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State/Territory Name: New York

State Plan Amendment (SPA) #: 16-0020

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS 179 Form

3) Approved SP A Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: GC: SPA NY-16-0020

November 30, 2016

Jason Helgerson
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP-1211)
Albany, New York 12237
RE: New York 15-0038

Dear Mr. Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #16-0020 has been approved for adoption into the State Medicaid Plan with an effective date of July 1, 2016. This State Plan Amendment proposes to revise the IEP eligibility ratio formula for school-based health services for school-age children and extend the sunset date to June 30, 2017.

Enclosed are copies of SPA # 16-0020 as approved. If you have any questions or wish to discuss this SPA further, please contact Gary Critelli. Mr. Critelli may be reached at (518) 518-396-3810.

Sincerely,

[redacted]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

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: **16-0020**	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, 2016**	

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: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/16-09/30/16 $ 1,500** **b. FFY 10/01/16-06/30/17 $ 6,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 10-1E, 10-1F, 10-1G, 17(s), 17(s)(i), 17(u)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 10-1E, 10-1F, 10-1G, 17(s), 17(s)(i), 17(u)**

10. SUBJECT OF AMENDMENT:
School Supportive Health - Preschool
(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]	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: SEP 2 9 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **NOVEMBER 30, 2016**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **JULY 01, 2016**	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: **MICHAEL MELENDEZ**	22. TITLE: **ASSOCIATE REGIONAL ADMINISTRATOR** **DIVISION OF MEDICAID & CHILDREN'S HEALTH**

23. REMARKS:

FORM HCFA-179 (07-92)

[Rehabilitative Services
(continued)

Preschool Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated]

[Rehabilitative Services
(continued)

With the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Nursing Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

Psychological Counseling Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.]

[Rehabilitative Services
(continued)

Psychological Evaluations

The fee is fee-for-service and is made up of 1) directs costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.]

New York
17(s)

3. **Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology for counties will include all clinicians that are employees of a county and will utilize a time log approach that accounts for 100 percent of time for each county employed clinician. This methodology will generate a Direct Medical Service time study percentage that will be applied to the appropriate direct costs to determine the Direct Medical Service costs.

   The direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. *For example*, for cost reporting period July 1, 2012 through June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013 and April 2013 to June 2013.

Direct Medical Service TS Percentage

a. Fee-For-Service TS Percentage
   i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

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

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

A = All Codes
D = IEP Direct Medical Services (Activity Code 4.b)
R = Redistributed Activities (Activity Code 10)
U = Unallowable (Activity Code 11)

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

4. **IEP Medicaid Eligibility Ratio:** A county-specific IEP Ratio will be established for each participating county. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The IEP ratio will be based on child count reporting of students with a direct medical service in an IEP during the school year [required for Individuals with Disabilities Education Act (IDEA) on the first Wednesday in October of the Fiscal Year] for which the report is completed. *For example,* for the cost reporting period covering July 1, 2012 through June 30,

2013, the IEP Ratio will be based on the student [count] of students with an IEP at any time during the July 1, 2013 through June 30, 2013 school year [from October 3, 2012].

[The names and birthdates of students with an IEP with a direct medical service will be identified from the Student Count Report as of the first Wednesday in October and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid.] The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed. [with a direct medical service, as outlined in their IEP.] The denominator will be the total number of students in the LEA with an IEP with a direct medical service as outlined in their IEP at any time during the school year reporting period. Direct medical services are those services billable under the PSSHS program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts, as described above, and MMIS data [as of the first Wednesday of October] for the fiscal year for which the cost report is completed.

5. **Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for each county for Direct Medical Services.

E. Special Transportation Services Payment Methodology

Effective for dates of service on or after October 1, 2011, providers will be paid on a cost basis. Providers will be reimbursed interim rates for PSSHS Special Transportation services as specified the *Special Transportation* paragraph of the EPSDT section of this Attachment. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

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

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

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

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17(u)

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

H. Cost Reconciliation Process

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

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

I. Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual PSSHSP Cost Report is due on or before December 31st of the same year. The final reconciliation will occur prior to the 24th month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

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

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

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

J. Sunset Date

Effective for dates of service on or after October 1, 2011 through June 30, [2016] 2017; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, [2016] 2017.