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

HEALTH

Sue Kelly Executive Deputy Commissioner

April 1, 2014

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 #13-76 Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-76 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective September 1, 2013 (Appendix I). This amendment is being submitted based on enacted legislation. 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 §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the $\underline{\text{New York State}}$ Register on August 28, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 13-76	2. STATE
STATE FLAN WATERIAL	15-76	New York
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TI SOCIAL SECURITY ACT (MEDI-	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	September 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One):	l	
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☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONS.		AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEND 6. FEDERAL STATUTE/REGULATION CITATION:	MENT (Separate Transmittal for each an 7. FEDERAL BUDGET IMPACT:	nendment)
42 CFR Part 447.205	a. FFY 09/01/13-09/30/13 \$ 3,612.	.000
Social Services Law Section 368-d & 368-e	b. FFY 10/01/13-09/30/14 \$ 43,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	
Attachment 4.19-B Pages: 17(o)(i)(a), 17(o)(i)(b), 17(o)(i)(c),	SECTION OR ATTACHMENT (If App	olicable):
$ \begin{array}{c} \text{Attachment 4.19-B 1 ages. } 17(0)(i)(a), 17(0)(i)(b), 17(0)(i)(c), \\ 17(0)(i)(d), 17(0)(i)(e), 17(0)(i)(f), 17(0)(i)(g), 17(0)(i)(h), 17(0)(i)(i), \\ 17(0)(i)(j), 17(i)(i)(k) \end{array} $		
10. SUBJECT OF AMENDMENT: School Supportive Health Services Program - NYC (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 SPEC	IFIED:
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: New York State Department of Healt	
13. TYPED NAME: Jason A. Helgerson	Bureau of Federal Relations & Provid 99 Washington Ave – One Commerce	
14. TITLE: Medicaid Director	Suite 1430	
Department of Health	Albany, NY 12210	
15. DATE SUBMITTED: April 1, 2014		
FOR REGIONAL OFFI	CE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE C	OPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OF	FICIAL:
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

Appendix I 2014 Title XIX State Plan First Quarter Amendment Amended SPA Pages

New York 17(o)(i)(a)

School Supportive Health Services Program (SSHSP) - New York City

A. Reimbursement Methodology for School Supportive Health Services

School-based services, known as School Supportive Health Services (SSHS), are delivered by the school districts and include the Medicaid services as described in Attachments 3.1-A and 3.1-B of the Medicaid State Plan under item 4.b., Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT). School districts will be paid only for direct Medicaid-covered services provided pursuant to an Individualized Education Program (IEP). School Supportive Health Services include:

- 1. Physical Therapy Services
- 2. Occupational Therapy Services
- 3. Speech Therapy Services
- 4. Psychological Counseling
- 5. Skilled Nursing Services
- 6. Psychological Evaluations
- 7. Medical Evaluations
- 8. Medical Specialist Evaluations
- 9. Audiological Evaluations
- 10. Special Transportation

B. Direct Medical Payment Methodology

Effective dates of service on or after September 1, 2013, providers located in a city with a population of over one million will be paid on a cost basis. Providers will be reimbursed interim rates for SSHS direct medical services per unit of service at the statewide interim rate as specified in the EPSDT section of this Attachment. On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period. SSHSP providers must maintain organized and confidential documentation regarding the services provided, including written orders; session notes; and students' Individualized Education Programs. Such documentation must be maintained for a period of six years from the date the services were furnished or billed, whichever is later.

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New York 17(o)(i)(b)

C. Data Capture for the Cost of Providing Health-Related Services

<u>Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:</u>

- 1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data sources:
 - a. SSHS cost reports received from school districts, in the State of New York, inclusive of the Allowable cost categories defined in Section D.1 and D.2;
 - <u>b.</u> Random Moment Time Study (RMTS) Activity Code 4.b (Direct Medical Services) and Activity Code10 (General Administration):
 - <u>Direct medical RMTS percentage; and</u>
 - c. School District specific Individualized Education Program (IEP) Medicaid Eligibility Ratios.

A glossary of the key terms used in the cost reporting process described in this SPA can be found as Appendix 2 of the NYS Department of Health (DOH) Guide to Cost Reporting for the School Supportive Health Service Claiming Program.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by school districts under the Attachments 3.1-A and 3.1-B of the State Plan, excluding transportation personnel costs which are to be reported under Special Transportation Services Payment Methodology section as described in paragraph E of this section. These direct costs will be calculated on a Medicaid provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual SSHS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited district level payroll and general ledger data maintained at the district level.

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a. Direct Medical Services

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits;
- iii. Medically-related purchased services; and
- iv. <u>Medically-related supplies and materials.</u>

b. Contracted Service Costs

Contracted service costs represent the costs incurred by the Local Education Agency (LEA) for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

<u>Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.</u>

c. Tuition Costs

Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district (private school, §4201 school) or preschool agency setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each out of district provider and will be calculated annually based on annual financial reports, the CFR, submitted to the New York State Education Department (SED). The CFRs used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering September 1, 2013 - June 30, 2014, the CFRs from the 2011-2012 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health (https://www.health.ny.gov/health_care/medicaid/program/psshsp/) and the State Education Department

(http://www.oms.nysed.gov/medicaid/CPEs/home.html) websites. The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

NOTE: Effective with the cost reporting period beginning on July 1, 2013, a health related portion of tuition payments related to the provision of IEP direct medical services for students in §4201 schools may be included in the cost report for the school district of residence. For cost reporting periods prior to July 1, 2013 school districts will not be allowed to include any costs associated with

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tuition payments made to §4201 schools as these entities were eligible to bill for Medicaid services during these periods.

d. Intergovernmental Agreement Costs

Intergovernmental agreement costs represent costs for services provided through a contractual or tuition based arrangement in which the LEA purchasing the services and the LEA providing services are both public school districts or counties. Relationships between public schools and private schools, 4201 schools, BOCES, private vendors, or other non-public entities would be reported as described in section b (Contracted Service Costs) or c (Tuition Costs).

<u>Intergovernmental Agreement Contracted Service Costs</u>

<u>Contracted service costs represent the costs incurred by the LEA for IEP direct medical services rendered by a public school or county through a contractual agreement. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.</u>

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

A revenue offset must be reported by the public school or county providing the IEP direct medical service equal to the expense reported by the school district purchasing the service. The total for all intergovernmental agreement contract costs is expected to equal \$0 in the aggregate, statewide.

ii. Intergovernmental Agreement Tuition Costs

Tuition costs represent the costs incurred by the LEA for a student placed in another public school or county for all services (educational and IEP direct medical services). Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services. The health related portion of the tuition costs will be determined through the application of a health related tuition percentage to the annual tuition costs reported by the school district. The health related tuition percentage will be specific to each public school or county and will be calculated annually based on annual financial reports, the ST-3, submitted to the New York State Education Department. The ST-3s used in calculating the health related tuition percentage will be those from the most current, complete year available. For example, for the cost reports covering September 2013 — June 30, 2014, the ST-3s from the 2011-2012 school year were used in calculating the health related tuition percentages. The methodology used to calculate health related tuition percentages is currently available on the Department of Health

(https://www.health.ny.gov/health care/medicaid/program/psshsp/) and the State Education Department

(http://www.oms.nysed.gov/medicaid/CPEs/home.html) websites.

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The methodology is also found in the approved Cost Reporting Guide and on the Dashboard of the web-based cost reporting tool.

A revenue offset must be reported by the public school or county providing the services under the tuition arrangement (receiving the tuition payment) equal to the expense reported by the school district paying the tuition. The total for all intergovernmental agreement tuition costs is expected to equal \$0 in the aggregate, statewide.

2. Indirect Costs: Indirect costs are determined by applying the school district specific unrestricted indirect costs rate to the Direct Medical Service Costs, defined in section D.1.a., following the application of the Direct Medical Service Time Study Percentage, defined in D.3. New York public schools use predetermined fixed rates for indirect costs. The New York State Education Department (SED), in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by public school districts. Pursuant to the authorization in 34 CFR §75.561(b), the New York State Education Department, which is the cognizant agency for school districts, approves unrestricted indirect cost rates in cooperation with the ED. The indirect cost rates are reviewed and updated annually. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

- <u>a.</u> Apply the New York Public Schools Cognizant Agency Unrestricted Indirect Cost rate applicable for the dates of service in the rate year.
- <u>b.</u> The New York UICR is the unrestricted indirect cost rate calculated by the New York State Education Department.
- 3. Time Study: A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology will utilize two cost pools: one cost pool for direct therapy staff (includes staff providing Occupational Therapy, Physical Therapy, and Speech Therapy services) and one cost pool for all other direct service staff (includes staff providing Audiological Evaluations, Medical Evaluations, Medical Specialist Evaluations, Psychological Counseling, Psychological Evaluations, and Skilled Nursing services). A minimum number of completed moments will be sampled each quarter in accordance with the Time Study Implementation Plan to ensure time study results will have a confidence level of at least 95 percent with a precision of plus or minus two percent overall. The Direct Medical Service time study percentage for the Direct Medical Service - Therapy cost pool will be applied only to those costs associated with direct medical service therapy. The Direct Medical Service time study percentage for the Direct Medical Service - All Other cost pool will be applied only to those costs associated with direct medical service all other.

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The RMTS direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. For example, for cost reporting period July 1, 2014 through June 30, 2015, the RMTS quarters would be October 2014 to December 2014, January 2015 to March 2015 and April 2015 to June 2015.

<u>Direct Medical Service Therapy RMTS Percentage</u>

- <u>a.</u> <u>Fee-For-Service RMTS Percentage</u>
 - i. <u>Direct Medical Service Therapy Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.</u>
- b. General Administrative Percentage Allocation
 - i. Direct Medical Service Therapy Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

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Direct Medical Service All Other RMTS Percentage

- <u>a. Fee-For-Service RMTS Percentage</u>
 - i. <u>Direct Medical Service All Other Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.</u>
- b. General Administrative Percentage Allocation
 - i. <u>Direct Medical Service All Other Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.</u>

The formula below details the Direct Medical Percentage (code 4.b) with the applicable portion of General Administration (Activity Code 10) reallocated to it. The same calculation is completed for the Direct Medical Service Therapy and Direct Medical Service All Other cost pools.

A = All Codes

D = IEP Direct Medical Services (Activity Code 4.b)

R = Redistributed Activities (Activity Code 10)

<u>U</u> = <u>Unallowable</u> (Activity Code 11)

$$\underline{\text{Direct Medical Service Percentage} =} \qquad \underline{D + \left(\frac{D}{(A - R - U)} * R\right)}$$

$$(A - U)$$

4. IEP Medicaid Eligibility Ratio: A district-specific IEP Ratio will be established for each participating school-district. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students.

The IEP ratio will be based on child count reporting required for Individuals with Disabilities Education Act (IDEA) on the first Wednesday in October of the Fiscal Year for which the report is completed. For example, for the cost reporting period covering July 1, 2014 through June 30, 2015, the IEP Ratio will be based on the student count from October 3, 2014. The names and birthdates of students with an IEP with a direct medical service will be identified from the Student Count Report as of the first Wednesday in October and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator will be the number of Medicaid eligible IEP students in the LEA with a direct medical service, as outlined in their IEP. The denominator will be the total number of

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students in the LEA with an IEP with a direct medical services as outlined in their IEP. Direct medical services are those services billable under the SSHS program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts as of the first Wednesday of October for the fiscal year for which the cost report is completed.

<u>**5.**</u> Total Medicaid Reimbursable Cost: The results of the previous steps will be a total Medicaid reimbursable cost for each school district for Direct Medical Services.

E. Special Transportation Services Payment Methodology

Effective dates of service on or after September 1, 2013, providers will be paid on a cost basis. Providers will be reimbursed interim rates for SSHS Special Transportation services as specified in the *Special Transportation* paragraph of the EPSDT section of this Attachment. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

The State requires providers billing the Medicaid program to keep a log of one-way trips. The State conducts audits of School Supportive Health Services Program providers through the Office of the Medicaid Inspector General, including special transportation services. Audit protocols developed include review of documentation of Medicaid services other than transportation delivered to the student on the day he or she received special transportation services.

Special transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

- 1. Special transportation is specifically listed in the IEP as a required service;
- <u>2.</u> The child required special transportation in a vehicle that has been modified as documented in the IEP;
- 3. A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed; and
- 4. The service billed represents a one-way trip.

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<u>Transportation costs included on the cost report worksheet will only include those</u> <u>personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:</u>

- 1. Personnel Costs Personnel costs include the salary and benefit costs for transportation providers employed by the school district. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers (defined under Section D of this plan). The personnel costs may be reported for the following staff:
 - a. Bus Drivers;
 - b. Attendants;
 - c. Mechanics; and
 - d. Substitute Drivers.
- **2.** Transportation Other Costs Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include:
 - a. Lease/Rental costs;
 - b. Insurance costs;
 - c. Maintenance and Repair costs;
 - <u>d.</u> Fuel and Oil cost;
 - e. Contracted Transportation Services and Transportation Equipment costs; and
 - <u>f.</u> Other transportation non-personnel costs.
- <u>3.</u> <u>Transportation Equipment Depreciation Costs Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than \$5,000.</u>

The source of these costs will be audited payroll and general ledger data for each district.

School districts may report all transportation expenditures incurred during the period covered by the annual cost report. School districts will be required to complete the Specialized Transportation Ratio in order to apportion their transportation expenditures between specialized transportation and non-specialized transportation.

All transportation costs reported on the annual cost report will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One-Way Trip Ratio.

Medicaid One-Way Trip Ratio- A district-specific Medicaid One-Way Trip Ratio will be established for each participating school district. When applied, this Medicaid One-Way Trip ratio will discount the transportation costs by the percentage of Medicaid IEP one-way trips. This ratio ensures that only Medicaid allowable transportation costs are included in the cost settlement calculation.

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The Medicaid One-Way Trip Ratio will be calculated based on the number of one-way trips provided to students requiring specialized transportation services per their IEP and receiving another Medicaid covered service on that same day. The numerator of the ratio will be based on the Medicaid paid one-way trips as identified in the state's Medicaid Management Information System (MMIS) data. The denominator will be based on the school district transportation logs for the number of one way trips provided to Medicaid eligible special education students with specialized transportation in the IEP.

Specialized Transportation Ratio — The Specialized Transportation Ratio is used to discount the transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible special education students receiving specialized transportation services in the school district. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services.

F. Certification of Funds Process

Each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous fiscal year covering July 1st through June 30th. The cost report is due on or before December 31st of the same year of the reporting period. The primary purposes of the cost report are to:

- 1. <u>Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and</u>
- 2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SSHS Cost Reports are subject to a desk review by the DOH or its designee.

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H. Cost Reconciliation Process

Once all interim claims (CPT/HCPCS claims) are paid, the State will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual SSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments and tentative settlements for school health services delivered during the reporting period as documented in the MMIS and CMS-64, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

<u>I. Cost Settlement Process</u>

For services delivered for a period covering July 1st through June 30th, the annual SSHSP Cost Report is due on or before December 31st of the same year. A tentative reconciliation may be submitted prior to the final reconciliation. Such tentative reconciliation will be based on actual submitted annual cost report data discounted twenty-five percent and interim feefor-service claims. It is anticipated that the final reconciliation will occur prior to 24th month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

If interim claiming and tentative settlement payments exceed the actual, certified costs of the provider for SSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for SSHSP services exceed the interim claiming and tentative settlement, the DOH and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider in the CMS-64 quarter corresponding to the date of payment.

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Appendix II 2014 Title XIX State Plan First Quarter Amendment Summary

SUMMARY SPA #13-76

This State Plan Amendment proposes to update rates paid for Medicaid coverage for school supportive health services programs (SSHSP) in New York City. School supportive health services programs are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported §4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHSP are authorized under §1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

Appendix III 2014 Title XIX State Plan First Quarter Amendment Authorizing Provisions

S.2809-B/A-4009.B - Part H

- § 6. Section 368-d of the social services law is amended by adding three new subdivisions 4, 5 and 6 to read as follows:
- 4. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by public school districts and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law for medical care, services and supplies, including related special education services and special transportation, furnished to children with handicapping conditions.
- 5. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under subdivision four of this section without a competitive bid or request for proposal process, provided, however, that:
- (a) The department of health shall post on its website, for a period of no less than thirty days:
- (i) A description of the proposed services to be provided pursuant to the contract or contracts;
 - (ii) The criteria for selection of a contractor or contractors;
- (iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and
- (iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;
- (b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and
- (c) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.
- 6. The commissioner shall evaluate the results of the study conducted pursuant to subdivision four of this section to determine, after identification of actual direct and indirect costs incurred by public school districts and state operated/state supported schools, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision five of section three hundred sixty-eight-e of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fiftyeight of the laws of two thousand five.
- § 7. Section 368-e of the social services law is amended by adding three new subdivisions 3, 4 and 5 to read as follows:

- 3. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by counties for medical care, services and supplies, including related special education services and special transportation, furnished to pre-school children with handicapping conditions.
- 4. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under subdivision three of this section without a competitive bid or request for proposal process, provided, however, that:
- (a) The department of health shall post on its website, for a period of no less than thirty days:
- (i) A description of the proposed services to be provided pursuant to the contract or contracts;
 - (ii) The criteria for selection of a contractor or contractors;
- (iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and
- (iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;
- (b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and
- (c) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.
- 5. The commissioner shall evaluate the results of the study conducted pursuant to subdivision three of this section to determine, after identification of actual direct and indirect costs incurred by counties for medical care, services, and supplies furnished to pre-school children with handicapping conditions, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public In the event such claims are submitted, if federal expenditures. reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision six of section three hundred sixty-eight-d of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

Appendix IV 2014 Title XIX State Plan First Quarter Amendment Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311 or visit our web site at: www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for September 2013 will be conducted on September 10 and September 11 commencing at 10:00 a.m. These meetings will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE

Office of Fire Prevention and Control

Pursuant to Section 176-b of the Town Law, the Office of Fire Prevention and Control hereby gives notice of the following:

Application for Waiver of the Limitation on Non-resident Members of Volunteer Fire Companies

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Fort Hunter Fire District, County of Montgomery.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Bryant D. Stevens, State Fire Administrator, Office of Fire Prevention and Control, State Office Campus, 1220 Washington Ave., Bldg. 7A, Fl. 2, Albany, NY 12242

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief Donald Fischer, Office of Fire Prevention and Control, State Office Campus, 1220 Washington Ave., Bldg. 7A, Fl. 2, Albany, NY 12242, (518) 474-6746, e-mail: Dfischer@dhses.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS) provided in school districts and counties in a city with a population over one million, effective on or after September 1, 2013. SSHS are provided to Medicaid -eligible students with disabilities. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is \$100.2 million.

The public is invited to review and comment on this proposed state plan amendment, which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan amendment will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County 250 Church Street New York, New York 10018

Queens County, Queens Center 3220 Northern Boulevard Long Island City, New York 11101

Kings County, Fulton Center 114 Willoughby Street Brooklyn, New York 11201 Bronx County, Tremont Center

Appendix V 2014 Title XIX State Plan First Quarter Amendment Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES State Plan Amendment #13-76

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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 payments, a complete listing of providers that return a portion of their payments, 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: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

- 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 through 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 governmental 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: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

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: The payments authorized for this provision are not supplemental or enhanced payments.

4. For clinic or outpatient hospital services 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.

Response: Question is not applicable as SSHS are not clinic or outpatient hospital services.

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: The rate methodology included in the State Plan for school supportive health services is cost-based subject to ceilings. Rates of payment for services are currently based upon the 2010 Medicare fee schedule, except for rates for special transportation services, which are based on a cost study. Effective on or after September 1, 2013, on an annual basis, a district-specific cost reconciliation and cost settlement for all over and under payments will be processed. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

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 \underline{not} [\checkmark] 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: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.