STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

December 30, 2009

Dear Administrator:

This letter is to inform you of the forth coming changes to the reporting process for the AHCF-1 annual cost report submitted by the Diagnostic and Treatment Centers (D&TCs) to the Department of Health (Department). This is the result of an agreement between the Department and the Centers for Medicare and Medicaid Services (CMS) to resolve mutual concerns regarding the cost reports.

The cost report data has been used by the Department to demonstrate that our current and proposed Medicaid reimbursement to D&TCs meets CMS's requirement for federal financial participation. The requirement sets a limitation on provider payments based on a reasonable estimate of the amount that would be paid under federal reimbursement principles. The avenue for demonstration of the State's compliance with this requirement is the Upper Payment Limit (UPL) calculation. The Department must develop the UPL by incorporating cost, visit and payment data for all freestanding clinics licensed in the State. Clinic cost and threshold visit data as reported on the AHCF-1 report are utilized in the demonstration; therefore the consistency and integrity of the data as well as timeliness of cost reporting have become increasingly important.

A UPL demonstration, based on 2006 cost reports where available, was submitted to CMS for review on June 11, 2009. As a result of this review, along with internal reviews by the State, it has been found that there is a lack of uniform reporting in the respective AHCF-1 cost report. While there has not been a need to review the reported data for rate setting purposes since the Medicaid rate freeze in 1995, with the proposed move to the APG rate methodology, the CMS has made it clear that the concern over the data integrity and timely submission of reports are critical, and therefore, CMS is withholding the approval of State Plan Amendments and the related federal funding until the Department can assure them that the cost reporting process will be improved. Consequently, it is imperative that each provider work with us to ensure the much needed improvement of the clinic cost report data and timeliness of their submissions.

To that end, this letter serves as a notice to all providers that they must prepare and submit a cost report that is accurate, complete and independently audited for all cost reporting periods beginning with the 2009 reporting period. Besides, beginning with the 2010 reporting period, there will be updates to the reports and accompanying instructions to provide more pertinent information given today's healthcare delivery system and reimbursement methodologies. The following issues have been agreed on with CMS as improvements in the process for the cost reporting periods beginning on or after January 1, 2010:

Data Integrity

- Providers must improve the accuracy of the beneficiary visit data for all payers, in a format that will be independently audited and reported on the cost report. For each clinic service visit reported, the costs must also be reported so that there is an exact correlation between the costs and the visits for each applicable clinic service.
- In addition to threshold visits, for certain services which are billed on a weekly or other than visit basis, the number of billable units related to such visits for Medicaid fee for service will now be required to be reported. For example weekly billings for methadone maintenance must be reported as well as the number of visits.
- The visit information for all programs must distinguish between those services provided at the licensed site, including licensed satellite sites, and those services that are provided by program staff at homeless shelters, community residences, etc (applicable to FQHC clinics)
- CMS requires "non-clinic costs" to be discretely defined and separately reported to be excluded from the UPL calculation. (The cost report instructions and forms are already adequate, so long as they are completed in sufficient detail. For example, such expense items as transportation costs of clients from residence to service site should be included on the appropriate expense lines to allow exclusion from the UPL calculation.).

Certification of Data/Related Training

- It is currently required that all the clinic cost reports be independently audited and certified to, and this level of certification will be maintained. However, the review of the reports shows that there are inaccuracies in the certified data. We are in agreement with CMS that the cost report data must be improved and certified to for accuracy.
- To rectify the data inconsistencies, the Department of Health will initiate regional training sessions to ensure that providers and independent auditors are fully informed on the content and expectations for the cost reports.

Enforcement

- Commencing with the AHCF-1 cost reports for the 2009 reporting periods, Department of Health will review the reports for improvements in visit and cost data integrity and will enforce the penalty procedures for incomplete or inaccurate reports as provided for in the Commissioner of Health's Rules & Regulations (Part 86 – 4), or other enacted statutory language.
- Also commencing with the cost reports for the 2009 reporting periods, if an accurate and certified cost report is not submitted to the State on a timely basis, the State will enforce the penalty procedures for non-filers, as provided for in Part 86 -4.

Updated 2010 AHCF-1 Cost Report software with detailed instructions will be available to all Article 28 and dual-licensed clinics during 2010. We will be working with clinics and their associations to develop this revised report.

We share a common concern with CMS as well as the Diagnostic and Treatment Center provider community, in improving the cost reporting and UPL demonstration process Therefore, we hope to make this increased effort and cooperation a smooth transition by providing any training and enhanced reporting instructions to you. If you have any questions on this, please contact, Mr. John Gahan Jr., Director Bureau of Primary and Acute Care Reimbursement at 474-3267 or other Bureau contacts).

Sincerely,

Jana K. Lefebure (for)

John E. Ulberg, Jr.
Director
Division of Health Care Financing