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State/Territory Name: New York

State Plan Amendment (SPA) #:15-0019

This file contains the following documents in the order listed:

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

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: SA:NY1500019Approval

February 17, 2016

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

Dear Deputy Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #15-0019 has been approved for adoption into the State Medicaid Plan with an effective date of October 1, 2015. The SPA implements the International Classification of Diseases, Revision 10 – Clinical Modification (ICD-10-CM) for hospital outpatient services.

I have enclosed copies of the approved SPA #15-0019 materials. If you have any questions or wish to discuss, please contact Stephen Abbott at (518) 396-3810 Ext. 113 or John Guhl at (212) 616-2438.

Sincerely,

[redacted]

Signed by: Ricardo E. Holligan -S

Ricardo E. Holligan
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: MMelendez
JUlberg
KKnuth
RGallagher
RWeaver
LTavener
JGuhl
SJew
SAbbott

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: **15-0019**	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 **October 1, 2015**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **§1902 (a)(30) of the Social Security Act and 42 CFR §447.204**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 10/01/2015-09/30/2016 $ 00.00** **b. FFY 10/01/2016-09/30/2017 $ 00.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 1(f), 1(g), 1(h), 1(k), 1(l)(ii)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 1(f), 1(g), 1(h), 1(k), 1(l)(ii)**

10. SUBJECT OF AMENDMENT:
ICD-10-CM (Hospital Outpatient)
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. [redacted]	16. RETURN TO: **New York State Department of Health** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: NOV 24 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **FEBRUARY 17, 2016**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **OCTOBER 01, 2015**	20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**
21. TYPED NAME: **RICARDO E. HOLLIGAN**	22. TITLE: **Acting Associate Regional Administrator** **Division of Medicaid & Children's Health Operations**

23. REMARKS:

New York
1(f)

Ambulatory Patient Group System – Hospital Outpatient

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 - Hospital Outpatient 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] ICD-10-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M Health Information Systems' grouping logic outlined in the APG Definitions Manual. A link to the APG Definitions Manual versions and effective dates is available in the APG Reimbursement Methodology - Hospital Outpatient 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. A link to the APG relative weights for all periods is available in the APG Reimbursement Methodology- Hospital Outpatient section.

New York
1(g)

Associated Ancillaries shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

APG Software shall mean the New York State-specific version of the APG computer software developed and published by Health Information Systems, Inc. (3M) to process HCPCS/CPT-4 and [ICD-9-CM] ICD-10-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.

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 - Hospital Outpatient section.

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 - Hospital Outpatient section.

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 is maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

New York
1(h)

"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] 10th Revision-Clinical Modification ([ICD-9-CM)] ICD-10-CM) is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US 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 - Hospital Outpatient section.

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APG Rate Computation – Hospital Outpatient

The following is a description of the methodology to be utilized in calculating rates of payment for hospital outpatient department, ambulatory surgery, and emergency department services under the Ambulatory Patient Group classification and reimbursement system.

I. Claims containing [ICD-9-CM] ICD-10-CM diagnostic and CPT-4/HCPCS 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 hospital outpatient and emergency 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 2005 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 2005 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., outpatient department, ambulatory surgery, and emergency department services) during the 2007 calendar year and associated ancillary payments will be added to an investment of $178 million on an annualized basis for periods through November 30, 2009, and $270 million on an annualized basis for periods thereafter to form the numerator. A link to the base rates can be found in the APG Reimbursement Methodology – Hospital Outpatient section.

- For APG reimbursement to out-of-state hospitals, 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.

System updating

The following elements of the APG reimbursement system shall be updated no less frequently than annually:

- the listing of reimbursable APGs and the relative weight assigned to each APG;
- the base rates;
- the applicable [ICD-9-CM] ICD-10-CM codes utilized in the APG software system;
- the applicable CPT-4/HCPCS codes utilized in the APG software system; and
- the APG software system.