-8.13 Out-of-State Providers

The proposed amendment adds a new section 86-8.13, which stipulates how out-of-state providers will be reimbursed for services under this subpart.

86-8.14 Non-APG Payments

The proposed amendment adds a new section 86-8.14, which stipulates that the following services will be reimbursed based on specified rates and fees established by the Department: psychotherapy services; wheelchair evaluation services; and eyeglass dispensing services.

Pursuant to the authority vested in the Commissioner of Health by sections 2807(2-a)(e) of the Public Health Law, Subpart 86-8 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, and to read as follows:

SUBPART 86-8

OUTPATIENT SERVICES: AMBULATORY PATIENT GROUP

(Statutory authority: Public Health Law § 2807(2-a)(e))

Sec.

86-8.1 Scope

86-8.2 Definitions

86-8.3 Record keeping, reports and audits

86-8.4 Capital reimbursement

86-8.5 Administrative rate appeals

86-8.6 Rates for new facilities during the transition period

86-8.7 APGs and relative weights

86-8.8 Base rates

86-8.9 Diagnostic coding and rate computation

86-8.10 Exclusions from payment

86-8.11 System updating

86-8.12 Payments for extended hours of operation

86-8.13 Out-of-state providers

86-8.14 Non-APG payments

Section 86-8.1 is amended to read as follows:

§ 86-8.1 Scope

(a) This Subpart shall govern Medicaid rates of payments for ambulatory care services provided in the following categories of facilities for the following periods:

(1) outpatient services provided by general hospitals on and after December 1, 2008;

(2) emergency department services provided by general hospitals on and after January 1, 2009;

(3) ambulatory surgery services provided by general hospitals on and after December 1, 2008;

(4) ambulatory services provided by diagnostic and treatment centers on and after [March] September 1, 2009; and

(5) ambulatory surgery services provided by free-standing ambulatory surgery centers on and after [March] September 1, 2009.

(b) Notwithstanding subdivision (a) of this section, the provisions of this Subpart shall not apply to the following:

(1) facilities whose Medicaid reimbursement is governed by subdivision 8 of section 2807 of the public health law, except when the provisions of this Subpart are made applicable pursuant to paragraph (f) of such subdivision;

(2) payments for services which are not provided pursuant to a facility's licensure under article 28 of the public health law; <u>and</u>

(3) payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program[; and

(4) payments made to facilities located outside the boundaries of New York State].

Subdivision (g) of Section 86-8.2 is amended to read as follows:

(g) Discounting shall mean the reduction in APG payment that results when [unrelated] additional procedures [or ancillary services are performed during a single patient visit.] <u>do not consolidate. Additional occurrences of the same ancillary APG within a single visit or episode will also discount.</u>

Subdivision (k) of Section 86-8.2 is amended to read as follows:

(k) 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. <u>Medical visits also package with significant procedures, unless specifically excepted in this regulation.</u>

Subdivision (p) of Section 86-8.2 is amended to read as follows:

(p) Visit shall mean a unit of service consisting of all the APG services performed for a patient [on] that are coded on the same claim and share a common [a single] date of service[, provided, however, that services provided in an emergency department which extend into a second calendar date may be treated as one visit for reimbursement purposes].

Section 86-8.2 is amended to add new subdivisions (p-1) and (p-2) to read as follows:

(p-1) Episode shall mean a unit of service consisting of all services on a claim, regardless of the coded dates of service. Under episode billing, an episode shall consist of all medical visits and/or procedures that are provided by a clinic to a patient on a single date of service plus any associated non-carved-out ancillaries, regardless of the date of service of those ancillaries. For emergency departments, the significant procedures and/or medical visits comprising the non-carved-out ancillary services portion of an episode need not be on a single date of services and may instead be on consecutive dates of service. Multiple episodes shall not be coded on the same claim.

(p-2) 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. References to "visits" in this Subpart shall be deemed to refer also to "episodes" for rate-setting purposes.

Section 86-8.6 is amended to read as follows:

Section 86-8.6 Rates for new facilities during the transition period.

(a) 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 section 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:

(1) for the period December 1, 2008 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 average payment per visit as calculated by the department, and 25% of such rates shall reflect APG rates as computed in accordance with this Subpart;

(2) for the period [January 1, 2010] December 1, 2009 through December 31, 2010, 50% of such rates shall reflect the historical 2007 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;

(3) for the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 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;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) 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 section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

(b) Diagnostic and treatment centers which commence operation after December 31, 2007 and prior to January 1, 2012, and for which rates computed pursuant to public health law section 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 cost component of their rates computed in accordance with the following:

(1) for the period [March] 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 computed in accordance with this Subpart;

(2) for the period [January 1, 2010] December 1, 2009 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 computed in accordance with this Subpart;

(3) 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 computed in accordance with this Subpart;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) 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 diagnostic and treatment center claims for each peer group, as defined in section 86-4.13 of this Part, 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 section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

(c) Free-standing 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 section 2807(2) are not available shall have the capital cost component of their rates computed in accordance with section 86-8.4(c) of this Subpart and shall have the operating cost component of their rates computed in accordance with the following:

(1) for the period [March] 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 computed in accordance with this Subpart;

(2) 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;

(3) 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;

(4) for periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this Subpart.

(5) 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 free-standing ambulatory surgery centers 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 section 86-8.10 of this Subpart, divided by the total visits on claims paid under such rate codes.

Subdivisions (a) and (h) of section 86-8.10 of subpart 86-8 are amended to read as follows:

(a) 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 subject to this Subpart, and as may be subsequently modified by the Department, HIV counseling and testing visits, post-test HIV counseling visits (positive results), HIV counseling visit (no testing), 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.

(h) The following APGs shall not be eligible for reimbursement pursuant to this Subpart:

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 [LEVEL I] ORTHODONTICS

[372 LEVEL II 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

Subpart 86-8 is amended by adding a new section 86-8.13, to read as follows:

§ 86-8.13 Out-of-state providers

(a) Rates for services specified in section 86-8.1(a) of this Subpart provided in outpatient facilities located outside New York state shall be as follows:

(1) 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, Bergin, Hudson, Essex, Union, Middlessex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield; and

(2) 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.

(b) Notwithstanding any inconsistent provision of this section, 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. Prior approval by the Department shall be required with regard to services provided by such providers.

(c) For the 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.

Subpart 86-8 is amended by adding a new section 86-8.14, to read as follows:

§ 86-8.14 Non-APG payments

(a) Psychotherapy services by clinical social workers. To the extent authorized pursuant to section 2807(2-a) of the Public Health Law, payments for individual psychotherapy services provided by clinical social workers, as defined by section 86-4-9 of this Subpart, shall be established at $40.64 for encounters lasting between twenty and thirty minutes and at $62.33 for encounters lasting between forty-five and fifty minutes and at $69.93 for family therapy encounters lasting between forty-five and fifty minutes.

(b) Wheelchair evaluation services. Payments for comprehensive wheelchair evaluations, which shall include assessments, fittings and training consisting of at least two hours of direct patient care services, shall be established at $302.

(c) Eyeglasses dispensing. Payments for dispensing eyeglasses shall be established at $89.77, plus capital, when such service includes the cost of providing the eyeglasses and at $38.05, plus capital, when such service does not include the cost of providing the eyeglasses. The capital add-on per visit for each provider shall be the provider's capital

add-on per visit as otherwise calculated pursuant to applicable provisions of section 2807(2) of the Public Health Law.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Authority for the promulgation of these regulations is contained in section 2807(2-a)(e) of the Public Health Law, section 79(u) of part C of chapter 58 of the laws of 2008 and section 129(l) of part C of chapter 58 of the laws of 2009, which authorizes the Commissioner of Health to adopt and amend rules and regulations, subject to the approval of the State Director of the Budget, establishing an Ambulatory Patient Groups methodology for determining Medicaid rates of payment for diagnostic and treatment center services, free-standing ambulatory surgery services and general hospital outpatient clinics, emergency departments and ambulatory surgery services.

Further, part C of Chapter 58 of the laws of 2009, amended Public Health Law section 2807(2-a). Amendments pertinent to these proposed regulations include: (1) section 14 of part C of chapter 58 of the laws of 2009 alters the schedule under which providers' reimbursement transitions fully to APG reimbursement (2) section 15 of part C of chapter 58 of the laws of 2009 provides authority for the commissioner of health to promulgate regulations establishing alternative payment methodologies, or utilize existing payment methodologies, when the APG methodology is not, or is not yet, appropriate or practical for specified services; and (3) sections 27 and 16-a of part C of chapter 58 of the laws of 2009 provides authority for APG reimbursement of cardiac rehabilitation services and for the commissioner of health to promulgate regulations establishing alternative payment methodologies for certain psychotherapy services.

Legislative Objective:

The Legislature's mandate is to convert, where appropriate, Medicaid reimbursement of ambulatory care services to a system that pays differential amounts based on the resources required for each patient visit, as determined through APGs.

Needs and Benefits:

The proposed regulations are in conformance with statutory amendments to provisions of Public Health Law section 2807(2-a), which mandated implementation of a new ambulatory care reimbursement methodology based on APGs. This reimbursement methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services. It also allows for greater payment homogeneity for comparable services across all ambulatory care settings (i.e., Outpatient Department, Ambulatory Surgery, Emergency Department, and Diagnostic and Treatment Centers). By linking payments to the specific array of services rendered, APGs will make Medicaid reimbursement more transparent. APGs provide strong fiscal incentives for health care providers to improve the quality of, and access to, preventive and primary care services.

COSTS

Costs for the Implementation of, and Continuing Compliance with this Regulation to the Regulated Entity:

There will be no additional costs to providers as a result of these amendments.

Costs to Local Governments:

There will be no additional costs to local governments as a result of these amendments.

Costs to State Governments:

There will be no additional costs to NYS as a result of these amendments. All expenditures under this regulation are fully budgeted in the SFY 09/10 enacted budget.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Local Government Mandates:

There are no local government mandates.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

This regulation does not duplicate other state or federal regulations.

Alternatives:

These regulations are in conformance with Public Health Law section 2807(2-a). Alternatives would require statutory amendments.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon publication of a Notice of Adoption in the New York State Register.

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect on Small Business and Local Governments:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals, diagnostic and treatment centers, and free-standing ambulatory surgery centers. Based on recent data extracted from providers' submitted cost reports, seven hospitals and 245 DTCs were identified as employing fewer than 100 employees.

Compliance Requirements:

No new reporting, record keeping or other compliance requirements are being imposed as a result of these rules.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Economic and Technical Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are intended to further reform the outpatient/ambulatory care fee-for-service Medicaid payment system, which is intended to benefit health care providers, including those with fewer than 100 employees.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. The Department of Health considered approaches specified in section 202-b (1) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given that this reimbursement system is mandated in statute.

Small Business and Local Government Participation:

Local governments and small businesses were given notice of these proposals by their inclusion in the SFY 2009-10 enacted budget and the Department's issuance in the State Register of federal public notices on February 25, 2009, and June 10, 2009.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 44 counties have a population less than 200,000:

Allegany
Cattaraugus
Cayuga
Chautauqua
Chemung
Chenango
Clinton
Columbia
Cortland
Delaware
Essex
Franklin
Fulton
Genesee
Greene
Hamilton
Herkimer
Jefferson
Lewis
Livingston
Madison
Montgomery
Ontario
Orleans
Oswego
Otsego
Putnam
Rensselaer
St. Lawrence
Saratoga
Schenectady
Schoharie
Schuyler
Seneca
Steuben
Sullivan
Tioga
Tompkins
Ulster
Warren
Washington
Wayne
Wyoming
Yates

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany
Broome
Dutchess
Erie
Monroe
Niagara
Oneida
Onondaga
Orange

Compliance Requirements:

No new reporting, record keeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. The Department of Health considered approaches specified in section 202-bb (2) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given that the reimbursement system is mandated in statute.

Opportunity for Rural Area Participation:

Rural areas were given notice of these proposals by their inclusion in the SFY 2009-10 enacted budget and the Department's issuance in the State Register of federal public notices on February 25, 2009 and June, 10, 2009.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed regulations, that they will not have a substantial adverse impact on jobs or employment opportunities.