New York State
Patient Centered Medical Home (NYS PCMH)
Medical Billing Guidance

New York State Medicaid
Fee-for-Service and Medicaid Managed Care
Provider Policy Manual
2025-Version 2

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1 Links and eMedNY Contacts

New York State (NYS) Department of Health's Office of Health Insurance Programs Bureau of Health Access, Policy, and Innovation

- 518-473-2160
- For PCMH inquiries: pcmh@health.ny.gov

NYS Patient Centered Medical Home (NYS PCMH) Program
The NYS PCMH website provides an overview about NYS PCMH, resources for recognition, historical information, as well as PCMH quarterly reports.
NYS PCMH – NYSDOH

National Committee for Quality Assurance (NCQA)
The NCQA website provides an overview of the NYS PCMH program which can be found at the following weblink: NYS Patient-Centered Medical Home - NCQA

New York State Medicaid Updates
Medicaid Updates are published monthly. Updates to NYS Patient Centered Medical Home (NYS PCMH) reimbursement guidance may be made periodically and posted on the Medicaid Update website.

Provider Communications
Provider communications may periodically be posted on eMedNY's PCMH website. Please follow the link provided and click on the Provider Communications icon under "Featured Links" for further information visit:

eMedNY

- https://www.emedny.org
- (800) 343-9000
- eMedNY Contacts PDF

The eMedNY LISTSERV® is a Medicaid mailing system that offers providers, vendors, and other subscribers the opportunity to receive a variety of notifications from eMedNY. The email notifications are provided as a free service to subscribers and may include information on provider manual updates, fee schedules, edit status changes, billing requirements and other helpful notices. Additional information regarding eMedNY LISTSERV® can be found at: https://www.emedny.org/listserv/emedny_email_alert_system.aspx

Program periodically sends email updates to NYS PCMH Providers utilizing the email they have on file with NCQA.

New York State Medicaid General Policy Manual – Information for All Providers
General Medicaid Policy information and billing guidance is available at:
https://www.emedny.org/ProviderManuals/AllProviders/index.aspx

New York Codes, Rules and Regulations, Title 18 (Social Services)
http://www.health.ny.gov/regulations/nycrr/title_18/

New York Codes, Rules and Regulations, Title 10
(Health)http://www.health.ny.gov/regulations/nycrr/title_10/

Provider Enrollment Forms: https://www.emedny.org/info/ProviderEnrollment/index.aspx

Change of Address for Enrolled Providers:
https://www.emedny.org/info/ProviderEnrollment/changeaddress.aspx

Provider Quick Reference Guide:
https://www.emedny.org/contacts/telephone%20quick%20reference.pdf

General Billing:
https://www.emedny.org/ProviderManuals/AllProviders/index.aspx

Guide to Timely Billing Information for all Providers – General Policy:
https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf

Timely Billing Information: https://www.emedny.org/info/TimelyBillingInformation_index.aspx

New York State Electronic Medicaid System Remittance Advice Guideline:
General_Remittance_Guidelines.pdf (emedny.org)

Guide to Claim Denial Reasons:
Medicaid Update, April 2105, Page 13

Medicaid Eligibility Verification System (MEVS):
https://www.emedny.org/ProviderManuals/5010/MEVS/MEVS_DVS_Provider_Manual_(5010).pdf

Medicaid Managed Care (MMC) Plan Directory:
https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf

ePACES Reference Guide
https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Reference_Guide.pdf

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3 Overview

Article 5, Title 11 of the New York Social Services Law, Section 364-m, enabled the Commissioner of Health to provide enhanced reimbursement to the National Committee for Quality Assurance-recognized Patient-Centered Medical Home providers who participate in Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MMC). This enhanced reimbursement is known as the Statewide Patient-Centered Medical Home program.

In April 2018, the New York State Department of Health (the Department) collaborated with the National Committee for Quality Assurance (NCQA) to develop a customized Patient-Centered Medical Home (PCMH) recognition program. NYS PCMH supports initiatives that improve primary care through the medical home model which promotes the goals of improved health, better health care and consumer experience, and lower cost.

The NYS PCMH Recognition Program helps practices:
• Improve patient-centered access and patient experience.
• Perform comprehensive health assessments to identify patient needs.
• Deliver better preventive care such as immunizations and cancer screenings.
• Prioritize comprehensive care management to keep chronic conditions under control.
• Coordinate with other clinicians to improve continuity of patient care by closing the referral loop and gaps in services.

Adoption of these strategies leads to lower healthcare costs, improved patient experience, and better health outcomes. Practices that are recognized as a New York State Patient-Centered Medical Home (NYS PCMH) by the National Committee for Quality Assurance (NCQA) are eligible to receive incentive payments ("add-on" payments) from the NYS Medicaid program. Payments are provided in the form of either per member per month (PMPM) capitation payments for Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members, or as a per-visit "add-on" payment for eligible claims billed for services provided to Medicaid Fee-For-Service (FFS) members.

4 Definitions

4.1 Article 28 Clinics (Diagnostic and Treatment Centers (Clinics) (ny.gov)

An Article 28 clinic refers to a healthcare facility licensed under Article 28 of the New York Public Health Law (PHL). These clinics include Hospital Outpatient Departments (OPDs), and freestanding Diagnostic and Treatment Centers (D&TCs), which provide a wide range of outpatient services such as primary care, diagnostic testing, and minor surgical procedures. Article 28 clinics are regulated by the New York State Department of Health (the Department) and are required to meet specific standards for facility management, patient safety, and care quality. Unlike private practices, these clinics operate under more stringent oversight and can be free-standing or affiliated with hospitals.

4.2 Current Procedural Terminology (CPT) Codes

CPT codes are developed by the American Medical Association. They describe the specific medical services and procedures performed by physicians and other qualified healthcare professionals during patient encounters. CPT codes are five-digit numeric codes used universally by healthcare providers to report medical, surgical, and diagnostic services. (Link: https://www.ama-assn.org/topics/cpt-codes)

4.3 Health Commerce System (HCS)

The Health Commerce System is used by the Department to communicate important and time-sensitive information to healthcare providers. The NYS PCMH Provider list is sent directly from the NCQA to the Department and is posted on the HCS for users to access. Every user accessing the Health Commerce System must have their own HCS account.

4.4 Institutional Claims

An Institutional 837I claim is an electronic claim form used by institutional healthcare providers, such as hospitals, nursing facilities, and other large healthcare institutions, to submit claims to Medicaid. The 837I (Institutional) is part of the HIPAA-mandated set of electronic claim forms and is specifically designed for billing institutional services. Pursuant to the NYS Medicaid General Billing Guidelines (https://www.emedny.org/providermanuals/allproviders/General_Billing_Guidelines_Institutional.pdF), all outpatient clinic and inpatient facility claims must be submitted via an electronic 837I claim submission.

4.5 New York State-Patient Centered Medical Home (NYS PCMH)
The NYS PCMH Recognition Program is a modification of NCQA's original PCMH program and is exclusive to New York State. It supports the state's initiative to improve primary care and promote better health, lower costs, and better patient experience.

4.6 Patient-Centered Medical Home (PCMH)
The Patient-Centered Medical Home, developed by NCQA, is a care delivery model where the primary care team, along with the patient (and family, when appropriate), are responsible for managing the full spectrum of health care needs. The PCMH model emphasizes care coordination, population health, evidence-based guidelines, and effective use of Health Information Technology (HIT) to meet the patient's needs. Practices that earn recognition show that they have committed to providing quality improvement within their practice and a patient-centered approach to care.

4.7 Professional Claims
Professional claims are billing documents submitted by providers for services rendered. These services can range from consultations to surgeries, encompassing any care provided professionally. Such claims are typically submitted using the CMS-1500 form, a standard for healthcare claims submitted to Medicare and Medicaid.

4.8 Rate Codes
New York State Medicaid FFS rate codes are unique 4-digit numerical identifiers used by institutional billers to specify facility types, services, or procedures eligible for Medicaid reimbursement. Each rate code corresponds to a specific service or category of services, such as inpatient care, outpatient services, specialty treatments, diagnostic testing, and other medical procedures.

4.9 Remittance Advice
The remittance advice shows a record of claim transactions and assists providers in identifying and correcting billing errors.

4.10 The National Committee for Quality Assurance (NCQA)
An independent nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. New York State collaborated with the NCQA, the creator of the NYS PCMH Recognition Program, to develop an exclusive transformation model for all eligible primary care providers in New York State.

5 NYS PCMH Recognition Requirements

5.1 New York State Patient-Centered Medical Home (NYS PCMH) Recognition
The NYS PCMH recognition program is built around 6 concept areas or principles. Within each concept area, there are established "core" and "elective" criteria. They are the activities for which a practice must demonstrate satisfactory performance to earn NYS PCMH Recognition. Criteria were developed from evidence-based guidelines and best practices.

To earn NYS PCMH Recognition, a practice must meet all 40 core criteria, and 11 NYS required criteria (these are elective criteria under the original PCMH program but are required for the NYS PCMH program). Additionally, practices must earn a total of 25 credits in elective criteria across 5 of 6 concepts, (15-17 credits are earned by the required NYS criteria). Practices decide which of the remaining 8-10 credits of elective criteria to complete.

More information regarding the NYS PCMH Recognition Program can be found at the following link: NYS Patient-Centered Medical Home - NCQA

5.2 Clinicians who qualify for PCMH based on NCQA Eligibility Requirements:

(Reproduced with permission from NCQA Patient Centered Medical Home (PCMH) Standards and Guidelines (Version 10) by the National Committee for Quality Assurance (NCQA). To obtain a copy of this publication, contact NCQA Customer Support at 888-275-7585, or visit store.ncqa.org/pcmh:

- Clinicians who hold a current, unrestricted license as a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Advanced Practice Registered Nurse (APRN), or Physician's Assistant (PA).
- Only clinicians who can be selected by a patient/family as a *personal clinician** are eligible to be listed on NCQA's website in addition to the practice recognition. The practice may define a "personal clinician" as:
    - A residency group under a supervising clinician or faculty physician
    - A combination physician and APRN or PA who share a panel of patients.
- Physicians, APRNs (including nurse practitioners, and clinical nurse specialists), and PAs who practice internal medicine, family medicine, or pediatrics, with the intention of serving as the personal clinician for their patients. These clinicians will be identified individually with the Recognized practice.
- Physician-led practices applying with identified APRNs or PAs:
    - Patients may choose the APRN or PA as their primary care clinician, **or**
    - APRNs or PAs share a panel of patients as a primary care team with the physician.

NOTE: Clinicians who are part of the practice but are not considered personal clinicians (e.g., behavioral healthcare clinicians, dentists, OB/GYNs) will not be identified individually, but their work on behalf of patients can be used to demonstrate that the practice meets PCMH criteria.

**Personal clinician* is NCQA terminology; the NYS Medicaid Program refers to "personal clinicians" as Primary Care Providers.

6 NYS PCMH Recognition Files

6.1 Monthly NYS PCMH-Recognized Provider List

Practices achieving NYS PCMH recognition by NCQA are added to NCQA's recognition directory. Each month, NCQA transmits an updated list of NYS PCMH-recognized providers to the Department. The file contains provider and practice details, including provider and site names, NPIs, address, 9-digit zip code, and recognition begin and end dates. The Department

does not alter provider information or recognition time frames on this file; any needed changes must be made by NCQA and delivered to the Department on subsequent monthly file transmissions.

The Department uploads this file to eMedNY and uses it during claims processing to apply the fee-for-service PCMH add-on payment. The Department also creates a simplified version of this file and posts it to the Health Commerce System for MMCs to retrieve.

6.2 Health Commerce System (HCS) Monthly File

The Health Commerce System (HCS) is used by the Department to communicate information to healthcare providers and plans.

- The first week of each month, the New York State Department of Health's Office of Health Insurance Programs (OHIP) posts the most recent list of PCMH-recognized practices and their providers to the HCS.
    - The list is based on information provided to NCQA by each PCMH-recognized practice.
    - Any updates to providers or practices, including the addition or deletion of providers, must be communicated directly with NCQA, who will relay the information to the Department. For example, if a new provider joins a practice, it is the responsibility of the practice to notify NCQA to add that provider to the PCMH-recognized list.
- MMC plans use this list to identify which practices and providers in their networks are eligible to receive the PCMH PMPM payments and the rate they should receive.
- Due to the monthly schedule of data transmissions from NCQA to the Department of Health and from the Department of Health to HCS, it takes approximately 60 to 90 days after recognition is awarded, for health plans to be notified of a new or changed recognition status.
    - Due to this lag, providers may experience a two-to-three-month delay in receiving PCMHPMPM payments.
    - FFS claims will be retroactively paid back to the start date of the certification.
    - MMC plans are required to pay PMPM payments to recognized providers for the entire period of their recognition, starting from the month of initial recognition. Regardless of the recognition effective date, payments to providers must include the entire first month of their recognition and should not be prorated.

7 Fee for Service Billing Guidance

7.1 Fee-for-Service (FFS) Medicaid: PCMH Payment Overview

Add-on payments are only payable for primary care or preventive medicine services rendered to Medicaid-only enrollees provided by physicians, physician assistants, and nurse practitioners that are included on the PCMH-recognized provider list created by NCQA and who are NYS Medicaid-enrolled**.** The add-on amount paid is based on **the specific type of claim submitted (Professional Claim or an Institutional Claim).**

Medicaid FFS providers will be paid an add-on payment for eligible claims with dates of service that fall within the provider's PCMH recognition period.

- Add-on payments can be applied to claims as of the original date of PCMH

recognition. If a provider submits a claim **prior** to the Department receiving the most up-to-date recognition information from NCQA, the add-on will not be initially applied.
- Providers are not required to adjust paid claims that were adjudicated prior to the recognition date.
- A search will be performed on a monthly basis to identify and reprocess claims based on the following criteria:
  - The NPIs of BOTH the clinic provider and attending provider on the claim are on the PCMH recognized provider list.
  - The submitted rate code is eligible for the PCMH add-on (refer to chart 7.7).
  - The zip+4 on the claim matches the providers' zip+4 listed on the PCMH provider listing.
  - The claim service begin date is on or after the certification begin date.
  - The claim did not already receive any other Medical Home add-on (ADK).
  - The claim does not have a third-party payment (Medicare or Commercial insurance).

- If providers have changes to their practice, they must be directly communicated to NCQA who will communicate updates to the Department of Health through transmittal of the monthly PCMH recognition list.

7.2 Applicable Codes for FFS Add-On Payments

Add-on payments are only available for:
- Primary care or preventive medicine services (i.e., non-specialty care services)
- Specific Evaluation and Management (E&M) codes
- Specific Preventive Medicine codes
- Specific Institutional Rate Codes

Refer to the Chart labeled: "Claim Requirements Check List" in Section 7.7.

7.3 FFS Billing for Office-Based Practitioners: Professional Claim

Office-based practitioners providing primary care services will receive a per-visit add-on payment on a Professional Claim when they meet criteria 1 OR 2 (based on type of practice, individual or group), plus ALL criteria 3-6.

1. In an **individual** provider's practice:
   - the practitioner must be included on the NYS PCMH Recognized Provider List
   - the individual practitioner's NPI must be included on the claim

2. In a **group** practice **both** of the following must be present for add-on payment:
   - The group practice NPI must be included on the NYS PCMH Recognized Provider List, **and**
   - the NPI of the rendering provider must be included on the NYS PCMH Recognized Provider List
   - the practice is responsible for notifying NCQA to add new providers to the PCMH-Recognized Provider List. Regardless of when a provider is added, the

expiration date of every provider will be the same as the practice.
    - NOTE: It is important to remember there is a lag time from when a provider is added to the NCQA PCMH Recognition List to when this data is received by the Department of Health.

3. The claim must include the 9-digit zip code of the recognized provider's site-specific physical location, as reported to NCQA.

- Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at any time, afterwards, that a new location is added.
- If the locator code on the claim is tied to a servicing location that does not match the address information (zip code plus 4 digits) on the recognition list, the claim is not eligible for the add-on
- NOTE: It is the responsibility of the provider to notify Medicaid of any change of address or other pertinent information within 15 days of the change. For information on where to direct address change requests, please refer to the following link: Provider Enrollment - Change of Address (emedny.org)
    - The Medicaid Enrolled Provider Listing which will show active service addresses including zip +4 can be found at: https://health.data.ny.gov/Health/Medicaid-Enrolled-Provider-Listing/keti-qx5t/about_data .
        - Select the "Actions" tab > "Query Data"
        - Enter NPI number
        - Provider information will be displayed.
            - Confirm that the information in Health.Data.NY.gov is accurate.
            - Confirm that this accurate information (including zip+4 digits) corresponds with the NCQA PCMH information located on the Health Commerce System.

Additionally, a report can also be requested (once every six months) to receive locator codes by visiting: Request for Providers Reports - form # 610901 (emedny.org)

4. The Place of Service (POS) code on the claim must be office (POS "11").

5. The claim must contain, and the services provided must be consistent with, one of the following E&M codes: 99202-99205, 99211-99215; or one of the following Preventive Medicine codes: 99381-99386, 99391-99396. (Refer to "Claims Requirement for Billing-Professional Claim" in the reference table.)

6. The claim paid amount must be greater than 0 and claims are not eligible for the PCMH add-on if they contain a third-party payment such as Medicare, or commercial insurance.

7.4 FFS Billing for Article 28 Clinics: Institutional Claims

Article 28 clinics will receive the per-visit add-on amount on an Institutional Claim when they meet all the following criteria:

1. Both the Billing Facility and the Attending Provider must be on the PCMH Recognized Provider list.

2. Since PCMH recognition is site-specific, the Medicaid FFS Institutional Claim must include the 9-digit zip code of the recognized clinic's site-specific physical location where services were rendered to the Medicaid member. **Do not** use the 9-digit zip code associated with the main facility or health system to which Medicaid payments are made.

3. The claim must contain, and the services provided must be consistent with, one of the following E&M codes: 99202-99205, 99211-99215; or one of the following Preventive Medicine codes: 99381-99386, 99391-99396. (Refer to the Chart labeled: "Claims Requirement Checklist: Claims Requirement for Billing-Institutional Claims" in Section 7.7)

4. Institutional claims must also include an eligible rate code. The submitted rate code must be one of the following: 1400, 1407, 1422, 1425, 1432, 1434, 1444, 1447, 1450, 1453, 2887, 2888, 2889, 2940-2942, 2945, 2985, 2987, 4012, 4013. (Refer to the Chart labeled: "Claims Requirement Checklist: Claims Requirement for Billing-Institutional Claims" in Section 7.7)

5. The claim paid amount must be greater than 0 and claims are not eligible for the PCMH add-on if they contain a third-party payment such as Medicare, or commercial insurance.

7.5 System Edit on FFS PCMH Institutional Claims

A system edit was implemented into the eMedNY claiming system for all Medicaid FFS Institutional claims. This edit withholds the PCMH add-on payment in situations where the 9-digit zip code submitted on the claim was not located on the provider's rate file for the submitted rate code. The inability of the eMedNY system to locate the submitted 9-digit zip code on the provider's rate file causes the claim to trigger edit "02068" (Provider Rate Found Without Matching ZIP/Locator Code). The PCMH add-on payment will be withheld from any FFS institutional claim that triggers edit "02068".

- The FFS institutional claim will still adjudicate as normal; however, the PCMH add-on payment will be withheld.
- Providers are responsible for reviewing their remit statements to ensure payment of the PCMH add-on.
- Providers must resubmit a claim adjustment to Medicaid with the correct 9-digit zip code that reflects the actual service location to be eligible to receive the add-on payment.
- Note: This edit is not seen on the Provider's remittance statement. **It is the responsibility of the provider to evaluate the remittance for the corresponding PCMH add-on payment.**

7.6 FFS Billing Reminders

The add-on is only triggered if the necessary components are included:

- For both institutional and professional claims to contain the correct physical location address of the practice, including the 9-digit zip code, clinical group NPI, individual servicing provider´s NPI, and an Evaluation and Management (E&M) code designated by the Department as primary care. The claim paid amount must be greater than zero.

The New York State Medicaid General Billing Guidelines for Professional Claims can be found

at the following link: General_Billing_Guidelines_Professional.pdf (emedny.org)

The New York State Medicaid General Billing Guidelines for Institutional Claims can be found at the following link: General_Billing_Guidelines_Institutional.pdf (emedny.org)

For guidance on Electronic Provider Assisted Claim Entry System (ePACES), a web-based application that will allow Providers to create/submit claims and other transactions in HIPAA format; refer to the following link: Self Help (emedny.org)

7.7 FFS Remittance Statements and Medicaid Timely Filing

Remittance advice contains the following information:

- A listing of all claims (identified by several pieces of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The status of each claim (deny/paid/pend) after processing
- The eMedny edits (errors) failed by pending or denied claims
- Subtotals and grand totals of claims and dollar amounts
- Other financial information such as recoupments, negative balances, etc.

PCMH information is located on FFS Remittance Advice:

- Electronic 835 remittances: The provider will see “Claim Adjustment Contractual Obligation (CO) 144” with the corresponding PCMH add-on amount.
- Paper or PDF remittance: The remittance will indicate: “Medical Home Add-On” with the corresponding PCMH add-on amount.

FFS timely filing billing rules

- To be considered timely, providers have 90 days from the date of service to submit a claim.

Claim Adjustments

There are no “claim adjustment reason codes” if a provider does not receive an expected PCMH add-on payment.

- For example, if the 9-digit zip code does not match the PCMH Provider file, the add-on will not occur. **It is the responsibility of the provider to evaluate the remittance for the corresponding add-on.**
- If the provider does not receive a PCMH add-on to a claim, the provider has 60 days to submit for adjustments with the appropriate delay reason code.
    - A listing and explanation of Delay Reason (DR) codes can be found at the following link: PowerPoint Presentation (emedny.org).
    - Additional NYS Medicaid billing guidance is available at https://www.emedny.org/ProviderManuals/AllProviders/index.aspx.

7.7 FFS Claim Requirement Checklist

<table>
<tr><th colspan="5">Claim Requirements Check List</th></tr>
<tr><th>Claim Type</th><th>Zip Code + 4 digit add-on</th><th>National Provider Number (NPI)</th><th>Place of Service (POS) for Professional Claim/Rate Codes for Institutional Claim</th><th>Evaluation and Management (E&M) Codes eligible for the PCMH Add-On</th></tr>
<tr><td>Professional Claim</td><td rowspan="2">□ Zip + 4 site-specific physical location where services were provided</td><td>□ PCMH-recognized Primary Care Provider</td><td>□ 11-Office</td><td rowspan="2">99204, 99205, 99211, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99391, 99392, 99393, 99394, 99395</td></tr>
<tr><td>Institutional Claim: Article 28 Clinics</td><td>□ PCMH-recognized clinic, AND
□ PCMH-recognized Primary Care Provider</td><td>Select Corresponding Rate Code: 1400, 1407, 1422, 1425, 1435, 1444, 1447, 1450, 1453, 2887, 2888, 2889, 2940, 2941, 2942, 2945, 2985, 2985, 2987, 4012, 4013</td></tr>
</table>

8 Medicaid Managed Care (MMC) PCMH Payment Overview

8.1 NYS PCMH Managed Care Payments

PCMH payments are made directly to the provider by the MMC plan(s) with which the provider contracts.

- The payments are distributed as per the table below for per member per month capitation payment. The PCMH PMPM payments due to a NYS PCMH-recognized provider are based on the number of Medicaid members assigned to that provider by the MMC plan each month. Each MMC plan calculates the payments owed to NYS PCMH-recognized providers in their network based on their record of their member's assigned Primary Care Provider.
- The Department posts updated PCMH-recognition lists on the Health Commerce System (HCS) each month for health plans to retrieve.
- MMC plans are required to pay PMPM to recognized providers for the entire period of their recognition, starting from the month of initial recognition. Regardless of the recognition effective date, payments to providers must include the entire first month of their recognition and should not be prorated.

Each MMC plan determines the frequency/schedule of PMPM payments. MMC plans are required to distribute payments at least bi-annually. MMC plans can establish a more frequent payment schedule.
All questions regarding MMC payment distribution schedules, retroactive payments, and provider recognition data should be directed to the individual MMC plan(s) with which the provider contracts. A MMC directory by plan can be found on the Department's website here: Managed Care Organization (MCO) Directory by Plan (ny.gov)

NOTE: To receive the PCMH payment, the provider's NPI must match the records of NYS PCMH and the MMC plan. The provider's information originates from NCQA therefore any changes must be directly communicated through NCQA.

8.2 NYS PCMH Managed Care Incentive Enhancement (New)

Effective April 1, 2024, Primary Care Providers recognized under the NYS PCMH program are entitled to an incentive enhancement of $4 per member per month (pmpm) for Medicaid Managed Care (including mainstream, HARP, and HIV SNP members) and CHPlus members under 21; and $2 pmpm for those 21 and over, in addition to the current $6 pmpm payment.

To receive this enhanced incentive payment after April 1, 2025, providers are required to develop a workflow to refer patients to a Social Care Network (SCN) and submit an attestation by March 31, 2025, confirming their SCN participation.

INCENTIVE ENHANCEMENT PAYMENT SCHEDULE

- April 1, 2024-March 31, 2025: all NYS PCMH providers will receive the incentive enhancement. (Refer to Column B in the NYS PCMH Payment in the chart below)

- As of April 1, 2025: NYS PCMH providers that submit SCN attestation by March 31, 2025, will continue to receive the incentive enhancement. (Column C)

- NYS PCMH providers that do not attest to participation in an SCN will receive the $6 pmpm PCMH payment without the incentive enhancement. (Column D)
- NYS PCMH practices can submit attestations after the March 31, 2025, deadline and the PCMH practice will be included in the subsequent participation list for the additional $2/$4 enhancement.
- NYS PCMH practices that submit attestations after March 31, 2025, will forfeit the $2/$4 enhancement beginning April 1, 2025, until the attestation is received.

- For more information on Social Care Networks, refer to the following link: Social Care Networks (ny.gov)
  - **Chart for NYS PCMH Payment:**
    - **NOTE: CHPlus is included in the chart below in order to provide a complete picture of the PCMH payment. Any questions on the PCMH Program in CHPlus should be directed to CHPlus: chplus@health.ny.gov**

NYS PCMH Payment							
	A	B		C		D	
Incentive	1/1/2024-3/31/2024	3/31/2024-3/31/2025		4/1/2025 with Social Care Network (SCN) Attestation		4/1/2025 without SCN Attestation	
Ages	All Ages	Under 21	21 and over	Under 21	21 and over	Under 21	21 and over
PMPM add-on Mainstream MMC, HIV SNP, and HARP Providers	$6.00	$10.00	$8.00	$10.00	$8.00	$6.00	$6.00
PMPM add-on CHPlus Providers	$6.00	$10.00	N/A	$10.00	N/A	$6.00	N/A
PMPM add-on for ADK Providers (MMC)	$7.00	$11.00	$9.00	$11.00	$9.00	$7.00	$7.00
PMPM add-on for ADK Providers (CHPlus)	$7.00	$11.00	N/A	$11.00	N/A	$7.00	N/A

FFS add-on for Professional Claims	$29.00	$29.00	$29.00	$29.00	$29.00	$29.00	$29.00
FFS add-on for Institutional Claims	$25.25	$25.25	$25.25	$25.25	$25.25	$25.25	$25.25

8.3 Medicaid Managed Care Operating Report (MMCOR)

PCMH spending is reported to the Department by the health plans in the Medicaid Managed Care Operating Report (MMCOR). The MMCOR outlines the way PCMH spend should be submitted by premium group—all premium groups included in the PCMH section of the MMCOR are allowable.

- NYS PCMH payments are based on the State Fiscal Year (April 1-March 31)
- Plans will report Medical Home expenses in every quarter on a year-to-date basis
- MMCOR and HIV SNPOR-Medical Home Tables will be added to the 1Q 2024 reports for Medicaid, HARP, and HIV SNP lines of business.
- The timing of the Medical Home payments to Plans will be two times per year based on the State Fiscal Year.

Aid Categories by Age: Plans are required to break out the following premium groups into kids (Under 21) and adults (21 and over) on the Medicaid Managed Care Operating Report (MMCOR) Cost Reports:

- MMCOR-Medicaid line of business-Medicaid SSI
- HIV SNPOR-HIV SNP line of business
- HIV-Negative SSI (Homeless)
- HIV-Negative Transgender
- TANF HIV-Negative Transgender SSI.

All other aid categories used for PCMH spend reporting are already broken out by age group.

9 Adirondack (ADK) Program

Separate and distinct from the Statewide PCMH program authorized under Article 5, Title 11 of the New York Social Services Law, NYS also has an Adirondack Medical Home program (“ADK”). Article 29, Title 2, Section 2959 of the NYS Public Health Law provides the Commissioner of Health with the authority to establish a multi-payor medical home demonstration project in the Adirondack region of NYS.

The most notable differences between the Statewide PCMH Program and the ADK Program are:

1. ADK is a multi-payer program, while the Statewide program is specific to NYS Medicaid,
2. ADK operates in specific geographic regions, (six counties in the Adirondacks: Hamilton, Franklin, Clinton, Essex, Warren, and northern Saratoga) while the Statewide program provides financial incentives throughout NYS.
3. The payers involved and the amount of enhanced payments given to PCMH-recognized

practices differs by PCMH program. (Refer to Chart for NYS PCMH Payment for payment amounts by program.)

If a PCMH-recognized provider and/or practice participates in the Adirondack Program, and has a contract with an MMC Plan for the ADK PMPM, they are not eligible to receive the enhanced PMPM payments under the Statewide Program.
A PCMH recognized provider can be contracted with an MMC Plan for the ADK Program or the Statewide Program, but not both.

10 Appendix

10.1 Evaluation and Management (E&M) Codes eligible for the PCMH Add-On

CPT Code	Code Description
99202	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more
99203	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more
99204	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more
99205	New patient office or other outpatient visit with a high level of medical decision making, if using time, 60 minutes or more
99211	Office or other outpatient visit for the evaluation and management of established patient that may not require presence of healthcare professional
99213	Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more.
99214	Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more
99215	Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more
99381	Initial new patient preventive medicine evaluation (age younger than 1 year)
99382	Initial new patient preventive medicine evaluation (age 1 through 4 years)
99383	Initial new patient preventive medicine evaluation (age 5 through 11 years)
99384	Initial new patient preventive medicine evaluation (age 12 through 17 years)
99385	Initial new patient preventive medicine evaluation (age 18 through 39)
99386	Initial new patient preventive medicine evaluation (age 40-64 years)
99391	Established patient periodic preventive medicine examination (age younger than 1 year)
99392	Established patient periodic preventive medicine examination (age 1 through 4 years)

99393	Established patient periodic preventive medicine examination (age 5 through 11 years)
99394	Established patient periodic preventive medicine examination (age 12 through 17 years)
99395	Established patient periodic preventive medicine examination (age 18 through 39 years)

10.2 Rate Code Descriptions:

Rate Code	Description
1400	Hospital Outpatient APG
1407	Diagnostic & Treatment (D&T) Clinic APG
1422	DTC General Clinic-APG Episode Base Rate
1425	General Clinic MR/DD
1432	Hospital Clinic-APG Episode Base Rate
1435	D&T Clinic APG- Gen Clinic (MR/DD/TBI Patient)
1444	Hospital Outpatient APG-School Based Health Pro
1447	D&T Clinic APG-School Based Health Project
1450	Hospital APG-School Based Health Clinic (Episode)
1453	D&T Clinic APG-School Based Health (Episode)
2887	Child Rehabilitation
2888	Comp Physical Exam (School Health Project)
2889	Routine visit (School Health Project)
2940	AIDS Clinic, Initial Visit
2941	AIDS Clinic, Follow -Up Visit, Extended
2942	AIDS Clinic, Follow-Up Visit (Routine)
2945	AIDS Clinic, Subsequent Comprehensive Visit
2985	Initial Comp HIV Medical Evaluation Visit
2987	Monitoring Visit-Asymptomatic HIV Disease
4012	FQHC Off-site Services (Individual)

10.3 Frequently Asked Questions (FAQs)

Q1. Where can I find the Standards and Guidelines for NYS PCMH and information on getting started as a NYS Patient-Centered Medical Home?
A. Getting Started with NYS PCMH recognition can be found at the following weblink: NYS Patient-Centered Medical Home - NCQA

Q2. What organizations are eligible for NYS PCMH recognition?
A. The NYS PCMH Recognition is open to all primary care practices in New York State that are not 100% virtual. Practices that are 100% virtual are not eligible to receive Medicaid-enhanced reimbursement. If you have questions about this policy, please email publicpolicy@ncqa.org

Q3. What is the price for NYS PCMH recognition?

A. Pricing for NYS PCMH Recognition is outlined on the NCQA website at Pricing – NCQA. The pricing is determined by NCQA, not by the NYS DOH.

Q4. What enrollee populations are included as part of the NYS PCMH-Recognized Program?
A. Populations that are covered in the New York Statewide Medicaid PCMH Recognized Program include: Mainstream Medicaid Managed Care (MMC), Medicaid Fee-for-Service (FFS), Child Health Plus (CHPlus), HIV Special Needs Plan (HIV SNP), and Health and Recovery Plans (HARP), including those in a TANF or SSI (adult or child) premium group.

Q5. What programs do not allow for NYS PCMH payments?
A. Medicare-Medicaid members (duals), members with third-party health insurance (TPHI), or members with the following coverage: Essential Plans (EP), Qualified Health Plans, Managed Long-Term Care (MLTC), and Programs of All-Inclusive Care for the Elderly (PACE).

Q6. If an enrollee has Medicare as a Primary and FFS Medicaid as a secondary, is the claim eligible for the PCMH add-on?
A. No. Add-ons are only given to practices for Medicaid enrollees who do not have Medicare or other third-party coverage.

Q7. How will I be paid by health plans for mainstream MMC, CHPlus, HIV SNPs, and HARPs?
A. Practices will be paid on a schedule determined by each individual plan with which they participate. Plans distribute MMC payments at least two times per year but may be distributed more frequently. Questions regarding payment distribution frequency should be directed to the individual MMC plans.

Q8. How will I be paid by Medicaid FFS?
A. Medicaid FFS claims are paid on a billing cycle set by eMedNY. The FFS add-on is reflected in the explanation of benefits summary. Questions regarding FFS claims can be directed to the eMedNY call center at 1-800-343-9000.

Q9. What criteria is necessary on an eligible Medicaid FFS claim to ensure receipt of the PCMH add-on?
A. It is necessary for both institutional and professional claims to contain the correct physical location address of the practice, including the 9-digit zip code, clinical group NPI, individual servicing provider's NPI, and an Evaluation and Management (E&M) code designated by the New York State Department of Health (NYS DOH) as primary care. The claim paid must be greater than zero.

Institutional claims must also include an eligible rate code. (See chart labeled: **Rate Code Description)**

For professional claims, the place of service on the claim must be 11 (office).

Institutional and Professional claims are not eligible for the PCMH add-on if they contain a third-party payment such as Medicare, or commercial insurance.

Q10. If a PCMH provider has more than one location, will a provider receive the PCMH add-on for all locations?
A. No. If a group practice has multiple locations but only one location is listed on the PCMH recognition file, the PCMH add-on only applies to the members assigned to that specific practice listed on the file. If a site location is not specifically listed on the file, it does not qualify for the add-on even if it's part of a group with other recognized practices.

Q11. Are there any references that explain the Patient-Centered Medical Home program in detail?
A. The following links will provide guidance.
NCQA - PCMH Recognition Process
NYDOH PCMH Webpage

NYS Patient-Centered Medical Home - NCQA Medicaid Updates about PCMH
If you still have questions, please contact www.pcmh@health.ny.gov

Q12. How does a provider receive PCMH payments?
You can receive the PCMH payment two ways – as an add-on to Fee-For-Service (FFS) claims and as a per member per month (pmpm) payment directly from managed care plans. All information (NPI, address, zip code, rate code, etc.) must be correct on the fee-for-service claim for the add-on payment to trigger. Both the individual clinician and the site must be PCMH-recognized.

Q13. How can I find a listing of PCMH Providers in New York State?
A. NCQA Report Card is a directory of practices and clinicians that are NCQA-Recognized as PCMH Medical Homes.

Q14. How can I find a listing of Delay Reason (DR) Codes?
A. A listing and explanation of DR codes can be found at the following link: PowerPoint Presentation (emedny.org). Additional information regarding Timely Billing Information can be found at Timely Billing Information (emedny.org).

Q15. How can I confirm that my practice locations are correct and current in eMedNY, and correspond to what is listed in the NYS PCMH file?
A. The Medicaid Enrolled Provider Listing can be found at Health Data New York (HDNY) at the following link: Medicaid Enrolled Provider Listing | State of New York (ny.gov).
This will provide information to the Provider on how their practice locations (including zip+4) are listed in eMedNY. To receive the PCMH enhancement, the provider listing (including zip + 4) located on the HDNY must correspond to the information listed on the NYS PCMH-recognized listing that can be found at the Health Commerce System (HCS).

If the provider listing does not match what is listed in HDNY; contact Provider Enrollment and complete the Change of Address for Enrolled Providers at the following link: Provider Enrollment - Change of Address (emedny.org)

- If the information in the NYS PCMH listing is incorrect, contact NCQA directly. NYS DOH cannot make the changes to NCQA's PCMH list. Once NCQA updates the

information, they will send it on to NYS DOH and the HCS file will be updated. This can take up to 60-90 days.