



January 21, 2022

## OASAS Rate Enhancements as a Result of the American Rescue Plan Act of 2021 (ARPA)

OASAS is working to implement the following Medicaid rate enhancements in response to additional Federal funding made possible by the American Rescue Plan Act of 2021 (ARPA).

**IMPORTANT NOTE:** All of these proposals are contingent upon receipt of the applicable Federal and State approvals. Those approvals are anticipated, but not guaranteed. Providers should keep this caveat in mind as they analyze the effect the proposed changes will have on their programs financially and clinically.

**NOTE:** These proposals apply only to “rehabilitation services” as technically defined by CMS. In terms of OASAS services, that definition applies only to:

- **Freestanding (non-hospital) Part 822 outpatient services** reimbursed under APGs (Ambulatory Patient Groups) or under the OASAS OTP (Opioid Treatment Program) weekly bundles, and
- **Part 820 Residential Services**, with the intent that in addition to the Stabilization and Rehabilitation elements of the Part 820 service, the Reintegration element will also become a Medicaid reimbursable service (again, subject to CMS approval).

**Freestanding Outpatient Services** – Freestanding providers will receive a temporary **10% base rate increase** for all APG rate codes and all OTP weekly bundle rate codes for dates of service **from 11-1-21 to 6-30-22**. This increase will be paid retroactively to the extent necessitated by approval delays.

In addition, new “in-community” (off-site) APG rate codes will be created for in-person Part 822 services provided outside a certified setting. These new rate codes will have the same 10% bump other APG rate codes will receive, as well as an additional 10% increase. Until those in-community rates are approved and loaded, providers should bill for in-community services under existing APG rate codes. Providers should clearly document and track those services provided in-community for purposes of adjustment. Once the necessary approvals are received the new rates will be loaded under the new rate codes and providers can adjust their claims to the new, higher-paying, rate codes. Do not “void and rebill”, instead “adjust” your claims to the new rate codes. The new in-community rate codes are 1080 for CD clinics and OP rehab and 1088 for OTP. Providers will be notified as soon as these rate codes become available. In the meantime, again, bill in-community services under your existing APG rate codes.

The in-community enhancement **does not apply to the OTP weekly bundles**; however, OTP providers always have the option of billing any given week for any given patient under an APG rate code as opposed to an OTP weekly bundle rate code. Providers may not bill under APGs (“in-community” or otherwise) **and** an OTP weekly bundle for the same patient for the same week.

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**Part 820 Residential Services** – The Stabilization and Rehabilitation elements (rate codes 1144 and 1145) will receive a **10% rate increase for dates of service from 11-1-21 to 6-30-22**. This increase will be paid retroactively to the extent necessitated by approval delays. On 7-1-22, the rates for rate codes 1144 and 1145 will revert to their previous levels.

A new rate code for the Reintegration element of Part 820 services will be created effective 11-1-21. Upstate and Downstate regional rates will be established for the new rate code (rate code 1146). For the period 11-1-21 to 6-30-22 the rates will be set at 150% of the level of the ongoing rates. Beginning 7-1-22, the rates will revert to 100% of the level of the ongoing rates and continue at that level for the foreseeable future. Providers will not be able to bill against rate code 1146 until the necessary approvals have been received and the rates are loaded to eMedNY. Therefore, providers that operate certified Part 820 Reintegration programs that serve Medicaid patients should accumulate the necessary information to bill Medicaid but not attempt to bill. Once the rates are loaded, OASAS will notify eMedNY that claims against rate code 1146 are going to be submitted beyond the normal deadline for billing Medicaid (90 days from the date of service) and eMedNY will allow those “late” claims to process. Do not attempt to bill prior to being notified/instructed to do so by OASAS. A “delay reason code” will be required on the claim. That code will likely be 03 – Authorization Delay. Upon notification, providers will have only 30 days to bill all rate code 1146 claims with dates of service more than 90 days prior to the notification of approval to bill by OASAS.

For questions regarding this information please contact the [Healthcare Finance Mailbox](#).