DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

November 23, 2020

Donna Frescatore
Medicaid Director
NYS Department of Health
One Commerce Plaza
Suite 1211
Albany, NY 12210

Reference: TN 20-0062

Dear Ms Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 20-0062. Effective July 1, 2020, this amendment proposes to make administrative revisions to the Psychiatric Residential Treatment Facility (PRTF) plan language with no changes to the reimbursement methodology except to clarify: (1) defined terminologies under operating and capital costs; and the basis for appeals particularly with regards for new facilities who experience changes in capacity; and (2) methods for smooth transition of services or closure of facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447.

This is to inform you that Medicaid State plan amendment 20-0062 is approved effective July 1, 2020. The CMS-179 and the amended plan pages are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

For

Rory Howe
Acting Director

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: 20 — 0062

2. STATE: New York

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2020

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 447.272(a)

7. FEDERAL BUDGET IMPACT
a. FFY 07/01/20-09/30/20 $ 0.00
b. FFY 10/01/20-09/30/21 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Part III Page: 3, 3(a), 4, 4(a), 5, 6, 7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part III Page: 3, 3(a), 4, 4(a), 5, 6, 7

10. SUBJECT OF AMENDMENT
Residential Treatment Facility (RTF) Rate Methodology Updates (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
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
September 25, 2020

16. 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 REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
11/23/20

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted] For

21. TYPED NAME
Rory Howe

22. TITLE
Acting Director

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Appendix I
2020 Title XIX State Plan
Third Quarter Amendment
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. Alternate Cost Reports may be utilized to align with appealed rate periods until such time that the appealed information would be fully reflected in the facilities annual cost report. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 90 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 will be that which was in effect June 30, 2011.

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

Effective July 1, 2015, 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. The Fee-for-Service Program will be utilized for the purchase of eligible pharmaceuticals commencing on the date the child is determined to be Medicaid eligible. The cost of medications provided to the child before the determination of Medicaid eligibility 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/Direct Care (C/DC). This category of costs includes salaries and fringe benefits for clinical and direct care staff.

(ii) [Other than Clinical Care.] Administration, Maintenance and Supports (AMS). This category of costs includes the costs associated with administration, maintenance and child support.

(iii) Purchased Health Services (PHS). This category of costs includes clinical services such as dental services, purchased on a contractual basis 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 per diem operating costs in the category of [clinical care] C/DC 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.]

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Allowable per diem operating costs in the category of other than clinical care are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the [clinical and other than clinical] C/DC and AMS categories are computed as follows. For RTFs located in the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the average per diem cost for all RTFs in this geographic area and 50 percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent. For RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the average per diem cost for all RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 50 percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent.

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, July 1, 2009 through June 30, 2010, July 1, 2013 through June 30, 2014 and July 1, 2014 through December 31, 2014, where no inflation factor will be used to trend costs. Effective January 1, 2015, allowable operating costs] will be trended by the Medicare inflation factor.

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] Prior Approval Review (PAR) 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] will 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 shall

- Capital projects approved by the Commissioner in connection with OMH's [certificate of need] PAR procedures.
- OMH approved changes in staffing plans submitted to DOH in a form as determined by the DOH.
- OMH approved changes in capacity approved by the Commissioner in connect with OMH's PAR procedures;
- Other rate revisions may be based on [additional staffing] require[d]ments 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 will utilize existing facility cost reports, adjusted as necessary. The rates of payment will be subject to total allowable costs, total allowable days, staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner. These rates must be certified by the Commissioners of OMH and DOH and approved by the Director of the Budget.

4. NEW RESIDENTIAL TREATMENT FACILITIES WITH INADEQUATE COST EXPERIENCE

Rates of payment for a new residential treatment facility with inadequate cost experience [shall] will be determined on the basis of satisfactory cost projections as submitted to the Commissioner. The rate of payment [shall] will [take into consideration] be subject to total allowable costs, total allowable days, [and shall be subject to] staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner.

Financial reports, reflecting actual cost and statistical information, in a form prescribed by the Commissioner, [shall] will be required within one hundred twenty days following the first six month period during which the Residential Treatment Facility has operated at an average utilization of at least ninety percent or one year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened.

5. DISPROPORTIONATE SHARE ADJUSTMENT

Due to State's reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for residential treatment centers for children and youth does not include a disproportionate share adjustment.

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[year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened, unless the Commissioner determines that the facility has not achieved the status of a stable, ongoing operation with reliable cost information, in which case the budget based rate will be continued, adjusted as necessary, for updated budget projections as appropriate.

5. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

Effective twelve months after the date the RTF submits financial reports reflecting actual operating costs or two years after the RTF begins operating, whichever is earlier, if it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the RTF because a medically necessary long term care bed is not available in the community, and it is determined by the Commissioner that there is a significant excess of operational beds at the RTF or in the RTFs located in the OMH region in which the RTF is located, the RTF will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services are furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the RTF for the most recently reported twelve month period is less than 80 percent in the case of RTFs with certified bed capacities greater than 20 beds or 60 percent in the case of RTFs with certified bed capacities of 20 beds or less, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational bed exists in an OMH region if the overall occupancy rate for RTFs in the region is less than the weighted average of 80 percent for RTFs in the region with certified bed capacities greater than 20 beds and 60 percent for RTFs in the region with certified bed capacities of 20 beds or less. The occupancy rate shall be determined without including alternate care days. The determination of average occupancy rate for RTFs in the region is applied to each of the five geographical OMH regions and is based on RTFs which are subject to the provisions of this section and which are located within the same OMH Region.

Alternate care determinations must be reported to the Office of Mental Health on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data prior to the effective date of the reduced payment provision.]

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[Due to State's reliance on Section 1923(e) of the Social Security Act, the reimbursement methodology for residential treatment centers for children and youth does not include a disproportionate share adjustment.]

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[A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly composed of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH' facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.]