NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

September 29, 2023

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #23-0072
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #23-0072 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2023 (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 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.

A copy of pertinent sections of enacted legislation 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 June 28, 2023, 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 Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0072

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(4)(b) Early and Periodic Screening, Diagnostic, and Treatm

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/23-09/30/23 $ 3,125,000
b. FFY 10/01/23-09/30/24 $ 12,500,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supplement: Pages 2(xii)(A), 2(xii)(G), 2(xii)(K), 2(xii)(L)
Attachment 3.1-B Supplement: Pages 2(xii)(A), 2(xii)(G), 2(xii)(K), 2(xii)(L)
Attachment 4.19-B: Pages 17(l), 17(l)(i), 17(l)(ii), 17(l)(iii), 17(l)(iii)(1), 17(m), 17(o)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Supplement: Pages 2(xii)(A), 2(xii)(G), 2(xii)(K), 2(xii)(L)
Attachment 3.1-B Supplement: Pages 2(xii)(A), 2(xii)(G), 2(xii)(K), 2(xii)(L)
Attachment 4.19-B: Pages 17(l), 17(l)(i), 17(l)(ii), 17(l)(iii), 17(m), 17(o)

9. SUBJECT OF AMENDMENT

Preschool SSHSP

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
September 29, 2023

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

SPA 23-0072

Attachment A

Annotated Pages

Annotated Page: 17(l)(iii)

New York
17(l)(iii)

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.

   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, 2012 through June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013 and April 2013 to June 2013.

Direct Medical Service Therapy RMTS Percentage

a. Fee For Service RMTS Percentage

   i. 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.

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.

Direct Medical Service All Other RMTS Percentage

a. Fee For Service RMTS Percentage

   i. 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.

Appendix I
2023 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

New York
2(xii)(A)

1905(a)(4)(b)~~.~~ Early and ~~p~~Periodic ~~s~~Screening, ~~d~~Diagnostic and ~~t~~Treatment ~~S~~services ~~(EPSDT).~~

School Supportive Health Services and Pre-School Supportive Health Services

School Supportive Health Services (SSHS) and Pre-School Supportive Health Services (PSSHS) are services provided by or through a school district, a county in the State, or New York City to children with disabilities, who attend public or State Education Department approved schools or preschools. The services must be:

- medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
- ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
- included in the child's Individualized Education Program (IEP) (psychological evaluations and counseling do not need to be recommended in an IEP);
- provided by qualified professionals under contract with or employed by a school district or a county in the State or the City of New York;
- furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions; and
- included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Effective September 1, 2009, the services covered by the SSHS and PSSHS Program for Medicaid eligible children under the age of 21 who are eligible for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) include medically necessary physical therapy services, occupational therapy services, speech therapy services, psychological counseling, skilled nursing services, psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation within the limits of EPSDT services. A school district, a county in the State, and New York City must be enrolled as a Medicaid provider in order to bill Medicaid.

1. Physical Therapy Services

Definition: Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR 440.110(a).

New York
2(xii)(G)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

- spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

Services ~~may~~ will be rendered in the setting in which the child's IEP will be implemented, including but not limited to Article 28 facilities, Board of Cooperative Educational Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, at home and/or in community based settings.

4. Psychological Counseling

Definition: Psychological counseling services outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42 CFR Section 440.60(a) and 440.50(a)(2).

Services: Psychological counseling provided by or through a school district; a county in the State or the City of New York must have a referral from a physician, physician assistant, or nurse practitioner who is acting within the scope of his or her practice under NYS law or an appropriate school official or other voluntary health or social agency and must be provided to a child by or under the direction of a qualified practitioner. ~~Psychological counseling services must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).~~

Medically necessary EPSDT services are health care, diagnostic services, treatments and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological counseling services include:

- treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are severe enough to require treatment.

Psychological counseling services ~~may~~ will be provided in an individual or group setting.

programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

6. Psychological Evaluations

Definition: Psychological evaluations outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 21 years of age, who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary. These services are provided in accordance with 42CFR Section 440.50(a) and 42CFR Section 440.60(a).

Psychological evaluations provided by or through a school district; a county in the State or the City of New York must have a referral from a physician, physician assistant, or nurse practitioner acting within his or her scope of practice under New York State law or an appropriate school official or other voluntary health or social agency and must be provided to a child by a qualified practitioner. ~~Psychological evaluations must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.~~

Services: Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate physical defects, mental illnesses, and other disabilities.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results, and
- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

Providers: Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services ~~may~~ will only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.

New York
2(xii)(L)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

Services ~~may~~ will be provided by:

- a New York State licensed and registered psychiatrist, qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or

- a New York State licensed and registered psychologist, qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

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A medical evaluation is the recording of:

- chief complaints;

- present illness;

New York
2(xii)(A)

1905(a)(4)(b)~~.~~ Early and Periodic Screening, Diagnostic and Treatment ~~S~~services ~~(EPSDT).~~

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- provided by qualified professionals under contract with or employed by a school district, or a county in the State or the City of New York;
- furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations; including those for provider qualifications, comparability of services, and the amount, duration and scope of provisions; and
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New York
2(xii)(G)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

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- Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

Providers: Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Psychological evaluation services ~~may~~ will only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluation services in the community.

New York
2(xii)(L)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

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- a New York State licensed and registered psychologist, qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Services ~~may~~ will be rendered in ~~the~~ settings ~~in which the child's IEP will be implemented,~~ including but not limited to Article 28 facilities, Board of Cooperative Education Services (BOCES) programs, approved preschool programs, public schools, approved private schools, Section 4201 schools, state operated schools, in private practitioner's offices, and/or in community based settings.

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Medical evaluations provided by or through: a school district; a county in the State or the City of New York must be performed by a physician, physician assistant, or nurse practitioner acting within the scope of his or her practice under New York State law. A medical evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child's health related needs as a part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

A medical evaluation is the recording of:

- chief complaints;
- present illness;

New York
17(l)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

a. *Direct Medical Services*
Non-federal cost pool for allowable providers consists of:
i. Salaries;
ii. Benefits (employer paid);
iii. Medically-related purchased services; and
iv. Medically-related supplies and materials.

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.

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. Contracted service costs are not eligible for the application of the unrestricted indirect cost rate.

~~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 and are not eligible for the application of the unrestricted indirect cost rate. 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 October 1, 2011 – June 30, 2012, the CFRs from the 2009-2010 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 website at:~~

~~https://www.health.ny.gov/health_care/medicaid/program/psshsp/~~

~~and the State Education Department website at:~~

~~http://www.oms.nysed.gov/medicaid/CPEs/home.html.~~

~~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. Effective July 1, 2013 §4201 schools are not eligible to bill for Medicaid services.~~

New York
17(l)(i)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

~~For cost reporting periods prior to July 1, 2013 school districts will not be allowed to include any costs associated with tuition payments made to §4201 schools as these entities were eligible to bill for Medicaid services during these periods.~~

~~***NOTE:***~~ When an LEA incurs costs for a student receiving services through a BOCES, or private school program, the costs for the IEP direct medical services must be discretely identified and included as contracted service costs (as defined in D.1.b). ~~LEAs will not be permitted to report BOCES costs as tuition costs.~~

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 paragraph~~s~~ b (Contracted Service Costs) ~~or c (Tuition Costs)~~ of this section.

i. Intergovernmental Agreement Contracted Service Costs

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.

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.

The revenue offset will be calculated based on the calculation of the Medicaid Allowable Costs for the LEA incurring the expense. Therefore, the revenue offset will be calculated using the IEP Ratio of the LEA reporting the expense. This will ensure that the net Medicaid Allowable Cost for the transaction will be $0.

~~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 October 1, 2011 – June 30, 2012, the ST-3s from the 2009-2010 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 website at:~~

~~https://www.health.ny.gov/health_care/medicaid/program/psshsp/~~

~~and the State Education Department website at:~~

~~http://www.oms.nysed.gov/medicaid/CPEs/home.html.~~

~~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 paragraph D.1.a., following the application of the Direct Medical Service Time Study Percentage, defined in paragraph D.3. The unrestricted indirect cost rate will not be applied to Contracted Service Costs (D.1.b), ~~Tuition Costs (D.1.c),~~ Intergovernmental Agreement Costs (D.1.d) and Contracted Transportation Service Costs (E.2.e). New York public schools use predetermined fixed rates for indirect costs. The New York 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 SED, 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

a. Apply the New York Public Schools Cognizant Agency Unrestricted Indirect Cost rate applicable for the dates of service in the rate year.
b. The New York UICR is the unrestricted indirect cost rate calculated by the New York State Education Department.

New York
17(l)(iii)

1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

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. When the participant is providing a direct medical service, as part of their response, they will indicate how medical necessity has been established (IEP/IFSP, other plans of care) and that will determine which direct service code the moment is assigned to. 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.

   The average of the three sample period time studies will be used to determine the percentage of time spent on the provision of medical services to students with an IEP/IFSP, other medical plans of care or where medical necessity has been otherwise established and applied statewide. All regular school days are part of the RMTS universe. The average of the three sample period time studies will be applied to the costs that accrue during the summer period.

   RMTS Sampling Periods
   Effective on 7/1/2023: The sampling period is defined as follows for the SSHS Program:
   • Sample Period 1 = mid-August – December 31*
   • Sample Period 2 = January 1 – March 31
   • Sample Period 3 = April 1 – June 30
   • Sample Period 4 = July 1 – mid-August** (the summer sample period)

   *the time study period will begin with the first regular school day when any participating district returns from the summer break and will continue until the end of December

   **no time study will be generated. The sample period will run from the day after the last regular school day until the day before the first regular school day for any participating district

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1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

3. **Time Study (continued):**

Direct Medical Service Therapy RMTS Percentage

a. Fee-For-Service RMTS Percentage

i. Direct Medical Service Therapy Cost Pool (IEP): 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.

ii. Direct Medical Service Therapy Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.c.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

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.

Direct Medical Service All Other RMTS Percentage

a. Fee-For-Service RMTS Percentage

i. Direct Medical Service All Other Cost Pool (IEP): 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.

ii. Direct Medical Service All Other Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.c.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

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1905(a)(4)(b) Early and Periodic Screening, Diagnostic and Treatment services

~~b.General Administrative Percentage Allocation~~

~~i. 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.~~

~~The formula below details the Direct Medical Percentage (Activity 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 = Unallowable (Activity Code 11)~~

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

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 of students that had a direct medical service in an IEP during the school year for which the report is completed. *For example*, for the cost reporting period covering July 1, 2012 through June 30, 2013, the IEP Ratio will be based on the count of students with an IEP at any time during the July 1, 2012 through June 30, 2013 school year. The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed. The denominator will be the total number of students in the LEA with an IEP with a direct medical service as outlined in their IEP at any time during the school year reporting period. 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 described above, and MMIS data for the fiscal year for which the cost report is completed.

   Medicaid Enrollment Ratio for non-IEP Other Medical Plans of Care (for example, including Individual Health Care Plans, Behavioral Health Care Plans, 504 Plans, etc.). The Medicaid Enrollment Ratio for Other Plans of Care will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to medical plans of care other than an IEP/IFSP. The numerator of this rate will be Medicaid eligible non-IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed and the denominator will be the total number of students. This ratio will be calculated for each LEA on an annual basis.

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1905(a)(4)(b) Early and Periodic Screening, Diagnostic, and Treatment ~~S~~services

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 for school health services delivered during the reporting period as documented in the MMIS and CMS-64 form, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State ~~may~~ will 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.

I. Cost Settlement Process

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. The final reconciliation will occur prior to the 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.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance ~~may~~ will be subjected to a corrective action plan.

If final reconciled 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, 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 on the CMS-64 form for the quarter corresponding to the date of payment.

~~J. Sunset Date~~

~~Effective for dates of service on or after July 1, 2020 through June 30, 2023; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, 2023.~~

Appendix II
2023 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #23-0072

This State Plan Amendment proposes to continue certified public expenditures (CPEs) reimbursement methodology for School Supportive Health Services. The Department also proposes to expand the Preschool/School Supportive Health Services Program (SSHSP) to include services provided to Medicaid-enrolled students without Individualized Education Plans (IEPs) under 'free care' option (ref. SMD letter 14-0006).

Appendix III
2023 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

SPA 23-0072
Authorizing Provisions

Sections 368-D and 368-E of the Social Services Law:

§ 368-d. Reimbursement to 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.

1. The department of health shall review claims for expenditures made by or on behalf of local 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 which are furnished to children with handicapping conditions or such children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such local public school district, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, which furnished the care, services or supplies either directly or by contract.

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

3. The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

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.

(d) Upon selection of a contractor or contractors, the department of health shall provide written notification of such selection and a summary of the criteria employed in such selection to the chair of the senate finance committee and the chair of the assembly ways and means committee.

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, 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 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 one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal years 2013-14 and 2014-15, the excess amount shall be transferred to such public school districts in amounts proportional to their percentage contribution to the statewide savings; an amount equal to thirteen and five hundredths percent of any decrease in the state share of annual expenditures pursuant to this section for such recipients in state fiscal year 2015-16 and any fiscal year thereafter shall be transferred to such public school districts in amounts proportional to their percentage contribution to the statewide savings. Any amount transferred pursuant to this section 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.

§ 368-e. Reimbursement to counties for pre-school children with handicapping conditions. 1. The department of health shall review claims for expenditures made by counties and the city of New York for medical care, services and supplies which are furnished to preschool children with handicapping conditions or such preschool children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such county or city which furnished the care, services or supplies either directly or by contract. Notwithstanding any provisions of law, rule or regulation to the contrary, any clinic or diagnostic and treatment center licensed under article twenty-eight of the public health law, which as determined by

the state education department, in conjunction with the department of health, has a less than arms length relationship with the provider approved under section forty-four hundred ten of the education law shall, subject to the approval of the department and based on standards developed by the department, be authorized to directly submit such claims for medical assistance, services or supplies so furnished for any period beginning on or after July first, nineteen hundred ninety-seven. The actual full cost of the individualized education program (IEP) related services incurred by the clinic shall be reported on the New York State Consolidated Fiscal Report in the education law section forty-four hundred ten program cost center in which the student is placed and the associated medical assistance revenue shall be reported in the same manner.

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

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.

(d) Upon selection of a contractor or contractors, the department of health shall provide written notification of such selection and a summary of the criteria employed in such selection to the chair of the senate finance committee and the chair of the assembly ways and means committee.

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 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, 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 one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal years 2013-14 and 2014-15, the excess amount shall be transferred to such counties in amounts proportional to their percentage contribution to the statewide savings; an amount equal to thirteen and five hundredths percent of any decrease in the state share of annual expenditures pursuant to this section for such recipients in state fiscal year 2015-16 and any fiscal year thereafter shall be transferred to such counties in amounts proportional to their percentage contribution to the statewide savings. Any amount transferred pursuant to this section 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.

The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

Appendix IV
2023 Title XIX State Plan
Third Quarter Amendment
Public Notice

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

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.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 comply with Sections 368-d and 368-e of the Social Services Law. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2023, the Department of Health proposes to request federal approval to extend utilization of certified public expenditures (CPEs) reimbursement methodology for School Supportive Health Services. The Department also intends to request federal approval to include coverage of medical services under the Medicaid School Supportive Health Services Program (SSHSP) for all Medicaid-enrolled students, including those without an Individualized Education Plan.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $25 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

New York City Deferred Compensation Plan and NYCE IRA

The New York City Deferred Compensation Plan & NYCE IRA (the "Plan") is seeking proposals from qualified vendors to provide Investment Consulting Services for the City of New York Deferred Compensation Plan. The Request for Proposals ("RFP") will be available beginning on Monday, June 12, 2023. Responses are due no later than 4:30 p.m. Eastern Time on Friday, June 30, 2023. To obtain a copy of the RFP, please visit the Plan's website at www1.nyc.gov/site/olr/about/about-rfp.page and download and review the applicable documents.

If you have any questions, please email them to: Georgette Gestely, Director, at RFPMail@nyceplans.org

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State
F-2023-0357
Date of Issuance – June 28, 2023

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act (CZMA) of 1972, as amended.

The applicant has certified that the proposed activities comply with and will be conducted in a manner consistent with the federally approved New York State Coastal Management Program (NYSCMP). The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2023-0357, the applicant, Gina Yannucci, is proposing to remove existing fixed dock and floats and install a new 4' x 120' open grate catwalk leading to seasonal 3' x 30' ramp, 5' x 40' float, 15' x 15' float, and 6' x 12' jet ski float. Catwalk to be elevated 4' over tidal vegetation, supported by (22) 10″ diameter piles, and floats will be chocked 24″ off bottom. This project is located at 98 Old Field Road, Village of Old Field, Suffolk County, Conscience Bay

The applicant's consistency certification and supporting information are available for review at: https://dos.ny.gov/system/files/documents/2023/06/f-2023-0357.pdf or at https://dos.ny.gov/public-notices

The proposed activity would be located within or has the potential to affect the following Special Management or Regulated Area(s):

- Conscience Bay, Little Bay, & Setauket Harbor Significant Coastal Fish and Wildlife Habitat: https://dos.ny.gov/system/files/documents/2020/03/conscience_bay_little_bay_setauket_harbor.pdf

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice or July 28, 2023.

Comments should be addressed to: Department of State, Office of Planning and Development and Community Infrastructure, Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000. Electronic submissions can be made by email at: CR@dos.ny.gov

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

Appendix V
2023 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #23-0072

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 the 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: Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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 Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

The federal and non-federal shares associated with the provisions of this SPA are funded from appropriations by the State Legislature to two separate State agencies, the State Education Department (SED) and the State Department of Health (SDOH). The SED non-federal share appropriation authority is transferred or sub-allocated from the SED to the SDOH (the single state Medicaid agency) which enables the SDOH to draw general funds dollars directly to fund the non-federal share of payments for SSHS. This transfer authority for the federal share is already resident in the SDOH budget; transferring budget authorization from SED to DOH enables the SDOH to make the 100% computable payment.

Specific to the certified public expenditure (CPE) methodology, the State and CMS review the cost report final calculations for each participating Preschool/School Supportive Health Services (P/SSHS) provider to verify the eligibility of the reported expenditures for Federal matching funds.

		4/1/23 – 3/31/24	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund	$12.5M	$25M

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

   In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate

claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

B. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	$5.200B
Suffolk County	$226M
Nassau County	$217M
Westchester County	$204M
Erie County	$194M
Rest of State (53 Counties)	$1.187B
Total	**$7.228B**

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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 Medicaid payments under this State Plan Amendment are not supplemental 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. Under regulations at 42 CFR 447.272, 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: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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 this State Plan for school supportive health services is cost-based. Rates of payment for services are currently based upon the 2017 Medicare fee schedule, except for rates for special transportation services, which are based on a cost study. 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 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: The State complies 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 17-0065, 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.