Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 16-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JH:SPA-NY-16-0002-Approval

May 2, 2017

Jason Helgerson
State Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP 1211)
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #16-0002 has been approved for adoption into the State Medicaid Plan with an effective date of January 1, 2016. This State Plan Amendment extends the Ambulatory Patient Group (APG) methodology for freestanding clinics and ambulatory surgery center services from January 1, 2016 through December 31, 2017. This SPA also includes corrective actions to be taken by the State to address data deficiencies found in the latest Upper Payment Limit (UPL) submissions.

Enclosed are copies of SPA #16-0002 and the HCFA-179 form, as approved.

If you have any questions, please contact Joanne Hounsell at (212) 616-2446.

Sincerely,

[redacted]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures: HCFA-179 Form
State Plan Pages

cc:
J. Ulberg
R. Deyette
M. Levesque
P. LaVenia
S. Bass
C. Wilson
K. Wright
R. Weaver
R. Holligan
N. McKnight
M. Varon
S. Jew
J. Hounsell
M. Lopez

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0002**

2. STATE: **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§ 1902(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT: **(in thousands)**
a. FFY 01/01/16-09/30/16 $ 0
b. FFY 10/01/16-09/30/17 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Page 2(g)(1); 2(u); 2(u.1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Page 2(g)(1); 2(u)

10. SUBJECT OF AMENDMENT:
APG Extension – Freestanding Clinics (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: FEB 18 2016

16. RETURN TO:
New York State Department of Health
Division of Finance & Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
MAY 02, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JANUARY 01, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
MICHAEL MELENDEZ

22. TITLE:
RATOR
DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

FORM HCFA-179 (07-92)

New York
2(g)(1)

APG Reimbursement Methodology – Freestanding Clinics

For the purposes of sections pertaining to the Ambulatory Patient Group, and excepted as otherwise noted, the term freestanding clinics shall mean freestanding Diagnostic and Treatment Centers (D&TCs) and shall include freestanding ambulatory surgery centers.

For dates of service beginning September 1, 2009 through December 31, [2015] 2017, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

New York
2(u)

Upper Payment Limit

The State, in order to comply with the Upper Payment Limit (UPL) regulations at 42 CFR 447.321, will mandate the following for all clinics licensed by the NY State Department of Health, Office of Mental Health, [Office of Mental Retardation and] Office for People with Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services.

- All clinic providers will prepare and file cost reports. For clinics with costs of $100,000 or more, [T]the cost reports must be independently audited for cost and visits [data]. Those clinics that do not submit an independently audited cost report with costs below $100,000 will be given no UPL margin in the UPL calculations. If a clinic fails to submit an Ambulatory Health Care Facility (AHCF) or Consolidated Fiscal Report (CFR) cost report, or the cost report is incomplete, the payments will be included in the Medicaid side of the UPL calculation without any proxy for costs;

- The State will issue notices to all clinic providers no later than December 31, 2009, that providers must maintain beneficiary "threshold visit" data for all payers, in a format that will be independently audited and reported on the provider's annual cost report and/or as a supplemental report for all cost reporting periods beginning on or after January 1, 2010;

- All clinic claims will be subjected to appropriate eMedNY payment edits, which will deny a claim for incorrect and/or inaccurate billing and coding information, starting no later than December 31, 2009;

- The aggregate UPL for each category of clinic (private, state owned or operated, non-state government owned or operated) will be calculated using an average cost per visit or such other method that may be authorized by federal statute or regulation;

- All costs must be costs that would be allowable using Medicare cost reporting and allocation principles;

- The State will remove all costs and payments associated with services that do not meet the definition of a clinic as described in 42 CFR 440.90, for example, transportation, in-home services, etc.;

- The State will provide a progress report to Centers for Medicare and Medicaid Services (CMS) by June 30, 2011 on eMedNY editing, claims coding, and the cost reporting process;

- The State will submit an addendum to the July 12, 2012 progress report by September 30, 2013 to include the status of providers who submitted 2010 and 2011 audited cost reports, and such audited reports will be provided to CMS based on CMS' sample; and

- The State will submit a full UPL for calendar year 2018 using [2011] 2017 cost data by [December] March 31, [2013]2018. However, if the state makes the following corrective

actions to address data deficiencies sooner than this time frame it may submit a UPL for CMS review and approval for the period in which the deficiencies were corrected:

a) Add a page to the Consolidated Fiscal Report (CFR) with utilization statistics by payer similar to Exhibit 1 G&S Information D of the AHCF cost report in order to help ensure total visits are reported for all payers;

b) Update the CFR instructions to define an Opioid Treatment Program (OTP, formerly referred to as Methadone Maintenance Treatment Program (MMTP)) threshold visit to ensure concurrence with Medicaid visits per Medicaid Management Information System (MMIS);

c) The State will review, and if applicable, update the instructions for all other services to ensure threshold visits per cost report are consistent with Medicaid per the MMIS;

d) The State will review the reporting of costs and threshold visits in the cost report for ordered ambulatory services and billing units in MMIS to ensure that ancillary services can be separately identified for ordered ambulatory facilities. If the distinction cannot be made, they are to be considered services for patients in the clinic and, as such, the UPL should include all ancillary costs and applicable MMIS payments with no corresponding visit count; and

e) The costs for ancillary services that are provided by the same clinic that provided the medical visit (as opposed to ordered ambulatory ancillary services in paragraph d) will be included in the costs on the clinic's cost report. Only one "threshold visit" will be reported that corresponds to the costs provided for the entire visit (medical visit plus ancillary services).