



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

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

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

JUN 27 2018

RE: SPA #18-0043
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #18-0043 of the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2018 (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 enacted legislation are enclosed for your information (Appendix III). Copies of the public notice of this plan amendment, which were given in the New York State Register on June 28, 2017 and clarified June 6, 2018, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 18-0043	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, 2018	

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: Social Services Law Section 367-u	7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/18-09/30/18 \$ 876.96 b. FFY 10/01/18-09/30/19 \$ 3,507.84
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att 3.1-A Supplement: Page 2(a)(ii)(B); 2(a)(ii)(C) Att 3.1-B Supplement: Page 2(a)(ii)(B); 2(a)(ii)(C) Att 4.19-B : Page 4(a)(i)(6); 4(a)(i)(7)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Att 3.1-A Supplement: Page 2(a)(ii)(B); 2(a)(ii)(C) Att 3.1-B Supplement: Page 2(a)(ii)(B); 2(a)(ii)(C) Att 4.19-B : Page 4(a)(i)(6); 4(a)(i)(7)
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10. SUBJECT OF AMENDMENT:
Telehealth Store and Forward Technology and Remote Patient Monitoring (FMAP = 50%)

11. GOVERNOR'S REVIEW (Check One):

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

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: Donna Frescatore	
14. TITLE: Medicaid Director Department of Health	
15. DATE SUBMITTED: JUN 27 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
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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
2018 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
2(a)(ii)(B)**

Telehealth Services – Remote Patient Monitoring

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth services provided by remote patient monitoring.

The purpose of providing telehealth remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Telehealth remote patient monitoring services use synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an “originating site”; this information is then transmitted to a provider at a “distant site” for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, poly pharmacy, mental or behavioral problems and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Telehealth remote patient monitoring services are based on medical necessity and should be discontinued when the patient’s condition is determined to be stable/controlled.

Telehealth remote patient monitoring services [may be provided] will be ordered by a [facility licensed under Article 28 of Public Health Law or by a] physician, nurse practitioner, or a midwife [, or physician assistant who has examined the patient and] with whom the patient has a[n established,] substantial and ongoing relationship. Payment for remote patient monitoring while receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to public health law 3614 section (3-c) (a-d).

The Commissioner will reimburse for telehealth remote patient monitoring services if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient’s plan of care.

All services delivered via telehealth remote patient monitoring must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.

TN 18-0043 **Approval Date** _____

Supersedes TN #16-0015 **Effective Date** _____

**New York
2(a)(ii)(c)**

Telehealth Services – Store and Forward

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth store and forward technology.

Telehealth store and forward technology is the asynchronous, secure electronic transmission of a patient’s health information in the form of patient-specific digital images and/or pre-recorded videos from a [qualified physician, nurse practitioner, midwife, or physician assistant,] provider at an originating site to a consulting physician at a distant site.

[Telehealth store and forward technology may be utilized in the specialty areas of dermatology, ophthalmology and other disciplines, as determined by the Commissioner.]

Reimbursement for telehealth store and forward services is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

The Commissioner [shall] will reimburse for services, specifically telehealth store and forward technology, if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient’s plan of care.

All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.

TN #18-0043

Approval Date _____

Supersedes TN # 16-0015

Effective Date _____

**New York
2(a)(ii)(B)**

Telehealth Services – Remote Patient Monitoring

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The purpose of providing telehealth remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Telehealth remote patient monitoring services use synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an “originating site”; this information is then transmitted to a provider at a “distant site” for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, poly pharmacy, mental or behavioral problems and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Telehealth remote patient monitoring services are based on medical necessity and should be discontinued when the patient’s condition is determined to be stable/controlled.

Telehealth remote patient monitoring services [may be provided] will be ordered by a [facility licensed under Article 28 of Public Health Law or by a] physician, nurse practitioner, a midwife [, or physician assistant who has examined the patient and] with whom the patient has a[n established,] substantial and ongoing relationship. Payment for remote patient monitoring while receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to public health law 3614 section (3-c) (a-d).

The Commissioner will reimburse for telehealth remote patient monitoring services if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient’s plan of care.

All services delivered via telehealth remote patient monitoring must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.

TN 18-0043 **Approval Date** _____

Supersedes TN #16-0015 **Effective Date** _____

**New York
2(a)(ii)(c)**

Telehealth Services – Store and Forward

Effective on or after [June 1, 2016] April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth store and forward technology.

Telehealth store and forward technology is the asynchronous, secure electronic transmission of a patient’s health information in the form of patient-specific digital images and/or pre-recorded videos from a [qualified physician, nurse practitioner, midwife, or physician assistant,] provider at an originating site to a consulting physician at a distant site.

[Telehealth store and forward technology may be utilized in the specialty areas of dermatology, ophthalmology and other disciplines, as determined by the Commissioner.]

Reimbursement for telehealth store and forward services is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

The Commissioner [shall] will reimburse for services, specifically telehealth store and forward technology, if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient’s plan of care.

All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.

TN #18-0043

Approval Date _____

Supersedes TN # 16-0015

Effective Date _____

New York
4(a)(i)(6)

Telehealth Services – Store and Forward

The Commissioner of Health is authorized to establish fees, approved by the Director of the Budget, to reimburse the cost of consultations in the specialty areas of ophthalmology and dermatology via telehealth store and forward technology.

Telehealth store and forward technology involves the asynchronous, secure electronic transmission of a patient’s health information in the form of patient-specific digital images and/or pre-recorded videos from a [qualified physician, nurse practitioner, midwife, or physician assistant,] provider at an originating site to a consulting physician at a distant site without the patient present. Reimbursement for telehealth store and forward services is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

The Commissioner [shall] will reimburse for telehealth store and forward technology if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient’s plan of care.

Reimbursement will be made to the consulting physician. Telehealth store and forward technology is reimbursed at [50] 75% of the applicable physician fee for the evaluation and management code that applies. The physician fee schedule can be found at

<https://www.emedny.org/ProviderManuals/Physician/>

TN 18-0043 Approval Date _____

Supersedes TN #16-0015 Effective Date _____

New York
4(a)(i)(7)

Telehealth Services – Remote Patient Monitoring

Rates established by the Commissioner of Health and approved by the Director of the Budget [shall] will reflect telehealth remote patient monitoring costs on a [daily] monthly basis when medically necessary remote patient monitoring has taken place. A [daily] monthly fee will be paid to the ordering telehealth provider for each [day] month the telehealth remote patient monitoring equipment is used to monitor/manage the patient's care. [This amount will not exceed a designated monthly rate.]

Effective for services on or after [June 1, 2016] April 1, 2018, rates for remote patient monitoring [shall] will be the amount billed by the provider not to exceed \$48.00 per [day] month. The [maximum rate] minimum time that may be billed for remote patient monitoring is 30 minutes per month per patient [shall not exceed \$32.00]. Services less than 30 minutes are not eligible for reimbursement.

TN #18-0043

Approval Date _____

Supersedes TN # 16-0015

Effective Date _____

Appendix II
2018 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #18-0043

This State Plan Amendment proposes to further expand Telehealth on store and forward technology and remote patient monitoring. Store and forward technology is the asynchronous, electric transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos. Remote patient monitoring uses synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an "originating site"; this information is then transmitted to a provider at a "distant site" for use in treatment and management of medical conditions that require frequent monitoring. The law defines telehealth modalities and practitioners entitled to receive reimbursement for provision of services via telehealth and establishes guidelines for the delivery of telehealth services by such practitioners.

Appendix III
2018 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 18-0043

Social Services

§ 367-u. Payment for home telehealth services. 1. Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

2. Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

**Appendix IV
2018 Title XIX State Plan
Second Quarter Amendment
Public Notice**

The aggregate payment amounts total up to \$1,500,000 for the period May 10, 2018 through March 31, 2019.

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 of Health'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 also 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 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 comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

The following is a clarification to the June 28, 2017 noticed provision for reimbursement for provision of services via telehealth. The increase in gross Medicaid expenditures for telehealth services has increased since the previous publication.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$3.5 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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New York, New York 10018

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Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Nassau County Deferred Compensation Plan Board

Nassau County, New York, acting through the Nassau County Deferred Compensation Plan Board, is seeking proposals from certified public accounting firms authorized to do business in the State of New York to provide annual audits for the Nassau County Deferred Compensation Plan.

RFP # MB0402-1805

Due Date & Time of Response:

June 25, 2018 by 4:00 p.m. EST

Location to Submit Response:

Seven copies to:

Steven Conkling, One West St., 5th Fl., Mineola, NY 11501

Electronic copy should also be submitted to:
sconkling@nassaucountyny.gov

Inquires may be directed to Steven Conkling. The Board prefers that any contact with the Authorized Contact Person be made by e-mail.

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before April 30, 2018.

This notice is published pursuant to Section 109 of the Retirement and Social Law of the State of New York.

A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Cavanagh, Daniel P - Geneseo, NY

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

The Temporary rate adjustments have been reviewed and approved for the CINERGY Collaborative, with aggregate payment amounts totaling up to \$30,000,000 for the period July 1, 2017 through March 31, 2018.

The estimated net aggregate increase in Gross Medicaid Expenditures attributable to this initiative contained in the budget for State Fiscal Year 17/18 is as follows: Long Term Care \$30,000,000.

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.

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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, spa_inquiries@health.ny.gov

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 non-institutional services to comply with Chapter 550 of the laws of 2014. The following changes are proposed:

Non-Institutional Services

The amendments to public health law, insurance law and the social services law changed the definitions of telehealth modalities and practitioners entitled to receive reimbursement for provision of services via telehealth. These revisions are necessary to further align with amendments to the public health law, insurance law and social services law related to the delivery and reimbursement of health care services via telehealth. Medicaid has been covering services provided via telemedicine since 2011. These statutory amendments are intended to expand the reimbursement of health care services provided via telehealth and establish guidelines for the safe and effective delivery of such services. They will serve to eliminate barriers to care resulting

from distance and practitioner shortage and will benefit NYS Medicaid enrollees by improving access to medical care and services.

The amendments will also serve to increase access to health care services by eliminating barriers to care faced by Medicaid recipients in rural communities and in areas where there is a shortage of health care practitioners. In addition, they will make it possible for telehealth providers at distant sites to collect/monitor health information and medical data from Medicaid recipients with chronic impairments and technology dependent care needs, who are located at originating sites. This amendment will be effective on or after July 1, 2017.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$1.25 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:

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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 non-institutional services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective July 1, 2017 in accordance with Section 365-a of the Social Services Law, Medical assistance shall include the coverage of a set of services to ensure improved outcomes of women who are in the process of ovulation enhancing drugs, limited to the provision of such treatment, office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing; services shall be limited to those necessary to monitor such treatment, contingent on ninety percent federal financial participation being approved for such services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$50 million.

Appendix V
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #18-0043

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 2 CFR 200 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.

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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There are no additional provider taxes levied and no existing taxes have been modified.

2. 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: Supplemental or enhanced payments are not made for the services outlined in this State Plan Amendment.

- 3. 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: For hospital-based outpatient clinics: The State and CMS staff are having ongoing conversations to finalize the 2018 OP UPL.

For freestanding clinics: State staff are working with CMS to submit a 2018 clinic UPL demonstration.

- 4. 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: Both Freestanding D&TCs and Hospital-Based Outpatient Departments may engage in provisions on services involving remote patient monitoring and store and forward technology.

Freestanding D&TCs: The rate methodology included in the State Plan for freestanding diagnostic and treatment 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.

Hospital-Based Outpatient: The rate methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's 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 17-0065, 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.