NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 30, 2013

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #13-49
Institutional Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-49 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2013 (Appendix I). This amendment is being submitted based upon adopted regulations. A summary of the proposed amendment is contained 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 adopted regulations are 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 26, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VII, respectively).

If you have any questions regarding this matter, 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

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **13-49**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2013**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR §447.27z(a)**	7. FEDERAL BUDGET IMPACT: **a. FFY 07/01/13-09/30/13 ($250,000)** **b. FFY 10/01/13-09/30/14 ($1,000,000)**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A – Part III: Pages 3, 4**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A – Part III: Pages 3, 4**	
10. SUBJECT OF AMENDMENT: **2013/14 OMH – RTF Continuance of Rate (FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**	
13. TYPED NAME: **Jason A. Helgerson**		
14. TITLE: **Medicaid Director** **Department of Health**		
15. DATE SUBMITTED: September 30, 2013		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of [98] 96 percent and a minimum utilization of [95] 93 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

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

Effective July 1, 2012 through June 30, 2013, the rate of payment shall be that which was in effect June 30, 2011.

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

1. OPERATING COSTS

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

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

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

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

Allowable operating costs as determined in the preceding paragraphs will be increased annually by the Medicare inflation factor for hospitals and units excluded from the prospective payment system except for the rate periods effective July 1, 1995 through June 30, 1996, [and] July 1, 2009 through June 30, 2010, and July 1, 2013 through June 30, 2014 where no inflation factor will be used to trend costs.

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

3. APPEALS

The Commissioner may consider requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in service, programs, or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Other rate revisions may be based on additional staffing required to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

Appendix II
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #13-49

This State Plan Amendment proposes to reflect no trend factor applied to allowable costs, an updating of the base year from 2008-09 to 2011-12, and an adjustment to the utilization range for the 2013-14 rate year for residential treatment facilities for children and youth (RTFs) licensed by the Office of Mental Health.

Appendix III
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions

EMERGENCY/PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

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

I.D. No. OMH-29-13-00010-EP
Filing No. 700
Filing Date: 2013-06-28
Effective Date: 2013-06-28

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

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

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Finding of necessity for emergency rule: Preservation of public health, public safety and general welfare.

Specific reasons underlying the finding of necessity: The specific reasons underlying the finding of necessity for emergency filing are as follows:

The amendments to 14 NYCRR Part 578 remove the trend factor from the 2013-14 Medicaid rate calculation for residential treatment facilities (RTF) for children and youth, which are identified as a subclass of hospitals under Section 31.26 of the Mental Hygiene Law. As a result, the rate of growth in Medicaid expenditures is slowed, yet the RTF's quality and availability of services are maintained. The amendments also include an adjustment to the imputed occupancy rates, which will mitigate the potential impact of vacant beds caused by reducing the lengths of stay in the program.

The amendments are an Administrative Action consistent with the 2013-2014 enacted State Budget, and with actions taken by the Department of Health for other inpatient services. They reflect the serious fiscal condition of the State. It is estimated that this action will result in an annual reduction in Medicaid growth of approximately $1.0 million State share of Medicaid ($2.0 million gross Medicaid). Existing regulations provide for a trend factor effective July 1, 2013; therefore, it is imperative that this rule be adopted on an Emergency basis until such time as it has been formally adopted through the SAPA rule promulgation process.

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

Purpose: To remove the trend factor from the 2013-14 Medicaid rate calculation and adjust the occupancy rates.

Text of emergency/proposed rule: 1. Paragraph (4) of subdivision (a) of Section 578.8 of Title 14 NYCRR is amended to read as follows:

(4) The allowable costs, as set forth in paragraph (1) of this subdivision, that meet the requirements stated in paragraphs (2) and (3) of this subdivision, shall be trended by the applicable Medicare inflation factor for hospitals and units excluded from the prospective payment system except for the rate periods effective July 1, 1996 through June 30, 1997, and July 1, 2009 through June 30, 2010, where the inflation factor used to trend costs will be limited to the inflation factor for the first year of the two-year period. *No trend shall be applied to allowable costs for the rate period effective July 1, 2013 through June 30, 2014.*

2. Subdivision (d) of Section 578.9 of Title 14 NYCRR is amended to read as follows:

(d) For a currently certified residential treatment facility decreasing certified bed capacity by 20 percent or more, the rate of payment may be computed using the facility's existing reimbursement adjusted by the budgeted variable costs associated with the decrease in certified capacity. Rate(s) of payment may be calculated to reflect a phase down period, and a budget based period thereafter. Each period may not exceed 12 months.

(1) Rates of payment calculated for the phase down period shall be developed from the residential treatment facility's existing reimbursement, adjusted by any variable cost decreases or extraordinary cost increases, and adjusted by the phase down utilization. More than one rate of payment may be calculated to coincide with the facility's phase down period, which shall be determined at the commissioner's discretion.

(i) The existing rate of payment is multiplied by the patient days used in the calculation of that rate of payment, resulting in a dollar amount of reimbursement.

(ii) The amount of reimbursement is adjusted by the applicable amount of variable cost decrease and the amount of any extraordinary cost associated with the phase down.

(iii) The total reimbursement is then divided by the product of the targeted certified capacity for the applicable period of the phase down, multiplied by the number of days in the period and by a minimum utilization of [97] *96* percent.

(2) The rate of payment for the subsequent budget based period shall be developed from the residential treatment facility's existing reimbursement, adjusted by any variable cost decreases or extraordinary cost increases, adjusted for inflation as appropriate, and adjusted to the staffing standards for medical/clinical and nursing categories, as approved by the commissioner.

(i) The existing rate of payment is multiplied by the patient days used in the calculation of that rate of payment, resulting in a dollar amount of reimbursement. The reimbursement is then increased by an appropriate inflation factor, as determined by the commissioner.

(ii) The amount of reimbursement is adjusted by the applicable amount of variable cost decrease and the amount of any extraordinary cost associated with the phase down.

(iii) Costs for the medical/clinical and nursing categories are deleted, and are substituted as follows. Medical/clinical and nursing costs are computed using the full time equivalent staffing standards, as approved by the commissioner, multiplied by the facility's salary and fringe benefit cost experience. The resulting combined amount is subject to the average salary and fringe benefit screens, as specified in section 578.8(a)(2)(ii) and (iii) of this Part, multiplied by the approved staffing standards. The cost data is made comparable by applying the appropriate trend factors as determined by the commissioner.

(iv) Capital costs shall be updated in accordance with the approved costs as specified in section [578.8(a)(6)] *578.8(a)(5)* of this Part.

(v) The total reimbursement (the sum of immediately preceding subparagraphs (i) through (iv) of this paragraph) is then divided by the product of the certified capacity for the phased down budget based period, multiplied by the number of days in the period and by a minimum utilization of [97] *96* percent.

3. Subdivision (a) of Section 578.13 of Title 14 NYCRR is amended to read as follows:

(a) For purposes of determining a rate of payment, allowable patient days shall be computed using the higher of allowable days pursuant to section 578.4(b) of this Part or a minimum utilization of [95] *93* percent of certified bed capacity, provided that the number of allowable days shall not exceed a maximum utilization of [98] *96* percent of certified bed capacity.

This notice is intended: to serve as both a notice of emergency adoption and a notice of proposed rule making. The emergency rule will expire September 25, 2013.

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

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

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

Regulatory Impact Statement

1. Statutory authority: Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the authority and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.

Section 43.02 of the Mental Hygiene Law provides that the Commissioner has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services provided by facilities, including residential treatment facilities for children and youth licensed by the Office of Mental Health.

2. Legislative objectives: Article 7 of the Mental Hygiene Law reflects the Commissioner's authority to establish regulations regarding mental health programs. The amendments to Part 578 are needed to reduce the growth rate of Medicaid reimbursement associated with residential treatment facilities for children and youth regulated by the Office of Mental Health (OMH) thereby ensuring consistency with the enacted 2013-2014 state budget. The amendments also reflect adjustments to the imputed occupancy rates used to calculate the Medicaid rates, thereby more accurately reflecting the impact of reduced lengths of stay in the programs.

3. Needs and benefits: The amendments remove the trend factor from the 2013-14 Medicaid rate calculation for residential treatment facilities (RTF) for children and youth, which are identified as a subclass of hospitals under Section 31.26 of the Mental Hygiene Law. As a result, the rate of growth in Medicaid expenditures is slowed, yet the RTF's quality and availability of services are maintained. This is an Administrative Action consistent with the 2013-2014 enacted State Budget, and with actions taken by the Department of Health for other inpatient services. It reflects the serious fiscal condition of the State. The amendments also include an adjustment to the imputed occupancy rates, which will mitigate the potential impact of vacant beds caused by reducing the lengths of stay in the program.

4. Costs:

(a) cost to State government: It is estimated that this action will result in an annual reduction in Medicaid growth of approximately $1.0 million State share of Medicaid ($2.0 million gross Medicaid).

(b) cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) cost to regulated parties: This regulatory amendment will not result in any additional cost to regulated parties, but will reduce the rate of growth in Medicaid payments that the RTF providers receive.

5. Local government mandates: These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. Paperwork: This rule should not substantially increase the paperwork requirements of affected providers.

7. Duplication: These regulatory amendments do not duplicate existing State or federal requirements.

8. Alternatives: As noted above, this amendment is consistent with the 2013-2014 enacted State Budget and the budgetary constraints included therein. OMH has determined that the elimination of the trend factor for RTFs would not affect the ability of those programs to continue to function and serve the children and youth who are receiving services there, and that the change in the occupancy rates used to impute patient days in the rate calculation will more accurately reflect the operation of the program and the reduced lengths of stay. The only alternative to this rule making would have been to make budgetary cuts to another program which would not have been as sustainable as the residential treatment facilities, and to leave the current occupancy rates unchanged thereby not reflecting the changes observed in lengths of stay. Therefore, that alternative was not considered.

9. Federal standards: The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: The regulatory amendments would become effective immediately upon adoption.

Regulatory Flexibility Analysis

The proposed rule amending 14 NYCRR Part 578 removes the trend factor from the 2013-2014 Medicaid rate calculation for residential treatment facilities for children and youth, and as a result, slows the rate of growth in Medicaid payments while maintaining the program's quality and availability of services. The amendments are the result of an Administrative Action consistent with the 2013-2014 enacted State Budget and with actions taken by the Department of Health for other inpatient services. In addition, the rule includes an adjustment to the occupancy rates used to impute patient days in the rate calculation to more accurately reflect the operation of the program and the reduced lengths of stay. There will be no adverse economic impact on small business or local governments; therefore a Regulatory Flexibility Analysis for Small Business and Local Governments has not been submitted with this notice.

Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis is not submitted with this notice because the amendments will not impose any adverse economic impact on rural areas. The proposed rule removes the trend factor from the 2013-2014 Medicaid rate calculation for residential treatment facilities for children and youth, and as a result, slows the rate of growth in Medicaid payments while maintaining the program's quality and availability of services. In addition, the rule includes an adjustment to the occupancy rates used to impute patient days in the rate calculation to more accurately reflect the operation of the program and the reduced lengths of stay.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because the purpose of the rule is to remove the trend factor from the 2013-2014 Medicaid rate calculation for residential treatment facilities for children and youth regulated by the Office of Mental Health. This is an Administrative Action consistent with the 2013-2014 enacted State budget and with actions taken by the Department of Health for other inpatient services. The rule includes an adjustment to the occupancy rates used to impute patient days in the rate calculation to more accurately reflect the operation of the program and the reduced lengths of stay. The result of this rule making is the rate of growth in Medicaid expenditures is slowed, but a program's quality and availability of services is maintained. There will be no adverse impact on jobs and employment opportunities.

Office for People with Developmental Disabilities

EMERGENCY RULE MAKING

Implementation of the Protection of People with Special Needs Act and Reforms to Incident Management

I.D. No. PDD-29-13-00012-E
Filing No. 702
Filing Date: 2013-06-28
Effective Date: 2013-06-30

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

Action taken: Amendment of Parts 624, 633 and 687, and addition of new Part 625 to Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 13.07, 13.09(b) and 16.00; L. 2012, ch. 501

Finding of necessity for emergency rule: Preservation of public health, public safety and general welfare.

Specific reasons underlying the finding of necessity: The immediate adoption of these amendments is necessary for the preservation of the health, safety, and welfare of individuals receiving services.

Last December, the Governor signed the Protection of People with Special Needs Act (PPSNA). This new law created the Justice Center for the Protection of People with Special Needs (Justice Center) and established many new protections for vulnerable persons, including a new system for incident management in services operated or certified by OPWDD and new requirements for more comprehensive and coordinated pre-employment background checks.

The amendment of OPWDD regulations, effective June 30, 2013 is necessary to implement many of the provisions contained in the PPSNA.

The promulgation of these regulations is essential to preserve the health, safety and welfare of individuals with developmental disabilities who receive services in the OPWDD system. If OWPDD did not promulgate regulations on an emergency basis, many of the protections established by the PPSNA vital to the health, safety and welfare of individuals with developmental disabilities would not be implemented or would be implemented ineffectively. Further, protections for individuals receiving services would be threatened by the confusion resulting from inconsistent requirements. For example, the emergency regulations change the categories of incidents to conform to the categories established by the PPSNA. Without the promulgation of these amendments, agencies would be required to report incidents based on one set of definitions to the Justice Center and incidents based on a different set of definitions to OPWDD. Requirements for the management of incidents would also be inconsistent. Especially concerning regulatory requirements related to incident management and pre-employment background checks, it is crucial that OPWDD regulations be changed to support the new requirements in the PPSNA so that this initiative is implemented in a coordinated fashion.

OPWDD was not able to use the regular rulemaking process established by the State Administrative Procedure Act because there was not sufficient time to develop and promulgate regulations within the necessary timeframes.

Subject: Implementation of the Protection of People with Special Needs Act and reforms to incident management.

Purpose: To enhance protections for people with developmental disabilities served in the OPWDD system.

Substance of emergency rule: The emergency regulations conform OPWDD regulations to Chapter 501 of the Laws of 2012 (Protection of People with Special Needs Act or PPSNA) by making a number of revisions. The major changes to OPWDD regulations made to implement the PPSNA are:

• Revisions to 14 NYCRR Part 624 (now titled "Reportable incidents and notable occurrences") to incorporate categories of "reportable incidents" as established by the PPSNA. Programs and facilities certified or operated by OPWDD must report "reportable incidents" to the Vulnerable Persons' Central Register (VPCR), a part of the Justice Center for the Protection of People with Special Needs (Justice Center). Part 624 is amended to incorporate other revisions related to the management of

Appendix IV
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
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, Bureau of HCRA Operations & Financial Analysis, 99 Washington Ave. – One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa__inquiries@health.state.ny.us

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 inpatient hospital services for Residential Treatment Facilities for Children and Youth to: (1) reflect no trend factor applied to allowable costs; (2) to update the base year from 2008-09 to 2011-12; and, (3) to make an adjustment to the utilization range, with all such changes to be effective July 1, 2013.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is ($2,000,000).

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
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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa__inquiries@health.state.ny.us

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 40, Subdivision f, of the Retirement and Social Security Law on or before July 31, 2011. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St, in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Washington, Gerald L - Chatham, NY

For further information contact: Mary Ellen Kutey, New York State Retirement Systems, 110 State St., Albany, NY 12244, (518) 474-3502

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 340, Subdivision f, of the Retirement and Social Security Law on or before December 31, 2010. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St, in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Beckwith, Stanley C - Shelter Island, NY

For further information contact: Mary Ellen Kutey, New York State Retirement Systems, 110 State St., Albany, NY 12244, (518) 474-3502

Appendix V
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

INSTITUTIONAL SERVICES
State Plan Amendment #13-49

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-A 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: The total annual Medicaid reimbursement for all nineteen RTFs is approximately $95.9 million. Five of the nineteen Residential Treatment Facilities (RTFs) covered under this proposed Plan Amendment currently have capital construction bonds outstanding that were issued by the Dormitory Authority of the State of New York (DASNY). A portion of the Medicaid payments for these five facilities (i.e. an amount equal to the debt service on the bonds) is paid directly to the OMH. The OMH acts as an agent and forwards these funds to DASNY which makes the debt service payments on the bonds for these providers. The entire balance of Medicaid payments that is paid directly to the RTFs is retained by them to support their costs of operations.

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

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

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

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

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

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

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

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

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

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

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

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the**

cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

Response: 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.

Appendix VI
2013 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Responses to Standard Access Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-49

CMS Standard Access Questions

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

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

   Response: This amendment seeks to recognize lower lengths of stay resulting in increased bed turnover without increasing the Program's cost. It will maintain patient access and quality of care.

   The State Plan for the Residential Treatment Facilities for Children and Youth established the framework for setting Medicaid rates for the 19 providers licensed by the Office of Mental Health. In doing so, eligible children and youths have been and are currently receiving inpatient treatment that they may not have otherwise been afforded.

   This proposed amendment will not have an adverse effect on providers, because the current rates paid to these providers continues to be adequate to ensure access and quality of care.

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

   Response: This amendment does adjust rates based on the proposed changes to the utilization standards and the rebasing of costs.

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

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

will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

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

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

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2013-14 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

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

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

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