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(09/09)

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Freestanding Diagnostic and Treatment Center APG Base Rate Table

Peer Group	Region	Rate Start Date	Base Rate Effective 09/1/2009
General Clinic	Downstate	09/01/09	$212.07
General Clinic	Upstate	09/01/09	$174.74
General Clinic MR/DD/TBI	Downstate	09/01/09	$254.48
General Clinic MR/DD/TBI	Upstate	09/01/09	$209.69
Dental School	Downstate	09/01/09	$268.35
Dental School	Upstate	09/01/09	$223.22
Renal	Downstate	09/01/09	$235.70
Renal	Upstate	09/01/09	$196.06
Ambulatory Surgery	Downstate	09/01/09	$ 88.69
Ambulatory Surgery	Upstate	09/01/09	$ 86.39]

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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 [June 30, 2012] March 31, 2013, 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 [on page 2(m) of this] 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.

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APG Reimbursement Methodology – Freestanding Clinics

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

3M APG Crosswalk, version 3.3:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

APG Alternative Payment Fee Schedule; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from version of 4/1/08, updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Consolidation Logic" and then on "2008."

APG 3M Definitions Manual Versions; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "3M Versions and Crosswalk."

APG Investments by Rate Period; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

Associated Ancillaries; as of 07/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

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Base Rates, Freestanding Clinics; effective 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "APG Rates," and then "Freestanding Diagnostic and Treatment Center . . . "

Carve-outs; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

Modifiers; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

Non-50% Discounting APG List; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Non-50% Discounting APG List."

Uniform Packaging Ancillaries; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Uniform Packaging APGs."

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Freestanding Clinic and Ambulatory Surgery Centers APG Base Rate Table

Peer Group	Region	Rate Start Date	Base Rate Effective 12/1/2009
Academic Dental	Downstate	09/01/09	$173.67
Academic Dental	Upstate	09/01/09	$176.16
Ambulatory Surgery Centers	Downstate	09/01/09	$ 88.69
Ambulatory Surgery Centers	Upstate	09/01/09	$ 86.39
General Clinic/School-Based Health Center	Downstate	09/01/09	$158.78
General Clinic/School-Based Health Center	Upstate	09/01/09	$129.14
General Clinic MR/DD/TBI*	Downstate	09/01/09	$190.53
General Clinic MR/DD/TBI*	Upstate	09/01/09	$154.97
Renal	Downstate	09/01/09	$138.98
Renal	Upstate	09/01/09	$128.09

*Mentally retarded/developmentally disabled/traumatic brain injured.

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Ambulatory Patient Group System - Freestanding Clinics

[For dates of service beginning September 1, 2009 through June 30, 2012, 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 on Page 2(m) of this 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.]

The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system. Links to detailed APG reimbursement methodology lists are located in the APG Reimbursement Methodology – Freestanding Clinics section.

Allowed APG Weight shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting[;].

Ambulatory Patient Group (APG) shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M's grouping logic outlined in the APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M[;]. A link to the APG Definitions Manual versions and effective dates is available in the APG Reimbursement Methodology – Freestanding Clinics section.

APG Relative Weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

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Associated Ancillaries shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. The ancillary policy for freestanding clinics has been delayed from September 1, 2009, to July 1, 2011. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

APG Software shall mean the New York State-specific version of the APG computer software developed and published by 3M Health Information Systems (3M) to process HCPCS/CPT-4 and ICD-9-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software[,] can perform the computations by accessing the APG definitions manual, which is available on the 3M web site. The appropriate link can also be found on the NYS DOH website.

Base Rate shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

Carve-outs shall mean certain procedures which are not paid using the APG reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. If the procedure is not reimbursable thru the APG methodology or on the fee schedules as stated, they are not reimbursable in Medicaid. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

Case Mix Index is the actual or estimated average final APG weight for a defined group of APG visits.

Coding Improvement Factor is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. A link to the coding improvement factors for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section. [The current coding improvement factors are 10.20 for freestanding clinics, 3.59 for ambulatory surgery centers, 2.14 for renal centers, and 4.57 for dental schools.]

Consolidation/Bundling shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual, a link to which is provided in the APG Reimbursement Methodology – Freestanding Clinics section. [version 3.1 dated March 6, 2008, and as subsequently amended by 3M.]

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Current Procedural Terminology-fourth edition (CPT-4) is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and the HCPCS [are] is maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

Discounting shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting [is always] will be at the rate of 50% until January 1, 2010, with the exception of those discounts listed in the link to the Non-50% Discounting APG List provided in the APG Reimbursement Methodology – Freestanding Clinic Section.

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Packaging shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software. A link to the list of uniform packaging APGs for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

"Peer Group" shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. There are ten [DTC] freestanding clinic peer groups for initial APG implementation: General Clinic/School-Based Health Centers upstate; General Clinic/School-Based Health Centers downstate; Academic Dental upstate; Academic Dental downstate; Ambulatory Surgery Centers upstate; Ambulatory Surgery Centers downstate; Renal upstate; Renal downstate; Mental Retardation, Developmental Disability, Traumatic Brain Injured upstate(MR/DD/TBI); and Mental Retardation, Developmental Disability, Traumatic Brain Injured downstate.

"Procedure-based Weight" shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a given HCPCS/CPT code as compared to the expected average resource utilization for other HCPCS/CPT codes or APGs. If a procedure code has not been assigned a procedure-based weight, the APG relative weight for the APG to which that procedure code groups will be used as the basis for reimbursement for that procedure code (subject to the consolidation, discounting and packaging logic).

"Region" shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

"APG Visit" shall mean a unit of service consisting of all the APG services and associated ancillary services performed for a patient that are coded on the same claim and share a common [on a single] date of service [and related ancillary services].

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Final APG Weight shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable for bundling, packaging, and discounting.

"HCPCS Codes" are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

Modifier shall mean a HCPCS Level II code used in APGs, based on its meaning in the HCPCS lexicon, to modify the payment for a specific procedure code or APG.

Never Pay APGs shall mean an APG where all the procedure codes that map to the APG are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay APG file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

Never pay procedures shall mean procedure codes that are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay Procedures file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

No-blend APG shall mean an APG that has its entire payment calculated under the APG reimbursement methodology without regard to the historical average operating payment per visit for the provider. A link to a list of no-blend APGs for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section.

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"Episode" shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a freestanding clinic or ambulatory surgery center to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.

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Reimbursement Methodology – Freestanding Clinics

I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.

II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights shall be updated at least annually based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. A link to t [T]he list of APG[']s and their relative weights is available in the APG Reimbursement Methodology – Freestanding Clinics section. [are published on the NYS Department of Health website at: http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proposed_regulations.pdf.]

b. The APG relative weights shall be re[-]weighted prospectively. The initial re[-]weighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re[-]weightings will be based on Medicaid hospital claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

III. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. [The initial r] Recalculations of case mix indices for periods prior to January 1, 2010, will be based on freestanding D&TC and ambulatory surgery center Medicaid data for 2007. Such revisions for the period commencing January 1, 2010, will be based on such data from the January 1, 2009 through November [30] 15, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve-month period.

IV. The APG base rates shall be updated at least annually. [The initial u] Updates for periods prior to January 1, 2010, will be based on claims data from 2007. The update commencing January 1, 2010, [the September] will be based on claims data from the January 1, 2009 through November [30] 15, 2009 period, and subsequent updates will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.

a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. [APG payments shall also reflect an investment of $13.54 million for dates of service from September 1, 2009 through March 31, 2010, and $12.5 million for each annual period thereafter. The case mix index shall be calculated using 2005 claims data.]

V. [For the period September 1, 2009 to November 30, 2009, the] APG base rates shall initially be calculated using the total operating reimbursement for services and [related] associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of [$13.54] $9.375 million for dates of service from September 1, 2009 through [March 31, 2010] November 30, 2009, and [$12.5] $50 million for each annual period thereafter. A link to the allocation of all APG investments across peer groups for all periods is available in the APG Reimbursement Methodology – Freestanding Clinic section. The case mix index shall initially be calculated using 2005 claims data.

a. [For all rate periods subsequent to November 30, 2009, estimated] The calculation of total operating reimbursement for services and [related] associated ancillaries and the [estimated] number of visits shall be calculated based on historical claims data. Calculations for periods prior to January 1, 2010, shall be based on Medicaid claims data for 2007. Calculations for the period commencing January 1, 2010, shall be based on Medicaid claims data for the period January 1, 2009 [The initial re-estimation will be based on claims data from the September 1, 2009] through November [30] 15, 2009.[, and s] Subsequent [modifications] calculations will be based on Medicaid freestanding clinic and ambulatory surgery center claims data from the most recent twelve-month period[,] and will be based on complete and accurate data.

b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. This initial estimate will be adjusted prior to January 1, 2010, based on Medicaid freestanding [D&TC] clinic and ambulatory surgery center claims data from 2007 [the September 1, 2009 through November 30, 2009 period]. For January 1, 2010, the case mix index will be recalculated using January 1, 2009, to November 15, 2009, claims data. [and] Any subsequent modifications will be based on Medicaid freestanding [D&TC] clinic and ambulatory surgery center claims data from the most recent twelve-month period[,] and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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VI. Rates for new freestanding D&TC clinics during the transition period

a. Freestanding D&TC clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to the Public Health Law are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:

b. For the period September 1, 2009 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

c. For the period December 1, 2009, [January 1, 2010] through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average peer group payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility-specific Medicaid reimbursement paid for freestanding D&TC clinic claims for each peer group, as defined [on Page 2(j) of this plan amendment] in the list of definitions under the Ambulatory Patient Group Reimbursement System – Freestanding Clinic section, paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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VII. Rates for new freestanding ambulatory surgery centers during the transition period

a. Freestanding ambulatory surgery centers which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available, shall have the capital cost component of their rates computed in accordance with the methodology described in [item IV on page 2(o) of this plan amendment] the APG Rate Computation – Freestanding Clinics section and shall have the operating cost component of their rates computed in accordance with the following:

b. For the period September 1, 2009 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

c. For the period December 1, 2009, [January 1, 2010] through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as described [beginning on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

d. For the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section;

e. For periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as described [on Page 2(k) of this plan amendment] in the Reimbursement Methodology – Freestanding Clinics section; and

f. For the purposes of this subdivision, the historical 2007 regional average peer group payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for freestanding ambulatory surgery centers services claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology, divided by the total visits on claims paid under such rate codes.

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APG Rate Computation – Freestanding Clinics

The following is a description of the methodology to be utilized in calculating rates of payment for freestanding clinics and ambulatory surgery center services under the Ambulatory Patient Group classification and reimbursement system.

I. Claims containing ICD-9 diagnostic and CPT-4 procedure codes are submitted to the Department on appropriate forms or in the accepted electronic format.

II. Claims are reviewed electronically to assign each valid procedure code to the appropriate APG using the APG software logic. Invalid codes will be assigned to an error APG and not given further consideration in the payment process.

III. Each valid APG on the claim is assigned a relative weight. At this time the software logic also determines an allowed weight based upon whether each APG on the claim is to be paid in full, packaged, consolidated, or discounted.

IV. The allowed weights for each valid APG on the claim are then summed to arrive at the final weight for this claim. This final weight is multiplied by an operating base rate that is specific to the peer group to which the claim has been assigned resulting in the APG operating cost reimbursement amount for this claim. For freestanding clinic services, capital will continue to be paid as an add-on using the existing, previously approved methodology. The capital cost component for ambulatory surgery services shall be the result of dividing the total amount of capital cost reimbursement paid to such facilities pursuant to the current Products of Ambulatory Surgery (PAS) system for the 2007 calendar year for the Upstate Region and for the Downstate Region and then dividing each such regional total amount by the total number of claims paid through the PAS system within each such region for the 2007 calendar year.

V. A separate base rate calculation shall be calculated for each peer group established by the Department. All Medicaid reimbursement paid to facilities for services moving to the APG reimbursement system (e.g., freestanding clinic and ambulatory surgery center services)[;] during the 2007 calendar year and associated ancillary payments will be added to an investment of [$13.54] $9.375 million for dates of service from September 1, 2009 through [March 31, 2010] November 30, 2009, and [$12.5] $50 million for each annualized period thereafter to form the numerator. A link to the base rates can be found in the APG Reimbursement Methodology – Freestanding Clinics section. The peer group specific case mix index multiplied by the coding improvement factor and the 2007 base year visits will form the denominator resulting in a base rate for that peer group.

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The following is an example of a sample APG base rate calculation:

a.	2007 Peer Group Reimbursement	$51,000,000
b.	Additional Investment	$25,000,000
c.	Case Mix Index	8.1610
d.	Coding Improvement Factor	1.05
e.	2007 Base Year Visits	50,000

($51,000,000 + $25,000,000) / (8.1610 x *1.05 * 50,000) = $177.38 (Base Rate)

VI. During the transition period, reimbursement for freestanding clinic and ambulatory surgery center services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending [December 31] November 30, 2009) 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. [During 2010] For the period December 1, 2009, through December 31, 2010, the blend will be 50/50. During 2011, the blend will be 75/25. Payments will be based upon 100% of the APG operating component beginning on January 1, 2012. [Per the enabling statute, as new services the Education APGs and the Extended Hours APGs are not subject to the blend requirement.

Effective for dates of service on and after September 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a freestanding clinic shall be reimbursed entirely on the APG methodology.] A link to the list of APGs that are not subject to the blend is available in the APG Reimbursement Methodology – Freestanding Clinics section.

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[Effective September 1, 2009, immunization services provided in a freestanding clinic when no other medical services are provided during that patient visit shall be reimbursed entirely on the APG methodology.]

Effective for dates of service on and after September 1, 2009, payments to freestanding clinics for the following services shall be based on fees or rates established by the Department of Health: (1) wheelchair evaluations, (2) eyeglass dispensing, and (3) individual psychotherapy services provided by licensed social workers to persons under the age of 21, and to persons requiring such services as a result of or related to pregnancy or giving birth, and (4) individual psychotherapy services provided by licensed social workers at freestanding clinics that provided, billed for, and received payment for these services between January 1, 2007 through December 31, 2007. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. A link to the APG alternative rates for all periods is available in the APG Reimbursement Methodology – Freestanding Clinics section. [The agency's current fee schedule rates are available at http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_alternative_payment_fee_schedule.pdf.]

VII. Rates for services provided in freestanding clinic and ambulatory surgery center facilities located outside of New York State shall be as follows:

- APG rates in effect for similar services for providers located in the downstate region of New York State shall apply to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth; in the Pennsylvania county of Pike; and in the Connecticut counties of Fairfield and Litchfield; and rates in effect for similar services for providers located in the upstate region of New York State shall apply to all other out-of-state providers.

- In the event the Department determines that an out-of-state provider is providing services which are not available within New York State, the Department may negotiate payment rates and conditions with such a provider up to, but not in excess of, the provider's usual and customary charges. Prior approval by the Department shall be required with regard to services provided by such providers.

- For the purpose of APG reimbursement to out-of-state providers, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

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The following APGs shall not be eligible for reimbursement through the APG system:

065 RESPIRATORY THERAPY
066 PULMONARY REHABILITATION
[094 CARDIAC REHABILITATION]
117 HOME INFUSION
118 NUTRITION THERAPY
190 ARTIFICIAL FERTILIZATION
311 FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
312 FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
313 HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
314 HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
319 ACTIVITY THERAPY
320 CASE MANAGEMENT - MENTAL HEALTH OR SUBSTANCE ABUSE
371 ORTHODONTICS
427 BIOFEEDBACK AND OTHER TRAINING
430 CLASS I CHEMOTHERAPY DRUGS
431 CLASS II CHEMOTHERAPY DRUGS
432 CLASS III CHEMOTHERAPY DRUGS
433 CLASS IV CHEMOTHERAPY DRUGS
434 CLASS V CHEMOTHERAPY DRUGS
450 OBSERVATION
452 DIABETES SUPPLIES
453 MOTORIZED WHEELCHAIR
454 TPN FORMULAE
456 MOTORIZED WHEELCHAIR ACCESSORIES
492 DIRECT ADMISSION FOR OBSERVATION INDICATOR
500 DIRECT ADMISSION FOR OBSERVATION - OBSTETRICAL
501 DIRECT ADMISSION FOR OBSERVATION - OTHER DIAGNOSES
999 UNASSIGNED

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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 Developmental Disabilities, and the Office of Alcoholism and Substance Abuse.

- All clinic providers will prepare and file cost reports. The cost reports must be independently audited for cost and visit data;
- 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 provide a interim UPL based on 2009 data to CMS by January 1, 2012] The State will provide an addendum to the progress report by December 31, 2011 to include the status of providers who submitted 2010 audited cost reports, and such audited reports will be provided to CMS based on CMS' sample; and
- The State will submit a full UPL using 2010 cost data by [June 30, 2012] December 31, 2012.