DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

June 10, 2010

Donna Frescatore
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Frescatore:

This is to notify you that New York State Plan Amendment (SPA) #06-61 has been approved for adoption into the State Medicaid Plan with an effective date of January 1, 2007. The SPA concerns the rates of payment for adult day health care services provided to persons with AIDS or HIV related illnesses. Specifically, the SPA provides for an additional funding amount, based on the Medicaid utilization for each eligible provider. The rates of payment will reflect trend factor adjustments that are computed in accordance with the general trend factor methodology that is included in the State Plan.

This SPA approval consists of 10 Pages. We are approving the following Pages which was submitted with the State's May 18, 2010 electronic submission to the CMS SPA Mailbox: Attachment 4.19-B-Pages 2, 2(a), 2(a)(i), 7(b)(ii), and 7(b)(ii)(A), Attachment 3.1-A-Pages 6 and 7, and Attachment 3.1-B-Pages 6 and 7. At that time, New York requested that these 10 Pages replace the Pages which were provided with its SPA submission of September 6, 2006 (originally, only Attachment 4.19-B-Page 2, 7(b)(i) and 7(b)(ii), a total of 3 Pages, were submitted). In addition, in that electronic transmission, New York requested that originally requested effective date of August 1, 2006 be changed to January 1, 2007. This approval reflects the change in the effective date for 06-61 to January 1, 2007 and is for the 10 newly provided Pages.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of the SPA #06-61 and the HCFA-179, as approved.

If you have any questions or wish to discuss this SPA further, please contact Michael Melendez or Shing Jew of this office. Mr. Melendez may be reached at (212) 616-2430, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

/s/

Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: SPA #06-61
HCFA-179 Form

CC: JUlberg
PMossman
SIrwin
SGaskins
LTavener
GCritelli
MSamuel
SJew

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OME NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **06-61**	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, 2007**	

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)(30) of the Social Security Act** **42 CFR 447.204**	7. FEDERAL BUDGET IMPACT: a. FFY **1/1/07-9/30/07 $ 1,312,653** b. FFY **10/1/07-9/30/08 $ 1,859,597**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 2, 2(a), 2(a)(i), 7(b)(i), 7(b)(ii), 7(b)(ii)(A)** **Attachment 3.1A: Pages 6, 7** **Attachment 3.1B: Pages 6, 7**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 2, 2(a), 7(b)(i), 7(b)(ii)** **Attachment 3.1A Supplement: Pages 6, 7** **Attachment 3.1B Supplement: Pages 6, 7**

10. SUBJECT OF AMENDMENT:
AIDS ADHC Annual COLA **** SEE REMARKS**

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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Donna Frescatore**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: **May 18, 2010 (originally submitted September 6, 2006)**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **JUN 10 2010**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **JAN 01 2007**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: **Sue Kelly**	22. TITLE: **Associate Regional Administrator Division of Medicaid and State Operations**

23. REMARKS:

The following pages were submitted via State's May 18, 2010 electronic submission:

Attachment 4.19-B-Pages 2, 2(a), 2(a)(i), 7(b)(ii), and 7(b)(ii)(A), Attachment 3.1-A-Pages 6 and 7, and Attachment 3.1-B-Pages 6 and 7. At that time, New York requested that these 10 Pages replace the Pages which were provided with its SPA submission of September 6, 2006 (originally, only Attachment 4.19-B-Page 2, 7(b)(i) and 7(b)(ii), a total of 3 Pages, were submitted).
In addition, in that electronic transmission, New York requested that originally requested effective date of August 1, 2006 be changed to January 1, 2007.
This approval reflects the change in the effective date for 06-61 to January 1, 2007 and is for the 10 newly provided Pages.

responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate. Payment for these services are in compliance with 42 CFR 447.325.

AIDS/HIV Adult Day Health Care Services For Diagnostic And Treatment Centers

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV by a free standing ambulatory care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated if these two requirements are not met.

Core services include:

- Medical visits
- Nursing visits

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- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

Health related (non-core) services include:

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided on and after January 1, 2007, medical assistance rates of payment to diagnostic and treatment centers shall be increased to an annual amount of $2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

Effective for adult day health care services rendered on and after January 1, 2007 through December 31, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology. Such adjustments shall be applied to the operational cost component of the rate.

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Hospital Based Ambulatory Surgery Facilities Certified Under Article 28 of the Public Health Law

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates of payment in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through September 30, 2007, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

Freestanding-Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Surgery Centers

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through September 30, 2007, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.

patients for which fee-for-service reimbursement is available as determined by the Department of Health.

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV by a residential health care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated if these two requirements are not met.

Core services include:

- Medical visits
- Nursing visits
- Individual and group Mental Health services
- Individual and group Nutrition counseling services
- Individual and group Substance Abuse counseling services
- Medication group counseling
- Activities of Daily Living
- Physical and Occupational Therapy services
- Case management services
- Prevention/Risk reduction counseling
- Any routine assessment performed by an appropriately credentialed staff person

Health related (non-core) services include:

- Group exercise sessions
- Acupuncture
- Breakfast and/or lunch
- Therapeutic massage
- Yoga
- Pastoral care
- Therapeutic recreation and structured socialization services
- Tai-chi

For adult day health care services provided on and after January 1, 2007, medical assistance rates of payment to residential health care facilities shall be increased up to an annual amount of $2.8 million in the aggregate. Such amount shall be allocated proportionally among eligible providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the Department of Health. Such allocated amounts will be included as an adjustment to each provider's daily rate of payment for such services.

For adult day health care services rendered on and after January 1, 2007, through December 31, 2009, medical assistance rates of payments shall reflect trend factor adjustments computed in accordance with the previously approved trend factor methodology contained on page 1(c)(i) in this Attachment.

(h) For the period April 1, 2007 and thereafter, rates of payment for adult day health care services provided by residential health care facilities, shall be computed in accordance with the following:

(i) the operating component of the rate for an adult day health care program that has achieved an occupancy percentage of 90% or greater for a calendar year, prior to April 1, 2007, shall be calculated utilizing allowable costs reported in the 2004, 2005, or 2006 calendar year residential health care facility cost report filed by the sponsoring residential health care facility, whichever is the earliest of such calendar year cost reports in which the program has achieved an occupancy percentage of 90% or greater, except that programs receiving rates of payment based on allowable costs for a period prior to April 1, 2007 shall continue to receive rates of payment based on that period;

(ii) for programs that achieved an occupancy percentage of 90% or greater prior to calendar year 2004 but did not maintain occupancy of 90% or greater in calendar years 2004, 2005, or 2006, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2004 calendar year cost report divided by visits imputed at 90% occupancy.

(iii) programs that have not achieved an occupancy of 90% or greater for a calendar year prior to April 1, 2007, will have the operating component of the rate of payment calculated utilizing allowable costs reported in the first calendar year after 2006 in which the program achieves an occupancy of 90% or greater effective January first of such calendar year except for calendar year 2007, effective no earlier than April first of such year, provided, however, that effective January 1, 2009 programs that have not achieved an occupancy of 90% or greater for a calendar year prior to January 1, 2009, the operating component of the rate of payment will be calculated utilizing allowable costs reported in the 2009 cost report filed by the sponsoring residential health care facility divided by actual visits or imputed at 90% occupancy, whichever is greater.

(iv) For residential health care facilities approved to commence operation of an adult day health care program on or after April 1, 2007, rates of payment for these programs will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility, and total estimated annual visits by adult day health registrants of not less than 90% of licensed occupancy. Each program shall also be required to submit an individual budget. Multiple programs operated by the same residential health care facility shall each have separate rates of payment;

(v) Rates developed based upon budgets shall remain in effect for no longer than two calendar years from the earlier of:

(A) the date the program commences operations; or
(B) the date the sponsoring residential health care facility submits a full calendar year residential health care facility cost report in which the program has achieved 90% or greater occupancy. If a sponsoring residential health care facility submits such a cost report within two years of the date the program commences operation, rates shall then be computed

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Attachment 3.1-A
Supplement
(10/06)

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

11a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provisions of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

11b. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess or prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

11c. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

11a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provisions of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

11b. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess or prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Attachment 3.1-B
Supplement
(10/06)

11c. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

TN #06-61 **Approval Date** _____

Supersedes TN #91-52 **Effective Date** JAN 01 2007