



## 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

SEP 27 2018

RE: SPA #18-0021  
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #18-0021 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 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). A copy of the public notice of this plan amendment, which was given in the New York State Register on **March 28, 2018** is 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 Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>18-0021</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>July 1, 2018</b>	
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: <b>Section 1902 (a) of the Social Security Act and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: ( <i>in thousands</i> ) a. FFY 07/01/18 - 09/30/18 \$766.66 b. FFY 10/01/18 - 09/30/19 \$3,066.66	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 3.1-A Supplement – Page 6</b> <b>Attachment 3.1-B Supplement – Page 6</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 3.1-A Supplement – Page 6</b> <b>Attachment 3.1-B Supplement – Page 6</b>	
10. SUBJECT OF AMENDMENT: <b>Physical therapy 40 visit limit effective 7/1/18 forward.</b>			
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 		16. RETURN TO: <b>New York State Department of Health</b> <b>Division of Finance &amp; Rate Setting</b> <b>99 Washington Ave – One Commerce Plaza</b> <b>Suite 1432</b> <b>Albany, NY 12210</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Medicaid Director</b> <b>Department of Health</b>			
15. DATE SUBMITTED: <b>SEP 27 2018</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
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**  
**Third Quarter Amendment**  
**Amended SPA Pages**

**New York  
6**

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

**Physical Therapy Services**

- 11a. Effective on or after [October 1, 2011] July 1, 2018, services are limited to coverage of [twenty] forty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

**Occupational Therapy Services**

- 11b. Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

TN #18-0021

Approval Date \_\_\_\_\_

Supersedes TN #11-0037

Effective Date \_\_\_\_\_

**New York  
6**

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

**Physical Therapy Services**

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**Occupational Therapy Services**

- 11b. Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

TN #18-0021

Approval Date \_\_\_\_\_

Supersedes TN #11-0037

Effective Date \_\_\_\_\_

**Appendix II**  
**2018 Title XIX State Plan**  
**Third Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #18-0021**

This State Plan Amendment proposes to increase the physical therapy visit limit for fee-for-service and mainstream managed care from 20 visits to 40 visits per member in a 12-month period.

**Appendix III**  
**2018 Title XIX State Plan**  
**Third Quarter Amendment**  
**Authorizing Provisions**



18-0021

NYS SSL 365-a(2)(h)

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative services and occupational therapy; provided, however, that speech therapy and occupational therapy each shall be limited to coverage of twenty visits per year; physical therapy shall be limited to coverage of forty visits per year; such limitation shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury;

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

# 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](http://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

Division of Criminal Justice Services  
Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Law Enforcement Agency Accreditation Council to be held on:

Date: Monday, April 2, 2018  
Time: 1:00 p.m.  
Place: Division of Criminal Justice Services  
Alfred E. Smith Office Bldg.  
80 S. Swan St.  
CrimeStat Rm. (Rm. 118)  
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact:* Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: <http://www.criminaljustice.ny.gov/pio/openmeetings.htm>

## PUBLIC NOTICE

Division of Criminal Justice Services  
Municipal Police Training Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Municipal Police Training Council to be held on:

Date: Friday, March 30, 2018 (tentative)  
Time: 9:30 a.m.

Place: Division of Criminal Justice Services  
Alfred E. Smith Office Bldg.  
80 S. Swan St.  
CrimeStat Rm. (Rm. 118)  
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact:* Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: <http://www.criminaljustice.ny.gov/pio/openmeetings.htm>

## 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, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

### Non-Institutional Services

Effective on or after April 1, 2018, this initiative proposes to eliminate the supplemental medical assistance payments of \$6 million annually made to providers of emergency medical transportation.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$6 million.

Effective on or after April 1, 2018, the professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be updated to \$10.08, to align with current costs.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2018/2019 is \$795,531.

Effective on and after October 1, 2018, Medicaid will cover ABAs. ABAs are State Education Department (SED) licensed practitioners who provide intensive treatment for persons diagnosed with autism spectrum disorder using applied behavioral analysis treatment modalities. These services and practitioners are currently covered by Early Intervention (EI), Child Health Plus (CHIP), and all major commercial payers. The Medicaid Program does not currently recognize or reimburse ABA's, which results in a break in coverage for those children who age out of the EI program.

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 \$12.1 million.

Effective on and after July 1, 2018, the physical therapy cap under both fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per member in a 12-month period. The following populations are exempt from the 40-visit limitation: children (0-21 years of age); individuals with developmental disabilities; Medicare/Medicaid dually eligible individuals when the service is



covered by Medicare; and individuals with a traumatic brain injury. Revision of the physical therapy cap will provide members an opportunity to obtain additional rehabilitation therapy to treat low back pain as well as other physical conditions which will help reduce the need for opioid treatment.

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 \$4.6 million.

Effective on and after April 1, 2018, Medicaid will begin covering Centers for Disease Control (CDC) certified National Diabetes Prevention Program (NDPP). The NDPP is a CDC recognized educational and support program designed to assist at-risk individuals from developing Type 2 diabetes. The program focuses on lifestyle interventions and the long-term effects of diet and exercise. These intense interventions demonstrate a greater influence on the reduction in diabetes risk, return to normoglycemia, and weight loss than less intense programs.

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 \$1.03 million.

Effective on or after April 1, 2018, the Early Intervention Program reimbursement methodology for the targeted case management (service coordination) services will be revised from an hourly rate billed in fifteen-minute units to two separate categories of fixed rates for initial case management services and one per member per month fixed rate for ongoing case management services. These rates are being revised to create administrative efficiencies for billing providers and adjust for administrative activities assumed by providers in direct billing to third party payers through a state fiscal agent established April 1, 2013. These revisions will make the State Plan content and format consistent with Medicaid requirements for case management.

Initial service coordination services not followed by an Individualized Family Service Plan meeting will have a minimum base of two hours with no cap; those followed by an Individualized Family Service Plan meeting will have a minimum base of three hours with no cap. Ongoing service coordination services will have a minimum base of 1.25 hours per month. Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capital costs, and regional cost differences.

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

Effective on or after April 1, 2018, this proposal is to establish a ten percent rate increase to the Hospice Residence rates, set a benchmark rate and include specialty rates in the weighted average rate calculation. The proposal would increase Medicaid Hospice Residence rates to help cover current costs and avoid closure of Hospice Residence programs.

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 \$1.7 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2018 through March 31, 2019, 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. Payments may be added to rates of payment or made as aggregate payments.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, 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, 2018 through March 31, 2019, 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.

Effective on or after April 1, 2018, The Department of Health proposes to amend the Public Health Law § 3001, create new Public Health Law § § 2805-z and 3001-a, and amend the Social Services Law § 365-a to permit health care providers to collaborate on community paramedicine programs that allow emergency medical personnel to provide care within their certification, training and experience in residential settings.

The annual increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$2.3 million.

#### Institutional Services

Effective on or after April 1, 2018, the commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one-percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one-percent reduction in capital expenditures beginning with State fiscal year 2018/2019.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$13.4 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, 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 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. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2018, payments to hospitals that meet the criteria as an enhanced safety net hospital, the criteria is as follows: In any of the previous three calendar years has had not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

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 \$40 million.

**Long Term Care Services**

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in \$2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

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 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at \$70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of \$70 million.

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 \$140,000,000.

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](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.

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 1432, Albany, NY 12210, or e-mail: [spa\\_inquiries@health.ny.gov](mailto: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 institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

- Strong Memorial Hospital

The aggregate payment amounts total up to \$4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to \$4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to \$4,370,030 for the period April 1, 2020 through March 31, 2021.

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](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

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



**NON-INSTITUTIONAL SERVICES  
State Plan Amendment #18-0021**

**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 the state plan. 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.

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 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 have been no new provider taxes and no existing taxes have been modified.

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 is working towards submitting the 2018 clinic UPL.

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 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.

#### **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 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.