

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-25-26  
Baltimore, Maryland 21244-1850



---

## State Demonstrations Group

January 16, 2025

Amir Bassiri  
Medicaid Director, Deputy Commissioner  
New York Department of Health  
Empire State Plaza, Corning Tower, Room 1466  
Albany, NY 12237

Dear Director Bassiri:

New York submitted a draft, updated Designated State Health Programs (DSHP) Claiming Protocol on May 22, 2024, and a revised version on January 14, 2025, in accordance with the Special Terms and Conditions (STCs), specifically, STC 11.4. The Centers for Medicare & Medicaid Services (CMS) is approving the January 14, 2025 protocol as an attachment to the STCs for New York's section 1115 demonstration project entitled, "Medicaid Redesign Team (MRT)" (Project No. 11-W-00114/2), effective through March 31, 2027. A copy of the approved attachment is enclosed and will be incorporated into the STCs as Attachment O.

This approval is conditioned upon compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project. In addition, as stipulated in the STCs, the state must continue conducting monitoring and evaluation of all DSHP-funded initiatives.

We look forward to our continued partnership on the MRT section 1115 demonstration. If you have any questions, please contact your CMS project officer, Jonathan Morancy, at [Jonathan.Morancy@cms.hhs.gov](mailto:Jonathan.Morancy@cms.hhs.gov).

Sincerely,

Angela D. Garner  
Director  
Division of System Reform Demonstrations

Enclosure

cc: Melvina Harrison, State Monitoring Lead, Medicaid and CHIP Operations Group

**ATTACHMENT O**  
**Claiming Protocol for Designated State Health Programs (DSHPs)**  
**Updated January 16, 2025**

To support the goals of improving health outcomes and promoting health equity, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Special Terms and Conditions (STCs) section 11 of New York's Medicaid Redesign Team (MRT) Demonstration 11-W-00114/2 through March 31, 2027. This attachment contains the protocol for such determination of cost.

Federal regulation 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

All sources of non-federal funding must be compliant with section 1903 (w) of the Social Security Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

CMS may review the sources of the non-federal share of funding for the demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the program's financial status shall require the state to provide information to CMS about all sources of the non-federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

In accordance with STC 11.2(c)(iii) DSHP expenditures submitted to CMS will not include payment for:

- a. Bricks and mortar.
- b. Shelters, vaccines, and medications for animals.
- c. Coverage/services specifically for individuals who are not lawfully present or are undocumented.
- d. Revolving capital funds; and
- e. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

Below are descriptions of each DSHP program approved under Project Number 11-W-00114/2. The programs have been arranged based on program groups. The list of the DSHP programs is attached as an appendix.

## **PROGRAM GROUP A: Statewide Financial System (SFS)**

---

Programs in this group are those for which all required program funding source information and data to determine expenditures eligible for DSHP may be obtained through New York's state agency accounting system, the Statewide Financial System (SFS).

**Funding Sources:** Programs in this group may use either State General Fund (GF) appropriations, Special Revenue-Other (SRO) appropriations, or a combination thereof.

SFS is the state's accounting system or the 'book-of-record' for New York State. Each agency enters vouchers into SFS. Vouchers are the records of system transactions created for the processing of supplier invoices, which are requests for payment by a supplier for goods and services. Vouchers are generated by state agencies upon receipt of an invoice from a supplier and are reviewed and approved by the receiving agency and the Office of the New York State Comptroller (OSC). Upon approval, accounting entries for vouchers are created in the General Ledger in SFS, and the funds are disbursed to pay the invoice.

Such payment ties back to the specific budget appropriation for the relevant program. State law requires that claiming information be maintained for a period of not less than seven years. Program staff maintain the Annual State Aid Application and the Quarterly Expenditure Reports. The DOH audit unit has been tasked with performing audits of the Local Health Department claims (external audits). The Department's internal audit unit is tasked with performing necessary process reviews (internal audits). When the State transitioned into SFS, DOH established unique program codes within SFS for all of its programs to track disbursements. OSC reviews, approves, and then processes the payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a journal process that is built into SFS. Such a mechanism also serves as a budget tool to track expenditures and provide a history of such expenditures by program that can be used for audit purposes.

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC section 11:

1. Disbursement reports from SFS will then be used to prepare the DSHP claim. The reports are customized using criteria pertaining to each program and based on disbursement date.
2. The state will verify that payments and associated claimed expenditures are commensurate with actual program services delivered. The State will also verify that the expenditures meet the requirements for the DSHP Claiming Process described in STC 11.5 and for Prohibited DSHP Expenditures described in STC 11.2.
3. Per STC 11.2.b, the 9.2 percent adjustment for unmatchable expenditures will be applied to account for expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid.
4. The state will submit claims to CMS for FFP based on the total computable expenditure incurred by the State in making eligible payments to providers. The expenditure claims

will be claimed in accordance with STC section 11. The State attests that expenditures used are correct and verifiable as allowable DSHP.

The reports pull data directly from SFS via standard system reports and customized criteria pertaining to each program. Reports are compiled quarterly and based on Disbursement Date.

**Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFS. Disbursement reports will include Description and codes as follows:

1. Program Identifiers (Major Program, Department, Appropriation, Transactional Program, Transactional Fund)
2. Budget Year Reference
3. Chartfield 1 11850 Code – an indicator used to identify how a cost is accounted for in the DOH’s Central Office Cost Allocation Claim (COCAC). Since none of the DSHP costs are eligible for federal Medicaid match outside of the DSHP process (as required by the STCs), all costs included in this section would be identified by a CF1 code of 11850.
4. Account Payable/General Ledger Journal Reference #
5. Disbursement Date

## **PROGRAM GROUP B: eMedNY & SFS**

---

Programs in this group are those for which required program funding source information and data to determine expenditures eligible for DSHP may be obtained through New York's state agency accounting system, SFS, and through New York's statewide Medicaid Management Information System (MMIS), eMedNY.

### **A. Vital Access Providers Assurance Program (VAPAP)**

**State Agency:** Department of Health

**Program Codes:** N/A

**Funding Sources:** State General Fund

#### **Brief Description:**

The VAPAP program provides State-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery.

Additional information can be found here:

- For Hospitals: <https://www.health.ny.gov/facilities/hospital/vapap/>
- For Nursing Homes: <https://www.health.ny.gov/facilities/nursing/vapap/>

#### **Eligible Populations:**

N/A

#### **Eligible Providers:**

The eligibility requirements for financial assistance under VAPAP are expansive, as this is a discretionary State funding program. All requests for VAPAP financial assistance are filed through the submission of a VAPAP application (refer to link below in application process section of this narrative). Because VAPAP is a discretionary program, eligibility for a VAPAP award does not ensure that an eligible distressed provider will receive funding under the VAPAP program or receive the amount of funding that it has requested. The State conducts reviews of the VAPAP applications and determines awards based on factors including a facility's financial condition and other aspects of facility sustainability.

Eligible facilities include:

- A public hospital, which shall mean a general hospital operated by a county, municipality, or a public benefit corporation.

- A federally designated critical access hospital.
- A federally designated sole community hospital.
- A general hospital that is a safety net hospital which shall mean a hospital in which; (1) at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or (2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or (3) such hospital that, in the discretion of the commissioner, serves a significant population of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.
- An Article 28 residential health care facility, with less than 15 days of cash equivalents on hand or negative operating margins within the last two complete calendar years, and is not currently the subject of known investigation or enforcement action by CMS, the Department of Justice, HHS-OIG, the Office of the Attorney General or the Office of the Medicaid Inspector General.

**Claiming Process:**

Payments are made by either the NYS Medicaid Claiming System (eMedNY) or the Statewide Financial System (SFS).

**eMedNY Claiming Process:**

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed, and implemented. New York State’s MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY provides the Department of Health (DOH) with the capability to reimburse Medicaid providers with a Lump Sum Payment. The term Lump Sum signifies a supplemental payment, which differs from claim-based payments, because supplemental ones do not originate from a Medicaid provider entering a claim in the eMedNY system. Rather, supplemental payments are developed by the Department of Health and entered in eMedNY to be processed and paid. Consequently, the provider’s weekly Medicaid check is comprised of both its claims and lump sums.

Lump sum payments can only go to Medicaid-enrolled service providers or Medicaid-enrolled Managed Care Plans. Furthermore, lump sum payments must exhibit funding that is a combination of Federal, State, and Locally capped shares.

Since lump sum payments are not subject to eMedNY’s extensive claim edits, appropriate checks & balances have been put in place to ensure accuracy and integrity. Payment upload packages must contain all the necessary documents required to upload payments, these include payment request forms, Division of Budget and OHIP authorizations, and Federal authorization (if the payment utilizes Federal funding).

To ensure each payment is uploaded and charged correctly, and the provider receives the appropriate amount, lump sum payments processed through eMedNY require the following information:

- General Ledger (GL) Code - General Ledger Codes exist for each Federal grant program. These codes are used to determine how the payments will be Federally funded. They are also used to determine how the payments will be recorded on the Statewide Financial System (SFS) and how they will be reported to the Centers for Medicare and Medicaid Services (CMS).
- Provider ID - When a provider enrolls in the Medicaid Program, they are assigned an 8-digit MMIS ID. This 8-digit MMIS ID corresponding to the provider(s) is required with all payment requests.
- Reason Code (RSN) - OHIP has created “Reason Codes” corresponding to the most common payment types. The RSN codes are used to map the lump sum payment to the correct State appropriation.
- Payment Amount - Every provider listed in the lump sum payment request needs a payment amount. The total payment amount should align with the approved Division of the Budget (DOB) letter.
- County Code – Represents the County fiscally responsible for the Local Share of each payment, this code ensures the appropriate county is charged.

**Statewide Financial System (SFS)/Claiming Process:**

The VAPAP program was established through legislative action (§2826 of NYS Public Health Law) with reimbursement to distressed providers determined by DOH. Program funding is provided annually through an appropriation established in the NYS aid to localities budget legislation. Provider cash flows and financial documents are submitted regularly depending on the severity of financial distress and reviewed for appropriateness by DOH staff prior to payment. Electronic payment is made through the Statewide Financial System (SFS). The SFS process for VAPAP aligns with the SFS process outlined under Program Group A in this protocol. The VAPAP program is uniquely defined in SFS with the following Chart of Accounts coding:

	<u>Department</u>	<u>Program</u>	<u>Fund</u>	<u>Account</u>	<u>CF 1</u>	<u>Bud Ref</u>
VAPAP	3450000	xxxx	10000	60303	XXXXXX	2024-25

## B. Health Care Workforce Bonus (HWB) Program

**State Agency:** Department of Health (DOH)  
Office for People with Developmental Disabilities (OPWDD)  
Office of Mental Health (OMH)  
Office of Addiction Services and Supports (OASAS)

**Program Codes:** 28353 & 28623

**Funding Sources:** General Fund

### Brief Description:

In accordance with section 367-w of the Social Services Law, this initiative recognizes certain frontline healthcare workers and authorizes bonus payments. For an employee to qualify for a bonus payment they must meet the following requirements:

1. Work for a qualified employer as defined in SOS §367-w(2)(b) and (c);
2. Work in one of the eligible titles listed in SOS §367-w(2)(a)(i)-(iii);
3. Receive an annual base salary of \$125,000 or less (excluding any bonus or overtime pay paid by the employer);
4. Be employed by a qualified employer at all times during the “vesting period” as defined in SOS §367-w(2)(d) (vesting periods defined in the chart below):

Vesting Period	Submission Start Date	Submission End Date
One (10/1/21 - 3/31/22)	August 3, 2022	September 2, 2022
Two (4/1/22 - 9/30/22)	October 1, 2022	November 30, 2022
Three (10/1/22 - 3/31/23)	April 1, 2023	May 1, 2023
Four (4/1/23 - 9/30/23)	October 1, 2023	October 31, 2023
Five (10/1/23 - 3/31/24)	April 1, 2024	May 1, 2024

5. Must not be excluded or suspended from participation in the Medicaid program; and
6. Must have worked the required minimum number of hours (at least 20 hours per week) during the vesting period to be eligible for the bonus.

### Eligible Population:

Qualified employers (description below) will pay bonus amounts to qualified employees (list below) based on the number of hours worked during the vesting period as defined below:

- Qualified employees who work at least 20 hours but no more than 30 hours per week are eligible for a bonus of \$500;
- Qualified employees who work at least 30 hours but no more than 35 hours per week are eligible for a bonus of \$1,000; and
- Qualified employees who work at least 35 hours per week are eligible for a bonus of \$1,500.



A qualified employee is eligible for up to two vesting periods per employer. The maximum any employee may receive is \$3,000.

**Eligible titles are as follows:**

Frontline Direct Care Health and Mental Hygiene Workers  
Activity/Creative Arts Therapist  
Admitting Clerk  
Admitting Clerk Cashier  
Advanced Emergency Medical Technician  
Assistant Program or Assistant Site Director  
Behavior Intervention Specialist 1  
Behavior Intervention Specialist 2  
Building Attendant  
Building Service Aide  
Building Service Worker  
Cardiovascular Technologists and Technician  
Case Manager  
Certified First Responders  
Certified Recovery Peer Advocate  
Clerks  
Clinical Coordinator  
Clinical Laboratory Technologists and Technician  
Counseling Aide/Assistant – Alcoholism and Substance  
Counselor  
Counselor – Alcoholism and Substance Abuse (CASAC)  
Counselor – Rehabilitation  
Crisis Prevention Specialist  
Critical Care Clerk  
Custodian  
Dental Assistants  
Dental Hygienists  
Developmental Disabilities Specialist QIDP-Direct Care  
Developmental Disabilities Specialist/Habilitation  
Diagnostic Medical Sonographers  
Dietary Aide  
Dietary Worker  
Dietetic Technician  
Dietician/Nutritionist  
Dining Aide  
Dining Assistant  
Discharge Control Clerk  
Early Recognition Specialist  
Emergency Medical Technician  
Emergency Services Clerk  
Environmental Service Aide/Tech

Environmental Services Worker  
Exercise Physiologists  
Floor Maintenance Worker  
Food & Nutrition Aide  
Food Prep/Service Worker  
Front Desk Clerk  
Housekeeping Worker and Maid  
Intake/Screening  
Intensive Case Manager  
Intensive Case Manager/Coordinator  
Job Coach/Employment Specialist  
Lead Intake Specialist  
Licensed Mental Health Counselor  
Licensed Mental Health Counselor (OASAS)  
Licensed Mental Health Counselor (OCFS)  
Licensed Practical and Licensed Vocational Nurse  
Licensed Practical Nurse  
Licensed Psychoanalyst  
Magnetic Resonance Imaging Technologist  
Maintenance/Physical Plant workers  
Manager  
Marriage and Family Counselor/Therapist  
Medical Assistants  
Medical Fellow  
Medical Resident  
Mental Hygiene  
Mental Hygiene Worker  
Nuclear Medicine Technologist  
Nurse Anesthetist  
Nurse Midwives  
Nurse Practitioner  
Nurse Practitioner/Nursing Supervisor  
Nurses  
Nurse's Aide/Medical Aide  
Nursing Assistants  
Occupational Therapist  
Occupational Therapy Aide  
Occupational Therapy Assistant  
Operating Room Clerk  
Ophthalmic Medical Technician  
Orderlies  
Orthotist  
Other Clinical Staff/Assistants  
Other Direct Care Staff  
Paramedic  
Peace Officer  
Peer Professional-Non-CRPA (OASAS Only)

Peer Specialist  
Pharmacist  
Pharmacy Technician  
Phlebotomist  
Physical Therapist  
Physical Therapy Aides  
Physical Therapy Assistant  
Physician Assistant  
Program or Site Director  
Prosthetist  
Psychiatric Aide  
Psychologist (Licensed)  
Psychologist (Master's Level)/Behavioral Specialist  
Psychology Worker/Other Behavioral Worker  
Radiation Therapist  
Radiologic Technologist  
Recreational Therapist  
Registered Nurse  
Registration Clerk  
Residence/Site Worker  
Residential Treatment Facility (RTF)  
Respiratory Therapist  
Sanitation Worker  
Security Guard  
Senior Counselor  
Service Worker  
Social Worker-Licensed (LMSW, LCSW)  
Social Worker-Master's Level (MSW)  
Specialist QIDP-Clinical  
Speech Therapist  
Speech-Language Pathologist  
Supervisor  
Support Services Worker  
Surgical Technologist  
Technologists and Technicians  
Therapists  
Therapy Assistant/Activity Assistant  
Transition Coordinator  
Unit Assistant  
Unit Associate  
Unit Clerk  
Unit Coordinator  
Unit Receptionist  
Unit Secretary  
Ward Clerk

## **Eligible Providers:**

Qualified employers include certain providers with at least one employee, and that bill for services under the Medicaid state plan or a home or community-based services (HCBS) waiver, providers that have a provider agreement to bill for Medicaid services provided or arranged through a managed care organization or a managed long term care plan, and certain educational institutions and other funded programs. These include certain providers, facilities, pharmacies, and school-based health centers licensed under the state Public Health Law, Mental Hygiene Law, and Education Law, as well as certain programs funded by the Office of Mental Health (OMH), Office for the Aging, Office of Addiction Services and Supports (OASAS), and the Office for People with Developmental Disabilities (OPWDD).

## **eMedNY Claiming Process:**

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed, and implemented. New York State's MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

eMedNY provides the Department of Health (DOH) the capability to reimburse Medicaid providers with a Lump Sum Payment. The term Lump Sum signifies a supplemental payment, which differs from claim-based payments, because supplemental ones do not originate from a Medicaid provider entering a claim in the eMedNY system. Rather, supplemental payments are developed by the Department of Health and entered in eMedNY to be processed and paid. Consequently, the provider's weekly Medicaid check is comprised of both its claims and lump sums.

Lump sum payments can only go to Medicaid-enrolled service providers or Medicaid-enrolled Managed Care Plans. Furthermore, lump sum payments must exhibit funding that is a combination of Federal, State, and Locally capped shares.

Since lump sum payments are not subject to eMedNY's extensive claim edits, appropriate checks & balances have been put in place to ensure accuracy and integrity. Payment upload packages must contain all the necessary documents required to upload payments, these include payment request forms, Division of Budget and OHIP authorizations, and Federal authorization (if the payment utilizes Federal funding).

To ensure each payment is uploaded and charged correctly, and the provider receives the appropriate amount, lump sum payments processed through eMedNY require the following information:

- General Ledger (GL) Code - General Ledger Codes exist for each Federal grant program. These codes are used to determine how the payments will be Federally funded. They are also used to determine how the payments will be recorded on the Statewide Financial

System (SFS) and how they will be reported to the Centers for Medicare and Medicaid Services (CMS).

- Provider ID - When a provider enrolls in the Medicaid Program, they are assigned an 8-digit MMIS ID. This 8-digit MMIS ID corresponding to the provider(s) is required with all payment requests.
- Reason Code (RSN) - OHIP has created “Reason Codes” corresponding to the most common payment types. The RSN codes are used to map the lump sum payment to the correct State appropriation.
- Payment Amount - Every provider listed in the lump sum payment request needs a payment amount. The total payment amount should align with the approved Division of the Budget (DOB) letter.

County Code – Represents the County fiscally responsible for the Local Share of each payment, this code ensures the appr

### **Statewide Financial System (SFS) Claiming Process:**

The Department of Health (DOH), Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Addiction Services and Supports (OASAS) enters vouchers into the SFS system for payment. The Office of State Comptroller (OSC) reviews, approves, and then processes such payments. The OSC process includes budget checks against appropriations and segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a journal process that is built into SFS.

The agencies use the SFS to process contracts and vouchers for the review, approval, and payment by the State Comptroller. When the State transitioned into SFS, the agencies established unique codes within SFS for all its programs to track disbursements. For the HWB SFS payments the State takes the following steps:

- Step 1. Claims for reimbursement are submitted by the eligible employers for eligible employees during the 30-day submission period after each prescribed vesting period.
- Step 2 An agency contract manager reviews the information and enters the claim into the SFS system. Upon approval, payments are disbursed through the SFS system. For all qualified providers, the agency keeps the State standard voucher, expenditure reports, narrative expenditure report, and the submitted claim.
- Step 3 The following Chart of Accounts is used to code reimbursement claims for this program:

Departments: DOH: 3450405, OMH: 3650000, OPWDD: 3660000, OASAS - 3670000

Program Codes: 28353 & 28623

Fund: 10000

Budget Reference: Dependent on claim period

- Step 4            The SFS system budget tracks the transaction to ensure sufficient funds are available within the segregation/appropriation authority established through an approval process with the NYS Division of the Budget and the Office of State Comptroller. Such a mechanism also serves as a budget tool to track expenditures and provide a history of such expenditures by program that can be used for audit purposes.
- Step 5            DSHP expenditures for this program will constitute the voucher payments and advances described and paid through this process.

NOTE: The HWB claims do not get processed for FFP.

## **Appendix DSHP List**

### **Program Group A:**

- Health Workforce Retraining Initiative (Increase Training Capacity)
- Doctors Across New York (DANY) Diversity in Medicine
- DANY Physician Loan Repayment and Practice Support
- Nurses Across New York (NANY)
- Area Health Education Centers (AHEC)
- Alzheimer's Caregiver Support
- CSEA Buy-in
- MLTC Ombudsman
- NY Connects
- Supportive Housing Initiative
- Cancer Services
- Obesity - Diabetes Prevention Programs
- Elderly Pharmaceutical Insurance Coverage (EPIC)
- Tobacco Control
- Newborn Screening
- End of AIDS
- Nourish NY
- Rural Health
- The Healthcare Education and Life-Skills Program (HELP)
- The Healthcare Workers Are Our Future Scholarship Program
- Caregiver Flexibility
- Community Services for the Elderly (CSE)
- Wellness in Nutrition
- Expanded In-home Services for the Elderly (EISEP)
- Opioid Overdose Prevention
- HIV, STD, and Hep C Prevention
- Supplemental Support to Ryan White Programs

### **Program Group B:**

- Health Care Worker Bonus (HWB) Program
- Vital Access Provider Assurance Program (VAPAP)