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

MAY 24 2016

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 #16-0037
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0037 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2016 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of enacted 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 30, 2016, 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, Office of Health Insurance Programs 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: **16-0037**

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, 2016

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 04/01/16-09/30/16 $ 71,750.00
b. FFY 10/01/16-09/30/17 $ 71,750.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Page 2(c)(v)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Page 2(c)(v)

10. SUBJECT OF AMENDMENT:
2016 Outpatient UPL
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: MAY 2 4 2016

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

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
2016 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
2(c)(v)

Hospital Outpatient Payment Adjustment

Effective for the period January 1, 2002 through March 31, 2002, and state fiscal years beginning April 1, 2002, for services provided on or after January 1, 2002, the Department of Health will increase the operating cost component of rates of payment for hospital outpatient and emergency room services for public general hospitals other than those operated by the State of New York or the State University of New York, which experienced free patient visits in excess of 20 percent of their total self-pay and free patient visits based on data reported on Exhibit 33 of their 1999 Institutional Cost Report and which experienced uninsured outpatient losses in excess of 75% of their total inpatient and outpatient uninsured losses based on data reported on Exhibit 47 of their 1999 Institutional Cost Report, and are located in a city with a population of over one million. The amount to be paid will be thirty seven million dollars for the period beginning January 1, 2002 and ending March 31, 2002 and one hundred fifty-one million dollars annually for state fiscal years beginning April 1, 2002 and ending March 31, 2005. For state fiscal year beginning April 1, 2005 and ending March 31, 2006, the amount to be paid will be $222,781,000. For state fiscal year beginning April 1, 2006 and ending March 31, 2007, the amount to be paid will be $229,953,000. For state fiscal year beginning April 1, 2007 and ending March 31, 2008, the amount to be paid will be $211,865,219. For state fiscal year beginning April 1, 2008 and ending March 31, 2009, the amount to be paid will be $183,365,199. For state fiscal year beginning April 1, 2009 and ending March 31, 2010, the amount to be paid will be $179,191,153. For state fiscal year beginning April 1, 2010 and ending March 31, 2011, the amount to be paid will be $153,834,433. For state fiscal year beginning April 1, 2011 and ending March 31, 2012, the amount to be paid will be $153,834,433. For state fiscal year beginning April 1, 2012 through March 31, 2013, the amount to be paid will be $153,834,433. For state fiscal year beginning April 1, 2013 through March 31, 2014, the amount to be paid will be $153,834,433. For state fiscal year beginning April 1, 2014 through March 31, 2015, the amount to be paid will be $105,802,261. For state fiscal year beginning April 1, 2015 through March 31, 2016, the amount to be paid will be $153,834,433. For state fiscal year beginning April 1, 2016 through March 31, 2017, the amount to be paid will be $287,000,000. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all Medicaid outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

Appendix II
2016 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #16-0037

This State Plan Amendment continues hospital outpatient payment adjustments for certain public general hospitals located in cities with a population over one million, for the period April 1, 2016 through March 31, 2017.

Appendix III
2016 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA #16-0037

Chapter 57 of the Laws of 2015

Part B

§ 19. Section 14 of part A of chapter 1 of the laws of 2002, relating 27 to the health care reform act of 2000, is amended to read as follows:
§ 14. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period January 1, 2002 through March 31, 2002, and state fiscal years thereafter **until March 31, 2011**, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over one million, which experienced free patient visits in excess of twenty percent of their total self-pay and free patient visits based on data reported on exhibit 33 of their 1999 institutional cost report and which experienced uninsured outpatient losses in excess of seventy-five percent of their total inpatient and outpatient uninsured losses based on data reported on exhibit 47 of their 1999 institutional cost report, of up to thirty-four million dollars for the period January 1, 2002 through March 31, 2002 and up to one hundred thirty-six million dollars annually for state fiscal years thereafter as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

§ 20. Section 14 of part B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:
§ 14. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period January 1, 2002 through March 31, 2002, and state fiscal years thereafter **until March 31, 2011**, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over one million, which experienced free patient visits in excess of twenty percent of their total self-pay and free patient visits based on data reported on exhibit 33 of their 1999 institutional cost report and which experienced uninsured outpatient losses in excess of seventy-five

percent of their total inpatient and outpatient uninsured losses based on data reported on exhibit 47 of their 1999 institutional cost report, of up to thirty-seven million dollars for the period January 1, 2002 through March 31, 2002 and one hundred fifty-one million dollars annually for state fiscal years thereafter as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

§ 21. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2011 through March 31, 2012, and state fiscal years thereafter, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population over one million, up to two hundred eighty-seven million dollars annually as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's 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. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

Part E

§ 2. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for periods on and after April 1, 2015, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act for general hospital outpatient

services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

Appendix IV
2016 Title XIX State Plan
Second Quarter Amendment
Public Notice

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($12 million).

• Effective on or after April 1, 2016, a new specialty rate will be implemented for the Neurodegenerative disease population. The population shall include only those patients who are diagnosed with Huntington's disease (HD) and Amyotrophic Lateral Sclerosis (ALS). Individuals within New York State that have neurodegenerative motor function disorders (and their families/caretakers) will have access to comprehensive and coordinated outpatient and inpatient services within New York State throughout the continuum of the disease.

The rate has been created to enable participating providers to deliver more appropriate and necessary care to those residents who have been diagnosed with Huntington's or Amyotrophic Lateral Sclerosis.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $6.3 million.

• The quality incentive program for non-specialty nursing homes will continue for the 2016 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2016/17.

Non-Institutional Services

• For state fiscal year beginning April 1, 2016 through March 31, 2017, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, 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 may be added to rates of payment or made as aggregate payments.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Early Intervention Program rates for approved services rendered on or after April 1, 2016 shall be increased by one percent. The rate increase adjusts for additional administrative activities required of providers for billing and claiming of approved Early Intervention services associated with the implementation of a State Fiscal Agent.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $2.4 million.

• Effective April 1, 2016, eligibility procedures will be streamlined for infants and toddlers referred to the Early Intervention Program (EIP). Children referred to the EIP will be screened to determine whether the child is suspected of having a disability and requires a multidisciplinary evaluation to determine eligibility. Children referred to the EIP with a diagnosed condition with a high probability of developmental delay that establishes the child's eligibility for the program will not be screened and will receive an abbreviated multidisciplinary evaluation. New screening and evaluation rates are being established. Until such time as new screening and evaluation rates are established, existing rates for screening and supplemental evaluation rates will be used to reimburse for these services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/17 is ($5.4 million).

• Effective April 1, 2016, in accordance with an amendment to Section 367-a(I)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service for a member that only has Medicaid coverage.

Currently, the Medicaid program pays the full co-payment or co-insurance amounts for Medicare Part C claims, even when the provider has received more than the amount the Medicaid program would have paid for that service. Under the new limitations, the Medicaid program would not pay any co-payment/co-insurance amount if the provider received payment equal to or greater than the Medicaid amount. The provider would be required to accept the Medicare Part C health plan payment as payment in full for the service and the member could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

The estimated annual net aggregate decrease in Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($22.9 million) gross.

• Effective April 1, 2016, the Department of Health will increase access, and improve education/outreach, for the comprehensive coverage and promotion of long acting reversible contraception (LARC) by requiring separate payments be made for the cost of post-partum LARC methods to providers and allowing Federally Qualified Health Centers (FQHCs) providers to be paid for the cost of LARC in addition to the PPS rate.

Long acting reversible contraception (LARC) methods include the intrauterine device (IUD) and the birth control implant. According to The American College of Obstetricians and Gynecologists (ACOG), both methods are highly effective in preventing pregnancy and are reversible.

Potential savings would result from a reduction in unintended pregnancies and better spacing between pregnancies (improved health outcomes for baby and mother). In particular, increasing use of LARC in the adolescent population has significant potential to reduce unintended pregnancies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative in the budget for state fiscal year 2016/2017 is ($12.6 million).

• Effective on or after April 1, 2016, the State will claim additional FMAP for certain services provided to managed care recipients. CMS authorizes states to claim 1% additional FMAP for USPSTF A&B recommended preventive services when there is no cost-sharing. The State Plan will be amended so that the additional 1% FMAP can be claimed for all USPSTF A&B recommended preventative services provided to managed care recipients for which there is no cost sharing.

Prescription Drugs:

• Effective April 1, 2016, establish price ceilings on critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers. When a critical prescription drug dispensed to a NYS Medicaid enrollee (managed care or fee-for-service) exceeds the ceiling price for the drug, the drug manufacturer will be required to provide rebates to the Department, in

Appendix V
2016 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0037

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: For the period April 1, 2016 through March 31, 2017 supplemental payments authorized in this Attachment will be paid to providers of services in an amount totaling up to $287 million. These payments will be made to the non-state owned or operated provider category. The non-Federal share of these payments will be funded via an IGT payment from the local government (New York City). The

transfer of funds must take place prior to the State making the payment to the eligible providers. New York City does have general taxing authority.

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: CMS and the State are having ongoing discussions related to prior years UPLs of which the 2016 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: Hospital-Based Outpatient: The rate methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

ACA Assurances:

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

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z)**

would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

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

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

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

   Response: 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.