

MEDICAL ASSISTANCE FOR CHEMICAL DEPENDENCE 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)

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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 chemical dependence providers certified or co-certified by the Office of Alcoholism and Substance Abuse Services. This Part does not apply to hospital based programs.

(b) The payments determined under these standards and methods established by this Part are intended to be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated programs in order to provide chemical dependence 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 of the Office of Alcoholism and Substance Abuse Services to adopt standards including necessary rules and regulations pertaining to chemical dependence services.
- (b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.
- (c) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services 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 of the Office of Alcoholism and Substance Abuse Services 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 of the Office of Alcoholism and Substance Abuse Services 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 chemical dependence services certified by the Office of Alcoholism and Substance Abuse Services.
- (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 described in subdivision (c) of section 841.14 of this Part 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 chemical dependence outpatient clinic services otherwise subject to the provisions of this Part.

841.3 Applicability.

These regulations apply to any eligible provider as defined in this Part.

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 a chemical dependence 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 chemical dependence inpatient rehabilitation program which is certified under Part 818 of this Title by the Office of Alcoholism and Substance Abuse Services; or

(2) a chemical dependence crisis program which is certified under Part 816 of this Title by the Office of Alcoholism and Substance Abuse Services to provide inpatient medically supervised withdrawal services or outpatient medically supervised withdrawal services; or

(3) a chemical dependence outpatient or opioid treatment program certified under Part 822 of this Title by the Office of Alcoholism and Substance Abuse Services; or

(4) an outpatient chemical dependency services for youth program and service certified under Part 823 of this Title by the Office of Alcoholism and Substance Abuse Services; or

(5) a residential chemical dependency services for youth program certified under Part 817 of this Title by the Office of Alcoholism and Substance Abuse Services.

(c) "New eligible provider" shall mean an eligible provider that has operated a chemical dependence treatment program for which relevant historical chemical dependence services costs are not available.

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

(e) "Episode of care" for purposes of this Part means: (1) in a chemical dependence outpatient program, the period of time beginning with the first contact by a prospective patient that leads to a face-to-face service within 30 days resulting in admission to a chemical dependence outpatient treatment program and concluding 30 days following the discharge date; (2) in an opioid treatment program, the period of time beginning with admission of a patient and concluding every twelve months thereafter.

841.5 Financial and statistical reporting.

(a) Each eligible provider shall maintain financial records and records relative to numbers and types of services provided and shall prepare and submit to the commissioner financial and statistical reports in accordance with the requirements of the commissioner. A new eligible provider shall not be required to provide historical financial and statistical reporting unless requested by the commissioner.

(b) All financial reports to be prepared and submitted to the commissioner shall:

- (1) be prepared in accordance with generally acceptable accounting principles;
 - (2) 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 otherwise determined by the commissioner; and
 - (3) be accompanied by a complete copy of the eligible provider's certified financial statements.
- (c) All reports to be prepared and submitted to the commissioner shall:
- (1) be certified by the chief administrative officer or director of the eligible provider;
 - (2) be on forms prescribed by the commissioner; and
 - (3) include financial and statistical data for each service for which rates or fees are established.
- (d) 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 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.
- (e) If the eligible provider determines that the information on reports filed with the commissioner is inaccurate, incomplete or incorrect, the eligible provider shall immediately file with the commissioner the corrected reports which comply with the requirements of this section.
- (f) If the required financial and statistical reports are determined by the commissioner 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.
- (g) Penalties for Non-compliance. If an eligible provider fails to file the required financial and statistical reports, in accordance with subdivisions (a) through (f) of this section and on or before the due date or office approved extended due date, the office may, at its discretion, reduce said eligible provider's existing rate or fee by five 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, the office may, at its discretion, not promulgate a rate or fee for the rate or fee period or periods that were to be calculated based upon the delinquent reports. In such instances, a rate or fee shall be promulgated effective the first day of the month following the receipt of financial and statistical data necessary to calculate said rate or fee.

841.6 Non-discrimination.

- (a) No eligible provider shall discriminate against any Medicaid recipient in admission or provision of services solely on the basis of Medicaid eligibility.
- (b) No eligible provider shall discriminate against any person in admission or provision of services based on race, creed, color, sex, age, disability or sexual orientation.

841.7 Record keeping.

- (a) An eligible provider shall prepare, and keep for a period of six years, or three years after the patient reaches the age of eighteen, whichever period is longer, all records necessary to disclose the extent of services furnished to Medicaid recipients and all information regarding claims for payment submitted by, or on behalf of, the provider, in accordance with applicable state and federal law.
- (b) Subject to the requirements of part 2 of title 42 of the Code of Federal Regulations, an eligible provider shall furnish to the New York State Department of Health or the Secretary of the United States Department of Health and Human Services, and/or their fiscal agent and/or their contractors, any information they may request regarding payments claimed by the provider for furnishing services.

841.8 Billing.

- (a) The eligible provider shall levy no additional charges to patients for services paid for by the Medicaid Program.
- (b) Claims for payment by the Medicaid Program shall be submitted at rates/fees established and/or calculated by the office and approved by the Director of the Budget. Such billings shall be net of any individual or third-party liability.
- (c) 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.
- (d) Claims shall be submitted on officially authorized claim forms or formats and in accordance with the Department of Health standards and procedures for claims submission.
- (e) All information provided in relation to any claim for payment shall be true, accurate and complete.

841.9 Compliance with general medical assistance program requirements.

Each eligible provider shall comply with all applicable medical assistance program requirements of the Department of Health.

841.10 Medical assistance payments for chemical dependence inpatient services.

(a) Definitions. For purposes of this section:

(1) "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 chemical dependence services, related to patient care, and approved by the commissioner.

(2) "Patient Day" shall mean the unit of measure denoting lodging provided and 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.

(3) "Billable days" shall mean those patient days during which services have been provided which conform to the requirements of Part 818 of this Title for a chemical dependence inpatient rehabilitation provider; or a residential services provider pursuant to Part 820 of this Title.

(4) "Allowable days" shall mean the total of patient days provided by an eligible inpatient provider and calculated pursuant to subdivision (c) of this section.

(5) "Fiscal year" shall mean the 12-month period beginning January 1st and ending December 31st, except for chemical dependence inpatient services operated by the office in which case the fiscal year shall mean the 12-month period beginning April 1st and ending March 31st.

(6) "Rate year" shall be the calendar year.

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

(8) "Eligible inpatient provider" shall mean a chemical dependence inpatient provider who meets the requirements in this Part and is:

(i) a chemical dependence inpatient rehabilitation service provider; or

(ii) an inpatient medically supervised withdrawal service which has formerly been certified by the office to provide medical detoxification in alcoholism treatment centers; or

(iii) a residential services provider under 16 beds.

(9) "New eligible inpatient provider" shall mean an eligible inpatient provider as defined in subdivision (8) for which relevant historical chemical dependence service costs are not available.

(b) Financial and statistical reporting for new eligible inpatient providers.

(1) Each new eligible inpatient provider shall prepare and submit to the commissioner a budgeted cost report in accordance with the requirements of paragraphs 841.5(b)(1), 841.5(c)(1), and 841.5(c)(2) of this Part and subdivisions 841.5(e) and 841.5(f) of this Part. Such report shall:

(i) include a detailed projection of revenues and a line item expense budget with regard to staffing and non-personal service costs, including capital costs;

(ii) include a detailed staffing plan;

(iii) include a projected month by month bed utilization by program;

(iv) cover a 12 month period; and

(v) be completed and submitted at least 180 days prior to the beginning of the rate year for which a rate is being requested.

(c) Calculation of allowable patient days. For the purposes of determining rates of payment, allowable patient days for eligible inpatient providers shall be computed using the higher of allowable days in the base year or 90 percent of possible days based upon annualized certified bed capacity. For an eligible inpatient medically supervised service which has formerly been certified by the office to provide medical detoxification in alcoholism treatment centers allowable patient days shall be computed using the higher of allowable days in the base year or 85 percent of the possible days based upon annualized certified capacity.

(d) Calculation of allowable costs.

(1) General. To be considered as allowable in determining the rate of payment, costs must be properly chargeable to necessary patient care rendered in accordance with the operating requirements of the office pursuant to this Title, 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 commissioner 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 inpatient provider.

(3) Religious orders. Allowable costs shall include a monetary value assigned to services provided by religious orders.

(4) Dues. Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be other than for public relations, advertising, political contributions and lobbying.

(5) Capital expenditures. No capital expenditures for which approval by the Office is required in accordance with Section 841.15 of 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.

(6) Owner compensation. Reasonable compensation to owners of eligible inpatient provider or parties related to such owners, where services have been actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the commissioner under Section 841.15 of this Part. Compensation shall not be included in the rate of payment computation for any services which the owner of the eligible inpatient provider or relative of the owner of the eligible inpatient provider of services is not authorized to perform.

(7) Limits on Compensation. The maximum reimbursable costs for salaries for positions/titles shall be consistent with the requirements of Part 812 of this Title.

(e) Non-allowable costs.

(1) Costs. Allowable costs shall not include expenses or portions of expenses reported by an eligible inpatient provider which are determined by the commissioner not to be reasonably related to and commonly associated with the efficient and effective provision of chemical dependence services because of either the nature or amount of the particular item.

(2) Entertainment. Allowable costs shall not include costs which principally afford entertainment or amusement to owners, operators or employees of eligible inpatient providers or the referral sources.

(3) Penalties. Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, nor the costs of insurance policies obtained solely to insure against the imposition of such a penalty.

(4) Advertising, public relations or promotions. Allowable costs shall not include the direct or indirect costs of advertising, public relations and promotion except in those instances where the costs are specifically related to the operation of the eligible inpatient provider, i.e., advertising for staff recruitment, and not for the purpose of attracting residents.

(5) Political contributions. Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(6) Transfer costs. Allowable costs shall not include any costs which the commissioner determines result solely from the transfer of ownership of an eligible inpatient provider.

(7) Prosthetic or orthotic costs. Allowable operating costs shall not include the costs of prosthetic or orthotic appliances and devices, including hearing aids which are supplied by vendors who are eligible for payment for such appliances or devices in accordance with the established requirements of the Medicaid program.

(8) Educational costs. Allowable costs shall not include costs for academic, remedial, physical and vocational education provided directly to residents of eligible inpatient providers, by the eligible inpatient provider or by arrangement with local school districts.

(9) Dues. Allowable costs shall not include dues paid to any professional association or group for the purposes of public relations, advertising, political contributions, or lobbying.

(10) Fundraising. Allowable costs shall not include direct and indirect costs of fundraising.

(f) Costs of related parties. Costs applicable to services, facilities and supplies furnished to the eligible inpatient provider by related parties as defined in Section 841.16 of this Part are includable in the allowable cost of the eligible inpatient provider at the lower of the cost to the related party or the fair market value of the services, facilities or supplies.

(g) Rates of payment.

(1) Payment rates shall be established on a prospective basis.

(2) Separate payment rates shall be established by the office for different types of services in accordance with the provisions of this Title.

(3) Payment rates shall be all-inclusive per diem rates taking into account all allowable days pursuant to subdivision (c) of this section and all allowable costs pursuant to subdivision (d) of this section. Such principles shall be applied to new eligible inpatient providers.

(4) Payment rates established under this section shall be effective for a 12-month period beginning January 1st and ending December 31st.

(5) Transfer costs. Allowable costs shall not include any costs which the commissioner determines result solely from the transfer of ownership of an eligible inpatient provider.

(6) Payment rates established under this section shall be provisional pending the completion of an audit in accordance with Section 841.13 of this Part.

(7) For any rate year, an operating cost per diem and capital cost per diem shall be determined from the allowable costs in the base year. The base year is the year ending at least one year prior to the

first day of the rate year. The operating cost per diem and capital cost per diem shall be calculated by dividing the allowable cost by the allowable days pursuant to subdivision (c) of this section. For new eligible inpatient providers with at least six months but less than two years of cost experience, the most recent fiscal year will be used.

(8) In determining the allowable operating cost per diem for any base year, there shall be applied a growth factor limitation on the previous base year operating per diem. The growth factor limitation is determined by adding two percent to the final trend factor applicable to the base year. The trend factor shall be based on the Congressional Budget Office's Consumer Price Index for all Urban Consumers. The allowable operating cost per diem for the rate year shall be the lower of allowable operating cost per diem from the base year or the allowable operating cost per diem from the previous base year increased by growth factor limitation. In determining the allowable operating cost per diem for any rate year, there shall be applied a trend factor for allowable operating cost increases during the rate year.

(9) To the allowable operating cost per diem computed in accordance with the provisions of this subdivision there shall be added an allowable capital cost per diem. Allowable capital costs shall be determined by the application of the principles developed for determining payments as set forth pursuant to subdivision (d) (1) (i) and (d) (1) (ii) of this subdivision.

(10) Payment rates for each new eligible inpatient provider with less than six months of cost experience shall be determined as follows:

(i) Payment rates shall be only for the time period as approved in the budgeted cost report submitted by the new eligible inpatient provider.

(ii) The allowable capital per diem during the period covered by the budgeted cost report will be computed based upon the approved budgeted capital costs divided by allowable patient days.

(iii) The allowable operating per diem during the period covered by the budgeted cost report will be the lower of the approved budgeted operating costs divided by allowable patient days or 110 percent of the statewide average operating per diem for programs similar in size and geographic location. Where there are no similar programs for comparison, 115 percent (115%) of the statewide average operating per diem will be used.

(iv) The payment rate shall be determined by adding the allowable operating per diem and the allowable capital per diem.

(11) Upon submission of the financial reports pursuant to this subdivision, the commissioner may adjust retroactively the eligible inpatient provider's current budget based rate of payment to more accurately reflect the cost of operating the eligible inpatient provider pursuant to this section.

(12) Notwithstanding the provisions of this section, if the office determines that an eligible inpatient provider has violated regulations of the office by exceeding certified capacity, the commissioner may, at his or her discretion, adjust retroactively, any rates certified under this section to reflect the allowable costs and patient days incurred by the eligible inpatient provider for rendering such services consistent with its certified capacity. Such revised rates may be applied retroactively, shall be calculated according to the methodology set forth in this section, and shall become effective upon approval by the State Division of the Budget.

(h) Approval of rates. Payment rates established in accordance with the provisions of this Part shall be calculated by the commissioner and shall be approved by the State Division of the Budget. An eligible inpatient provider shall receive written notice of a payment rate after such certification and approval.

(i) Utilization review. Utilization review for chemical dependence inpatient rehabilitation providers and Part 820 residential services providers shall provide that:

(1) A physician must certify for each Medicaid recipient that services of the type provided are or were needed in accordance with Part 818 of this Title for a chemical dependence inpatient rehabilitation provider or a Part 820 residential services provider.

(2) The certification must be made within 72 hours prior or subsequent to admission, or, if an individual applies for Medicaid while in the facility, within 72 hours of application.

(3) The utilization review plan of an eligible inpatient provider shall include the following:

(i) provisions for review of each Medicaid recipient's need for the services furnished in accordance with the criteria of Part 818 of this Title for a chemical dependence inpatient rehabilitation provider or a Part 820 residential services provider;

(ii) provisions to ensure that utilization review of a Medicaid recipient's services shall be performed by a group of professionals that includes a physician, and at least one individual who is not directly responsible for the care of the recipient nor who has a financial interest in the eligible inpatient provider's service who shall solely be responsible for approval of the utilization plan;

(iii) procedures to be used by the committee to ensure that staff of the eligible inpatient provider take needed corrective action;

(iv) provisions to ensure that the patient's record includes all information required by Part 818 of this Title for a chemical dependence inpatient rehabilitation provider, or a Part 820 residential services provider 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 utilization review group;

(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 818 of this Title for a chemical dependence inpatient rehabilitation provider or a Part 820 residential services provider.

(4) The group performing utilization review shall ensure that the initial review for a continued stay of a recipient in an eligible program shall be no later than the 31st day after admission. The date assigned shall be noted in the patient's record.

(5) The group performing utilization review shall ensure that subsequent reviews for continued stay of a recipient in an eligible inpatient provider service are conducted no later than each fourteen days following the initial continued stay review until sixty days after admission. After sixty days, continued stay reviews shall be conducted each seven days until discharge. The date assigned for each subsequent continued stay review shall be noted in the patient's record.

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

(i) Review for continued stay shall be conducted by the utilization review group or a designee of the group.

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

(iii) The group or designee shall review and evaluate the documentation referred to in subparagraph (3)(iv) of this subdivision in relation to the criteria established in response to subparagraph (3)(vii) of this subdivision.

(iv) If the group or designee finds that a recipient's continued stay is needed, the group shall assign a new continued stay review date in accordance with paragraph (5) of this subdivision.

(v) A physician or physician assistant or nurse practitioner must certify that the services continue to be needed by each recipient.

(vi) If the group 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.

(vii) If the attending physician and the primary counselor do not present additional information or agree that continued stay is unnecessary, the utilization review group decision shall be final.

(viii) If the attending physician and primary counselor present additional information or clarification, the need for continued stay shall be reviewed by the entire utilization review group and its decision shall be final.

(ix) Any decision of the utilization review group 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.

(j) Application Procedures. To qualify for medical assistance payments, an eligible inpatient provider, with a current operating certificate issued by the office, shall apply for enrollment as a Medicaid provider on application forms supplied by the office.

841.11 Medical assistance payments for inpatient medically supervised withdrawal services

(a) Definitions. For the purposes of this section:

(1) "Eligible inpatient medically supervised withdrawal service provider" shall mean a medically supervised withdrawal service provider that has been certified by the office to provide inpatient medically supervised withdrawal services pursuant to Part 816 of this Title.

(2) "Patient day" shall mean the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hours on two successive days. A patient day is counted on the day of admission but not on the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(3) "Billable day" shall mean a patient day which conforms to the following requirements:

(i) A face to face contact must occur between the patient and medical or clinical staff for the provision of services provided pursuant to Part 816 of this Title.

(ii) Reimbursement shall only be made for inpatient medically supervised withdrawal services provided on the site of the inpatient medically supervised withdrawal program.

(b) Calculation of fees. Fees shall be developed for inpatient medically supervised withdrawal services. Fees will reflect geographic variations in costs. Fees shall be all inclusive and payment in full for inpatient medically supervised withdrawal services provided pursuant to Part 816 of this Title. Separate inpatient medically supervised withdrawal services fees shall be established for the upstate region and the downstate region.

(c) Fee Methodology. The fee for inpatient medically supervised withdrawal services shall be determined using a cost model based on the requirements of Part 816 of this Title and a review of

historical costs for inpatient medically supervised withdrawal services. The cost model shall contain personal service and non-personal service costs. Upstate and downstate fees shall be used to recognize cost differentials between these regions of the state. Two unit fee models shall be developed: inpatient medically supervised withdrawal downstate and inpatient medically supervised withdrawal service upstate.

(d) Utilization review and control. Utilization review and control for inpatient medically supervised withdrawal providers shall provide that:

(1) A physician must certify for each Medicaid recipient that services of the type provided are or were needed in accordance with Part 816 of this Title.

(2) The 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 inpatient medically supervised withdrawal provider shall include the following:

(i) provisions for review of each Medicaid recipient's need for services furnished in accordance with the criteria of Part 816 of this Title;

(ii) provisions to ensure that utilization review of a Medicaid recipient's services shall be performed by a group of professionals that includes a physician, and at least one individual who is not directly responsible for the care of the recipient nor who has a financial interest in the eligible inpatient medically supervised withdrawal provider's service who shall solely be responsible for approval of the utilization plan;

(iii) procedures to be used by the committee to ensure that staff of the eligible inpatient medically supervised withdrawal provider take needed corrective action;

(iv) provisions to ensure that the patient's record includes all information required by Part 816 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 utilization review group;

(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 816 of this Title.

(4) The group performing utilization review shall ensure that the initial review for a continued stay of a recipient in an eligible program shall be no later than the seventh day after admission. The date assigned shall be noted in the patient's record.

(5) The group performing utilization review shall ensure that subsequent reviews for continued stay of a recipient in an eligible inpatient medically supervised withdrawal provider service are conducted no later than each two 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.

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

(i) Review for continued stay shall be conducted by the utilization review group or a designee of the group.

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

(iii) The group or designee shall review and evaluate the documentation referred to in subparagraph (3)(iv) of this subdivision in relation to the criteria established in response to subparagraph (3)(vii) of this subdivision.

(iv) If the group or designee finds that a recipient's continued stay is needed, the group shall assign a new continued stay review date in accordance with paragraph (6) of this subdivision.

(v) A physician or physician assistant or nurse practitioner must certify that the services continue to be needed by each recipient.

(vi) If the group 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.

(vii) If the attending physician and the primary counselor do not present additional information or agree that continued stay is unnecessary, the utilization review group decision shall be final.

(viii) If the attending physician and primary counselor present additional information or clarification, the need for continued stay shall be reviewed by the entire utilization review group and its decision shall be final.

(ix) Any decision of the utilization review group 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.

841.12 Medical assistance payments for residential rehabilitation services for youth

(a) Definitions. For the purposes of this section:

(1) "Eligible residential rehabilitation services for youth provider" shall mean a residential rehabilitation services for youth provider that has been certified by the office to provide services pursuant to Part 817 of this Title.

(2) "Allowable" costs shall mean those costs incurred by an eligible residential rehabilitation services for youth 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 chemical dependence services, related to patient care, recurring, and approved by the commissioner.

(3) "Patient day" shall mean the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hours on two successive days. A patient day is counted on the day of admission but not on the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(4) "Billable day" shall mean a patient day during which services are provided that conform to the requirements of Part 817 of this Title.

(5) "Allowable days" shall mean the total patient days provided by an eligible residential rehabilitation services for youth provider; and shall be calculated pursuant to paragraph (e)(2).

(6) "Fee Period" shall be the calendar year.

(7) "Base year" shall mean the period from which fiscal and patient data are utilized to calculate rates of payment for the fee period.

(8) "Fee Cycle" shall mean either one fee period or more than one consecutive fee periods. Such fee or fees shall be derived from a common base year.

(9) "New eligible residential rehabilitation provider" shall mean an eligible residential rehabilitation services for youth provider, as defined in paragraph (1) above, for which relevant historical chemical dependence service costs are not available.

(10) "Service operating fee" shall mean fees calculated pursuant to 841.12(b) as payment in full for operating expenses as required by Part 817. Such fee shall not include the capital or admission review team add-ons.

(11) "Capital add-on" shall mean a provider-specific cost-based per diem calculated pursuant to subdivision (c) of this section and also Section 841.14 of this Title to address allowable and approved real property, equipment and start-up costs not included in 841.12(a)(10) or 841.12(a)(12).

(12) "Admission review team (ART) add-on" shall mean a per diem calculated pursuant to subdivision (d) of this section, and established to address the cost of the admission review team required by Section 817.3 of this Title.

(b) Calculation of service operating fees. Service operating fees for residential rehabilitation services for youth provided pursuant to Part 817 of this Title shall be developed by the office using a cost model based on the requirements of Part 817 of this Title. The cost model shall contain personal service and non-personal service costs. The cost model shall recognize cost differentials between the upstate and down- state regions of the state and also cost differentials between providers with differing service capacities. The service operating fee and any relevant add-ons to the fee shall be deemed to be inclusive of all service delivery costs and shall be considered payment in full to the residential rehabilitation services for youth provider for all non-capital costs related to delivery of services provided pursuant to Part 817 of this Title.

(1) For purposes of this section, the upstate and downstate geographic regions are defined as follows:

(i) The downstate region includes New York City and the counties of Nassau, Suffolk, Westchester, Rockland and Putnam. New York City includes the counties of New York, Bronx, Kings, Queens, and Richmond.

(ii) The upstate region includes all other counties in New York State.

(2) Within each geographic region, service operating fees shall be developed based on differing service capacities. The applicable fee level for a given residential rehabilitation services for youth facility shall be determined based on the geographic location of the facility, pursuant to 841.12(b)(1), and the residential rehabilitation services for youth provider's total statewide certified residential rehabilitation services for youth capacity.

(3) The service operating fees for each fee cycle, as defined in 841.12(a)(10), shall be developed by using base year patient and fiscal data. The base year fee calculation shall then be trended, using the Congressional Budget Office's Consumer Price Index for all Urban Consumers, to the first day of the fee cycle. The personal service component of the service operating fees shall be calculated by the office using the staffing requirements of Part 817 of this Title in conjunction with the applicable U.S. Department of Labor's Employment and Wage Estimates, as adapted by the office to coincide with the staffing position titles of Part 817 of this Title and the geographic regions defined in 841.12(b)(1). The fringe benefits, non-personal service and administrative components of the service operating fees shall be calculated by the office using fringe benefit, non-personal service and administrative fiscal data for providers operating residential rehabilitation services for youth.

(4) From time to time, at the discretion of the office, the service operating fees may be revised or updated. This process of revising or updating service operating fees may be based on the following:

(i) the application of an annual trend factor to the service operating fee. Such trend factor shall be based on the Congressional Budget Office's Consumer Price Index for all Urban Consumers and shall apply to all components of the service operating fee, but shall not apply to the capital or admission review team, add-ons to the service operating fee;

(ii) the establishment of a new base year and fee cycle;

(iii) a change in the number of service operating fees and/or the upper and lower service capacities applicable to a service operating fee within a geographic region; or

(iv) programmatic changes or cost variations which are determined by the office to warrant a revision or update to the service operating fees.

(c) Capital add-on.

(1) To be considered as allowable, capital costs must be both reasonable and necessary to patient care under Part 817 of this Title. Allowable capital costs shall be determined and reimbursed by the office in accordance with the requirements of Section 841.14 of this Part. Allowable patient days shall be determined in accordance with 841.12(e)(2) of this Part.

(2) The capital add-on to the service operating fee shall be calculated for each fee period on a provider-specific basis by dividing the provider's allowable capital costs for that fee period by the allowable patient days for that fee period.

(3) Interest on current working capital shall be treated and reported as an administrative operating expense and as such is not considered an allowable capital cost.

(4) The capital add-on may be adjusted on a retroactive or prospective basis to more accurately reflect the actual or anticipated capital cost. At the discretion of the office, when the capital add-on is adjusted retroactively actual patient days for the fee period of the adjustment may be used instead of allowable patient days.

(d) Admission review team (ART) add-on.

(1) The admission review team add-on shall be calculated by dividing the annual cost of the review team or teams by the aggregate of the annual Medicaid units of service for Medicaid eligible residential rehabilitation services for youth (RRSY) patients. The admission review team add-on may be calculated either prospectively or retroactively.

(i) When the admission review team add-on is calculated prospectively it shall be based on the estimated cost of the admission review team and the estimated aggregate of the annual Medicaid units of service for Medicaid eligible RRSY patients.

(ii) When the admission review team add-on is calculated retroactively it shall be based on the actual cost of the admission review team and the actual aggregate of the annual Medicaid units of service for Medicaid eligible RRSY patients.

(2) Admission review team costs may include consultants under contract to the office, staff employed by the office, and associated non-personal service costs. The calculated admission review team add-on shall be identical for all residential rehabilitation services for youth providers.

(3) All expenditures for the admission review team shall be the responsibility of the office. The admission review team add-on shall be recouped in its entirety from each residential rehabilitation services for youth provider to reimburse the office for admission review team expenditures.

(4) The admission review team add-on may be adjusted either prospectively or retroactively to more accurately reflect the actual or anticipated cost of the admission review team.

(e) Fees and Add-ons.

(1) Service operating fees shall be calculated as described in subdivision 841.12(b).

(2) Calculation of allowable patient days. For the purposes of determining rates of payment for capital costs, allowable patient days for eligible residential rehabilitation services for youth providers shall be computed using the higher of allowable days in the base year or 90 percent of possible days based upon annualized certified bed capacity.

(3) If the office determines that sufficient allowable expense exists, capital and admission review team add-ons shall be calculated and added to the service operating per diem fee. Capital and admission review team add-ons to the service operating fee shall be calculated as defined in 841.12(c) and 841.12(d).

(4) Per diem fee add-ons established under this section shall be effective for a 12 month period beginning January 1st and ending December 31st.

(5) At the discretion of the office, per diem fee add-ons may be calculated from approved budgeted cost or approved actual cost.

(6) Fees and add-ons established under this section shall be provisional pending the completion of an audit in accordance with section 841.13 of this Part.

(f) Exceeding certified capacity. The other provisions of this section notwithstanding, if the office determines that an eligible residential rehabilitation services for youth provider or a new eligible residential rehabilitation services for youth provider has violated regulations of the office by exceeding certified capacity, the commissioner may, at his or her discretion, adjust retroactively any fees or fee add-ons certified under this section to reflect the allowable costs and actual patient days incurred

by the eligible residential rehabilitation services for youth provider for rendering such services. Such revised fees or fee add-ons may be applied retroactively, shall be calculated according to the methodology set forth in this section, and shall become effective upon approval by the Division of the Budget.

(g) New eligible residential rehabilitation services for youth providers.

(1) Each new eligible residential rehabilitation services for youth provider shall prepare and submit to the commissioner a budgeted cost report in accordance with the requirements of paragraphs 841.5(b)(1), 841.5(c)(1), and 841.5(c)(2) of this Part and subdivisions 841.5(e) and 841.5(f) of this Part. Such report shall:

(i) include a detailed projection of revenues and a line item expense budget with regard to staffing and non-personal service costs, including capital costs;

(ii) include a detailed staffing plan;

(iii) include a projected month by month bed utilization by program;

(iv) cover a 12 month period; and

(v) be completed and submitted at least 180 days prior to the beginning of the rate year for which a rate is being requested.

(2) The service operating fee and admission review team add-on for each new eligible residential rehabilitation services for youth provider shall be calculated and reimbursed pursuant to the requirements of subdivisions (b) to (f) of this Section. The capital add-on shall be approved, calculated and reimbursed pursuant to the requirements of subdivisions (c), (e), and (f) of this Section and Section 841.14 of this Part.

(3) Upon submission of the financial reports pursuant to this subdivision, the commissioner may adjust retroactively the new eligible residential rehabilitation services for youth provider's existing capital add-on to more accurately reflect the reported operating costs and patient days of the eligible residential rehabilitation services for youth provider.

(h) Approval of fees and fee add-ons. Service operating fees and fee add-ons established in accordance with the provisions of this section or revised in accordance with the provisions of Section 841.13 of this Part shall be calculated by the commissioner and shall be approved by the State Division of the Budget. An eligible residential rehabilitation services for youth provider shall receive written notice of a fee after such approval.

(i) 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) provisions 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 subparagraph (3)(iv) of this subdivision in relation to the criteria established in response to subparagraph (3)(vii) of this subdivision.

(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.

841.13 Audits and revisions to rates for inpatient rehabilitation services and fees and fee add-ons for residential rehabilitation services for youth services (RRSY)

(a) Except where specifically stated otherwise, the requirements of this section shall apply to both eligible inpatient providers under Section 841.10 of this Part and eligible residential rehabilitation services for youth providers under Section 841.12 of this Part, hereafter collectively referred to as the "provider" for purposes of this section.

(b) Audits.

(1) Each provider shall keep and maintain the statistical and financial records which formed the basis of the reports submitted to the commissioner, as required in Section 841.5, for the later of:

(i) six years from the date on which the reports were due to the commissioner;

(ii) six years from the date on which the reports were submitted to the commissioner;

(iii) two years from the last day of any rate or fee period during which any part of a rate or fee was based on the required reports; or

(iv) for such longer period as may be required under Federal, State or local law.

(2) All such records shall be subject to audit during the time period of their keeping and maintenance, as described in paragraph (1) of this subdivision.

(i) Field audits or desk audits shall be conducted by the commissioner at a time and place and in a manner to be determined by the commissioner.

(ii) The commissioner may enter into agreements with other organizations or agencies having audit responsibilities to audit the financial and statistical records of providers. At the conclusion of such audit, the commissioner may either accept the audit findings as the audit findings of the commissioner or reject the audit findings and conduct an independent audit.

(iii) The audits may be performed on any financial or statistical records required to be maintained.

(iv) Any finding of an above described audit shall constitute grounds for a rate, fee, or fee add-on adjustment at the discretion of the commissioner and to the extent that the audit finding has been upheld in a decision after a hearing or a hearing has not been requested on such finding. The rate, fee, or fee add-on adjustment may be implemented prospectively or retroactively, at the discretion of the commissioner.

(v) All rates or fees shall be considered provisional and subject to revision under the provisions of subdivision (c) until an audit has been performed and completed or the period described in Section 841.13(b)(1) has expired.

(3) All administrative review of audits conducted to determine allowable Medicaid expenses and offsetting revenues shall be in accordance with this subdivision as follows:

(i) At the conclusion of the audit, a proposed audit report may be issued identifying the items which are being disallowed and advising the provider of the basis for the proposed action and the legal authority therefor. When feasible, the proposed report will also specify the amount of the overpayment or underpayment.

(A) The proposed report shall contain a statement of action to be taken, shall afford the provider the opportunity to object to the proposed action within 30 days and shall advise the provider that failure to object within the time provided may result in the adoption of the proposed action as the final action. The proposed report shall be accompanied by a document identifying the person to whom objections to the report should be mailed.

(B) The provider's objections to the proposed audit report must be mailed to the office within 30 days of receipt of the report by certified mail, return receipt requested. Such provider shall include a statement detailing the specific items of the proposed audit report to which the provider

objects and shall provide any additional material or documentation which the provider wishes to be considered in support of the objections.

(ii) After the office's receipt and review of the provider's objections and additional documentation, or at any time after the expiration of 40 days after mailing of the proposed audit report without objections having been received, a final audit report may be issued by the commissioner regarding those items in the proposed audit report to which the provider objected and a statement of the reasons therefor.

(A) A copy of the final audit report and notice of any proposed rate adjustment to be made based on such report shall be sent to the provider, within 120 days of issuance, by certified mail, return receipt requested. Such notice of proposed rate adjustment shall provide the provider with 30 days from receipt thereof to make a written request to the commissioner for a hearing on factual and legal issues.

(B) Requests for a hearing made pursuant to this section shall contain a statement of the legal authority and jurisdiction under which the hearing is requested to be held, a reference to relevant sections of statutes and rules, and a short and plain statement of relevant factual issues.

(iii) Upon receipt of a request for a hearing, the commissioner shall order that a hearing be held as soon as practicable and to the extent possible, at a time acceptable to all parties. Unless otherwise agreed by all parties, the hearing shall be scheduled no later than 60 days after receipt by the office of the request for a hearing.

(iv) Conduct of hearings requested pursuant to this section shall be in accordance with the provisions of Part 831 of this Title.

(4) At the commissioner's discretion, adjustments to rates, fees, or fee add-ons determined in accordance with the provisions of this section may be implemented prospectively, or retroactively to the beginning of the rate year or fee period covered by the audit.

(c) Revisions to rates for inpatient rehabilitation programs, revisions to capital and admission review team add-ons for residential rehabilitation services for youth programs, revisions to service operating fees for residential rehabilitation services for youth programs based on changes in certified capacity.

(1) The commissioner may revise or update rates, fees (based on changes in certified capacity), or fee add-ons at his or her own discretion or in response to requests from providers. Such revisions or updates shall be based on:

(i) errors made by the office in the calculation of the rate, determination of the volume fee or calculation of the fee add-ons;

(ii) errors in the financial or statistical data submitted to the commissioner by the provider;
(iii) significant changes in the overall operating costs and/or certified capacity of an eligible inpatient provider resulting from the implementation of substantial changes in programs or services approved for implementation under applicable operating requirements of the office pursuant to this Title, as such may be amended from time to time;

(iv) significant changes in the overall operating costs of an eligible inpatient provider or the eligible residential rehabilitation for service for youth provider resulting from substantial capital projects approved in accordance with the operating requirements of the office pursuant to this Title, as such may be amended from time to time;

(v) Federal or State mandated requirements resulting in approved cost increases;

(vi) additional staffing and non-personal service expenses approved by the commissioner for an eligible inpatient rehabilitation provider; or

(vii) significant changes in a service's certified operating capacity.

(2) Rate revision applications shall be made in writing to the commissioner and shall be sent by registered or certified mail.

(i) The applications shall set forth the basis for the revision and the issues of fact, and must comply with the following requirements:

(A) an application for revision based upon the grounds set forth in paragraph (1) (i) of this subdivision must be accompanied by a detailed statement of the correct financial or statistical data certified in accordance with the requirements of Section 841.5;

(B) an application for revision based upon the grounds set forth in paragraph (1) (i) or (ii) of this subdivision must be submitted within 120 days of receipt of the notice of the rate by provider; and

(C) an application for revision based upon the grounds set forth in paragraph (1) (iii) (vi) of this subdivision must be submitted within 60 days of the close of the rate year or fee period in question.

(3) Actions on appeal applications will be processed without unjustifiable delay.

(4) The burden of proof on appeal shall be on the provider to demonstrate that the rate, fee, or fee add-on requested in the revision application is necessary.

(5) There shall be a formal notification of the final determination of provider's revision request after administrative review. However, at no point in the revision process, shall the provider have a right to an interim report of any determination made by any of the parties to the revision request.

(6) Formal notification shall be sent to the provider by certified mail, return receipt requested, and shall include a statement of the reasons for the final determination. The determination after administrative review shall be final.

(7) A rate, fee, or fee add-on revised pursuant to a revision request shall not be considered final unless and until such request is granted by the office and approved by the State Division of the Budget.

(8) If the office grants the revision to the rate, fee, or fee add-on and the State Division of the Budget does not approve the revision, the provider shall have no further right to administrative review pursuant to this section.

(9) A revision to the rate, fee, or fee add-on determined pursuant to paragraph (1) of this subdivision shall be effective on the date for which the original certified rate, fee, or fee add-on of payment was effective.

841.14 Medical assistance payments for chemical dependence outpatient and opioid treatment programs.

(a) This Section shall govern Medicaid rates of payments for OASAS certified or co-certified ambulatory care services provided in the following categories of facilities:

- (1) chemical dependence outpatient clinics certified or co-certified pursuant to Part 822 of this Title;
- (2) opioid treatment clinics certified or co-certified pursuant to Part 822 of this Title;
- (3) chemical dependence outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title.

(b) Notwithstanding subdivision (a) of this section, the provisions of this Part shall not apply to the following:

- (1) hospital based chemical dependence outpatient clinics;
- (2) hospital based opioid treatment providers; and
- (3) payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program.

(c) Definitions

As used in this Part, the following definitions apply:

(1) “Ambulatory Patient Group (APG)” shall mean a defined group of outpatient procedures or services which reflect similar patient characteristics and resource utilization and which incorporate the ICD-9-CM diagnosis codes and CPT and HCPCS procedure codes as defined below.

(2) “Ancillary services” shall mean those laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment.

(3) “APG weight” shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average utilization for all other

APG's. Procedure-based APG weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a specific procedure. A procedure that has been assigned to its own weight shall have its payment derived from its procedure-specific weight without regard to the weight of the APG to which the procedure groups.

(4) "Base rate" shall mean the numeric value that must be multiplied by the APG weight for a given APG to determine the total Medicaid payment for a service.

(5) "Case mix index" shall mean the actual or estimated average final APG weight for a defined group of APG visits.

(6) "Coding Improvement Factor (CIF)" is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. The CIF will be developed to assure that New York Department of Health is in full compliance with federally approved reimbursement levels.

(7) "Consolidation/Bundling" shall mean the process for determining if a single 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 version 3.1 dated March 6, 2008 and as subsequently amended by 3M.

(8) "Current Procedural Terminology (CPT) Codes" is the systemic listing and coding of procedures and services provided to a patient. It is a subset of the Healthcare Procedure Coding System (HCPCS). The CPT and HCPCS are maintained by the American Medical Association and the Federal Centers for Medicare and Medicaid Services (CMS) and are updated annually.

(9) "Discounting" shall mean the reduction in APG payment that results when unrelated, additional procedures or ancillary services are performed during a single patient visit.

(10) "Episode" shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes cannot be coded on the same claim. The

calculation of the APG payment by the APG software may be either visit based or episode-based depending on the rate code used to access the APG software logic. References to "visits" in this Part shall be deemed to refer also to "episodes" for billing purposes.

(11) "Existing Payment for Blend" shall mean the reimbursement rate/fee in effect on June 30, 2011.

(12) "Final APG weight" shall mean the allowed APG weight for a given visit as expressed by the applicable APG software, and as adjusted by all applicable consolidation, packaging, discounting and other applicable adjustments.

(13) "Healthcare common procedure coding system (HCPCS codes)" shall mean a comprehensive, standardized coding and classification system for health services and products.

(14) "Hospital based" shall mean a program that is operated by and certified as a hospital pursuant to Article 28 of the Public Health Law and identified as such by the Department of Health.

(15) "International Classification of Diseases," means the most current version of this comprehensive coding system maintained by the Federal Centers for Medicare and Medicaid Services maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

(16) "Packaging" shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software.

(17) "Peer Group" shall mean a group of providers that share a common APG base rate. Peer groups may be established based on geographic region, types of services provided or categories of patients.

(18) "The Downstate Region" shall consist of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

(19) "The Upstate Region" shall consist of all counties in the state other than those counties included in the Downstate Region.

(20) "Visit" shall mean a unit of service consisting of all the APG services performed for a patient on a single date of service.

(d) System Transition. There will be a transition to APG reimbursement consisting of a blended payment. For chemical dependence outpatient clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 18 NYCRR 505.27 and the APG reimbursement

established pursuant to this Part. For opioid treatment clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 10 NYCRR 86-4.39 and the APG reimbursement established pursuant to this Part. The blended payment will be calculated as follows:

(1) The office shall identify the existing payment for blend payment for each provider based upon the reimbursement rate/fee in effect on June 30, 2011; and

(2) Payments will be made pursuant to the following transition schedule:

(i) Phase 1 shall be the 12-month period beginning on July 1, 2011.

Providers shall receive 75% of the existing payment for blend payment and 25% of the calculated value of the APG reimbursement established pursuant to this Part;

(ii) Phase 2 shall be the 12-month period following Phase 1. Providers shall receive 50% of the existing payment for blend payment and 50% of the calculated value of the APG reimbursement established pursuant to this Part;

(iii) Phase 3 shall be the 6 month period following Phase 2. Providers shall receive 25% of the existing payment for blend payment and 75% of the calculated value of the APG reimbursement established pursuant to this Part;

(iv) Phase 4 providers will receive 100% APG reimbursement established pursuant to this Part.

(e) APG Categories and associated weights.

(1) APG categories shall be subject to periodic revision; the most current listing shall be published in the “APG Policy and Medicaid Billing Guidance” manual available on the OASAS website.

(2) The Department of Health, in consultation with the office, shall assign weights associated with all CPT and HCPCS procedure codes which can be used to bill any APG category. The assigned weights shall be set forth at 10 NYCRR Part 86. The office shall maintain and update a list of weights associated with APG categories as published in the “APG Policy and Medicaid Billing Guidance” manual on the OASAS website. Such list may include APG categories not specifically associated with chemical dependency outpatient and opioid treatment services, but which may appropriately be billed by providers subject to this Part.

(f) Base Rates. Base rates for chemical dependence 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 as defined in section 841.14 of this Part. Base rates shall reflect differing regional cost factors, variations in patient population and service delivery, and capital reimbursement;

(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.

(g) System Updating.

(1) The following elements of the APG rate-setting system shall be reviewed at least annually, with all changes posted on the office's website:

(i) The listing of reimbursable APG categories and associated weights assigned to each such APG set forth in this Part;

(ii) The base rates;

(iii) The applicable ICD-9 codes, or subsequent ICD categorization, utilized in the APG software system;

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

(v) The APG software system.

(h) Medicaid claims.

Medicaid claims may be submitted for claims made under Medicaid fee-for-service for no more than two different services per day for any patient, not including complex care coordination, medication administration and observation, medication management and peer support services.

(i) Billing services.

Billing services include:

(1) Admission assessment services. Admission assessment services consist of three levels of billable services: brief assessment, normative assessment and extended assessment. No more than one admission assessment visit may be billed for any patient per day. No more than three admission assessment visits may be billed for any patient within an episode of care. No single program may bill for more than one extended assessment, under any circumstances, within an episode of care.

(i) Brief assessment – The program must document at least 15 minutes of face-to-face contact with the patient.

(ii) Normative assessment - The program must document at least 30 minutes of face-to-face contact with the patient.

(iii) Extended assessment - The program must document at least 75 minutes of face-to-face contact with the patient.

(2) Brief intervention. No more than one brief intervention may be billed for any patient per day. No single program may bill more than three pre-admission brief intervention services for any patient within an episode of care. The program must document at least 15 minutes of face-to-face contact with the patient.

(3) Brief treatment. No more than one brief treatment may be billed for any patient per day. The program must document at least 15 minutes of face-to-face contact with the patient.

(4) Collateral visit. No more than one collateral visit may be billed for any patient per day. No more than five collateral visits may be billed for any patient within an episode of care. The program must document at least 30 minutes of face-to-face contact with the collateral person. A collateral visit may occur at any time during an episode of care.

(5) Complex care coordination. No more than one complex care service may be billed for any patient per day. No more than three complex care services may be billed for any patient within an episode of care, unless clinical staff document in the treatment/recovery plan that additional complex care services are clinically necessary and appropriate. The program must document at least 45 minutes of services. Service time need not be consecutive. This service must occur within five working days of another program visit that includes a billable service.

(6) Group counseling. No more than one group counseling service may be billed for any patient per day. The program must document at least 60 minutes of face-to-face contact with the patient.

(7) Individual counseling. No more than one individual counseling service may be billed for any patient per day. Individual counseling consists of two billable levels of service: brief individual counseling and normative individual counseling.

(i) Brief individual counseling – The program must document at least 25 minutes of face-to-face contact with the patient.

(ii) Normative individual counseling - The program must document at least 45 minutes of face-to-face contact with the patient.

(8) Intensive outpatient services (IOS). No more than six weeks of IOS may be billed for any patient. However, additional IOS may be provided, if during the final week of scheduled IOS, clinical staff document in the treatment/recovery plan that additional IOS are clinically necessary and appropriate. The program must document a minimum of nine scheduled service hours per week to be provided in increments of at least three hours per day. Where a patient fails to receive a full daily increment of services, a program may bill for delivery of any services defined in Part 822 of this Title.

(9) Medication administration and observation. No more than one medication administration and observation service may be billed for any patient per day. This service may be of any duration. The program must document face-to-face contact with the patient.

(10) Medication management. Medication management consists of three levels of billable services: routine medication management, complex medication management and addiction medication induction. No more than one medication management service may be billed for any patient per day.

(i) Routine medication management -- The program must document at least 10 minutes of services including face-to-face contact with the patient and patient observation.

(ii) Complex medication management – The program must document at least 15 minutes of services including face-to-face contact with the patient and patient observation.

(iii) Addiction Medication Induction – The program must document at least 30 minutes of services including face-to-face contact with the patient and patient observation.

(11) Outpatient rehabilitation services. No more than one outpatient rehabilitation service may be billed for any patient per day. Programs that provide outpatient rehabilitation services may also bill for medication administration and observation, medication management, complex care coordination, peer support services and collateral visits consistent with the standards set forth in this subdivision. Programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service. Outpatient rehabilitation services consist of two billable levels of service: 2-4 hour duration and 4 hour and above duration.

(i) 2-4 hour duration – The program must document at least 2 hours of services but less than 4 hour hours of services.

(ii) 4 hour and above duration -- The program must document at least 4 hours of services.

(12) Peer support service – No more than one peer support service may be billed for any patient per day. No more than five peer support services may be billed for any patient within an episode of care, unless clinical staff document in the treatment/recovery plan that additional peer support services are clinically necessary and appropriate. The program must document at least 30 minutes of face-to-face contact with a patient.

(13) Screening. No more than one screening may be billed for any patient within an episode of care. The program must document at least 15 minutes of face-to-face contact with the patient.

(j) All standards of Medical Assistance reimbursement applicable to chemical dependence outpatient and opioid treatment programs shall be contingent on approval of the state plan amendment

associated with reimbursement of such programs as clinics pursuant to the ambulatory patient group fee methodology and Federal financial participation.

841.15 Capital costs.

- (a) This section shall apply only to those programs with Medicaid reimbursement calculated pursuant to Section 841.10 of this Title or Section 841.12 of this Title.
- (b) Allowable capital costs may include:
 - (1) the costs of owning or leasing real property;
 - (2) the costs of owning or leasing moveable equipment and personal property; and
 - (3) the cost of up to three months of pre-operational program start-up expenses, and associated interest, for new services, programs, or facilities for which initial reimbursement levels are being established. Pre-operational start-up costs may include, but are not limited to, rent, employee compensation, utilities, staff training and travel, and expensed equipment.
- (c) No capital or start-up expenditures for which approval by the office is required in accordance with the operating requirements of the office pursuant to this Title, as such may be amended from time to time, shall be included in allowable capital costs for purposes of computation of provider reimbursement unless such approval shall have been secured. For projects requiring approval by the office, reimbursement for capital costs shall be limited to the amount approved by the commissioner.
- (d) To be considered allowable for reimbursement capital and start-up costs must be both reasonable and necessary, incurred by the provider and chargeable to necessary patient care.
- (e) Capital costs incurred after the effective date of this section will not be considered allowable for reimbursement without the prior approval of the office. Capital costs incurred prior to the effective date of this section will be reimbursed only if they are determined by the office to be both reasonable and necessary for delivering services as required under applicable regulations of the office.
- (f) Allowable capital costs shall be determined in accordance with the following:
 - (1) 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 HIM 15, published by the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services.
 - (2) Where specific rules stated herein or in HIM 15 are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

(g) Unless specifically otherwise provided for 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.

(h) Depreciation shall be based upon the historical cost and useful life of buildings, fixed equipment and/or capital improvements.

(1) Historical cost shall be determined as follows:

(i) The historical cost of any real property which is transferred, purchased, altered, constructed, rehabilitated and/or renovated shall be equal to the amount approved by the office. In deciding whether to approve any such cost, the office shall consider whether the provider's reimbursement as a whole for the services in question, including the cost of purchase, transfer, construction, alteration, rehabilitation and/or renovation to be approved, would result in payment which is consistent with efficiency and economy. In no event shall the office approve an historical cost which exceeds the lesser of fair market value or the provider's actual costs.

(ii) The historical cost of any real property which is transferred or purchased from a party related to the provider is the lesser of fair market value or the acquisition cost of the real property to the transferor or seller.

(iii) Depreciation associated with that portion of the real property financed by capital grants obtained from the office or any other New York State agency is not includable for rate setting purposes. Where the previous owner of real property had the costs of such property funded, in whole or in part, by the State of New York, the historical cost of the property shall be the lesser of the acquisition cost of the property to the new owner, the seller's net book value, or the fair market value.

(iv) Where any real property for which previous Medicaid payment has been made is transferred by sale, purchase, acquisition or merger (other than as a result of a receivership under New York Mental Hygiene Law, section 19.41), the costs (including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies) attributable to the negotiation or settlement of sale or purchase are not allowable.

(v) Allowable costs for real property will be limited to the amount the provider of services could have been reimbursed if the provider of services had legal title to the property.

(vi) The historical cost of any alteration, construction, rehabilitation and/or renovation by a party related to the provider is the lesser of the fair market value of such alteration, construction, rehabilitation or renovation; or the related party's cost of the alteration, construction, rehabilitation or renovation.

(vii) If the previous owner is a related party to the provider purchasing the property, any amount previously paid by the State to the previous owner as depreciation or as rent in lieu of depreciation on the property shall be counted as paid depreciation and as funding for the costs of such property to the provider purchasing the property.

(viii) If the seller or transferor of the real property to the provider is not a party related to the provider, but any prior owner of the property in question is a party related to the provider, and the sale or transfer from the prior related party occurs within five years of the sale or transfer to the provider, the transaction shall be deemed to be between the provider and the prior owner related to the provider.

(ix) If the office cannot determine the historical cost of real property, the office shall use an appraisal value as the basis for depreciation. The appraisal value shall be based upon an appraisal which is done by the office or by an appraiser approved by the office, which uses an appraisal methodology which is generally accepted within the profession and which is factually correct in all significant matters.

(x) The commissioner may allow an alternative historical cost of ownership of real property obtained from a related party. The commissioner may allow such alternative historical cost if the following conditions are met:

(A) the provider demonstrates that allowing such alternative historical cost would make property available to providers which would not otherwise be available;

(B) such alternative historical cost is substantially less than the cost which would be allowed under this subdivision for property which is obtained from an unrelated party and which is similar function and value to the office and to the provider;

(C) the seller or transferor has owned the property in question for at least five years; and

(D) the fair market value of such property is greater than the sale price.

(2) Useful life of depreciable assets shall be determined as follows:

(i) Unless specifically otherwise provided for in this Part, the useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the most current edition of the "Estimated Useful Lives of Depreciable Hospital Assets" published by the American Hospital Association. This document is available from the American Hospital Association, 840 Lake Shore Drive, Chicago, Illinois 60611.

(ii) For construction or acquisition of a new residential service, program, or facility, which was first issued an operating certificate on or after January 1, 2006, the estimated useful life of the building for purposes of determining depreciation reimbursement shall be the greater of the term of the mortgage or 15 years.

(iii) A provider may use a different useful life or amortization period if such different useful life is approved by the office. The office shall base such approval upon historical experience, documentary evidence, loan agreements and need for the services for which the depreciable assets are used.

(3) A provider shall use the straight-line method of depreciation.

(4) Reasonable and necessary interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the commissioner and incurred for authorized purposes, and the principal of the debt does not exceed that which is either approved by the commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or non-movable equipment, a note payable secured by the non-movable equipment of a facility, or a capital lease;

(ii) incurred and approved for the purpose of financing the acquisition, construction or renovation of land, building, non-movable equipment, or related costs;

(iii) incurred for the purpose of financing approved moveable equipment or approved personal property;

(iv) incurred and approved for the purpose of advance refunding of debt; or

(v) found by the commissioner to be reasonable, necessary and in the public interest.

(vi) For interest on capital indebtedness to be considered an allowable cost:

(A) The interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay at the time the loan was made.

(B) The loan agreement shall be between the provider and a party not related to the provider.

The commissioner may waive this provision based on a demonstration of need for the services and cost savings resulting from the transaction.

(C) The capital indebtedness shall represent no more than the current approved value of the property after subtracting any equity contributions such as, but not limited to, grants applied to the property.

(D) Interest resulting from the refinancing of indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the approved indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of approved indebtedness may be allowable on acceptable demonstration to the commissioner that such refinancing will result in a debt service savings over the life of the indebtedness. In no case shall interest resulting from the refinancing of indebtedness be

an approvable cost unless it has the prior approval of the commissioner. Approved losses resulting from the advance refunding of debt shall be treated and reported as deferred charge. This deferred charge is to be amortized on a straight line basis from the time of the refinancing to the scheduled maturity date of the refunding debt.

(5) Interest expense resulting from the inclusion of the reasonable closing costs, such as, but not limited to, attorneys' fees, recording costs and points, is allowable for initial financing and start-up costs, and in the refinancing of the capital indebtedness.

(6) Interest on current working capital shall be treated and reported as an administrative operating expense and as such is not considered an allowable capital cost. Working capital interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, deferred compensation funds, secure investments and gifts, grants or endowments, whether restricted or unrestricted.

(i) Costs related to Dormitory Authority loans shall be allowable as follows:

(1) 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 the requirements and conditions of 841.14(h). 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.

(2) 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.

(3) 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 subdivision (i) of this section.

(4) Interest payment on Dormitory Authority loans pursuant to the provisions of this subdivision 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.

(5) The office may recoup, in full or in part, the interest and fee reimbursement for Dormitory Authority 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 Dormitory Authority

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.

(j) Costs of ownership of moveable equipment and personal property shall be allowable in the amount of depreciation and interest if the purchase is made through a multiple bid process. Depreciation shall be based upon the historical cost and useful life.

(1) If the equipment or personal property is purchased from a party not related to the provider, the historical cost shall be the lesser of the actual cost of purchasing the equipment or personal property or the fair market value of such equipment or personal property.

(2) If the equipment or personal property is purchased from a party related to the provider, the historical cost shall be the lesser of actual acquisition cost, fair market value; or the seller's cost.

(3) The useful life is the higher of the reported useful life or the useful life as reported in the most current edition of the "Estimated Useful Lives of Depreciable Hospital Assets" published by the American Hospital Association. A provider may use a different useful life if such different useful life is approved by the office. The office shall base such approval upon historical experience and documentary evidence.

(4) The provider shall use the straight-line depreciation method for moveable equipment and personal property.

(5) Costs of leasing moveable equipment and personal property shall be allowable as follows:

(i) If lease payments are made to a party which is not a related party, allowable costs shall be the lesser of the actual lease payments or the fair market rental.

(ii) If lease payments are made to a related party, allowable costs shall be the lesser of:

(A) the actual lease payments;

(B) the fair market rental; or

(C) the allowable depreciation, plus associated interest expense, if any, and other related expenses, including, but not limited to, maintenance costs.

(k) 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. Interest costs associated with approved start-up shall be reimbursed in accordance with this section, subject to the constraints outlined herein.

(l) Costs relating to leases for real property are subject to the following conditions:

(1) In order for lease costs to be allowable, the provider must submit the lease to the office for approval. In deciding whether to approve a lease, the office shall consider whether the lease is in the

best interest of the programs and the persons it serves and whether the lease in any way violates public policy. In deciding whether to approve an amount for rent, the office shall consider whether the provider's fee or rate, as a whole, including the amount of rent to be approved, would result in payment which is consistent with efficiency and economy.

(2) If an approved lease is between the provider and a party which is not a related party, allowable lease costs shall be the lesser of contract rent or fair market rental. If an approved lease is between the provider and a related party, allowable lease costs shall be the least of the contract rent; fair market rental; or the landlord's net cost.

(3) The office may waive the limitations on allowable costs upon a showing that the limitations would jeopardize the operation of the programs or services, this provision notwithstanding the requirements and conditions of paragraph 841.14(m)(1).

(4) The office may, upon application from a provider, allow lease costs in an amount equal to contract rent and greater than fair market rent if the provider has shown that it has made diligent efforts to negotiate a lease renewal for fair market rent or less, that the contract rent is necessary to ensure the continued operation of the program, and that the parties to the lease are not related. The commissioner will allow such lease costs only for as long as it is necessary for the provider to relocate the program or services located on the lease property.

(5) Contract rent incurred pursuant to an approved lease or approved proprietary lease which is renewed pursuant to an option to renew within the approved lease is allowable.

(6) Costs incurred pursuant to an approved lease or approved proprietary lease which is renewed other than pursuant to an option to shall be allowable as determined in accordance with this section. The office shall decide whether to approve any such renewal at least 30 days before the last day the lease may be renewed, if the provider has notified the office.

(7) The provider shall submit to the office a request for approval of lease renewals at least 120 days prior to the last date for renewing the lease.

841.16 Related party transactions.

(a) The determination as to whether two parties are related will be made by the office on a case-by-case basis. Such determination shall be based on the facts, circumstances, and history of the situation.

(b) Relatedness will be determined based on association, affiliation, control, common ownership, or an immediate family relationship.

(c) Two parties shall be deemed related if one party is, to a significant extent, associated or affiliated with, or has control of or is controlled by, the other party. Association and affiliation shall

include, but is not limited to, both business partnerships and familial relationships. Control shall exist where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of another organization or institution.

(d) Common ownership shall exist when an individual or individuals possess significant ownership or equity in both parties.

(e) The existence of an immediate family relationship shall create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests outlined in subdivisions (d) and (e) above are met. The following persons are considered immediate family:

(1) husband and wife;

(2) natural parent and child;

(3) siblings;

(4) adopted child and adopted parent;

(5) step parent, step child, step sister, and step brother; father in law, mother- in law, sister in law, brother in law, son in law, and daughter in law; and

(6) grandparent and grandchild.

(f) The commissioner will determine whether two parties are related. A provider may provide information to the commissioner to assist in making this determination, however the commissioner's determination will be final.

(g) The existence of any of the conditions in (1) through (5) of this subdivision will create a presumption that a transaction is between a provider and a related party. This list should not be considered to be all inclusive:

(1) The provider is a partnership and the other party to the transaction is a partner of the provider.

(2) The provider is a corporation or a limited liability company and the other party to the transaction is an officer, director, trustee, principal stockholder or controlling party of the provider.

(3) The provider is a corporation or a limited liability company and the other party to the transaction is a corporation, or limited liability company where someone is an officer, director, trustee, principal stockholder or controlling party of both corporations.

(4) The provider is a natural person and the other party to the transaction is either:

(i) a member of the provider's immediate family;

(ii) a partnership in which the provider is a partner;

(iii) a co-partner;

(iv) a corporation or a limited liability company in which the provider is an officer, director, trustee, principal stockholder or controlling party;

(v) a corporation or a limited liability company in which a member of the provider's immediate family is an officer, director, trustee, principal stockholder or controlling party a corporation in which any partnership in which the provider is a partner is a principal stockholder;

(vi) a corporation or a limited liability company in which a co-partner of the provider is an officer, director, trustee, principal stockholder or controlling party; or

(vii) a corporation or a limited liability company in which another corporation is a principal stockholder, where the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

(5) The provider is an unincorporated association and the other party to the transaction is either:

(i) someone who is a member of the provider;

(ii) someone, a member of whose immediate family is a member of the provider;

(iii) a partnership in which one partner is a member of the provider;

(iv) a corporation or a limited liability corporation in which a member of the provider is an officer, director, trustee, principal stockholder or controlling party;

(v) a corporation or a limited liability corporation in which a member of the provider has an immediate family member who is an officer, director, trustee, principal stockholder or controlling party;

(vi) a corporation or a limited liability corporation partnership, in which a member of the provider is a partner or a principal stockholder;

(vii) a corporation or a limited liability corporation in which a co-partner of a member of the provider is an officer, director, trustee, principal stockholder or controlling party; or

(viii) a corporation or a limited liability corporation in which another corporation is principal stockholder, where a member of the provider is an officer, director, trustee, principal stockholder or a controlling party of such other corporation.

841.17 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.