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State/Territory Name: New York

State Plan Amendment (SPA) NY: 20-0059

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

April 11, 2023

Amir Bassiri
State Medicaid Director
New York State Department of Health
99 Washington Ave
One Commerce Plaza, Suite 1605
Albany, NY 12237

RE: **New York State Plan Amendment (SPA) Transmittal Number 20-0059**

Dear Director Bassiri:

We have reviewed the proposed New York State Plan Amendment (SPA) to Attachment 4.19-B submitted under TN-20-0059, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 25th 2020. This State Plan Amendment proposes to extend the sunset date for the School Supportive Health Services Program Certified Public Expenditure reimbursement methodology to June 30th, 2023.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1st, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410)-786-5914 or Robert.bromwell@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

April 11, 2023

Amir Bassiri
Medicaid Director
99 Washington Ave
One Commerce Plaza Suite 1432
Albany, NY 12210

RE: New York Transmittal Number NY-20-0059

Dear Mr. Bassiri:

This letter is a companion to our approval of New York State plan amendment (SPA) 20-0059, which is effective July 1, 2020. SPA 20-0059 modified four pages of the payment methodologies associated with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services provided in school-based settings. The State plan includes four separate school-based services (SBS) payment methodologies and the changes associated with SPA 20-0059 extend "sunset dates" for each of the methodologies to June 30, 2023**.** The purpose of this letter is to provide New York with guidance on the changes to New York's State plan that are necessary to ensure the SBS methods meet all federal requirements effective July 1, 2023.

As part of our review of SPA 20-0059, CMS also reviewed the four SBS payment methodologies in their entirety, and found several items that appear inconsistent with current federal requirements. CMS advises New York to work with us proactively to ensure the State plan meets all federal requirements.

Costs Associated with Services Provided by Special Schools

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires Medicaid payment rates to be consistent with efficiency and economy. When certified public expenditures (CPEs) are used as the non-federal share of Medicaid payments, only the certifying government entity's actual, incurred costs associated with rendering Medicaid services may be claimed for FFP. In accordance with section 1903(w)(6) of the Act, only units of state and local government are eligible to provide for the non-federal share through a CPE process.

CMS continues to have concerns that the state's method of identifying Medicaid covered service costs based on the tuition costs paid to special schools does not accurately represent the actual, incurred cost associated with Medicaid service provision within the special schools. Rather than relying on a step-down of tuition payments as the basis to claim Medicaid service costs, which

may not reflect the actual cost of Medicaid services, CMS is interested in working with New York to determine a more accurate basis to identify the costs incurred by eligible certifying entities. For example, the local education agencies that are responsible for ensuring Medicaid covered children in special schools are receiving services may contract with the special schools directly for the provision of Medicaid services and record those contracted costs on a certified cost report used as part of a CPE process, and meeting the minimum documentation requirements for claiming. Alternatively, the state could potentially explore relying on Medicaid Management Information System (MMIS) fee-for-service claims data as a proxy for determining the actual amount of the payments associated with special schools are for Medicaid service provision, provided that data is available to understand the Medicaid services children receive within the special schools.

In addition, CMS has concerns over whether eligible units of state or local government are the entities actually certifying Medicaid expenditures for FFP within special schools or whether private entities that are ineligible to participate in a CPE process are certifying Medicaid expenditures. We have identified references within the State plan that seem to apply an indirect cost rate and random moment time study (RMTS) results to costs associated with special schools (even though the special school providers do not participate in the RMTS and do not appear to be state or local government staff). Because some of the special schools are not units of government and, as such, cannot certify Medicaid costs, we have concerns over whether the special schools are certifying Medicaid expenditures and selectively relying on statistics and cost principles associated with state or local units of government as the basis for determining their reimbursement.

We will work with the state to determine a claiming methodology that more precisely determines Medicaid service costs within special schools and to clarify the cost finding and certification processes used by the state for special schools so that the state is not at risk for inappropriately claiming for FFP.

Random Moment Time Study

The purpose of a RMTS used for Medicaid cost finding is to identify the portion of a provider's working time that is spent in the provision of Medicaid covered service activities. CMS has concerns over the validity and adequacy of the New York's RMTS for purposes of claiming FFP. The HHS Office of Inspector General (OIG) has identified similar concerns with New York's RMTS as part of audits issued in the HHS OIG report "New York Improperly Claimed $439 Million in Medicaid Funds for its School-Based Health Services Based on Certified Public Expenditures" from July 2021.

In order to be a viable sampling method, a RMTS must capture all of the various activities performed by providers during randomly assigned moments during the sample period, which must include all regular school days. The RMTS used by New York as part of the SBS cost finding methodology must reflect all of the time expended and activities performed by staff, whether allowable to Medicaid or not. All periods of the school year and 100% of the eligible workday moments must be included in the time study sample universe. In addition, if any providers' costs are included where the results of the time study are applied, then that provider's

work schedule must be included in the sample universe of the RMTS. Providers who are not included in the sample universe of the time study should not have the RMTS percentages applied to their costs. Providers of SBS should be included in the time study, unless their costs are fully accounted for in direct services.

CMS encourages New York to actively engage with us on revisions to the state's RMTS method to ensure that it is robust and accurately captures all of the data necessary to serve as an allocation statistic for claiming Medicaid service costs. In addition, the OIG's audit findings discussed deficiencies with the state's data verification for the SBS Medicaid Eligibility Ratio (MER) and issues with provider licensure. Although not directly addressed within the Medicaid state plan language, CMS is interested in engaging with New York on efforts to correct these issues.

Comprehensive State Plan Language

Federal regulations at 42 C.F.R. § 430.10 require that the State plan be a comprehensive written statement. CMS has generally interpreted this regulation to require states to describe their provider payment methodologies in a clear and comprehensive manner. We have identified several instances within the state's SBS payment methodologies appear to be ambiguous and subjective in nature and we are interested in working with New York to ensure the methodologies are understandable. We are also interested in working with the state to consolidate or streamline the methods, as appropriate, in order to ensure that CMS and providers understand how SBS are paid by New York. We would like to work proactively with the state to ensure that the methods are comprehensive and consistent with 42 C.F.R. § 430.10.

Conclusion

The state has 90 days from the date of this letter, to address the issues described above and start to discuss these with CMS, coming into compliance by 6/30/2023. This means the state needs to work with CMS on new provisions in the state plan and the time study implementation plan (TSIP). Any cost reports used need to be consistent with the state plan and TSIP.

Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any necessary technical assistance to the state and is willing to have bi-weekly calls with the state as it works to bring the SBS methodology into compliance with federal regulations.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410)-786-5914 or Robert.Bromwell@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

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 — 0059

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
~~§1902(a) of the Social Security Act, and 42 CFR 447~~ §1905(a)(4)(b)

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- B: Page 17(o), Page 17(u), Page 18(h), Page 18(q)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19- B: Page 17(o), Page 17(u), Page 18(h), Page 18(q)

10. SUBJECT OF AMENDMENT
School Supportive Health Services (SSHSP)
(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
September 25, 2020

18. DATE APPROVED
April 11, 2023

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Todd McMillion

22. TITLE
Director, Division of Reimbursement Review

23. REMARKS

Pen and Ink authorized on 04/13/2023 to Box 6: Federal Statute/Regulation Citation:
1905(a)(4)(b) Early and Periodic Screening, Diagnostic, and Treatment Services

New York
17(o)

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

H. Cost Reconciliation Process

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

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

I. Cost Settlement Process

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

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

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

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

J. Sunset Date

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

New York
17(u)

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

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 SSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the MMIS and CMS-64 form, resulting in cost reconciliation.

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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.

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New York
18(h)

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

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 and tentative settlement payments exceed the actual, certified cost 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.

I. Sunset Date

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New York
18(q)

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

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

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

I. Sunset Date

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