DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

SEP 0 9 2011

Jason A. Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgerson:

This letter is being sent in conjunction with the Centers for Medicare & Medicaid Services' (CMS) approval of New York State Plan Amendment (SPA) #08-32, which revises the 2008 and 2009 trend factors to be applied to various non-institutional services.

In reviewing SPA 08-32, CMS staff performed a program analysis of the corresponding services and a reimbursement analysis related to the services impacted by the provisions of the SPA. These analyses revealed coverage issues which the State needs to address through State plan amendments in order to meet the requirements of Section 1902 of the Social Security Act. To this end, CMS welcomes the opportunity to work with you and with your staff in resolving the concerns outlined below.

Corresponding coverage questions in NY 08-32:

1. Please confirm in the SPA that adult day health services are furnished in free-standing facilities by or under the direction of a physician and in accordance with 42 CFR 440.90.

2. Please list and describe in the SPA each of the individual services that are furnished as part of adult day health services. Please not that CMS does not reimburse for meals; educational, vocational and job training services; habilitation services; and recreational and social activities.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

John Guhl
Acting Associate Regional Administrator
Division of Medicaid and Children's Health

CC: JUlberg
PMossman
KKnuth
RWeaver
LTavener
MSchervish
JFrandson
AHiggs
GCritelli
SFuentes
PMarra
SJew

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: **08-32**

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
April 1, 2008

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:
Section 1902(a) of the Social Security Act, and 42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY **04/01/08 - 09/30/08 ($ 5,142,929)**
b. FFY **10/01/08 - 09/30/09 ($53,454,413)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1(b)(i), 1(b)(ii), 1(b)(iii), 1(c), 1(c)(i), 2(b)(i), 2(b)(ii), 2(c), 4, 4(1), 4(2), 6(a), 6(a)(1), 7(a)(i), 7(a)(ii)

**** SEE REMARKS**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 1(b)(i), 1(b)(ii), 1(c), 1(c)(i), 2(b)(i), 2(c), 4, 6(a), 7(a)(i)

10. SUBJECT OF AMENDMENT:
35% Reduction to 2008 Trend Factor (Non-Institutional)
(FMAP=50% 4/1/08-9/30/08; 58.78% 10/1/08-3/31/09; 60.19% 4/1/09-6/30/09; 61.59% 7/1/09-9/30/09)

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:

13. TYPED NAME: **Jason Helgerson**

14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**

15. DATE SUBMITTED:

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **SEP 0 9 2011**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **APR 0 1 2008**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **John R. Guhl**

22. TITLE: **Acting, Associate Regional Administrator Division of Medicaid and State Operations**

23. REMARKS:

The SPA, with an effective date of April 1, 2008, revises the 2008 and 2009 trend factors that will be applied to various non-institutional services.

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For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

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Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services

Hospital-Based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services. For dates of service on and after December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and until March 31, 2010, the operating component of rates for hospital based outpatient services 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, as modified by the APG methodology.

Reimbursement for providers designated as preferred primary care providers or for hospital based programs providing specialty clinic services is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system. Federally Qualified Health Centers (FQHCs) may choose to be paid under the APG methodology, or may choose to continue to receive payment under the existing prospective payment system (PPS) rate methodology. The payment methodology selected by the FQHC will apply to all claims submitted. PAC rates will continue to be available as a payment mechanism only for those FQHCs that opt to continue using them instead of switching to APG payments.

Under the PAC reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service, a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

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For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

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[medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.]

Ordered Ambulatory Services (specific services performed by a hospital on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient)

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services will not exceed the combined payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

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[payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.]

Trend Factors

Notwithstanding any inconsistent provision of this state plan, effective April 1, 2000, in those instances when trend factors are used in determining rates of payment for hospital outpatient services, diagnostic and treatment centers unless otherwise subject to the rate freeze set forth herein, certified home health agencies, and personal care services, the Commissioner of Health shall apply trend factors in accordance with the following:

(1) For rate periods on and after April first, two thousand, the Commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services whose rate of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.

(2) In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget outlook after June first of the rate year prior to the year for which rates are being developed.

(3) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in number two of this section and any difference will be included in the prospective trend factor for the current year.

Nothing in this section is intended to produce a change in any existing provision of law establishing maximum reimbursement rates.

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for medically supervised chemical dependence treatment and medically supervised withdrawal services

For dates of service beginning on July 1, 2002, for those facilities certified under Article 28 of the State Public Health Law, the Department of Health promulgates prospective, all-inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor (two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained in the Trend Factor section in this Attachment.

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For rates of payment effective for outpatient hospital services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

New

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient [hospital] services provided by general hospitals, provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007, as calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For dates of service beginning on December 1, 2008 through March 31, 2010, for hospital outpatient clinic services, the operating component of rates shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

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Laboratory Services

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates for services listed in this paragraph were set as of June 1, 2010 and are effective for services provided on or after that date. All rates are published on the Department of Health website at the following link:

https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory_Fee_Schedule.xls

[Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.]

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Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For rates of payment effective for services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

New

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Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

New

Out-of-State Services

Fee-based providers:

Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.

HMO's and Prepaid Health Plans

Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 442.302 and Part 447.361 including all federal requirements for the reimbursement methodology.

Personal Care Services

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for personal care services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For rates of payment effective for personal care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

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Such rates of payment shall be further adjusted to reflect costs associated with the recruitment and retention of non-supervisory workers. For programs providing services in local social service districts which include a city with a population of over one million persons, such rate adjustments will be calculated by allocating the total dollars available for the applicable rate period to each individual provider proportionally based on total claimed hours of services for personal care services provided in the district to recipients of medical assistance. The allocated dollars will be included as a reimbursable cost add-on to the Medicaid rates of payment based on the Medicaid utilization data as adjudicated through the Medicaid Management Information System (MMIS), or any successor entity, utilizing the most recently available total claimed hours of Medicaid services data, as agreed to by New York State and the district.

New

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(c) Allowable costs shall include, but not be limited to the following:

(1) applicable salary and non-salary operating costs;
(2) costs of transportation; and,
(3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 through March 31, 1999, July 1, 1999 through March 31, 2003, April 1, 2003 through March 31, 2005, and from April 1, 2005 through March 31, 2009, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

For adult day health care facilities, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.

For reimbursement of adult day health care services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of adult day health care services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

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For rates of payment effective for adult day health care services provided on and after September 11, 2008, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%.

For rates of payment effective for adult day health care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.