NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 28, 2012

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #12-18
Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-18 to the Title XIX (Medicaid) State Plan for institutional services to be effective September 1, 2012 (Appendix I). This amendment is being submitted based on promulgated regulations. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by 42 CFR §447.272(a).

A copy of the pertinent State regulation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on August 29, 2012, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **12-18**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **September 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR § 447.272(a)**	7. FEDERAL BUDGET IMPACT: a. FFY **09/01/12-09/30/12 ($31,250)** b. FFY **10/01/12-09/30/13 ($375,000)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, Part III: Page 3**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, Part III: Page 3**

10. SUBJECT OF AMENDMENT:
Revisions to OMH 2011-12 Residential Treatment Facilities (RTF) Drug Carve Out (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: September 28, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Amended SPA Pages

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of 98 percent and a minimum utilization of 95 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

Effective July 1, 2011 through June 30, 2012, the rate of payment shall be that which was in effect June 30, 2011.

Effective [July] September 1, 2012, such rate of payment will be lowered to reflect the removal of pharmaceutical costs, except as provided for in Section 1, below.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the Office of Mental Health, and will exclude eligible pharmaceuticals which will be reimbursed using the Fee-for-Service Program through the Medicaid formulary administered by the New York State Department of Health. Notwithstanding this program change, for those children who are deemed eligible for Medicaid subsequent to admission, and the eligibility is retroactive to date of admission, and who have received clinically documented necessary medications during the entire first 90 days of their stay, the pharmacy will bill the Medicaid formulary for the medications provided to the child beginning on day 91 of the stay. The cost of medications provided to the Medicaid eligible child during the first 90 days of stay will be the responsibility of the RTF and considered an allowable cost in the development of the provider's reimbursement rate for inpatient stays. In determining the allowability of costs, the Office of Mental Health reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

(i) Clinical Care. This category of costs includes salaries and fringe benefits for clinical staff.

(ii) Other than Clinical Care. This category of costs includes the costs associated with administration, maintenance and child support.

Allowable per diem operating costs in the category of clinical care are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. Clinical services such as dental services, purchased on a contractual basis will be considered allowable and not subject to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

Appendix II
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Summary

SUMMARY
SPA #12-18

This State Plan Amendment proposes to revise the effective date, from July 1, 2012 to September 1, 2012, to carve out the cost of eligible pharmaceuticals from the per diem reimbursement rate for Residential Treatment Facilities (RTFs) for children and youth licensed by the Office of Mental Health.

Appendix III
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Authorizing Provisions

the number and types of advisers that could be utilized by the Fund; (3) creates an inherent conflict between federal and state law that would make it impossible to do business with the Fund while complying with both; and (4) adds duplicative regulation in an area already substantially regulated at the state level and that is primed for further federal regulation through the imminent imposition of a federal pay-to-play regime on all registered broker-dealers acting as placement agents. In addition, SIFMA provided language that it believes would be consistent with the existing federal requirements on the use of placement agents. SIFMA requested that the Department either exclude from the proposed rule those placement agents who are registered as broker-dealers under the Securities Exchange Act of 1934 or delay the enactment of the proposed rule until the federal and state placement agent initiatives are finalized.

The Department does not have jurisdiction over placement agents, which makes it difficult to implement and enforce requirements on them. The Superintendent did consider other ways to limit the influence of placement agents, including a partial ban, increased disclosure requirements, and adopting alternative definitions of placement agent or intermediary. The Department considered limiting the ban to include intent on the part of the party using placement agents, or defining "placement agent" in more general terms. At the time, the Superintendent concluded that only an immediate, total ban on the use of placement agents could provide sufficient protection of the Fund's members and beneficiaries and safeguard the integrity of the Fund's investments.

The Department met with representatives from SIFMA on June 28th to gain further understanding of some of the issues raised in opposition to the proposed rule. We subsequently requested additional information from SIFMA. SIFMA provided the Department with additional information based upon actions taken and/or contemplated by pension fund regulators in other States. The Department will continue to assess the comments that have been received and any other information that may be submitted.

The Department is also evaluating the extent to which its proposed rule conforms with the Securities and Exchange Commission's "Pay-To-Play" regulation for financial advisors that was issued on July 1, 2010. This regulation is effective on September 13, 2010, with full compliance by March 14, 2011 for all affected investment advisers.

We are continuing to research best practices in use with large U.S. public pension funds before any further action will be taken with regards to the proposed rule. A number of policies/practices being researched include limits on the amount of business that may be placed through any single placement agent, and the feasibility of monetary penalties for investment managers/advisors who seek to circumvent procedures that are established to mitigate the risk of undue influence by politically connected persons.

Office of Mental Health

NOTICE OF ADOPTION

Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth

I.D. No. OMH-45-10-00006-A
Filing No. 57
Filing Date: 2011-01-12
Effective Date: 2011-02-02

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 578 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Subject: Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth.

Purpose: To carve out the cost of eligible pharmaceuticals from the per diem reimbursement rate for Residential Treatment Facilities.

Text or summary was published in the November 10, 2010 issue of the Register, I.D. No. OMH-45-10-00006-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Standards Pertaining to Payment for Hospitals Licensed by the Office of Mental Health

I.D. No. OMH-46-10-00017-A
Filing No. 58
Filing Date: 2011-01-13
Effective Date: 2011-02-02

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 574 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04 and 43.02; Social Services Law, sections 364 and 364-a

Subject: Standards Pertaining to Payment for Hospitals Licensed by the Office of Mental Health.

Purpose: Make minor technical corrections to existing regulation and use "person-first" language.

Text or summary was published in the November 17, 2010 issue of the Register, I.D. No. OMH-46-10-00017-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Office of Parks, Recreation and Historic Preservation

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Navigation of Vessels, Conduct of Regattas and Placement of Navigation Aids and Floating Objects on Navigable Waters

I.D. No. PKR-05-11-00001-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: This is a consensus rule making to repeal Appendix I-1 and Part 445; add new Part 445; and amend sections 377.1, 447.2, 447.3 and Part 448 of Title 9 NYCRR.

Statutory authority: Parks, Recreation and Historic Preservation Law, section 3.09(8); Navigation Law, sections 34, 34-a, 35, 35-a, 35-b, 36, 37, 41, 41(b), 43, 43(3), 45 and 46-aaaa

Subject: Navigation of vessels, conduct of regattas and placement of navigation aids and floating objects on navigable waters.

Purpose: To update obsolete state navigation rules or conform them to the U.S. Coast Guard Inland Navigation Rules.

Substance of proposed rule (Full text is posted at the following State website:www.nysparks.com): The Office of Parks, Recreation and Historic Preservation (OPRHP) is amending Title 9 NYCRR to update rules that address activities of its Bureau of Marine Services as follows:

Section 377.1(j) Regulated activities.

This section that pertains to the operation of vessels on Cuba Lake in Allegany County is repealed since the Office of Parks, Recreation and Historic Preservation (State Parks) no longer has jurisdiction over this Lake. The remaining subdivisions in this section are renumbered.

of transfer to existing child performer trust accounts. All documents related to this rule must be available for inspection by the Department, school attendance officers, the state education department or local school district, and the Comptroller.

The employer must notify the Department of its employment of the child performer in writing at least five business days prior to the start of the employment. The employer must report the name, address, and last four digits of the social security number of each child performer being employed, a description of each child performer's intended performance, the dates, location(s) and duration of such intended performance, and the name and contact information of the employer's representative who will be at the scene of the performance. Additionally, the employer must notify the Department of any additions, deletions, or other modifications to the information reported in such a notice within twenty-four hours of the change.

The rule also requires employers to provide a teacher for any child performer who is unable to fulfill his or her regular educational requirements due to work. The teacher must be available on any day the child performer is employed that his or her regular school is in session. The teacher must be certified or have credentials recognized by the child performer's state or nation of residence. Therefore, employers may be required to engage the services of professional educators to comply with this rule.

The rule also requires employers to provide a nurse for any child performer less than six (6) months of age. Child performers between the age of fifteen (15) days and six (6) weeks of age must have a nurse provided for each three (3) or few babies. Child performers between the six (6) weeks of age and to six (6) months of age must have a nurse provided for each ten (10) or few infants.

3. Costs:

Employers who are covered by this rule shall enter into contracts with professional educators and nurses in order to comply with this rule. The cost for individual employers will depend upon the number of hours their child performers are employed and the age of the child performers. Nurses are only required for child performers who are less than six (6) months of age. Employers may also be required to hire an additional staff to function as a responsible person, who will be present to represent the best interests of the child. Such responsible person may be a parent or guardian, however; so the cost of such staffing will be dependent on the extent to which the employer utilizes the availability of parents or guardians, as well as on the extent to which the employer utilizes child performers.

Other than staffing needs, costs associated with the rule will be administrative. Employers must prepare applications and notices, as well as regular transfers of a percentage of the child performer's gross income to a trust account. The fee to employers for an Employer Certificate of Eligibility shall be $350.00 for the initial Certificate and $200.00 for each renewal (such Certificates being valid for a period of three years), except that the fee to employers operating theaters containing fewer than 500 seats shall be $200.00 for the initial Certificate and $200.00 for each renewal. It is not anticipated that any child performer employer would have to retain additional outside professional services to prepare these documents and financial transfers, although most, if not all, likely retain accountants and other staff to manage payroll and financial transfers for other performers.

Legal services may be required to negotiate, draft or review contracts with individuals providing teaching services or acting as the responsible person. It is anticipated that a vast majority of child performer employers in the State already have procurement or legal staff who regularly work on such contracts.

The cost to comply with this rule is minimal for child performers and their parent or guardian. There is no cost to apply for or renew a Child Performer Permit. There may be minimal costs incurred in obtaining a physician's statement that the child performer is physically fit.

4. Minimizing adverse impact:

This rule is necessary to implement Labor Law § 154-a. This enabling legislation requires the promulgation of regulations to determine the hours and conditions of work necessary to safeguard the health, education, morals and general welfare of child performers. As discussed in the other SAPA documents related to this rule making, the Department included recommendations within the proposal to minimize adverse impact without jeopardizing the physical or mental health, education or general welfare of the children involved.

5. Rural area participation:

The Department sought input on these regulations from various employee representative groups which represent rural area employees. Additionally, the Department received input from various employer representative groups which also represent rural area employers.

Job Impact Statement

The rule will facilitate the orderly employment of child performers in New York by codifying procedures and policies that have applied to child performers for a number of years and further providing for the protection of child performers and assurances that the child performers will receive the education which is mandated under state law. This should increase the availability of child performers for the arts, entertainment, and advertising industries and bring more of this work to New York. It is apparent from the nature and purpose of the rule that it will not have a substantial adverse impact on jobs or employment opportunities, therefore no Job Impact Analysis is required.

Office of Mental Health

NOTICE OF ADOPTION

Correction of an Inaccurate State Agency Name

I.D. No. OMH-35-10-00023-A
Filing No. 1100
Filing Date: 2010-10-25
Effective Date: 2010-11-10

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 505 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 7.09

Subject: Correction of an inaccurate State agency name.

Purpose: To update the name of the Commission on Quality of Care and Advocacy for Persons with Disabilities within existing regulation.

Text or summary was published in the September 1, 2010 issue of the Register, I.D. No. OMH-35-10-00023-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Correction of an Inaccurate Address in Existing Regulation

I.D. No. OMH-35-10-00024-A
Filing No. 1101
Filing Date: 2010-10-25
Effective Date: 2010-11-10

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 510 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 33.02; and Public Officers Law (Freedom of Information Law), art. 6

Subject: Correction of an inaccurate address in existing regulation.

Purpose: To correct the address of the Department of State, Committee on Open Government.

Text or summary was published in the September 1, 2010 issue of the Register, I.D. No. OMH-35-10-00024-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth

I.D. No. OMH-45-10-00006-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: This is a consensus rule making to amend Part 578 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Subject: Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth.

Purpose: To carve out the cost of pharmaceuticals from the per diem reimbursement rate for Residential Treatment Facilities.

Text of proposed rule: A new subdivision (o) is added to Section 578.14 of Title 14 NYCRR to read as follows:

(o) Effective on or after January 1, 2011, and contingent upon federal approval, allowable operating costs shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. Such costs may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program.

Text of proposed rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Consensus Rule Making Determination

This rule making is filed as a Consensus rule on the grounds that it is non-controversial and makes a technical correction. No person is likely to object to this rule since its purpose is to provide fiscal relief to residential treatment facility (RTF) providers and to improve access to services by children and adolescents who require the level of care provided in a RTF.

The amendment to Part 578 specifies that, on or after January 1, 2011, and contingent upon approval by the Centers for Medicare and Medicaid Services (CMS), allowable operating costs for RTFs for children and youth licensed by the Office shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. These costs may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program.

This amendment will provide financial relief to RTFs, as the costs of psychiatric medications have increased more rapidly than the rate of inflation. Currently, RTF providers are paid on an all-inclusive basis, and rates are set prospectively. The rates are based upon allowable costs reflected in the provider's cost report, which is submitted two fiscal years prior to the rate year. Thus, there is a significant lag before increased costs are reflected in the provider's rate. Because pharmaceutical costs are high, and tend to rise quickly, this lag can result in a serious cash flow problem for providers. This amendment will give fiscal relief to providers and ultimately reduce taxpayer costs.

In addition, this amendment should allow for an improvement in access to services by high-need children and adolescents who require the level of care provided in a RTF. Often, high-need individuals have complex health care problems, but some RTF providers have been unable to admit these patients due to the fact that the cost of purchasing the required drug treatments was found to be financially impossible for the provider. The carve out of the pharmaceutical costs included in the New York State Medicaid formulary will permit RTF providers to access medically necessary drugs, including HIV/AIDS-related medications, directly from the fee-for-service billing pharmacy.

Statutory Authority: Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the authority and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction. Section 43.02 of the Mental Hygiene Law provides that the Commissioner has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services provided by facilities, including residential treatment facilities for children and youth licensed by the Office of Mental Health.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because it is evident by the nature of the rule that there will be no adverse impact on jobs and employment opportunities. This rule specifies that, effective on or after January 1, 2011, and contingent upon the approval of the Centers for Medicare and Medicaid Services approval, allowable operating costs for residential treatment facilities (RTF) will not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. These costs may, as appropriate, be reimbursed on a fee-for-service basis by the Medicaid program. This rule will provide financial relief to RTF providers and improve access to services provided in a RTF for children and adolescents.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Operation of Residential Programs for Adults

I.D. No. OMH-45-10-00009-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: This is a consensus rule making to amend section 595.9 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 31.04

Subject: Operation of Residential Programs for Adults.

Purpose: Clarify the due process protections of non-discharge ready residents who are no longer eligible for services.

Text of proposed rule: 1. Subdivision (c) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(c) A resident who is not discharge-ready *or who is no longer eligible for services* can be discharged provided discharge planning activities have been followed to the extent practicable under the circumstances, and one of the following conditions applies:

(1) the resident has permanently vacated the residence;

(2) the resident's condition has changed, as follows:

(i) the psychiatric or medical status of the resident has changed such that the resident requires inpatient hospital care; and/or

(ii) the resident's capacity for self preservation, as determined pursuant to section 595.16 of this Part, requires a level of care other than the residential program, or the resident is otherwise at risk due to requiring additional medical or psychiatric services or supports not available within the residential program; *or*

(iii) the psychiatric status of the resident has changed such that the services or support required can be provided in a less restrictive setting, and a clinically-appropriate less restrictive setting has been identified and is available;

(3) the resident fails to meet one or more material responsibilities for residency as described in section 595.10(a)(2) and (c) of this Part; or

(4) the resident's behavior poses an immediate and substantial threat to the health, safety and well-being of the resident or other individuals or creates a serious and ongoing disruption of the therapeutic environment of the residential program.

2. Subdivision (e) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(e) A discharge under paragraph (c)(2) of this section requires that a clinical assessment be conducted by clinical staff who are qualified by credentials, training and experience to conduct such assessments, *provided, however, that a determination under subparagraph (c)(2)(iii) of this section, such services and support required can be provided in a less restrictive setting, must be made by a physician.* If an individual is to be discharged because that individual is no longer capable of self preservation as determined pursuant to section 595.16 of this Part, or would be otherwise at risk due to requiring different or additional services, supports or physical environments not available within the residential program except to the extent required pursuant to the Federal Americans with Disabilities Act, the individual shall be notified in writing of the need for and intent to secure an appropriate alternative living arrangement.

3. Subdivision (f) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(f) A discharge under subparagraph (c)(2)(ii) *or (iii)* of this section, or a discharge under paragraph (c)(3) of this section, requires the following:

Text of proposed rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Appendix IV
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Public Notice

tions; and the geographic areas of the State to which it will direct assistance.

The AAP also describes NYS's planned use of approximately $67 million in federal fiscal year 2013 funds for the: NYS Community Development Block Grant Program ($40 million); HOME Investment Partnerships Program ($19 million); Housing Opportunities for Persons with AIDS Program ($2.1 million); and Emergency Solutions Grants Program ($5.9 million).

NYS encourages public participation in the development of its AAP and invites interested persons to review and comment on the draft AAP for 2013 during an upcoming public comment period.

This 30-day public comment period will begin on Thursday, September 6, 2012 and extend through close of business on Friday, October 5, 2012. Beginning on September 6, 2012, NYS's draft AAP for 2013 may be viewed on and downloaded from the NYS Homes and Community Renewal (HCR) website at www.nyshcr.org. In addition, copies can be requested by e-mail (HCRConPln@nyshcr.org) or by calling (518) 473-3031.

Comments should be mailed to: NYS HCR, Attention: Nancy Moreland, 38-40 State Street, Albany, NY 12207 or e-mailed to (HCRConPln@nyshcr.org). Comments must be received or postmarked by close of business Friday, October 5, 2012.

PUBLIC NOTICE
Office of Mental Health

The New York State Office of Mental Health hereby gives notice of the following:

On July 14, 2010, the Office of Mental Health (OMH) published a public notice stating that, as part of the 2010-11 Budget, OMH proposed to amend New York's Medicaid State Plan to reflect the carve-out of eligible pharmaceutical costs from the rate setting methodology for Residential Treatment Facilities for Children and Youth, which would become effective when Federal approval of the State Plan Amendment was received. OMH is hereby amending that notice to state that the amendment will be effective on September 1, 2012.

For further information, contact: Office of Mental Health, Counsel's Office, Jay Zucker, 44 Holland Ave.,Albany, NY 12229, (518) 474-1331

PUBLIC NOTICE
Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

The State is proposing to change the methods and standards for setting Medicaid payment rates for hourly community habilitation for persons with developmental disabilities. The current community habilitation services fee schedule will be reduced by 3.5 to 4.5 percent for all providers. The proposed changes will also limit Medicaid revenue interchange by identifying the minimum percentage of community habilitation program Medicaid revenue that must be used to fund the direct support of individuals within the community habilitation program. That percentage will be 90 percent at October 1, 2012 and 95 percent at January 1, 2014.

The reasons for the proposed changes are to reduce the clinical oversight component of the community habilitation fee to be in line with actual costs of providing clinical oversight, to achieve greater resource accountability and to support individuals in the most integrated setting.

The State estimates that there will be a decrease of approximately $6.1 million in annual aggregate expenditures as a result of this change.

Outside New York City, a detailed description of the changes is available for public review at the following addresses:

Albany
Albany County Department of Mental Health
175 Green St.
Albany NY 12202

Allegany
Allegany County Mental Health Department
45 North Broad St.
Wellsville NY 14895

Broome
Broome County Mental Health Department
229-231 State St., Fl 4
Binghamton NY 13901-6635

Cattaraugus
Cattaraugus County Community Services
1 Leo Moss Dr., Suite 4308
Olean NY 14760

Cayuga
Cayuga County Mental Health Department
146 North St.
Auburn NY 13021

Chautauqua
Chautauqua County Mental Health Services
HRC Bldg., 7 N. Erie St., 1st Floor
Mayville NY 14757

Chemung
Chemung County Mental Health Hygiene Department
425 Pennsylvania Ave.
Elmira NY 14902

Chenango
Chenango County Mental Hygiene Services
County Office Bldg., 5 Court St., Ste. 42
Norwich NY 13815

Clinton
Clinton County Mental Health/Addictions Services
16 Ampersand Dr.
Plattsburgh NY 12901

Columbia
Columbia County Department of Human Services
325 Columbia St.
Hudson NY 12534

Cortland
Cortland County Community Services
7 Clayton Ave.
Cortland NY 13045

Delaware
Delaware County Mental Health Clinic
1 Hospital Rd.
Walton NY 13856

Dutchess
Dutchess County Department of Mental Hygiene
82 Washington St.
Poughkeepsie NY 12601

Erie
Erie County Department of Mental Health
95 Franklin St., Rm. 1237
Buffalo NY 14202

Appendix V
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Responses to Standard Funding Questions

APPENDIX V
INSTITUTIONAL SERVICES
State Plan Amendment 12-18

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: The total annual Medicaid reimbursement for all twenty Residential Treatment Facilities (RTFs) is approximately $96.8 million. Five of the twenty RTFs covered under this proposed Plan Amendment currently have capital construction bonds outstanding that were issued by the Dormitory Authority of the State of New York (DASNY). A portion of the Medicaid payments for these five facilities (i.e. an amount equal to the debt service on the bonds) is paid directly to the Office of Mental Health (OMH). The OMH acts as an agent and forwards these funds to DASNY which makes the debt service payments on the bonds for these providers. The entire balance of Medicaid payments that is paid directly to the RTFs is retained by them to support their costs of operations.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In**

this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- **(i) a complete list of the names of entities transferring or certifying funds;**
- **(ii) the operational nature of the entity (state, county, city, other);**
- **(iii) the total amounts transferred or certified by each entity;**
- **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
- **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: The entire non-Federal share of Medicaid payments for inpatient hospital services under the State plan provided by RTFs is paid by State funds provided by appropriations enacted by the State legislature. There is no local share for RTFs.

Regarding CMS' inquiry as to the use of certified public expenditures (CPEs) and intergovernmental transfers (IGTs) by the State please note that New York does not utilize CPEs or IGTs to assist in financing any portion of the non-Federal share of Medicaid payments to RTFs.

Regarding CMS' inquiry as to the use of provider taxes by the State please note that New York does not impose any provider taxes to fund the non-Federal share of Medicaid payments to RTFs.

Regarding the State's practices for verifying that expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR §433.51(b), the State Department of Health (DOH) contracts with a fiscal agent, Computer Sciences Corporation (CSC), to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the EMEDNY System, a computerized payment and information reporting system. All claims are subjected to numerous system edits to help ensure only legitimate services are reimbursed to properly enrolled providers. In addition, both the DOH and the New York State Comptroller's office subject Medicaid claims to both prepayment and post-payment audits to ensure that providers comply with all applicable State and Federal laws and regulations.

In New York State Medicaid payments are issued to providers every Wednesday. CSC provides a weekly summary to the DOH that includes the total Federal, State, and local funding required to support all checks to be released for payment to providers. The DOH arranges for the required funds to be placed in an escrow account until they are needed to pay for the checks presented by providers. All Federal Medicaid matching funds are drawn down by the State in accordance with an agreement between the United Stated Department of the Treasury and the State as required by the Cash Management Improvement Act of 1990, as amended.

On a quarterly basis CSC provides a report of paid claims to the DOH. The DOH combines that expenditure information with data concerning other Medicaid expenditures made directly by the DOH or other State agencies. The DOH then submits the CMS-64 report to the Department of Health and Human Services, which enables the State to earn the appropriate Federal reimbursement for its certified claims submitted either by providers of service or by State agency representatives. These procedures are followed by the State in order to ensure that Federal Medicaid funds are only used to pay for legitimate Medicaid services.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

   Response: No supplemental or enhanced payments are made for Residential Treatment Facility services.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: All RTFs fall into the category of psychiatric residential treatment facilities, which are defined in Federal regulation as facilities "other than a hospital that provides psychiatric services...to individuals under age 21, in an inpatient setting." 42 CFR §483.352. This regulation permits a State to pay the customary charge of the provider, but not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. Therefore, although there is a UPL requirement, CMS does not require the State to perform additional work.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: There are no governmental providers providing RTF services in New York State. All providers are private, not-for-profit corporations.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: This SPA does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. The tribal leaders were sent information regarding the SPA via postal mail, and the health clinic administrators were emailed the same information. Copies of tribal consultation are enclosed.

Appendix VI
2012 Title XIX State Plan
Third Quarter Amendment
Institutional Services
Responses to Standard Access Questions

APPENDIX VI
INSTITUTIONAL SERVICES
State Plan Amendment #12-18

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to revise the effective date from July 1, 2012 to September 1, 2012, to carve-out the cost of prescription drugs from the reimbursement rate for Residential Treatment Facilities (RTFs) for children and youth licensed by the Office of Mental Health. In doing so, this amendment will generate savings to the greater Medicaid program by utilizing group discounts and rebates in the purchase of prescription drugs. By moving the effective date providers will have time to adjust to this change.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

   Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2010-11 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.