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such agency to the state and will be recouped [by the Department in a lump sum amount or] through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, and such agency's actual per-patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling will be remitted to each such agency by the Department in a lump sum amount [or through an increase in the Medicaid payments due to the agency].

(f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.

(g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than $200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to $200 million. Such reconciliation will not be subject to subsequent adjustment.

(h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.

(i) Effective May 1, 2012, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age, shall be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences.

The initial statewide episodic base price to be effective May 1, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

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February of 2010, will be included in the base price calculation. Low utilization episodes of care, as defined below, shall be excluded from the base price calculation. For high utilization episodes of care, costs in excess of outlier thresholds shall be excluded from the base price calculation. The remaining costs will be divided by the number of episodes to determine the unadjusted base price. The resulting base price shall be subject to further adjustment as is required to comply with the aggregate savings mandated by paragraph (b) of subdivision 13 of section 3614 of the Public Health Law (PHL). The applicable base year for determining the episodic base price will be updated not less frequently than every three years.

The case mix index applicable to each episodic claim, excluding low utilization claims, shall be based on patient information contained in the federal Outcome Assessment Information Set (OASIS). The patient shall be assigned to a resource group based on data which includes, but is not limited to, clinical and functional information, age group, and the reason for the assessment. A case mix index shall be calculated for each resource group based on the relative cost of paid claims during the base period.

A regional wage index will be calculated for each of the ten labor market regions in New York as defined by the New York State Department of Labor. Average wages will be determined for the health care service occupations applicable to certified home health agencies. The average wages in each region shall be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories reported in the most recently available agency Medicaid cost report submissions. Weighted average wages for each region will be compared to the statewide average wages to determine an index for each region. The wage index will be applied to the portion of each payment which is attributable to labor costs. If necessary, the Department will adjust the regional index values proportionately to assure that the application of the index values is revenue-neutral on a statewide basis.

Payments for low utilization cases shall be based on the statewide weighted average of fee-for-service rates for services provided by certified home health agencies, as adjusted by the applicable regional wage index factor. Low utilization cases will be defined as 60-day episodes of care with a total cost of $500 or less, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, calculated prior to the application of the regional wage index factor.

Payments for 60-day episodes of care shall be adjusted for high-utilization cases in which total costs, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, exceed outlier cost thresholds determined by the Department for each case mix group. In such cases the provider will receive the adjusted episodic base payment, plus 50% of the total costs which exceed the outlier threshold. Both the base payment and the excess outlier payment will be adjusted by the regional wage index factor. The percentage of excess costs to be reimbursed shall be subject to such further adjustment as deemed necessary to comply with the aggregate savings mandated by PHL section 3614(13)(b).

The outlier threshold for each resource group shall be equal to a specified percentile of all episodic claims totals for the resource group during the base period, excluding low utilization episodes. Such percentiles shall range from the seventieth percentile for groups with the lowest case mix index to the ninetieth percentile for groups with the highest case mix index.

Services provided to maternity patients, defined as patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy, may be reimbursed pursuant to this section without the submission of the patient information contained in the federal Outcome Assessment Information Set (OASIS), provided that providers billing for such services must bill in accordance with such special billing instructions as may be established by the Commissioner, and such patients shall receive a case mix designation based on the lowest acuity resource group.

Payments for episodes of care shall be proportionately reduced to reflect episodes of care totaling less than 60 days provided, however, that CHHAs will receive reimbursement for a full episode of care if the episode totaled less than 60 days and the patient was discharged to the home, to a hospital, or to a hospice, or if the episode ended due to the death of the patient. Payments will be proportionately reduced if the patient transferred to a different CHHA before the end of the 60-day episode.

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For services provided on and after May 1, 2012, please see the website below for detailed information, which includes information related to the following components of payments for 60-day episodes of care including (as posted on March 14, 2012):

- Definition of 60-day episode of care
- Base price
- Resource groups
- Case mix indices
- Outlier thresholds
- Regional wage index factors
- Weighted average rates used to calculate total costs

www.health.ny.gov/facilities/long_term_care/reimbursement/chha/index.htm