NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 26 2015

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 #15-0032
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0032 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 23, 2015 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on April 22, 2015, is also enclosed for your information (Appendix IV). In addition, responses to the five standard access 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 at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **15-0032**	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 23, 2015**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/23/15-09/30/15 $ 1,500.00** **b. FFY 10/01/15-09/30/16 $ 1,500.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 6.1**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 6.1**

10. SUBJECT OF AMENDMENT:
Ambulance Supplemental Payments
(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** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 6 2015	

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
2015 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
6.1

Emergency Medical Services Provider Supplemental Payment

The Department will supplement Medicaid fee-for-service reimbursements made to emergency medical services providers.

For the period July 1, 2006 to March 31, 2007, the aggregate amount of $3.0 million and for the period April 1, 2007 to March 31, 2008, the aggregate amount of $6 million will be available. For the period March 26, 2009 through March 31, 2009, the aggregate amount of $4,512,000 will be available. For the period May 30, 2014 through March 31, 2015, the aggregate amount of $6 million will be available. Annually, beginning with the period of April 23, 2015 through March 31, 2016, the aggregate amount of $6 million will be available.

This payment will be based upon a ratio of individual provider payments to total Medicaid provider payments in each quarter of the state fiscal year.

The following methodology applies in each state fiscal year:

- The aggregate amount will be divided by four as a payment will be made in each quarter of the state fiscal year, and further divided as follows:

  - Twenty five percent of the total aggregate amount will be paid to providers within the City of New York.

    - The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers within the City of New York, and will express that ratio as a percentage.

    - The Department will then multiply the percentage by one-quarter the supplemental amount available to be disbursed for emergency medical services providers based in the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".

    - In each quarter of the state fiscal year, these steps shall be repeated.

  - Seventy-five percent of the total aggregate amount will be paid to Medicaid providers outside the City of New York.

    - The Department will determine the ratio of an emergency medical services Medicaid provider's Medicaid reimbursements to the total Medicaid payments made to emergency medical services providers during that quarter of the state fiscal year to providers outside the City of New York, and will express that ratio as a percentage.

    - The Department will then multiply the percentage by one quarter the supplemental amount available to be disbursed to providers based outside the City of New York. The result of such calculation shall represent the "emergency medical service supplemental payment".

    - In each quarter of the state fiscal year, these steps shall be repeated.

Appendix II
2015 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #15-0032

This State Plan Amendment proposes to make annual supplemental Medicaid fee-for-service payments to emergency medical transportation services providers, beginning with the period April 23, 2015 through March 31, 2016.

Appendix III
2015 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 15-0032

Chapter 57 of the Laws of 2015 - Part B

§ 53. The opening paragraph of subdivision 1 and subdivision 3 of section 367-s of the social services law, as amended by section 8 of part C of chapter 60 of the laws of 2014, are amended to read as follows:

Notwithstanding any provision of law to the contrary, a supplemental medical assistance payment shall be made on an annual basis to providers of emergency medical transportation services in an aggregate amount not to exceed four million dollars for two thousand six, six million dollars for two thousand seven, six million dollars for two thousand eight, [**and**] six million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen**, and six million dollars annually beginning with the period April first, two thousand fifteen through March thirty-first, two thousand sixteen** pursuant to the following methodology:

3. If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed two million dollars for two thousand six, three million dollars for two thousand seven, three million dollars for two thousand eight [**and**], three million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen**, and three million dollars annually beginning with the period April first, two thousand fifteen through March thirty-first, two thousand sixteen**. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be two million dollars or three million dollars as applicable to the annual period.

Appendix IV
2015 Title XIX State Plan
Second 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

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 prescription drugs to comply with recently proposed statutory provisions. The following provides clarification to provisions previously noticed on March 25, 2015, unless otherwise indicated, and notification of new significant changes.

All Services

Permanently Eliminate Trend Factors Clarification (Part D/29-a)

• As previously noticed March 27, 2013, clarifies, effective on and after January 1, 2015, no greater than zero trend factors attributable to the 2015 and 2016 calendar year pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, certified home health agencies, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2015/16 is ($436.4) million.

VAP Award Criteria Considerations (Part B/51)

• Effective on or after April 1, 2015, the Commissioner of Health shall consider criteria for vital access provider (VAP) applications submitted to the Department that includes, but is not limited to:

- The applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

- The extent to which the applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient primary or residential health care services in a community;

- The extent to which the application will involve savings to the Medicaid program;

- The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

- The extent to which such applicant is geographically isolated in relation to other providers; or

- The extent to which such applicant provides services to an underserved area in relation to other providers.

Institutional Services

IP Cost Containment - Appropriately Allocate Capital Costs Clarification (Part D/2)

• Clarifies, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs, will continue effective April 1, 2015 through March 31, 2017.

IP Cost Containment – Continuation of.25 Trend Reduction Clarification (Part D/6)

• Clarifies, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25% and extends current provisions for services on and after April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is $114.5 million.

Hospital VAP Applications for Financially Distressed (Additional Article VII)

• Effective for the periods of April 1, 2015 through March 31, 2016, the Commissioner of Health may award a temporary adjustment to the non-capital component of rates, or make temporary lump-sum medical assistance payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Eligible general hospitals shall include: a public general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation; a federally designated critical access hospital; a federally designated sole community hospital; or a general hospital that is a safety net hospital.

- A safety net hospital shall be defined as having at least 30% of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

- Such hospital must serve at least 30% of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

- Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March 31, 2016. Evidence of such distress will be by:

• Certification that such applicant has less than 15 days cash and equivalents;

• Such applicant has no assets that can be monetized other than those vital to operations; and

• Such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

- For those applicants meeting such criteria, awards shall be made upon application to the Department of Health. Such awards shall include a multi-year transformation plan that is aligned with the Delivery System Reform Incentive Program (DSRIP) program goals and objectives which must be approved by the Department and demonstrate a path towards long term sustainability and improved patient care.

- Initial award payments to eligible applicant may be based solely on the aforementioned criteria; however, the Department may suspend or repeal an award if the eligible applicant fails to submit a multi-year transformation plan that is acceptable to the Department by no later than September 30, 2015.

- Applicants also must detail the extent to which the affected community has been engaged or consulted on potential projects within the application, as well as any outreach to stakeholder and health plans.

- Applications shall be reviewed by the Department to determine an applicant's eligibility; each applicant's projected financial status; each applicant's proposed use of funds to maintain critical services needed by the community; and the anticipated impact of the loss of such services.

- The Department, after review of all applications and determination of the aggregate amount of requested funds, shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

- Awards issued may not be used for: capital expenditures, including, but not limited to construction, renovation and acquisition of capital equipment, including major medical equipment; consultant fees; retirement of long term debt; or bankruptcy-related costs.

- Payments made to awardees shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial and activity reports, which shall include, but not be limited to: actual revenue and expenses for the prior month, projected cash need for current month, and projected need for the following month.

Long Term Care Services

LTC Cost Containment – Eliminate 96/97 Trend Factor Clarification (Part D/5)

• Clarifies, rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2015 through March 31, 2017.

LTC Cost Containment – Continuation of.25 Trend Reduction Clarification (Part D/6)

• Clarifies, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25% and extends current provisions to services on and after April 1, 2015 through March 31, 2017.

LTC Cost Containment – NH Medicare Maximization Clarification (Part D/7-9)

• Clarifies, long-term care Medicare maximization initiatives will continue effective April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is $117 million.

NH Cash Assessment Extension Clarification (Part D/3)

• Clarifies, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent will be effective for periods April 1, 2015 through March 31, 2017. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is $420 million.

Spousal Support Clarification (Part B/33)

• The initiative previously noticed regarding medical assistance being furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative and the refusal or failure of such absent relative to provide the necessary care and assistance was eliminated from the budget for state fiscal year 2015/2016.

Young Adult (Part B/47)

• Effective on or after April 1, 2015, the Commissioner of Health shall establish up to three young adult special populations demonstration programs to provide cost effective, necessary services and enhanced quality of care for targeted populations. Eligible individuals included in the programs shall have severe and chronic medical or health problems or multiple disabling conditions which may be combined with developmental disabilities. Such programs shall provide more appropriate settings and services for these individuals, help prevent out of state placements and allow repatriation back to their home communities. Eligible operators of such programs must have demonstrated expertise in caring for the targeted population and have a record of providing quality care.

- Funds for such programs may include, but not be limited to start up funds, capital investments and enhanced rates.

- Of the demonstrations at least one program shall be designed to serve persons ages 21-35 who are aging out of pediatric acute care hospitals or nursing homes; and at least one program shall be designed to serve persons 21-35 who have a developmental disability in addition to their severe and chronic medical or health problems and who are aging out of pediatric acute care hospitals, pediatric nursing homes or children's residential homes operated under the New York State Office for Persons With Developmental Disabilities.

- The Department of Health shall be responsible for monitoring the quality, appropriateness, and effectiveness of such programs.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal years 2015/2016 and 2016/2017 is $2M for each state fiscal year.

Refinancing/Shared Savings (Part B/52)

• Effective on or after April 1, 2015, for facilities with operating certificates granted on or after March 10, 1975, real property costs shall be based on historical costs to the owner of the facility, provided payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owners' equity.

- Owners' equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment has been provided by real property cost reimbursement.

- Further provided, the Commissioner of Health may modify such payments for real property cases for purposes of effectuating a shared savings program where facilities share a minimum of 50% of savings, for those facilities that elect to refinance their mortgage loans.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/206.

ATB 1% Give Back

• Clarifies, while alternative methods of cost containment continue, as partial restoration of the two per cent annual uniform reduction of Medicaid payments which was noticed on March 26, 2014, across the

board rate increases of one half the value of monies collected under such cost containment measures will be made.

Non-institutional Services

Non-institutional Cost Containment – Continuation of.25 Trend Reduction Clarification (Part D/6)

• Clarifies, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25% and extends current provisions to services on and after April 1, 2015 through March 31, 2017.

Non-institutional Cost Containment – CHHA A&G Cap Clarification (Part D/11-12)

• Clarifies, for certified home health agency administrative and general cost reimbursement limits, current provisions will be extended for the periods on and after April 1, 2015 through March 31, 2017.

Non-institutional Cost Containment – Home Care Medicare Max Clarification (Part D/10)

• Clarifies, home health care Medicare maximization initiatives will continue effective April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is $17.8 million.

Apply Cost-Sharing Limits for Medicare Part C Cross-Over Services Clarification (Part B/32)

• The initiative previously noticed to apply cost sharing limits for Medicare Part C cross over services was eliminated from the budget for state fiscal year 2015/2016.

CHHA Episodic Payment Extender (Part D/22)

• Continues, effective on and after April 1, 2015 through March 31, 2019, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under 18 and other discreet groups, shall be based on episodic payments. A statewide base price, for such payments, shall be established for each 60-day episode of patient care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

Annual Supplemental Assistance Payment for Emergency Medicaid Transportation (Part B/53)

Effective on and after April 1, 2015, provides a supplemental medical assistance payment to providers of emergency medical transportation not to exceed $6 million in state fiscal year 2015/2016.

Apply Cost-Sharing Limits for Medicare Part B Cross-Over Services Clarification (Part B/31)

• Clarifies the initiative related to cost-sharing limits will be applied to Medicare Part B cross-over services will now be effective July 1, 2015.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is $49.7 million.

Prescription Drugs

AWP Discount for Brand Name Drugs & Dispensing Fee Adjustment Clarification (Part B/2-3)

• The initiative for the Average Wholesale Price (AWP) for sole or multiple source brand name drugs and the dispensing fee for such was eliminated from the budget for state fiscal year 2015/2016.

340B Drugs Clarification (Part B/7)

• The initiative previously noticed related to claims for payment of outpatient prescription drugs submitted to a managed care provider by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b) was eliminated from the budget for state fiscal year 2015/2016.

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.

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 Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

New York State and Local Retirement Systems
Unclaimed Amounts Payable to Beneficiaries

Pursuant to the Retirement and Social Security Law, the New York State and Local Retirement Systems hereby gives public notice of the amounts payable to beneficiaries.

The State Comptroller, pursuant to Sections 109(a) and 409(a) of the Retirement and Social Security Law has received, from the New York State and Local Retirement Systems, a listing of beneficiaries or estates having unclaimed amounts in the Retirement System. 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 Systems located at 110 State St., in the City of Albany, New York.

Set forth below are the names and addresses (last known) of beneficiaries and estates appearing from the records of the New York State and Local Retirement Systems, entitled to the unclaimed benefits.

At the expiration of six months from the date of publication of this list of beneficiaries and estates, unless previously paid to the claimant, the amounts shall be deemed abandoned and placed in the pension accumulation fund to be used for the purpose of said fund.

Any amounts so deemed abandoned and transferred to the pension accumulation fund, may be claimed by the executor or administrator of the estates or beneficiaries so designated to receive such amounts, by filing a claim with the State Comptroller. In the event such claim is properly made, the State Comptroller shall pay over to the estates or to the person or persons making such claim, the amount without interest.

ABRAMTSEV, CHRISTINA T EST OF MOUNT KISCO NY
ACKERMAN, CARL W ESTATE OF LAKE HAVASU CITY AZ
ADAMS, ROBYN L SPARTANBURG SC
ADCOCK, BEULAH M ESTATE OF PHOENIX NY
ADLER, GORDON ELIZABETH CO
AIELLO, VERA UTICA NY
ALIX, EVELYN NEW ROCHELLE NY
ALLEN, LEO M ESTATE OF PLATTSBURGH NY

Appendix V
2015 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX V
NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0032

CMS Standard Access Questions & Assurances

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: The State is authorized to make supplemental medical assistance payments to providers of emergency medical transportation services. The authority was provided by Article VII language, Chapter 60 of the Laws of 2015, amending Section 365-h of the Social Service Law.

   A supplemental medical assistance payment shall be made on an annual basis to providers of emergency medical transportation services in an aggregate amount not to exceed six million dollars for the period April 23, 2015 through March 31, 2016 pursuant to the following methodology:

   (a) For each emergency medical transportation services provider that receives medical assistance reimbursement processed through the state Medicaid payment system, the department of health shall determine the ratio of such provider's state-processed reimbursement to the total such reimbursement made during each quarter of the applicable calendar year, expressed as a percentage.

   (b) For each such provider, the department of health shall multiply the percentage obtained pursuant to paragraph (a) of this subdivision by one-quarter of the applicable aggregate amount specified in the opening paragraph of this subdivision. The result of such calculation shall represent the "emergency medical transportation service supplemental payment" and shall be paid expeditiously to such provider on a quarterly basis.

   (c) The amount disbursed to emergency medical transportation services providers whose area of operation is within the city of New York will be twenty-five percent of the applicable aggregate amount, with the remaining seventy-five percent to be disbursed to all other emergency medical transportation services providers.

If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed three million dollars for the period April 23, 2015 through March 31, 2016. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be three million dollars as applicable to the annual period.

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: There is no rate change as part of this amendment therefore we expect that there will be no negative impact in access as a result of this amendment but would serve to enhance access by providing additional needed funds to emergency medical transportation providers.

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: Although this is not a rate modification, this amendment was enacted by the State Legislature as part of the negotiation of the 2015-2016 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: This amendment does not decrease ambulance rates, it is a supplemental Medicaid payment to emergency medical transportation providers. Therefore the amendment would not negatively impact access to emergency medical transportation services but would serve to enhance access by providing additional needed funds to emergency medical transportation providers.

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: This amendment is not for a rate change, therefore it should not impact access to emergency medical transportation services. No other

modifications to "counterbalance" the impact of this change are needed at this time.

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: 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. Copies of tribal consultation are enclosed.