NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

JUN 2 8 2012

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

RE: SPA # 12-15
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-15 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective September 1, 2012 (Appendix I). This amendment is being submitted based on recently enacted State 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 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 28, 2012, 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 John E. Ulberg Jr., Medicaid Chief Financial Officer, Division Finance & Ratesetting, at (518) 474-6350.

Sincerely,

Jason Helgerson
Medicaid Director
Deputy Commissioner
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: **#12-15**	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 **September 1, 2012**	

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: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. FFY **09/01/2012 - 09/30/2012** **($ 183,400)** b. FFY **10/01/2012 - 09/30/2013** **($ 2,200,779)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A: Page 2** **Attachment 3.1-B: Page 2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A: Page 2** **Attachment 3.1-B: Page 2**

10. SUBJECT OF AMENDMENT:
Reimbursement to private practicing podiatrists for podiatry services furnished to Medicaid eligible adults, age 21 and older, with a diagnosis of diabetes mellitus.
(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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: JUN 2 8 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Amended SPA Pages

Attachment 3.1-A
Supplement

4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or have not applied for certification to participate in Medicare.

Care days in nursing facilities are reimbursed for Medicaid patients requiring and receiving medically necessary lower level of care services. Medical Assistance is provided until such time as the appropriate level of care becomes available.

5. Prior approval is required for certain procedures which may be considered cosmetic or experimental. Physicians are informed of the specific prior approval requirements in the MMIS Physician Provider manual.

6. Care and services will be provided only if they are in accordance with regulations or the Department of Health.

6a. Medicaid does not cover routine hygienic care of the feet in the absence of pathology.

Fee-for-service podiatry payment will [only] be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife in accordance with the fee schedule for Podiatry, which can be found at the following link under the section entitled Podiatry Manual Contents:

https://www.emedny.org/ProviderManuals/Podiatry/index.aspx

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescription[s] drugs) for all recipients when ordered by a private practicing podiatrist.

Medicaid fee-for-service payment will be made to private practicing podiatrists for podiatry services furnished to Medicaid eligible adults, age 21 and older, with a diagnosis of diabetes mellitus. In order to be Medicaid reimbursable, such services must be provided pursuant to a written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MMIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.

Attachment 3.1-B
Supplement

4a. Prior approval is required for all out-of-state placements at Specialized Care Facilities for difficult to place individuals or High level Care facilities for the head injured.

Medicaid payments shall not be authorized for nursing facilities which are not certified or have not applied for certification to participate in Medicare.

Care days in nursing facilities are reimbursed for Medicaid patients requiring and receiving medically necessary lower level of care services. Medical Assistance is provided until such time as the appropriate level of care becomes available.

5. Prior approval is required for certain procedures which may be considered cosmetic or experimental. Physicians are informed of the specific prior approval requirements in the MMIS Physician Provider manual.

6. Care and services will be provided only if they are in accordance with regulations or the Department of Health.

6a. Medicaid does not cover routine hygienic care of the feet in the absence of pathology.

Fee-for-service podiatry payment will [only] be made for services provided to Medicaid eligibles under twenty-one years of age under the EPSDT program and only by written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife in accordance with the fee schedule for Podiatry, which can be found at the following link under the section entitled Podiatry Manual Contents:

https://www.emedny.org/ProviderManuals/Podiatry/index.aspx

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 inpatient facilities and certified clinics which include foot care services in the rate established for medical care for Medicaid recipients will continue to receive payments for these services through their rates. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescription[s] drugs) for all recipients when ordered by a private practicing podiatrist.

Medicaid fee-for-service payment will be made to private practicing podiatrists for podiatry services furnished to Medicaid eligible adults, age 21 and older, with a diagnosis of diabetes mellitus. In order to be Medicaid reimbursable, such services must be provided pursuant to a written referral from a physician, physician assistant, nurse practitioner or certified nurse midwife.

In the office setting, a podiatrist may only provide a limited number of clinical laboratory tests. Podiatrists are informed of the specific clinical laboratory tests they may perform, in their office setting, in the MMIS Podiatrists Manual. A podiatrist may only provide radiological services which are within the scope of podiatric practice. Amputation and bunion surgery may be performed by a podiatrist in a hospital setting.

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

SUMMARY
SPA #12-15

This State Plan Amendment proposes to provide reimbursement to private practicing podiatrists for podiatry services furnished to Medicaid eligible adults, age 21 and older, with a diagnosis of diabetes mellitus.

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

Chapter 56 of the Laws of 2012
S6256-D/A9056-D
Part D

SPA 12-15

S.6256-B/A.9056-B

§ 6. Subdivision 2 of section 365-a of the social services law is amended by adding four new paragraphs (w), (x), (y) and (z) to read as follows:

(w) podiatry services for individuals with a diagnosis of diabetes mellitus; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph.

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

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services and pharmacy to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

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

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

- To receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. The plan must also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement. The facility must also demonstrate how its plan and the investment will ultimately return savings long term for the Medicaid program.
- The Commissioner of Health will make the final decision concerning which facilities are eligible by applying the following criteria:
  - Demonstration of integration of services with other providers and improved quality, access, and efficiency;
  - Engagement with community stakeholders and responsiveness of plan to community health needs;
  - Financial viability based upon certain metrics (profitability, debt load, and liquidity);
  - Provision of care to financially and medically vulnerable populations;
  - Provision of essential health services; and/or
  - Provision of an otherwise unmet health care need (e.g., behavioral health services).
- Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:
  - Administrative and operational efficiencies;
  - Quality and population health standards;
  - Provision of essential services;
  - Improved integration or collaboration with other entities; and/or
  - Achieving health care cost savings.
- Furthermore, as part of the requirement for a provider to receive funds through this initiative, the Department of Health must approve of the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. In addition, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

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

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

The annual increase in gross Medicaid expenditures for both initia-

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

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

Institutional Services

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

Long Term Care Services

- Effective April 1, 2012, for rate periods on and after April 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall promulgate regulations, which may be emergency regulations, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than $40 million, as determined by the Commissioner.
  - If federal financial participation is not available for rate adjustments, or regulations promulgated thereunder, then, for such rate periods, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents 21 years of age or older. In addition, for such rate periods upward revisions to Medicaid rates shall be provided, however, such upward revisions shall not in the aggregate, as determined by the Commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less than $40 million.
- To clarify the previously noticed provisions of March 30, 2011, December 28, 2011 and March 14, 2012, related to Certified Home Health Agencies (CHHA) episodic pricing, Medicaid payments for services provided by CHHAs will be effective May 1, 2012.
- The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the periods April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the period April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall be up to $28.5 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2012 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

Non-institutional Services

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

- As of April 1, 2011, hospital outpatient clinics and DTCs may bill for Smoking Cessation Counseling (SCC) service as part of the provider's Ambulatory Patient Group (APG) claim for outpatient services. However, Federally Qualified Health Centers (FQHCs) that did not opt into APGs would not have the ability to bill for SCC services. The establishment of the FQHC SCC rates will allow FQHC providers to bill for SCC services. The rates that have been established are as follows: FQHC Individual Smoking Cessation Counseling and FQHC Group Smoking Cessation Counseling. These rates will be effective April 1, 2012 and thereafter. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is $8.50 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2012/2013 is $475.9 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2012/2013 is $1.4 billion.

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.

In addition, copies of the proposed state plan amendments will be on file and available for public review in each 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, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

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 clarifying changes are proposed:

Non-Institutional Services

The following clarifications are to the March 30, 2011 noticed provision for Health Home Services.

Effective April 1, 2012, the Department of Health, in collaboration with the Office of Mental Health, the Office for Alcoholism and Substance Abuse Services, and the Office of People with Developmental Disabilities will be authorized to begin Medicaid coverage for Health Home Services to high-cost, high-need enrollees in the counties of Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond, (Staten Island), Rockland, Suffolk, Sullivan, Ulster and Westchester. The previous effective date was October 1, 2011.

Payment for Health Homes service will be a per-member, per-month (PMPM) care management fee that is adjusted based on region and case mix (from 3M™ Clinical Risk Groups (CRG) method). This fee will eventually be adjusted by (after the data is available) patient functional status. As a result, reimbursement will be reflective of cost-associated adjustments in the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch).

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group, or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80 percent) of the active care management PMPM. The case finding PMPM is only available for up to the first three months after a patient has been assigned to a given Health Home, and this PMPM is intended to cover the cost of outreach and engagement. Once a patient has been assigned a care manager and is actively engaged in the Health Home program, the active care management PMPM may be billed.

If the State achieves overall savings from the implementation of this program, Health Home providers will be eligible to participate in a shared savings pool. The pool will be developed at the end of the first year of health home operation and will consist of a percentage (up to 30 percent) of the documented State share savings derived from Health Home operation. The State will use a method to adjust savings for regression to the mean before setting up the pool. If the federal portion of savings becomes eligible for shared savings with providers, then a portion of those savings will be included in the pool based on any federal conditions that may be applied to such savings.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative for the period April 1, 2012 through September 30, 2012 is $9.8 million and for the period October 1, 2012 through September 30, 2013 is $58.3 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

In addition, copies of the proposed state plan amendment will be on file and available for public review in each 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:

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #12-15

CMS Standard Funding Questions

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

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

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

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

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

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper**

payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: This question does not apply to this SPA.

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: Not applicable.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans

which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: This SPA does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

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

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

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

Response: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. The tribal leaders were sent information regarding the SPA via postal mail, and the health clinic administrators were emailed the same information. A copy of the tribal consultation is enclosed. No comments have been received.

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #12-15

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 expand coverage for adults, age 21 and older, who have a diagnosis of diabetes mellitus to obtain care from podiatrists in private practice. The provision of routine preventive foot care will facilitate early detection and treatment of lower extremity conditions associated with diabetes, which will improve healthcare outcomes and quality of life for these individuals. This change is being made in accordance with section 365-a of the State Social Services Law, which directs the Medicaid Program to expand podiatry coverage to private practicing podiatrists for eligible individuals with a diagnosis of diabetes mellitus. Currently, Medicaid reimburses Article 28 clinics providing podiatry services to adults, age 21 and older. This amendment will allow private practicing podiatrists to also provide podiatry services to this population and receive Medicaid reimbursement.

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, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor 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.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. 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 2012-13 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: Type II diabetes is highly prevalent in certain Medicaid populations. This expansion in coverage of podiatry services, which will provide routine preventive foot care for adults with a diagnosis of diabetes mellitus, is intended to decrease complications and associated high-cost medical treatments for this population.