Hospital Out of State APG Rates

Peer Group	Rate	Rate Code	07/01/09	10/01/09	12/01/09	01/01/10	07/01/10	10/01/10	01/01/11	04/01/11	07/01/11	01/01/12	05/01/12	04/01/22**	04/01/23***
DOWNSTATE RATES:															
Amb Surg	Base	1416	$156.91	$156.91	$156.91	$228.00	$215.50	$215.50	$197.29	$197.29	$195.59	$195.59	$195.59	$197.55	$210.39
Amb Surg	Capital	1418	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70	$115.70
Clinic*	Base	1413	$258.90	$258.90	$274.23	$304.39	$325.95	$313.50	$240.17	$224.47	$231.93	$199.89	$183.53	$185.37	$197.42
Clinic*	Blend	1414	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$0.00	$0.00	$0.00	$0.00
Clinic*	Capital	1415	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13
Clinic Episode*	Base	1441		$258.90	$274.23	$304.39	$325.95	$313.50	$240.17	$224.47	$231.93	$199.89	$183.53	$185.37	$197.42
Clinic Episode*	Blend	1442		$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$129.67	$0.00	$0.00	$0.00	$0.00
Clinic Episode*	Capital	1443		$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13
Clinic MR/DD/TBI*	Base	1501					$391.14	$376.20	$288.20	$269.36	$278.32	$239.87	$220.23	$222.43	$236.89
Clinic MR/DD/TBI*	Blend	1502					$129.67	$129.67	$129.67	$129.67	$129.67	$0.00	$0.00	$0.00	$0.00
Clinic MR/DD/TBI*	Capital	1503					$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13
Clinic MR/DD/TBI Episode*	Base	1489					$391.14	$376.20	$288.20	$269.36	$278.32	$239.87	$220.23	$222.43	$236.89
Clinic MR/DD/TBI Episode*	Blend	1490					$129.67	$129.67	$129.67	$129.67	$129.67	$0.00	$0.00	$0.00	$0.00
Clinic MR/DD/TBI Episode*	Capital	1491					$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13	$18.13
Emergency Department	Base	1419	$175.11	$175.11	$175.11	$196.94	$184.98	$184.98	$184.98	$193.41	$197.38	$197.38	$197.38	$199.35	$212.31
Emergency Department	Capital	1421	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61	$22.61
UPSTATE RATES:															
Amb Surg Out of State	Base	1416	$122.55	$122.55	$122.55	$176.13	$166.47	$166.47	$152.41	$152.41	$151.09	$151.09	$151.09	$152.60	$162.52
Amb Surg Out of State	Capital	1418	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48	$108.48
Clinic*	Base	1413	$199.00	$199.00	$210.79	$233.97	$249.56	$240.98	$184.61	$172.54	$178.28	$153.65	$140.52	$141.93	$151.16
Clinic*	Blend	1414	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$0.00	$0.00	$0.00	$0.00
Clinic*	Capital	1415	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16
Clinic Episode*	Base	1441		$199.00	$210.79	$233.97	$249.56	$240.98	$184.61	$172.54	$178.28	$153.65	$140.52	$141.93	$151.16
Clinic Episode*	Blend	1442		$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$92.61	$0.00	$0.00	$0.00	$0.00
Clinic Episode*	Capital	1443		$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16
Clinic MR/DD/TBI*	Base	1501					$299.47	$289.17	$221.53	$207.05	$213.94	$184.38	$168.63	$170.32	$181.39
Clinic MR/DD/TBI*	Blend	1502					$92.61	$92.61	$92.61	$92.61	$92.61	$0.00	$0.00	$0.00	$0.00
Clinic MR/DD/TBI*	Capital	1503					$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16
Clinic MR/DD/TBI Episode*	Base	1489					$299.47	$289.17	$221.53	$207.05	$213.94	$184.38	$168.63	$170.32	$181.39
Clinic MR/DD/TBI Episode*	Blend	1490					$92.61	$92.61	$92.61	$92.61	$92.61	$0.00	$0.00	$0.00	$0.00
Clinic MR/DD/TBI Episode*	Capital	1491					$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16	$12.16
Emergency Department	Base	1419	$135.27	$135.27	$135.27	$153.81	$144.47	$144.47	$144.47	$151.05	$154.15	$154.15	$154.15	$155.69	$165.81
Emergency Department	Capital	1421	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84	$13.84

For Clinic (effective 7/1/2009 & 10/1/2009) & MR/DD/TBI (effective 7/1/2010), please note that their rate codes and effective dates differ.

The Blend (Existing Rate for Blend) rates were set to $0 effective 1/1/2012 as the APG payment now reflects 100% of the Base rate.

*****Effective April 1, 2022 the Medicaid Ambulatory Patient Group (APG) base rates have been increased by 1% in accordance with the State Fiscal Year 2022/2023 Budget.***

*****Effective April 1, 2023 the Medicaid Ambulatory Patient Group (APG) base rates have been increased by 6.5% in accordance with the State Fiscal Year 2023/2024 Budget.***

Rates not available during this time period.

OUT OF STATE HOSPITAL APG RATES

Out of state providers located in counties contiguous to the NYS downstate rate region will receive the downstate base rates. Counties contiguous to the NYS downstate rate region include: Sussex, Passaic, Bergin, Hudson, Essex, Middlesex, Union and Monmouth Counties in New Jersey; Pike County in Pennsylvania; and Litchfield and Fairfield Counties in Connecticut. All other out of state providers will receive the NYS upstate rate.

Under the new ancillary policy NYS Medicaid intends to pay for stand alone ancillaries as part of the APG reimbursement. This means that all ancillaries associated with hospital clinic and emergency department visits billed under the Ambulatory Patient Group (APG) payment methodology must be included on the APG claim. In cases where the ancillary is performed by a vendor, rather than by the APG biller, the outside vendor may not bill NYS Medicaid directly, but rather must receive payment from the APG biller. Certain ancillaries are exempt from this policy and may be billed directly to NYS Medicaid by ancillary vendors (see the APG section of the DOH website for details). Additionally, an ancillary vendor may, when applicable and appropriate, bill Medicaid for the professional component of radiology services. Ancillary services associated with ambulatory surgery services billed under rate code 1416 are exempt from this policy.

To facilitate this process, DOH has instituted a new billing option for out of state providers effective October 1, 2009. This option is known as “episode payment.” To obtain payment for “stand alone” ancillaries APG billers (e.g., hospital clinics) must do one of two things:

a. If the recipient is dually eligible for Medicare and Medicaid, use rate code 1413 (non-episode payment) and “reassign” the actual date of service for the ancillary to the same date of service of the medical visit or procedure (so the ancillary will not be viewed by the payment system as a “stand alone”).

or

b. If the recipient is NOT dually eligible for Medicare and Medicaid, use rate code 1441 (episode payment) and code all ancillaries using their actual dates of service. Under episode payment all procedures coded on a claim, regardless of the coded dates of service, are viewed by the payment system logic as being part of the same visit. Therefore the concept of “stand alone” ancillaries does not apply so long as at least one medical visit or procedure is coded on the claim. The advantage of episode payment is that all procedures on the episode claim can be coded with their actual dates of service, rather than requiring reassigned dates of service as is necessary under non-episode payment.