

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 26, 2012

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, NY 10278

RE: SPA #12-14
Non-Institutional Services

Dear Mr. Melendez:

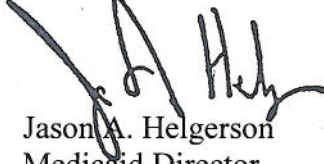
The State requests approval of the enclosed amendment #12-14 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2012 (Appendix I). This amendment is being submitted based on State regulation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

A copy of the pertinent section of State regulation is enclosed for your information (Appendix III). Copies of the public notices of this plan amendment, which were given in the New York State Register on March 28, 2012, and June 27, 2012, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions (Appendix V) and evidence of tribal consultation are also enclosed.

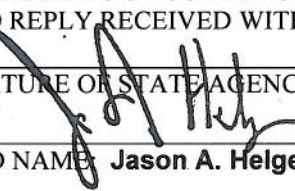
If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, at (518) 474-6350.

Sincerely,

A handwritten signature in black ink, appearing to read "Jason A. Helgerson". The signature is written in a cursive style with a large initial "J" and "H".

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 12-14	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 April 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30) of the Social Security Act and 42 CFR Part 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/12-09/30/12 \$ 0 b. FFY 10/01/12-09/30/13 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 2(g)(1)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: 2(g)(1)	
10. SUBJECT OF AMENDMENT: April and July 2012 Freestanding Clinic APG Weight Adjustments (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
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: Jason A. Helgerson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: JUN 26 2012			
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
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Amended SPA Pages

Appendix II
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #12-14

This state plan amendment revises the Ambulatory Patient Group (APG) reimbursement methodology for freestanding clinic and ambulatory surgery center services to reflect the recalculated weights for April 1, 2012, and July 1, 2012.

Appendix III
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Authorizing Provisions

and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Job Impact Statement

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment

The agency received no public comment since publication of the last assessment of public comment.

NOTICE OF ADOPTION

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-50-11-00015-A

Filing No. 172

Filing Date: 2012-02-28

Effective Date: 2012-03-14

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

Action taken: Amendment of Subpart 86-8 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

Subject: October 2011 Ambulatory Patient Groups (APGs) Payment Methodology.

Purpose: To refine the APG payment methodology.

Text or summary was published in the December 14, 2011 issue of the Register, I.D. No. HLT-50-11-00015-P.

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

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Regulatory Affairs Unit, Room 2438, ESP, Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

NOTICE OF ADOPTION

Clinic Treatment Programs

I.D. No. OMH-46-11-00006-A

Filing No. 169

Filing Date: 2012-02-27

Effective Date: 2012-03-14

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

Action taken: Amendment of Part 599 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04, 43.01 and 43.02; Social Services Law, art. 33, sections 364, 364-a and 365-m

Subject: Clinic Treatment Programs.

Purpose: Amend and clarify existing regulation and enable providers to seek reimbursement for certain services using State-only dollars.

Substance of final rule: This final adoption amends Part 599 of Title 14 NYCRR which governs the licensing, operation, and Medicaid fee-for-service funding of mental health clinics. 14 NYCRR Part 599 was originally adopted as final on October 1, 2010 and resulted in major changes in the delivery and financing of mental health clinic services. When the regulation was promulgated, the Office of Mental Health understood that there would be issues that might require clarification once providers and recipients of services had experience in operating under the new regulation. This rule making was designed to address those issues and add relatively minor program modifications that have occurred since the initial regulation was promulgated. Non-substantive changes were made to the final rule to further clarify the requirements found in 14 NYCRR Part 599. A summary of all changes, including those non-substantive changes that were made since publication of the Notice of Proposed Rule Making, are found in the narrative below.

- Clarification of the distinction between "injectable psychotropic medication administration" and "injectable psychotropic medication administration with monitoring and education" and the provisions regarding reimbursement for these services;

- Clarification of the definition of "health monitoring", "hospital-based clinic", "modifiers", and "psychiatric assessment", and inclusion of definitions for "Behavioral Health Organization" and "concurrent review". The final version of this regulation also expands the definitions of "diagnostic and treatment center", "hospital-based clinic" and "health monitoring". The term "smoking status" has been changed to "smoking cessation" for both adults and children, and the definition of "health monitoring" now includes "substance use" as an indicator for both adults and children - see new Subdivisions (r), (w) and (ab) of Section 599.4;

- Repeal of provisions requiring a treating clinician to determine the need for continued clinic treatment beyond 40 visits for adults and children;

- Amendment of the provisions regarding screening of clinic treatment staff by the New York Statewide Central Register of Child Abuse and Maltreatment;

- Clarification of requirements regarding required signatures on treatment plans. The final version of the regulation further clarifies that, for recipients receiving services reimbursed by Medicaid on a fee-for-service basis, the signature of the physician is required on the treatment plan. For recipients receiving services that are not reimbursed by Medicaid on a fee-for-service basis, the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment plan is required - see Section 599.10(j)(4);

- Addition of provisions regarding reimbursement modifications for visits in excess of 30 and 50 respectively (excluding crisis visits) for fiscal years commencing on or after April 1, 2011. Note - the final version of the regulation lists other services that are excluded from the 30/50 thresholds. These services, in addition to crisis visits, include off-site visits, complex care management and any services that are counted as health services - see Section 599.13(e);

Appendix IV
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Public Notice

*To be published in
NYS Register 6/27/12*

Public Notice
NYS 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 non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2012:

- Recalculated weights will become effective on July 1, 2012 as required by current state statute to update for changes required as a result of payment and policy modifications. These changes encompass more current Medicaid claims data as well as issues raised by providers or Medicaid Redesign Team updates.

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

The public is invited to review and comment on this proposed state plan amendment, which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed state plan amendment will also be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information, or to review and comment, please contact:

New York State Department of Health
Bureau of HCRA Operations & Financial Analysis
Corning Tower Building, Rm. 984
Empire State Plaza
Albany, New York 12237
(518) 474-1673
(518) 473-8825 (FAX)
spa_inquiries@health.state.ny.us

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 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 inpatient, long term care, and non-institutional services and pharmacy to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

- Effective April 1, 2012, the Essential Community Provider Network and the Vital Access Providers initiatives will be established to ensure access to care for patients.

Essential Community Provider Network: New York State will assume an active role in ensuring certain essential community providers (hospitals, nursing homes, D&TCs or home health providers) be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services.

- To receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. The plan must also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement. The facility must also demonstrate how its plan and the investment will ultimately return savings long term for the Medicaid program.
- The Commissioner of Health will make the final decision concerning which facilities are eligible by applying the following criteria:
 - Demonstration of integration of services with other providers and improved quality, access, and efficiency;

- Engagement with community stakeholders and responsiveness of plan to community health needs;
- Financial viability based upon certain metrics (profitability, debt load, and liquidity);
- Provision of care to financially and medically vulnerable populations;
- Provision of essential health services; and/or
- Provision of an otherwise unmet health care need (e.g., behavioral health services).
- Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:
 - Administrative and operational efficiencies;
 - Quality and population health standards;
 - Provision of essential services;
 - Improved integration or collaboration with other entities; and/or
 - Achieving health care cost savings.
- Furthermore, as part of the requirement for a provider to receive funds through this initiative, the Department of Health must approve of the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. In addition, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

Vital Access Providers (VAP): This initiative will be established to provide ongoing rate enhancement to a small group of hospitals, nursing homes, D&TCs, and home care providers, under more stringent basis over a longer term. These facilities will be required to submit a plan and a budget for meeting defined goals, which would include approaches to advance community care, but the purpose of these funds is to provide longer term operational support. Examples of providers that could receive this designation and enhancement could include efficient hospitals and other providers in rural communities that have already reconfigured services to create integrated systems of care and that require a rate enhancement to remain financially viable and continue to provide a service not offered elsewhere in the community (e.g., emergency department, trauma care, obstetrics). Furthermore, in urban areas, qualifying providers will be unique in that they serve a very high proportion of Medicaid and financially vulnerable populations, provide unique services that are not offered by other providers within the community, and have serious financial problems.

- The VAP provider designation and any allocation of funds are subject to approval by the Commissioner of Health and are pursuant to a dynamic plan to better the health of the community.
- Facilities will be required to demonstrate satisfaction of benchmarks specified by the Commissioner.
- Effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initia-

tives for state fiscal year 2012/13 is \$100 million, including the redirection of the hospital inpatient Phase II funding.

- Continues Ambulatory Patient Group (APG) rates of payment for Medicaid services for outpatient hospital services, general hospital emergency services, ambulatory surgical services, for dates of service on and after April 1, 2012, and for diagnostic and treatment center services, for dates of services on and after July 1, 2012, except those payments made on behalf of persons enrolled in Medicaid HMO or Family Health Plus.
- For state fiscal year beginning April 1, 2012 and forward provide Medicaid reimbursement to hospitals for inpatient and ambulatory care services, and to free standing diagnostic and treatment centers through modification of APG payments, for the provision of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is \$2.70 million.

Institutional Services

- For the state fiscal year beginning April 1, 2012 through March 31, 2013, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- Effective April 1, 2012, the Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than \$51 million annually for periods beginning April 1, 2012 through March 31, 2013, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the periods April 1, 2012 through March 31, 2013, and as a result of decreased PPRs and PPNOs for the period April 1, 2012 through March 31, 2013. Such rate adjustments or payment disallowances shall not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission. The annual decrease in gross Medicaid expenditures for state fiscal year 2012/13 is \$51 million.

Long Term Care Services

- Effective April 1, 2012, for rate periods on and after April 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall promulgate regulations, which may be emergency regulations, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than \$40 million, as determined by the Commissioner.
- If federal financial participation is not available for rate adjustments, or regulations promulgated thereunder, then, for such rate periods, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents 21 years of age or older. In addition, for such rate periods upward revisions to Medicaid rates shall be provided, however, such upward revisions shall not in the aggregate, as determined by the Commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less than \$40 million.

- To clarify the previously noticed provisions of March 30, 2011, December 28, 2011 and March 14, 2012, related to Certified Home Health Agencies (CHHA) episodic pricing, Medicaid payments for services provided by CHHAs will be effective May 1, 2012.
- The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the periods April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, \$340 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the period April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall be up to \$28.5 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2012 through March 31, 2014. Payments shall not exceed in the aggregate, \$100 million for each of the following periods: April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

Non-institutional Services

- For State fiscal years beginning April 1, 2012 through March 31, 2013, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments. The increase in Medicaid expenditures for state fiscal year 2012/13 is \$287 million.
- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after April 1, 2012. There is no estimated annual change to gross Medicaid expenditures as a result of this proposal.
- Effective on or after April 1, 2012, adults, age 21 and older, with a diagnosis of diabetes mellitus may obtain podiatry services from podiatrists in private practice. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is \$4.40 million.
- Effective on or after April 1, 2012, lactation counseling services for pregnant and postpartum women will be provided when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the Commissioner of Health. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is \$8.40 million.

Appendix V
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES State Plan Amendment #12-14

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 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 payments, a complete listing of providers that return a portion of their payments, 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: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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 through 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 governmental 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).

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

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: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services 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.

Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the appropriate UPL demonstration for 2012.

- 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: The rate methodology included in the State Plan for freestanding clinic and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system, with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

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: This SPA 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 SPA 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: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. Tribal leaders were sent information regarding this SPA via U.S. Postal Service, and health clinic administrators were sent the information via e-mail. Evidence of the mailing is attached to this SPA submission.