NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

November 12, 2026

Dear Health Plans:

The purpose of this letter is to provide Health Plans with information regarding recent approvals related to Medicaid Managed Care (MMC) hospital outpatient payments.

For dates of service April 1, 2026 – March 31, 2027, the Centers for Medicare and Medicaid Services (CMS) recently approved State Directed Payment rate add-ons to the MMC rates of payment for hospitals that qualified as safety net/financially distressed. These add-ons, which are included in the table below, are only applicable to Article 28 general clinic, ambulatory surgery and emergency department services, as outlined in the billing guidelines attachment to this letter. A separate rate file has also been posted to the Department of Health's Ambulatory Patient Group (APG) website.

Plans should treat these adjustments in accordance with Section 22.19 and Appendix V of the Managed Care Model Contract and the terms of their provider contracts with hospitals. This includes any reprocessing or claims settlements that should occur consistent with those agreements. The Department has effectuated premium payments to health plans to align with the updated MMC State Direct Payment add-ons associated with this rate publication.

Safety Net/Financially Distressed Hospital Rate Add-ons (4/1/2026 - 3/31/2027)		**Clinic**	**Ambulatory Surgery**	**Emergency Department**
Operating Certificate	**Hospital Name**	**Add-on Payment Per Visit**	**Add-on Payment Per Visit**	**Add-on Payment Per Visit**
7000001	Bronxcare Hospital Center	$123.00	$914.00	$150.00
7001002	Brookdale Hospital Medical Center	$369.00	$2,740.00	$450.00
7001003	Brooklyn Hospital Center	$246.00	$1,827.00	$300.00
3301008	Crouse Hospital	$123.00	$914.00	$150.00
7003001	Flushing Hospital Medical Center	$369.00	$2,740.00	$450.00
1401002	Golisano Children's Hospital of Buffalo	$246.00	$1,827.00	$300.00
7003003	Jamaica Hospital Medical Center	$246.00	$1,827.00	$300.00
7001020	Maimonides Medical Center	$369.00	$2,740.00	$450.00
7000006	Montefiore Medical Center	$123.00	$914.00	$150.00
5903001	Montefiore Mount Vernon Hospital	$246.00	$1,827.00	$300.00
3121001	Mount St Mary's Hospital	$246.00	$1,827.00	$300.00
3102000	Niagara Falls Medical Center	$246.00	$1,827.00	$300.00
7004010	Richmond University Medical Center	$246.00	$1,827.00	$300.00
7000014	SBH Health System	$369.00	$2,740.00	$450.00
7001024	St Johns Episcopal Hospital South Shore	$369.00	$2,740.00	$450.00
5907001	St Johns Riverside Hospital	$246.00	$1,827.00	$300.00
5907002	St Josephs Medical Center	$246.00	$1,827.00	$300.00
0602001	UPMC Chautauqua at WCA	$246.00	$1,827.00	$300.00
7001035	Wyckoff Heights Medical Center	$246.00	$1,827.00	$300.00

Should you have any questions regarding the above rate information, please submit your inquiry to HospFFSunit@health.ny.gov and either Tami Berdi or John Neuberger from the hospital fee-for-service rate setting unit will respond. Questions regarding Managed Care premium payments, add-ons or billing should be directed to phr@health.ny.gov.

Sincerely,

Michael Dembrosky
Bureau Director
Bureau of Managed Care Reimbursement

Attachment

Attachment
(Billing Guidance for Safety Net/Financially Distressed Hospital Rate Add-ons)

***A) Outpatient Clinic Visits*:** Outpatient Clinic Visits are defined as any hospital affiliated (licensed pursuant to Article 28 of the New York State Public Health Law) outpatient clinic service **excluding** services provided at the following sites of service:

- Federally Qualified Health Centers (FQHC)
- Chemical Dependence/Detox Clinic services (OASAS)
- Article 31 Mental Health Clinics (OMH)

Note: *Includes standalone renal dialysis centers and oncology/cancer treatment service centers. Article 28/31 dually licensed clinics are eligible for the add-on if the claim definition criteria are met.*

Claims Definition (Institutional Facility Claims only):

- Type of Bill: 13x, 71x, 72x, 74x, 75x, 78x, 79x, 83x, 84x, 85x

and

- Rate code is null and claim contains at least one of the following:
  - **Revenue Codes**: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0522, 0523, 0524, 0526, 0529 **or**
  - **Procedure codes**: 99201-99205, 99211-99215, 99241-99245, G0463, 99381-99429

or

- **Rate codes**: 1400, 1432, 1489, 1501
- **Article 28/31 Dually Licensed** Rate Codes: 1048, 1110, 1122, 1140, 1516, 1519, 1576, 1588

Note*: Only one add-on per claim*

***B) Outpatient Ambulatory Surgery Visits*:** Outpatient Ambulatory Surgery visits are defined as the primary claims where an ambulatory surgery procedure at a hospital affiliated site (licensed solely pursuant to Article 28 of the New York State Public Health Law) was performed.

- This does not include any pre or post-operative claims that may have been billed separately.

Claims Definition (Institutional Facility Claims only):

- Type of Bill: 13x, 83x, 85x **and**
- Claim contains at least one of the following:
  - **Revenue codes:** 0360, 0361, 0490, 0499 **or**
  - **Rate code:** 1401

Note*: Only one add-on per claim*

***C) Outpatient Emergency Room Visits*:** Outpatient Emergency Room visits are defined as services provided in a hospital emergency room (licensed solely pursuant to Article 28 of the New York State Public Health Law) needed to evaluate or stabilize and emergency medical condition, including psychiatric stabilization and medical detoxification from drugs or alcohol.

- Emergency Room admissions resulting in an inpatient stay or outpatient ambulatory surgery should be **excluded** from this category.

Claims Definition (Institutional Facility Claims only):

- Type of Bill: 13x, 85x **and**
- Claim contains at least one of the following:
  - **Revenue codes:** 0450, 0451, 0452, 0459, 0981 **or**
  - **Rate code:** 1402 **or**
  - **Procedure codes:** 99281-99285 **and**
- Claim does not meet criteria for Inpatient Acute, Inpatient Psychiatric, Outpatient Ambulatory Surgery.

Note*: Only one add-on per claim*

D) Hierarchy of Claims Assignment: In situations where a claim can be classified as more than one of the above, the following assignment is used:

- **Outpatient Ambulatory Surgery** if claim meets guidance for:
  - Outpatient Ambulatory Surgery **and**
  - Outpatient Emergency Room (ER) or Outpatient Clinic
- **Outpatient Emergency Room** if claim meets guidance for:
  - Outpatient Emergency Room (ER) **and**
  - Outpatient Clinic
- **Outpatient Clinic** if claim does not meet guidance for Outpatient Ambulatory Surgery or Outpatient Emergency Room (ER).

Note*: Only one add-on per claim*

Additional Claim Inclusion Criteria:

- All dual eligible members, wherein Medicaid is not the primary payor, must be excluded.
- Add-ons apply to both participating and non-participating hospitals.