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

June 30, 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 #15-0050
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0050 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 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 March 25, 2015 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 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: **15-0050**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 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, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/15-09/30/15 $ 4,286** **b. FFY 10/01/15-09/30/16 $ 8,430**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 1(m)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 1(m)**

10. SUBJECT OF AMENDMENT:
Hospital Quality Pool - Outpatient
(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: June 30, 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
1(m)

[-Reserved-]

Hospital Quality Pool Payments

1. For the rate periods on and after April 1, 2015, additional adjustments to the outpatient rates of payment for eligible general hospitals for the purpose of incentivizing and facilitating quality improvements shall be made in accordance with the following:

   a. General hospitals eligible for distributions pursuant to this Section will be those hospitals providing Article 28 hospital outpatient services.

   b. For the period April 1, 2015 through March 31, 2016, up to $90.8 million will be allocated.

   c. For the period April 1, 2016 through March 31, 2017, up to $87.8 million will be allocated.

   d. Each eligible general hospital will receive a minimum base payment that is subject to change each fiscal year.

   e. Each such hospital will also receive an amount that is based on their latest available total outpatient visits, as reported to the Department, in proportion to the total reported outpatient visits of all other eligible general hospitals. The total payments calculated in 1(d) and 1(e), plus the total payments calculated in the Hospital Quality Pool Payments section for hospital inpatient rates, will not exceed the defined amounts of this Section.

   f. Payments made pursuant to this Section will be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per visit to be added to the outpatient rates, for the applicable periods, will be established by dividing the total allocated funds, in accordance with paragraphs 1(d) and 1(e) of this Section, by the hospital's latest available Medicaid outpatient visits, as reported to the Department, for those rates to which the add-on is being applied.

Appendix II
2015 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #15-0050

This State Plan Amendment proposes to establish a general hospital quality pool for outpatient services for the purpose of incentivizing and facilitating quality improvements.

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

SPA #15-0050

Chapter 57 of the Laws of 2015 – Part B

§ 11. Section 2807 of the public health law is amended by adding a new subdivision 14 to read as follows:

14-a. Notwithstanding any provision of law to the contrary, and subject to federal financial participation, the commissioner is authorized to establish, pursuant to regulations, a statewide general hospital quality pool for the purpose of incentivizing and facilitating quality improvements in general hospitals. Awards from such pool shall be subject to approval by the director of budget. If federal financial participation is unavailable, then the non-federal share of awards made pursuant to this subdivision may be made as state grants.

(a) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(b) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

Appendix IV
2015 Title XIX State Plan
Second Quarter Amendment
Public Notice

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, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2015, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals of $339 million annually.

• Extends effective beginning April 1, 2015 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

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

• Continues, effective April 1, 2015, and thereafter, 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.

• Extends current provisions for services on and after April 1, 2015, 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%.

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.

• Effective April 1, 2015, authorizes the Commissioner of Health to establish a general hospital quality pool for the purpose of incentivizing and facilitating quality improvements. Payments for the period April 1, 2015 through March 31, 2016 will total $90.8 million gross and $87.8 million gross for the period April 1, 2016 through March 31, 2017.

• Effective June 1, 2015, provides that sole community hospitals, as defined in accordance with Title XVIII of the Federal Social Security Act, are eligible for enhanced payment and/or reimbursement for inpatient and/or outpatient services for the purpose of promoting patient access and improving quality of care. Payments for the period April 1, 2015 through March 31, 2016 will total $9.0 million gross and $12 million for each state fiscal year thereafter.

• Effective April 1, 2015, the amount allocated for Essential Community Provider Network and Vital Access Provider initiatives for Critical Access Hospital (CAHs) will be no less than $7.5 million annually. In addition, the Department of Health will provide a report to the Governor and legislature no later than June 1, 2015 providing recommendation on how to ensure the financial stability of, and preserve patient access to, CAHs, including an examination of permanent Medicaid rate methodology changes.

• Effective April 1, 2015, the amount allocated for Essential Community Provider Network and Vital Access Provider initiatives for essential community providers serving rural areas, including but not limited to hospitals; residential health care facilities; diagnostic and treatment centers; ambulatory surgery centers and clinics will be no less than $10 million. Payments will be made under a supplemental rate methodology for the purpose of promoting access and improving the quality of care. Such payments may include, but not be limited to, temporary rate adjustments; lump sum Medicaid payments; supplemental rate methodologies and any other payment as determined by the Commissioner.

• Effective April 1, 2015, any amount provided to public general hospitals related to payments for the hospital quality pool; sole community hospitals; and essential community provider network and vital access provider initiatives where the federal approvals for such payments on amounts or components thereof are not granted, such payments to public general hospitals shall be determined without consideration of such amounts or components. Public general hospitals shall refund to the State, or the State may recoup from prospective payments, any overpayment received, including those based on a retroactive reduction in the payments. Any reduction in the federal share related to federal upper payment limits applicable to public general hospitals other than those operated by the State University of New York shall apply first to amounts provided for such payments.

• Effective April 1, 2015, the $19.2 million reduction to the statewide base price will be eliminated.

Indigent Care

• Continues, effective for the period January 1, 2016 through December 31, 2018, indigent care pool payments will be made using an uninsured units methodology. Each hospital's uncompensated care need amount will be determined as follows:

- Inpatient units of service for the cost report period two years prior to the distribution year (excluding hospital-based residential health care facility (RHCF) and hospice) will be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year;

- Outpatient units of service for the cost report period two years prior to the distribution year (excluding referred ambulatory and home health) will be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year;

- Inpatient and outpatient uncompensated care amounts will then be summed and adjusted by a statewide adjustment factor and reduced by cash payments received from uninsured patients; and

- Uncompensated care nominal need will be based on a weighted blend of the net adjusted uncompensated care and the Medicaid inpatient utilization rate. The result will be used to proportionately allocate and make Medicaid disproportionate share hospital (DSH) payments in the following amounts:

• $139.4 million to major public general hospitals, including hospitals operated by public benefit corporations; and

• $994.9 million to general hospitals, other than major public general hospitals.

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

• For eligible public general hospitals effective with calendar years beginning January 1, 2015 and subsequent calendar years, the Indigent Care Adjustment will be allocated proportionately by group with public hospitals under the New York City Health & Hospitals Corporation at $376 million; State of New York or the State University of New York public hospitals at $4 million; and County public hospitals at $32 million and based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available data reported to the Department of Health as required by the Commissioner on a specified date through the Data Collection Tool.

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

Long Term Care Services

• Effective April 1, 2015, medical assistance shall be 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 responsibility 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. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with Title 6 of Article 3 and other applicable provisions of law.

The estimated annual net aggregate decrease in gross Medicaid

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0050

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

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

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

ACA Assurances:

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

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

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

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

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

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

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

   Response: 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 11-06, 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.