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 30 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 #16-0015
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0015 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective June 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 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 May 25, 2016 is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding 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: **16-0015**	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 **June 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: **Social Services Law Section 365-a**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 06/01/16-09/30/16 $ 416.67** **b. FFY 10/01/16-09/30/17 $ 1,250.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Att 3.1-A Supplement: Page 2(a)(ii)(B)** **Att 3.1-B Supplement: Page 2(a)(ii)(B)** **Att 4.19-B : Page (4)(a)(i)(6)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Telehealth Store and Forward Technology and Remote Patient Monitoring (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** **Bureau of Federal Relations & Provider Assessments** **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 30 2016	

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(a)(ii)(B)

Telehealth Services – Remote Patient Monitoring

Effective on or after June 1, 2016, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth services provided by remote patient monitoring.

The purpose of providing telehealth remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of telehealth intervention.

Telehealth remote patient monitoring services use synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an "originating site"; this information is then transmitted to a provider at a "distant site" for use in treatment and management of unstable/ uncontrolled medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Telehealth remote patient monitoring services are based on medical necessity and should be discontinued when the patient's condition is determined to be stable/controlled.

Telehealth remote patient monitoring services may be provided by a facility licensed under Article 28 of Public Health Law or by a physician, nurse practitioner, midwife, or physician assistant who has examined the patient and with whom the patient has an established, ongoing relationship. Payment for remote patient monitoring while receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to public health law 3614 section (3-c) (a-d).

The Commissioner will reimburse for telehealth remote patient monitoring services if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient's plan of care.

All services delivered via telehealth remote patient monitoring must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.

New York
2(a)(ii)(B)

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New York
4(a)(i)(6)

Telehealth Services – Store and Forward

The Commissioner of Health is authorized to establish fees, approved by the Director of the Budget, to reimburse the cost of consultations in the specialty areas of ophthalmology and dermatology via telehealth store and forward technology.

Telehealth store and forward technology involves the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a qualified physician, nurse practitioner, midwife, or physician assistant, at an originating site to a consulting physician at a distant site without the patient present. Reimbursement for telehealth store and forward services is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

The Commissioner shall reimburse for telehealth store and forward technology if such services are provided with federal Food and Drug Administration approved interoperable devices, which are incorporated as part of a patient's plan of care.

Reimbursement will be made to the consulting physician. Telehealth store and forward technology is reimbursed at 50% of the applicable physician fee for the evaluation and management code that applies. The physician fee schedule can be found at

https://www.emedny.org/ProviderManuals/Physician/

Appendix II
2016 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #16-0015

This State Plan Amendment proposes to expand telehealth beyond telemedicine (to include store and forward technology and remote patient monitoring); expand the provision and reimbursement of health care services provided via telehealth; and establish guidelines for the safe and effective delivery of such services. The amendment will serve to eliminate barriers to care resulting from distance and practitioner shortage and will benefit NYS Medicaid enrollees by improving access to medical care and services. The amendments align with changes to public health law, insurance law and the social services law which changed the definitions of telehealth modalities and practitioners entitled to receive reimbursement for provision of services via telehealth.

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

SPA 16-0015

Social Services

§ 367-u. Payment for home telehealth services. 1. Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

2. Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

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

Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional and non-institutional services to comply with statutory provisions of Chapter 550 of the Laws of 2014. The following changes are proposed:

Effective on or after June 1, 2016, telehealth services are being amended to change the definitions of telehealth modalities; expand telehealth beyond telemedicine to include store and forward technology and remote patient monitoring; expand the provision and reimbursement to practitioners of health care services provided via telehealth; and establish guidelines for the safe and effective delivery of such services.

The impact of these amendments will increase access to health care services by eliminating barriers to care faced by Medicaid recipients in rural communities and in areas where there is a shortage of health care practitioners. In addition, these amendments will make it possible for telehealth providers at distant sites to collect; review; and monitor health information and medical data from Medicaid recipients with chronic impairments and technology dependent care needs.

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 $1,250,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
City of Rochester

Request for Proposal

Auditing Services for Deferred Compensation Plan

The City of Rochester's Deferred Compensation Plan Committee is seeking written proposals from qualified auditors to provide auditing services for the Deferred Compensation Plan for City employees Established pursuant to Section 457 of the Internal Revenue Code.

The City's Plan has two accounts, deferred compensation and deferred FICA (OBRA) with approximately 2,400 participants, and a total plan value of $193.5 million as of December 31, 2015.

Interested firms may request a copy of the complete Request for Proposal from Charles A. Benincasa, Director of Finance, 30 Church St., Rm. 109-A, Rochester, NY 14614, (585) 428-7151, e-mail: benincc@cityofrochester.gov

Proposals must be received no later than 5:00 p.m. on June 16, 2016.

PUBLIC NOTICE
Department of State
F-2016-0067 and F-2016-0068
Date of Issuance – May 25, 2016

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2016-0067 Edward Riley and F-2016-0068 Gary Ziers, are proposing a bulkhead reconstruction project at 1650 and 1642 Old Edgemere Drive, Town of Greece, Monroe County. They propose to reconstruct an approximately 100 foot long existing break wall (inclusive of both properties) with a 12 inch waterward expansion of the existing footprint.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or June 09, 2016.

Comments should be addressed to the Consistency Review Unit, Department of State, Office of Planning and Development, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464. Electronic submissions can be made by email at: CR@dos.ny.gov.

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE
Department of State
F-2016-0297
Date of Issuance – May 25, 2016

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2016-0297, the Town of Branford - Stony Creek Harbor

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0015

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: Supplemental or enhanced payments are not made for the services outlined in this State Plan Amendment.

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: For hospital-based outpatient clinics: The State and CMS staff are having ongoing conversations related to the 2011-2014 OP UPL demonstrations which the 2016 demonstration is contingent upon.

   For freestanding clinics: The State and CMS staff are having ongoing conversations related to prior years' freestanding clinic UPL demonstrations which the 2016 demonstration 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: Both Freestanding D&TCs and Hospital-Based Outpatient Departments may engage in provisions on services involving remote patient monitoring and store and forward technology.

   Freestanding D&TCs: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

   -AND-

   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: 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: 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.