PART 841:
MEDICAL ASSISTANCE FOR ADDICTION SERVICES

(Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a), 43.01, and 43.02; Social Services Law Section 364; Executive Law Article 15; 10 NYCRR Part 86-8)

Sec.

Section 841.1 Background and intent.

(a) The purpose of this Part is to establish standards for reimbursement and participation in the Medical Assistance Program, as authorized by title 11 of article 5 of the Social Services Law, for services provided by addiction services providers certified or co-certified by the Office. This Part does not apply to programs dually licensed by Article 28 of the public health law and Article 32 of the mental hygiene law.

(b) The payments determined under the standards and methods established by this Part are intended to be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated programs in order to provide addiction services in conformity with applicable State and Federal laws, regulations and safety standards.

841.2 Legal basis.

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner to adopt standards including necessary rules and regulations pertaining to addiction services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.

(c) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(d) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

(e) Sections 43.01 and 43.02 of the Mental Hygiene Law grant the Commissioner the power and responsibility to adopt regulations that are necessary and proper to implement matters under his/her jurisdiction and to establish standards and methods of payment made by government agencies pursuant to title 11 of article 5 of the Social Services Law for eligible addiction services certified by the Office.

(f) Section 364 of the Social Services Law provides that each office within the Department of Mental Hygiene shall be responsible for establishing and maintaining standards for medical care and services in institutions serving Medicaid patients.

(g) Pursuant to section 23 of Part C of chapter 58 of the laws of 2009, the Commissioner is authorized, with the approval of the Commissioner of Health and the Director of the Budget, to promulgate regulations pursuant to Article 32 of the Mental Hygiene Law utilizing the Ambulatory Patient Group (APG) methodology for the purpose of establishing standards and methods of payments made by government agencies pursuant to title 11 of article 5 of the Social Services Law for addiction services otherwise subject to the provisions of this Part.

(h) Article 15 of the executive law defines the protected classes included in the state human rights law.

(i) Title 10 of the New York Code of Rules and Regulations Part 86-8 defines reporting and rate certifications for outpatient services ambulatory patient group.

841.3 Applicability.

This Part is applicable to any eligible provider as defined herein and as certified, approved or otherwise authorized pursuant to this Title.

841.4 Definitions.

(a) "Medicaid program" shall mean the medical assistance program, under Title XIX of the federal Social Security Act, in accordance with a state plan approved by the United States Department of Health and Human Services.

(b) "Eligible provider" shall operate an addiction services program and shall be approved by the single state agency to provide services and operate as a Medicaid provider; and is one of the following:

(1) a substance use disorder withdrawal and stabilization services program which is certified under Part 816 of this Title; or

(2) a substance use disorder residential rehabilitation services for youth program certified under Part 817 of this Title; or

(3) a substance use disorder inpatient rehabilitation services program which is certified under Part 818 of this Title; or

(4) a residential services program certified under Part 820 of this Title by the Office; or

(5) a substance use disorder outpatient program certified under Part 822 of this Title; or

(6) a children and family treatment and support services program certified or designated under Part 823 of this Title.

(c) "Single state agency" shall mean the New York State Department of Health.

(d) “Allowable costs” shall mean those costs incurred by an eligible inpatient provider which are eligible for payment by government agencies in accordance with title 11 of article 5 of the Social Services Law. To be allowable, costs must be reasonable and necessary for efficient provision of addiction services, related to patient care, and approved by the commissioner.

(e) “Per diem” or “patient day” shall mean the unit of measure denoting services rendered to one patient between the census taking hours on two successive days. In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(f) “Base year” shall mean the cost reporting period for which fiscal and patient data are utilized to calculate rates of payment.

841.5 Provisions applicable to all eligible providers

(a) Limits on Compensation. The maximum reimbursable costs for salaries for positions/titles shall be consistent with the requirements of the limits on executive compensation in this Title.

(b) Financial and Statistical Reporting:

(1) Each eligible provider shall maintain financial records and records relative to numbers and types of services provided and shall prepare and submit to the Office financial and statistical reports in accordance with the requirements of the Office.

(2) All financial reports to be prepared and submitted to the Office shall:

(i) be prepared in accordance with generally acceptable accounting principles;

(ii) be certified by an independent certified public accountant or an independent licensed accountant and shall include a statement of opinion on the data therein, unless this requirement is otherwise waived or modified by the Office; and

(iii) be accompanied by a complete copy of the eligible provider's certified financial statements.

(3) All reports to be prepared and submitted to the Office shall:

(i) be certified by the chief administrative officer or director of the eligible provider;

(ii) be on forms prescribed by the Office; and

(iii) include financial and statistical data for each service for which rates or fees are established.

(4) Reporting Requirements. Reports required to be submitted by this section shall be submitted within 120 days after the close of the eligible provider's fiscal year. Extensions of time for filing reports may be granted by the commissioner upon application received prior to the due date of the report and only in circumstances where the eligible provider establishes by documentary evidence that the reports cannot be filed by the due date for reasons beyond the control of the eligible provider.

(5) If the eligible provider determines that the information on reports filed is inaccurate, incomplete or incorrect, the eligible provider shall immediately file with the Office the corrected reports which comply with the requirements of this section.

(6) If the required financial and statistical reports are determined by the Office to be incomplete, inaccurate or incorrect, the eligible provider has 30 days from the date of receipt of notification from the office to provide the correct or additional data.

(7) Penalties for Non-compliance. (i) If an eligible provider fails to file the required financial and statistical reports, in accordance with this Part, on or before the due date, or Office approved extended due date, the Office may, at its discretion, reduce said eligible provider's existing Medicaid payments by up to twenty (20) percent, beginning the first day of the month following the original due date or approved extended due date and continuing until the first day of the month in which the reports are received by the Office. If the eligible provider fails to file the required financial and statistical reports by the end of the rate period during which the reports were due, such reduction may be increased in each subsequent month by up to ten (10) percent until receipt of the required information. All funds shall be returned to the provider once the provider is determined by the Office to be in compliance.

(8) Revocation of operating certificate. If, after a period of non-compliance resulting in reduced Medicaid payments, the Office determines that a program will likely be unable to meet its financial obligations, the Office may request the program voluntarily surrender its operating certificate or take action to revoke the operating certificate in accordance with this Title.

(c) Record keeping. An eligible provider shall furnish to the Office any information that it may request regarding payments claimed by the provider for furnishing services.

(d) Billing.

(1) The eligible provider shall levy no additional charges to patients for services paid for by the Medicaid Program.

(2) Claims for payment by the Medicaid Program shall be submitted at rates and/or fees established by the Office and approved by the Director of the Budget. Such billings shall be net of any individual or third-party liability.

(3) Claims shall be submitted only for services which were actually furnished to eligible persons and for which documentation of medical necessity is available at the time the services were furnished.

(4) Claims shall be submitted on officially authorized claim forms in formats and in accordance with the Department of Health standards and procedures for claims submission.

(5) All information provided in relation to any claim for payment shall be true, accurate and complete.

(e) Compliance with general medical assistance program requirements. Each eligible provider shall comply with all applicable medical assistance program requirements of the Department of Health.

(f) Calculation of allowable costs.

(1) General. To be considered as allowable, costs must be properly chargeable to necessary patient care as determined by the Office and rendered in accordance with the operating, financial and reporting requirements of the Office pursuant to this Title, and as such may be amended from time to time. The allowability of costs shall be determined in accordance with the following:

(i) Except where specific rules concerning allowability of costs are stated herein, the Office shall use as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM15, published by the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services.

(ii) Where specific rules stated herein or in HIM15 are silent concerning the allowability of costs, the Office shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

(2) Services. Allowable operating costs shall include the costs of all services necessary to meet the operating requirements of the Office pursuant to this Title and the special needs of the patient population to be served by an eligible provider.

(3) Capital expenditures. No capital expenditures for which approval by the Office is required in accordance with this Part shall be included in allowable capital costs for purposes of computation of the rate of payment unless such approval shall have been secured. Reimbursement for capital and start-up costs will be limited to those costs determined by the Office to be both reasonable and necessary.

(g) Application Procedures. To qualify for medical assistance payments, an eligible provider, with a current operating certificate issued by the office, shall apply for enrollment as a Medicaid provider on application forms as required by the NYS Department of Health.

(h) Approval of rates. Payment rates established in accordance with the provisions of this Part will remain in effect until such time as they are revised with the approval of the NYS Division of the Budget and the Centers for Medicare and Medicaid Services (where Federal share is applicable).

841.6 Medical assistance payments for inpatient substance use disorder withdrawal and stabilization services

(a) The provisions of this section are applicable to programs certified as substance use disorder inpatient withdrawal and stabilization services pursuant to Part 816.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located).

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Fee schedules used to determine rates include:

(i) Statewide OASAS Medically Supervised Inpatient Withdrawal (MSIW) fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) New facilities: Bed size for new facilities used for the fee calculation shall be based on 80% of the certified capacity rounded to the nearest integer. After the first full year of operation, the fee calculation shall be revised based on 90% of certified capacity rounded to the nearest integer. If the certified capacity changes for any MSIW program, including programs that have been in operation for less than one year, the fee shall be revised based on 90% of the new certified capacity, effective on the date of the capacity change.

(2) Minimum and maximum standards: Facilities with fewer than six (6) beds shall use the six (6) bed fee. Facilities with an excess of 120 beds (meaning “bed size” as calculated above) shall use the 120-bed fee.

(d) Appeals of Medically Supervised Inpatient Withdrawal Fees.

(1) Fee adjustment for underutilization. MSIW providers may request retroactive fee adjustments based on documented low service volume relative to certified capacity that resulted in an overall net loss in the program. These adjustments are approvable solely at the discretion of the Office and will require compelling justification relative to the program’s underutilization. MSIW beds that were used as “swing beds” for other

programs (e.g., Medically Monitored Inpatient Withdrawal) do not constitute underutilization and will not justify a fee increase.

(2) Other items of appeal. MSIW providers may also request retroactive fee adjustments based on significant financial losses in the program that resulted from programmatic expenses that were significantly out of proportion to the established level of reimbursement. The provider must fully and properly demonstrate that the fee adjustment requested in the appeal is necessary to ensure efficient and economic operation of the facility. The final determination as to the extent, if any, of a fee adjustment shall be made solely at the discretion of the Office.

(e) Base year. From time to time, and at the discretion of the Office, the fee calculation may be revised using new base year data. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

841.7 Medical assistance payments and utilization review for substance use disorder residential rehabilitation services for youth

(a) The provisions of this section are applicable to programs certified under Part 817.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs. There shall be no admission review team add-on.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located).

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Schedules used to determine fees include:

(i) Statewide OASAS Residential Rehabilitation Services for Youth (RRSY) fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) For existing and new inpatient rehabilitation facilities, the bed size will be based on the certified capacity of the program site.

(2) If the certified bed size changes, the fee will be revised accordingly and will be effective on the date of the bed size change.

(3) Facilities with fewer than fourteen (14) certified beds will use the fourteen-bed fee. Facilities with sixty (60) or more certified beds will use the sixty-bed fee.

(4) Bed size is determined at certification and listed on the program operating certificate issued by the Office.

(d) Base year. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

(e) Certification for treatment, utilization review and control.

(1) For an individual who is a Medicaid recipient when admitted to the residential rehabilitation services for youth program, certification of services must be made by an independent team as defined in Part 817 of this Title.

(2) For individuals who apply for Medicaid after admission to the residential rehabilitation for youth program, or for emergency admissions, certification of services must be made by the multidisciplinary team as defined in Part 817 of this Title. This team must include a physician. Emergency admission certification must be made within 14 days after admission. Certification must be made at the time of admission or, if an individual applies for Medicaid while in the facility, at the time of application.

(3) The utilization review plan of an eligible residential rehabilitation services for youth provider shall include the following:

(i) provision for review of each Medicaid recipient's need for services furnished in accordance with the criteria of Part 817 of this Title;

(ii) provisions to ensure that utilization review of a Medicaid recipient's treatment plan and services shall be performed by a multidisciplinary team that includes a physician as defined in Part 817 of this Title.

(iii) procedures to be used by the committee to ensure that staff of the eligible residential rehabilitation services for youth provider take needed corrective action;

(iv) provisions to ensure that the patient's record includes all information required by Part 817 of this Title, as well as the name of the patient's physician, the dates of Medicaid application and authorization if made after admission, initial and subsequent continued stay review dates, the reasons and plan for continued stay if continued stay is necessary, and other supporting material found necessary and appropriate by the multidisciplinary team;

(v) specification of records and reports to be made by the utilization review group;

(vi) provisions for maintaining the confidentiality of the identities of patients in the records and reports of the utilization review group; and

(vii) written criteria to assess the need for continued stay which conform to the requirements of Part 817 of this Title.

(4) The group performing utilization review shall ensure that subsequent reviews for continued stay of a recipient in an eligible residential service for youth program are conducted no later than each thirty-day period following the initial continued stay review. The date assigned for each subsequent continued stay review shall be noted in the patient's record.

(5) Continued stay reviews shall be performed in accordance with the following:

(i) Review for continued stay shall be conducted by the multidisciplinary team defined in Part 817 of this Title.

(ii) The review shall be conducted on or before the review date assigned.

(iii) The multidisciplinary team shall review and evaluate the documentation referred to in this Part in relation to the criteria established in this Part.

(iv) If the multidisciplinary team finds that a recipient's continued stay is needed, the multidisciplinary team shall assign a new continued stay review date in accordance with paragraph (4) of this subdivision.

(v) Any decision of the multidisciplinary team that continued stay is unnecessary shall be provided in writing within two days to the director, the attending physician, the primary counselor, and the patient; and Medicaid billing shall cease as of the day of notification. However, any decision to discharge or retain the patient shall be made on clinical grounds independent of the utilization review group's determination.

(vi) A multidisciplinary team must certify that the services continue to be needed by each recipient.

(vii) If the multidisciplinary team finds that a continued stay is not needed, it shall notify the recipient's attending physician and primary counselor within one working day and provide them two working days to present their views before a final decision.

841.8 Medical assistance payments for substance use disorder inpatient rehabilitation services

(a) The provisions of this section are applicable to programs certified under Part 818.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located). Geographic region and regional cost factor charts will be posted on the OASAS website.

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Schedules used to determine fees include:

(i) Statewide OASAS Freestanding Inpatient Rehabilitation fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) For existing and new inpatient rehabilitation facilities, the bed size will be based on the certified capacity of the program site.

(2) If the certified bed size changes, the fee will be revised accordingly and will be effective on the date of the bed size change.

(3) Facilities with fewer than 14 certified beds will use the 14-bed fee. Facilities with 120 or more certified beds will use the 120-bed fee.

(4) Bed size is determined at certification and listed on the program operating certificate issued by the Office.

(d) Base year. From time to time, and at the discretion of the Office, the fees may be revised using new base year data. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

841.9 Medical assistance payments for residential services

(a) The provisions of this section are applicable to programs certified to provide residential services under Part 820.

(b) The program's services are provided in three elements: Stabilization, rehabilitation, and reintegration. Only elements that are approved for federal financial participation are eligible for Medicaid reimbursement. Each reimbursable element shall have regional fees established and posted on the website of the Office. The regions include Downstate and Upstate. The Downstate region shall consist of New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. Upstate shall consist of all other counties in the state. Any annual or periodic fee adjustments shall be published on the Office's website. The initial fees shall be effective July 1, 2016.

(c) Allowable treatment costs shall be determined by the application of principles developed for determining reasonable cost payments for direct and indirect costs. Room and board related costs are not included in the rate.

(d) The fee development methodology shall consider each component of provider cost, as necessary to comply with requirements regarding economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of

payments are maintained. The fee development methodology will primarily consist of provider cost modeling, though provider compensation studies, cost data, available funding, and comparable fees of other States' residential Medicaid programs may be considered as well. The fees shall be established using the ratio of the calculated or estimated total annual allowable provider cost to the estimated annual billable per diem units.

(e) Periodic fee updates may be performed using provider cost modeling, reported actual cost, and/or any of the factors listed in the prior paragraph. Fee updates will require federal approval and will be posted to the Office website.

841.10 Medical assistance payments for substance use disorder outpatient programs

(a) Applicability. The provisions of this section are applicable to programs certified or co-certified to provide ambulatory care services provided by the following:

(1) substance use disorder outpatient clinics certified or co-certified pursuant to Part 822 of this Title;

(2) opioid treatment programs providing opioid full agonist treatment medications and certified under Part 822 of this Title;

(3) substance use disorder outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title; and

(4) substance use disorder medically supervised outpatient withdrawal and stabilization services certified under Section 816.8 of this Title; and

(5) integrated outpatient programs certified pursuant to Part 825.

Each program shall contain two peer groups, one upstate and one downstate.

(b) Billable services requirements and limitations must be delivered in accordance with the provisions of the Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance, as incorporated by reference in this Title (hereinafter referred to as the APG Manual), in effect at the time the service(s) was delivered.

(c) Definitions. All applicable definitions and rules covering standardized APG pricing logic for New York State's Medical Assistance program are found at Title 10 NYCRR Part 86-8.

(d) APGs and associated weights.

(1) APGs shall be subject to periodic revision; the most current listing shall be published in the APG Manual available on the Office website.

(2) The Department of Health, in consultation with the office, shall assign weights associated with all CPT and HCPCS procedure codes that can be used to bill under the APG methodology.

The office shall maintain and update a list of weights associated with APGs as published in the "APG Policy and Medicaid Billing Guidance" manual on the OASAS website. Such list may include APGs not

specifically associated with addiction outpatient and opioid treatment services, but which may appropriately be billed by providers subject to this Part.

(e) Base Rates. Base rates for addiction outpatient services shall be developed by the Office, and subject to the approval of the Department of Health, in accordance with the following:

(1) Separate base rates shall be established for each peer group. Base rates shall reflect differing regional cost factors, variations in patient population and service delivery, available funding levels, and capital expenditures;

(2) Additional discrete base rates may be developed by the Office for such peer groups as may be established by regulation in this Part; and

(3) Base rates may be periodically adjusted to reflect changes in provider case mix, service costs and other factors as determined by the Office.

(4) All base rates established by the Office shall be published on the Office's website.

(f) System Updating. The following elements of the APG rate-setting system shall be reviewed at least annually, with all changes posted on the New York State Department of Health's website:

(1) The listing of reimbursable APGs and associated weights,

(2) The applicable International Statistical Classification of Diseases and Related Health Problems, as incorporated by reference in this Title (ICD),-10 codes, or subsequent ICD categorization, utilized in the APG software system,

(3) The Applicable CPT/HCPCS codes utilized in the APG software system; and

(4) The APG software system's grouping and pricing logic.

(g) Bundled payment for opioid treatment program (OTP) services

(1) OASAS will establish regional weekly bundled payments for freestanding opioid treatment programs. Such payments will be available as an alternative to the reimbursement under the Ambulatory Patient Group (APG) fee methodology already in place for OTPs. Programs may bill any given week of OTP service for any given patient under either methodology (APGs or the bundled payment methodology), but not both. The initial bundled fees shall be effective March 16, 2020.

(2) For purposes of these bundled payments there will be two regions, downstate and upstate, with the regional assignment based on program location. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the State.

(3) The proposed bundled payments are based on service delivery that mirrors a subset of the Medicare OTP bundles in terms of both services and practitioners, as well as in terms of cost by practitioner for each service. Services covered by the bundled payment include: FDA-approved opioid agonist and antagonist treatment medications, dispensing and administering medications, substance use disorder counseling, individual and group therapy, toxicology testing, intake activities, and periodic assessments.

(4) Weekly fees shall be established in the following rate code classifications:

(i) Methadone Dispensing and/or Counseling – This code covers all of the services listed above for a patient being treated with Methadone.

(ii) Methadone Take Home – This code is billable when the patent has a supply of take-home medication in their possession for the week being billed. It cannot be billed for the same week as the dispensing and/or counseling code.

(iii) Buprenorphine Dispensing and/or Counseling – This code covers all of the services listed above for a patient being treated with Buprenorphine.

(iv) Buprenorphine Take Home – This code is billable when the patent has a supply of take-home medication in their possession for the week being billed. It cannot be billed for the same week as the dispensing and/or counseling code.

(5) The initial bundled payments, effective March 16, 2020, shall be calculated by using the unregionalized Medicare fees for the same services, meaning those fees shall not vary by region.

(6) Effective August 2, 2021 the fees shall be regionalized using the OASAS OTP regional factor of 1.1700 (Downstate relative to Upstate) for freestanding facilities. The regional factor shall be applied on a budget neutral basis assuming that the Downstate region would have 94.41% of the methadone bundle service volume based on a historical volume calculation by the Office. The medication take home fees shall continue to be identical to those used by Medicare, and, as with Medicare, not regionalized.

(7) The Office, may, at its discretion, periodically update the bundled fees using trends, actual cost, Medicare benchmarking, program modeling, or some combination of these techniques – subject to available funding, Federal approval, and NYS Division of the Budget approval.

841.11 Medical assistance payments for children and family treatment and support services

(a) The provisions of this section are applicable to rehabilitative health and behavioral health services provided by programs or providers certified or designated pursuant to Part 823 to provide Children and Family Treatment and Support Services (CFTSS).

(b) Billable Services: Billable services are those authorized and defined in the Children and Family Treatment Support Services Manual posted on the Department of Health website:

(1) Crisis Intervention (CI);

(2) Other Licensed Practitioners (OLP);

(3) Community Psychiatric Support and Treatment (CPST);

(4) Psychosocial Rehabilitation (PSR);

(5) Family Peer Support Services (FPSS); and

(6) Youth Peer Support and Training (YPST).

(c) Approved Modality and Setting. (1) Modality. Unless otherwise authorized, services should include face-to-face interaction with the child/youth and their family, as appropriate. Any such interactions, or the reason(s) such interaction could not be completed, should be documented in the patient treatment/recovery plan and case record.

(2) Setting. Services may be provided in a variety of settings, including an emergency room, health or behavioral health clinic setting, or other community location where the child/youth lives, attends school, works or engages in social activities. Services should be offered in the best setting suited for the desired outcomes and as referenced in the *Manual*.

(d) Rate Setting. Rate of reimbursement is as posted on the Department of Health website. The rate development methodology is composed of provider cost modeling, provider compensation studies and cost data. The following list outlines components which may be used in determining rate development:

(1) Staffing assumptions and staff wages;

(2) Employee-related expenses;

(3) Program-related expenses; and

(4) Program billable units.

841.12 Capital costs.

(a) This section shall apply to programs with Medicaid reimbursement calculated pursuant to this Part.

(b) No program or service governed by this Part shall have its own facility specific or program specific capital add-on. Instead, capital costs from submitted cost reports shall be reviewed by the Office and a regional, and not separately identifiable, capital component shall be built into the operating fees. Such fees shall constitute payment in full for all costs of operating the program, including capital costs, unless otherwise specified.

(c) Allowable Costs. (1) Allowable capital costs means the costs to a program operated by an applicant with respect to the acquisition of real property estates, interests, and cooperative interests in realty, their design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of a facility and as otherwise identified in this Title.

(2) Unless otherwise specified in this Part, costs of ownership of real property shall be allowable in the following categories; depreciation, interest, and closing costs on the purchase and financing of real property, including fees related to loans from the Dormitory Authority of the State of New York (DASNY). Providers should not report costs that were not actually incurred by the provider (e.g., debt service or fees on DASNY loans that were paid by the State of New York or refunded to the provider by the State of New York).

(3) Costs related to Dormitory Authority loans shall be allowable, unless otherwise paid by the State of New York, as follows:

(i) Interest cost accruing from Dormitory Authority mortgage loans pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, net of the portion of such interest cost attributable to operating costs, is an allowable cost. That portion of the interest cost attributable to allowable start-up costs is also allowable. That portion of the loan principal that is attributable to depreciable or amortizable costs, under the rules of HIM 15, is an allowable cost and shall be reimbursed as depreciation or amortization in accordance with any requirements and conditions. Any portion of the loan principal that is attributable to costs that are not depreciable or amortizable under the rules of HIM 15 is not allowable for reimbursement.

(ii) Fees imposed by the office and annual administrative fees imposed by the Dormitory Authority in connection with Dormitory Authority mortgage loans shall be allowable costs.

(iii) Interest payments on Dormitory Authority loans pursuant to this subdivision for capital indebtedness and start-up costs will be considered allowable where such interest expense results from approved capital indebtedness and/or start-up costs in accordance with this Title.

(iv) Interest payment on Dormitory Authority loans pursuant to the provisions of this Part are allowable in excess of the amount associated with the outstanding principal balance prior to refinancing only if the purpose of the additional debt is to acquire assets to be used for care of the persons served by the program and all other applicable requirements of this Part are met.

(v) The Office may recoup, in full or in part, the interest and fee reimbursement for DASNY loans attributable to a particular service. The office may also recoup, in full or in part, the annual depreciation or amortization reimbursement for costs financing through DASNY mortgage loans. The amount of Dormitory Authority mortgage loan interest, fee, depreciation, and amortization recoupments shall be equal to or less than the provider's actual reimbursement for such costs. In no case shall these recoupments exceed such reimbursement.

(d) Start-up costs. Upon the approval by the office, the approved start-up costs of new programs shall be amortized and reimbursed to the provider over a period not to exceed five years.

816.13 Utilization Review

(a) Except as otherwise specified, programs shall provide that:

(1) An Office approved tool was utilized to identify the appropriate level of care for treatment delivered to the patient.

(2) A practitioner must certify for each Medicaid recipient that services of the type provided are or were needed in accordance with the controlling Part under this Title.

(3) The utilization review plan of an eligible provider shall ensure that each provider have policies and procedures to address:

(i) Patients continue to require services furnished in accordance with the applicable criteria of the controlling Part of this Title and review of treatment planning and progress notes;

(ii) Patients are receiving care consistent with psychosocial needs and diagnosis for which they are receiving treatment; and,

(iii) patients have been referred for additional services consistent with their health and physical.

(4) Providers shall have policies and procedures for a utilization management team charged with meeting at least twice annually. Such team shall review the results of audits, utilization management process and other quality assurance activities that are related to charting and to create a comprehensive corrective action plan as needed to ensure compliance with state and federal laws, regulations and guidance issued by the Office.

841.14 Severability.

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.