Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

MAR 31 2015

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

Re: SPA #15-0018

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0018 to the Title XIX (Medicaid) State Plan for services provided in residential treatment facilities for children and youth licensed by the Office of Mental Health, to be effective January 1, 2015 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on December 31, 2014.

It is estimated that the changes represented by 2015 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate

share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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: **15-0018**	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 **January 1, 2015**	

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: **(in thousands)** **a. FFY 01/01/15-09/30/15 $ 808.75** **b. FFY 10/01/15-03/31/16 $ 539.17**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A Part III Page: 4**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A Part III Page: 4**

10. SUBJECT OF AMENDMENT:
1/1/15 RTF Trend
(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 Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: MAR 31 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2015 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

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 [June 30, 2015] <u>December 31, 2014</u>, where no inflation factor will be used to trend costs. <u>Effective January 1, 2015, allowable operating costs will be trended by the Medicare inflation factor.</u>

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
2015 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #15-0018

This State Plan Amendment proposes to reflect the inclusion of a trend factor applied to allowable costs effective January 1, 2015, for residential treatment facilities for children and youth (RTFs) licensed by the Office of Mental Health.

Appendix III
2015 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 15-0018

Chapter 60 of the Laws of 2014

PART I

Section 1. Subdivisions 3-b and 3-c of section 1 and section 4 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part N of chapter 56 of the laws of 2013, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [~~2014~~] **2016**, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [~~2014~~] **2016** and ending March 31, [~~2017~~] **2019**, the commissioners will develop the trend factor using the latest Medicare market basket index from the CMS.gov, Medicare Rehabilitation, Psychiatric, and long term care hospitals with Capital.

Access Provider denotes the Commissioner's determination to ensure patient access to a provider's essential services otherwise jeopardized by the provider's payer mix or geographic isolation.

530.2 Legal Base.

(a) Section 7.09 of the Mental Hygiene Law authorizes the Commissioner to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.

(b) Section 31.02 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for the provision of inpatient and outpatient mental health services.

(c) Section 43.02 of the Mental Hygiene Law authorizes the Office to establish rates or methods of payment for services at facilities subject to licensure or certification by the Office.

(d) Chapter 53 of the Laws of 2014 authorizes the Commissioner to provide special funding to certain designated providers.

530.3 Definitions.

(a) Vital Access Program ("VAP") means a program of supplemental funding and/or temporary rate or fee adjustments available to providers of mental health services that are determined by the Commissioner to be essential to the availability of mental health services in a geographic or economic region of the State but in financial jeopardy due to their payer mix or geographic isolation.

(b) Vital Access Provider means a provider of mental health clinic services that is licensed under Article 31 of the Mental Hygiene Law and that is designated by the Commissioner as eligible for participation in the Vital Access Program. It does not include a provider that is licensed under Article 28 of the Public Health Law.

530.4 Vital Access Program.

(a) The Commissioner may accept applications from licensed providers of mental health clinic services requesting designation as a Vital Access Provider eligible to receive supplemental funding or a temporary rate adjustment. The Commissioner may give priority to providers serving regions or populations in the State that he or she shall determine are in special need of services. Such applications must sufficiently demonstrate that:

(1) The provider is essential to maintaining access to the mental health services it is authorized to provide to individuals with mental illness who reside in the geographic or economic region of the State served by the provider;

(2) The provider is in financial jeopardy due to payer mix or geographic isolation;

(3) The additional resources provided by supplemental funding or a rate or fee adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the Commissioner.

(b) Application.

(1) The written application required pursuant to subdivision (a) of this Section shall be submitted to the Commissioner at least sixty (60) days prior to the requested effective date of the designation as a Vital Access Provider and shall include a proposed budget to achieve the goals identified in the application.

(2) The Commissioner may require that applications submitted pursuant to this Section be submitted in response to, and in accordance with, a Request For Applications or a Request For Proposals issued by the Office.

(c) Reimbursement.

A provider that is designated as a Vital Access Provider shall be eligible to receive supplemental funding or a temporary rate or fee adjustment.

(d) Conditions on Approval.

(1) Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time of no more than three years, as determined by the Commissioner, based upon review and approval of a specific plan of action to achieve one or more of the goals set forth in subdivision (a) of this section. At the end of the specified timeframe, the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology or fee schedule pertaining to such provider.

(2) The Commissioner may establish, as a condition of designation as a Vital Access Provider, benchmarks, goals and standards to be achieved, and may require such periodic reports as he or she shall determine to be necessary to ensure their achievement. A determination by the Commissioner of a failure to demonstrate satisfactory progress in achieving such benchmarks, goals and standards shall be a basis for revoking the provider's designation as a Vital Access Provider, and terminating the supplemental funding or temporary rate or fee adjustment prior to the end of the specified timeframe.

(3) No portion of the funds received pursuant to this Part shall be used for the payment of any prior debt or obligation incurred by the designated provider, or for any purpose not related to the purposes set forth in this Part.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 530.4(d)(1) and (2).

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

Revised Regulatory Impact Statement

The changes made to the published rule do not necessitate revision to the previously published Regulatory Impact Statement ("RIS") for the regulatory filing to create a new 14 NYCRR Part 503 – Vital Access Program and Providers. The revisions to the rule merely clarify the text by correcting technical errors (i.e., citation and grammar), which require no change to the RIS.

Revised Regulatory Flexibility Analysis

The changes made to the published rule do not necessitate revision to the previously published Regulatory Flexibility Analysis for Small Business and Local Governments ("RFASBLG") for the regulatory filing to create a new 14 NYCRR Part 530 – Vital Access Program and Providers. The revisions to the rule merely clarify the text by correcting technical errors (i.e., citation and grammar), which require no change to the RFASBLG.

Revised Rural Area Flexibility Analysis

The changes made to the published rule do not necessitate revision to the previously published Rural Area Flexibility Analysis ("RAFA") for the regulatory filing to create a new 14 NYCRR Part 530 – Vital Access Program and Providers. The revisions to the rule merely clarify the text by correcting technical errors (i.e., citation and grammar), which require no change to the RAFA.

Revised Job Impact Statement

The changes made to the published rule do not necessitate revision to the previously published Job Impact Statement ("JIS") for the regulatory filing to create a new 14 NYCRR Part 530 – Vital Access Program and Providers. The revisions to the rule merely clarify the text by correcting technical errors (i.e., citation and grammar), which require no change to the JIS.

Initial Review of Rule

As a rule that does not require a RFA, RAFA or JIS, this rule will be initially reviewed in the calendar year 2020, which is no later than the 5th year after the year in which this rule is being adopted.

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

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

I.D. No. OMH-47-14-00011-A

Filing No. 44

Filing Date: 2015-01-13

Effective Date: 2015-01-28

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

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

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

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

Purpose: Elimination of the trend factor effective July 1, 2014 through June 30, 2015.

Text or summary was published in the November 26, 2014 issue of the Register, I.D. No. OMH-47-14-00011-P.

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

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

Initial Review of Rule

As a rule that does not require a RFA, RAFA or JIS, this rule will be initially reviewed in the calendar year 2020, which is no later than the 5th year after the year in which this rule is being adopted.

Assessment of Public Comment

The agency received no public comment.

Appendix IV
2015 Title XIX State Plan
First Quarter Amendment
Public Notice

12-31-14

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2015 will be conducted on January 13 and January 14 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

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

PUBLIC NOTICE
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 institutional, non-institutional or long term care services to comply with enacted statutory provisions. The following changes are proposed:

All Services

• Effective January 1, 2015, the Department of Health and Division of Budget will determine the extent of Medicaid savings available under the Medicaid Global Spending Cap for distribution among Medicaid providers and managed care plans prior to the last quarter of each state fiscal year. Funds up to the amount available under the Medicaid Global Spending Cap will be distributed through an allocation plan that utilizes three years of the most recently available system-wide expenditure data reflecting both MMIS and managed care encounters. The dividend will be allocated proportionately by the Medicaid expenditure data. Distributions to managed care plans will be calculated using the administrative outlays stemming from participation in the Medicaid program.

No greater than fifty percent of the funding available for a dividend will be made available for the purposes of ensuring a minimum level of assistance to financially distressed and critically needed providers.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendment.

Non-Institutional Services

The Ambulatory Patient Group (APG) reimbursement methodology is extended for the period January 1, 2015 through March 31, 2017. Such methodology is revised to include recalculated weight and component updates that will become effective on or after January 1, 2015.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $1,944,230.

Institutional Services

• Effective January 1, 2015 through March 31, 2016, the New York State Office of Mental Health hereby gives notice that it is proposing to amend its Medicaid State Plan for Residential Treatment Facilities for Children and Youth. The amendment will reflect the inclusion of a trend factor applied to allowable costs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year (SFY) 2014/2015 is $508,864 and for SFY 2015/2016 is $2,035,457.

• Effective January 1, 2015 the State will change the methods and standards for determining payment rates for the services listed below to provide funding to support a two percent increase in annual salary and salary-related fringe benefits for direct care staff and direct support professionals, and in payment to foster parents and adoptive parents.

Effective April 1, 2015, a new two percent increase in annual salary and salary-related fringe benefits will be applied for direct care staff, direct support professionals and clinical staff, and in payment to foster parents and adoptive parents for the following programs:

- VOICF
- VOIRA – Supervised
- VOIRA – Supportive
- VO Day Habilitation
- VO Pre-Vocational
- VO Respite – Hourly
- VO Respite – Freestanding
- SO and VO Family Care
- VO Supported Employment
- VO Community Habilitation

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for SFY 2014/2015 is $11,291,837.

• As previously noticed September 10, 2014 and October 8, 2014, the additional temporary rate adjustment for Arnot Ogden Medical Center related to general hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers incorrectly stated the name of the provider. This will clarify that the provider should be St. Joseph's Hospital, which is part of Arnot Health.

Appendix V
2015 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #15-0018

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

   Response: The total annual Medicaid reimbursement for all nineteen RTFs is approximately $89 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 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).**

<u>Response:</u> 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. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

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

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

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

ACA Assurances:

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

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

   Response: The State 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 State 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.