NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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Commissioner

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

JUN 3 0 2016

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, New York 10278

RE: SPA #16-0026
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0026 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2016 (Appendix I). This amendment is being submitted based on enacted legislation. 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.

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 30, 2016, and May 11, 2016, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

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: **16-0026**	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, 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)(30) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/16-09/30/16 $ (5.725)** **b. FFY 10/01/16-09/30/17 $ (11.45)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B Supplement 1: Page 5**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Implement Cost Sharing Limits to Medicare Part C (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 3 0 2016	

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:

FORM HCFA-179 (07-92)

Appendix I
2016 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES–
OTHER TYPES OF CARE**

Explanation of Payment of Medicare Part C Coinsurance/Copayment for Medicaid Members

The Medicare Part C coinsurance/copayment policy applies to any persons who have both Medicaid and Medicare coverage (dually eligible) and are enrolled in a Medicare Part C health plan (Medicare Advantage or Medicare managed care plan).

If the service is an outpatient service provided to a dually eligible Medicaid member that is enrolled in a Medicare Part C health plan, Medicaid will reimburse eighty-five percent (85%) of the Medicare Part C coinsurance or copayment.

The only exceptions to this policy are:

- If the service is covered under a Medicare Part C health plan and is provided by an ambulance provider or a psychologist, Medicaid will reimburse one hundred percent (100%) of the Medicare Part C coinsurance and/or copayment.

Appendix II
2016 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #16-0026

Effective April 1, 2016, Medicaid reimbursement of Medicare Part C (Medicare Advantage or Medicare managed care) claims will be limited to eighty-five percent of the amount of any co-insurance or co-payment liability. The provider is required to accept the Medicare Part C health plan payment and any Medicaid payment as payment in full.

This change in reimbursement applies to both professional and instituional claims. Exceptions to this new Medicare Part C reimburement methodology are: ambulance providers and services provided by psychologists.The member may not be billed for any co-insurance or co-payment amount that is not reimbursed by Medicaid.

Appendix III
2016 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

SPA #16-0026
Chapter 59 of the Laws of 2016

§ 16. Paragraph (d) of subdivision 1 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(iv) If a health plan participating in part C of title XVIII of the federal social security act pays for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or to qualified medicare beneficiaries, the amount payable for services under this title shall be eighty-five percent of the amount of any co-insurance liability of such eligible persons pursuant to federal law if they were not eligible for medical assistance or were not qualified medicare beneficiaries with respect to such benefits under such part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, or a psychologist licensed under article one hundred fifty-three of the education law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

Appendix IV
2016 Title XIX State Plan
Third Quarter Amendment
Public Notice

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($12 million).

• Effective on or after April 1, 2016, a new specialty rate will be implemented for the Neurodegenerative disease population. The population shall include only those patients who are diagnosed with Huntington's disease (HD) and Amyotrophic Lateral Sclerosis (ALS). Individuals within New York State that have neurodegenerative motor function disorders (and their families/caretakers) will have access to comprehensive and coordinated outpatient and inpatient services within New York State throughout the continuum of the disease.

The rate has been created to enable participating providers to deliver more appropriate and necessary care to those residents who have been diagnosed with Huntington's or Amyotrophic Lateral Sclerosis.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $6.3 million.

• The quality incentive program for non-specialty nursing homes will continue for the 2016 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2016/17.

Non-Institutional Services

• For state fiscal year beginning April 1, 2016 through March 31, 2017, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, 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 amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments may be added to rates of payment or made as aggregate payments.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Early Intervention Program rates for approved services rendered on or after April 1, 2016 shall be increased by one percent. The rate increase adjusts for additional administrative activities required of providers for billing and claiming of approved Early Intervention services associated with the implementation of a State Fiscal Agent.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $2.4 million.

• Effective April 1, 2016, eligibility procedures will be streamlined for infants and toddlers referred to the Early Intervention Program (EIP). Children referred to the EIP will be screened to determine whether the child is suspected of having a disability and requires a multidisciplinary evaluation to determine eligibility. Children referred to the EIP with a diagnosed condition with a high probability of developmental delay that establishes the child's eligibility for the program will not be screened and will receive an abbreviated multidisciplinary evaluation. New screening and evaluation rates are being established. Until such time as new screening and evaluation rates are established, existing rates for screening and supplemental evaluation rates will be used to reimburse for these services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/17 is ($5.4 million).

• Effective April 1, 2016, in accordance with an amendment to Section 367-a(I)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service for a member that only has Medicaid coverage.

Currently, the Medicaid program pays the full co-payment or co-insurance amounts for Medicare Part C claims, even when the provider has received more than the amount the Medicaid program would have paid for that service. Under the new limitations, the Medicaid program would not pay any co-payment/co-insurance amount if the provider received payment equal to or greater than the Medicaid amount. The provider would be required to accept the Medicare Part C health plan payment as payment in full for the service and the member could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

The estimated annual net aggregate decrease in Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($22.9 million) gross.

• Effective April 1, 2016, the Department of Health will increase access, and improve education/outreach, for the comprehensive coverage and promotion of long acting reversible contraception (LARC) by requiring separate payments be made for the cost of post-partum LARC methods to providers and allowing Federally Qualified Health Centers (FQHCs) providers to be paid for the cost of LARC in addition to the PPS rate.

Long acting reversible contraception (LARC) methods include the intrauterine device (IUD) and the birth control implant. According to The American College of Obstetricians and Gynecologists (ACOG), both methods are highly effective in preventing pregnancy and are reversible.

Potential savings would result from a reduction in unintended pregnancies and better spacing between pregnancies (improved health outcomes for baby and mother). In particular, increasing use of LARC in the adolescent population has significant potential to reduce unintended pregnancies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative in the budget for state fiscal year 2016/2017 is ($12.6 million).

• Effective on or after April 1, 2016, the State will claim additional FMAP for certain services provided to managed care recipients. CMS authorizes states to claim 1% additional FMAP for USPSTF A&B recommended preventive services when there is no cost-sharing. The State Plan will be amended so that the additional 1% FMAP can be claimed for all USPSTF A&B recommended preventative services provided to managed care recipients for which there is no cost sharing.

Prescription Drugs:

• Effective April 1, 2016, establish price ceilings on critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers. When a critical prescription drug dispensed to a NYS Medicaid enrollee (managed care or fee-for-service) exceeds the ceiling price for the drug, the drug manufacturer will be required to provide rebates to the Department, in

proved services rendered on or after April 1, 2016 to be increased by one percent was not included in the budget for state fiscal year 2016/2017, and will not be pursued at this time.

• The proposal regarding eligibility procedures for streamlining infants and toddlers referred to the Early Intervention Program (EIP) was not included in the budget for state fiscal year 2016/2017, and will not be pursued at this time.

• The proposal regarding cost-sharing limits applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims is being amended to reflect the enacted provisions of the budget for state fiscal year 2016/2017. Under the enacted budget, Medicaid payment will now be limited to eighty-five percent of the amount of any co-payment or co-insurance liability. The provider would be required to accept the Medicare Part C health plan payment and any Medicaid payment as payment in full for the service and the member could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

The estimated annual net aggregate decrease in Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($11.45 million) gross.

Prescription Drugs:

• The proposal regarding establishing price ceilings on critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers, was not included in the budget for state fiscal year 2016/2017, and will not be pursued at this time.

• The proposal that would have limited fee-for-service reimbursement for a pharmacy prescription drug designated as a specialty drug by one or more Medicaid managed care providers to the amount such providers pay for the drug was not included in the budget for state fiscal year 2016/2017, and will not be pursued at this time.

• Clarifies the initiative previously noticed March 30, 2016, regarding the price of a generic prescription drug dispensed to a NYS Medicaid enrollee (managed care or fee-for-service) increases at a rate greater than three hundred percent of its State maximum acquisition cost (SMAC) in comparison to its SMAC at any time during the course of the preceding twelve months, the commissioner of health is authorized to require the drug manufacturer to provide rebates to the Department, limited to the amount by which the current SMAC for the drug exceeds three hundred percent. Such rebates shall be in addition to any rebates payable to the Department pursuant any other provision of federal or state law. During State fiscal year 2016-2017, if the Centers for Medicare and Medicaid Services has adopted a final methodology for determining the amount of additional rebates under the federal generic drug price increase rebate program pursuant to 42 U.S.C. § 1396r-8(c)(3), as amended by section 602 of the Bipartisan Budget Act of 2015, the department may collect for a given drug the portion of the rebate determined under this paragraph that is in excess of the rebate required by such federal rebate program.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($47.5 million) and state fiscal year 2017/2018 ($47.5 million).

The public is invited to review and comment on this proposed State Plan Amendment. Copies of 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 Amendments will 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 and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of State

A meeting of the New York State Board of Real Estate Appraisal will be held on May 23, 2016 at 10:30 a.m. at the Department of State, 99 Washington Ave., Rm. 505, Albany; 65 Court St., Rm. 208, Buffalo; and 123 William St., Rm. 231, New York City.

Should you wish to attend or require further information, please contact Sharon Charland, Board Coordinator, at sharon.charland@dos.ny.gov or (518) 473-2733.

PUBLIC NOTICE
Department of State
F-2015-1065
Date of Issuance – May 11, 2016

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2015-1065, Selkirk Lighthouse & Marina, is proposing to repair the existing erosion and protect the shoreline by adding a large rip-rap along the eastern shore of Salmon River near the mouth to Lake Ontario, in the Town of Richland. Selkirk Lighthouse & Marina proposes to construct approximately 170-feet of machined placed rip-rap wall to repair and provide erosion protection of the existing shoreline. The rip-rap will be placed at a max of 2H:1V slope. Rip-rap will be placed to re-align the shoreline where areas have been eroded. Some vegetative shoreline stabilization may be used as well, particularly in front of the one-story building in the northern portion of the project area. The total amount of fill placed below the mean high water line is a minimum of 48 CYS. Approximately 30 CYS will be removed and live loaded/removed offsite to allow the placement of the setting stone prior to placing the large machined place rip-rap. A turbidity curtain will be installed and a tracked excavator will be used from upland to prepare and place the large rip-rap. The stated purpose of the proposed action is the "Protection/restoration of shoreline and property."

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, May 26, 2016.

Appendix V
2016 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0026

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 07-0007C 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 budget 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: The State and CMS continue to have ongoing discussions related to prior years' outpatient UPL demonstrations to resolve remaining issues which the 2015 outpatient UPL is contingent upon.

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 Medicaid rate methodologies in which the Medicare coinsurance calculation is partially based detailed herein are either cost based subject to ceilings or based on the Ambulatory Patient Group reimbursement methodology. We are unaware of any currently Federal requirement, statute or regulation that limits individual provider 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: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-0006, and documentation of such is included

with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2016 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0038

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to apply cost-sharing limits to Medicare Part C claims. By applying such limits the Medicaid program reduces the payments of Medicare Part C co-insurances and co-payments by 15 %. Currently 100 % of the co-insurance/co-pay is reimbursed. This amendment reduces that payment to 85% of the co-insurance/co-pay.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues.

   For providers that are not subject to an approval process, the State monitors provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment. In addition, providers cannot discriminate based on source of payment.

   Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: This change was enacted by the State Legislature as part of the negotiation of the 2016-2017 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past several years, the State has undertaken a massive reform initiative to better align reimbursement and ensure the quality of the health care under the State's Medicaid program. This is based on the work of the Medicaid Redesign Team (MRT) with the goal to promote better health, better care, greater access, and lower costs.

   The State has modified and continues to modify many areas in the State Plan which will increase scope of services to existing and new provider types as well as increasing the provision of care in alternate settings. Examples of the State's ongoing efforts include:

   - New York State's Delivery System Reform Incentive Payment Program (DSRIP) - Primary DSRIP goals are to increase access to high quality health care that is provided in appropriate settings and to create opportunities for both payers & providers to share in generated savings.
   - Health Homes – The Health Homes program is an innovative care management service model geared toward Medicaid members with chronic conditions. Under Health Homes all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.
   - Managed Care expansions including the Fully-Integrated Dual Advantage (FIDA) - A FIDA plan is like a Medicare Advantage plan combined with an MLTC plan. The FIDA benefit package includes everything covered by Medicare, plus everything covered by Medicaid (including long-term care).