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 3 0 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 #16-0040
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0040 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective May 1, 2016 (Appendix I). This amendment is being submitted based on State Regulations. 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 State Regulations are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on April 20, 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: **16-0040**	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 **May 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 05/01/16-09/30/16 $2,028.00** **b. FFY 10/01/16-09/30/17 $2,434.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: 1(p)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: 1(p)**

10. SUBJECT OF AMENDMENT:
Rebase of State Operated Hospital Outpatient Clinic Rate (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 3 0 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:

FORM HCFA-179 (07-92)

Appendix I
2016 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
1(p)

[- RESERVED -]

Effective May 1, 2016, the methodology described in the Ambulatory Patient Group (APG) Reimbursement Methodology – Freestanding (Non-Article 28 Hospital) OMH Licensed Mental Health Clinics section in this Attachment for establishing base rates for the State-operated mental health clinic peer group will be terminated and the new methods and standards for establishing such base rates are described below.

Effective May 1, 2016, and updated effective April 1 each year thereafter, APG base rate for the State-operated mental health clinic peer group shall be set on an annual basis and submitted for approval by the Director of the Division of the Budget.

(1) **Reporting Requirements.** The Office of Mental Health (OMH) will report Psychiatric Hospital costs in accordance with the Centers for Medicare and Medicaid Services instructions for completing a Medicare Hospital cost report.

(2) **Definitions** applicable to this section:

(i) **Cost –** Per the Centers for Medicare and Medicaid Services (CMS), Medicare-certified institutional providers are required to submit an annual cost report to a Medicare Administrative Contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center in total and for Medicare. The Hospital Cost Report is prepared by OMH on form 2552.

(ii) **Valid Visit** – A recipient and / or collateral visit for clinic services for varying durations. A patient / collateral that receives multiple services per day will have multiple valid visits per day.

(iii) **Case Mix Index** (CMI) – The average diagnosis-related group (DRG) relative weight for OMH's system. CMI is a calculation of the DRG weight for all Medicare discharges divided by the number of discharges.

(3) **Computation of Rates (General)**

(i) There shall be one statewide base rate for State-operated mental health clinics for adults and State-operated mental health clinics for children & youth.

(ii) OMH shall use the total State-operated mental health adult clinic costs added to the State-operated mental health children & youth clinic costs from the most recently filed Medicare Hospital Cost Report divided by the total valid visits for State-operated mental health clinics for both adult and children & youth from the same reporting year.

(iii) The total clinic cost shall be trended forward to the rate year based on the Consumer Price Index for all urban consumers (CPI-U).

(iv) The result of section (3)(iii) is divided by the CMI resulting in the cost-based base rate for State-operated mental health clinics for the year.

(v) OMH will make an adjustment to the rate resulting from any final audit findings or reviews.

Appendix II
2016 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #16-0040

This State Plan Amendment proposes to rebase Office of Mental Health state-operated clinic rate to actual cost effective May 1, 2016.

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

14 CRR-NY 599.13
NY-CRR

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 14. DEPARTMENT OF MENTAL HYGIENE
CHAPTER XIII. OFFICE OF MENTAL HEALTH
PART 599. CLINIC TREATMENT PROGRAMS

14 CRR-NY 599.13
14 CRR-NY 599.13

599.13 Medical assistance clinic reimbursement system.

(a) Reimbursement for clinic treatment procedures will be fee based.

(b) A weight for each clinic procedure shall be established by the office which reflects the relative anticipated resource utilization for such procedure. For some procedures, fees shall be enhanced pursuant to section 599.14 of this Part through the use of billing modifiers for such things as procedures delivered after hours, services provided in languages other than English, and services of a minimum duration of 15 continuous minutes delivered by a physician or nurse practitioner in psychiatry.

(c) Providers will be categorized into peer groups pursuant to this section. The office will establish a base fee for reimbursement for each peer group. Such fee shall be reduced by 25 percent during the period in which any such provider retains an operating certificate with a duration of less than six months as a result of having been determined to be deficient in meeting applicable standards and requirements, pursuant to this Part.

(d) Peer group specific base fees may be adjusted as applicable by the office. Provider specific fee adjustments may be made to reflect pay for performance enhancements, penalties resulting from the office inspection and certification process, or for other reasons described in the regulations of the office.

(e) Payments for procedures will be determined by multiplying the assigned weight for the appropriate procedure code set forth at 10 NYCRR Part 86 by the base fee, and adjusting such fee for modifiers and discounts, as appropriate. When a modifier or discount is expressed as a percentage, it will adjust the payment by its percentage of the procedure weight. When more than one procedure applies to a visit, the highest value procedure shall be paid at its full fee value.

(1) Payments for additional procedures related to the visit will be discounted by 10 percent.

(2) Payments will be reduced by 25 percent for any visit in excess of 30, excluding crisis visits, off-site visits, complex care management, and any services that are counted as health services, provided during a state fiscal year to any individual who is 21 years of age or older on the first day of such fiscal year, and 50 percent for any visit in excess of 50, excluding crisis visits, off-site visits, complex care management, and any services counted as health services, provided during such fiscal year to any recipient, for fiscal years commencing on or after April 1, 2011, except that effective January 1, 2015, this reduction in payment will not apply to court-mandated services.

(f) The office will annually review procedure weights, modifier values, peer groupings and the base fees for each of the peer groupings, and will update them as needed. Any changes will be published in the *State Register* and posted on the office's website.

(g) The office will establish and make public a list of weights associated with all CPT and HCPCS procedure codes which can be used to bill specific mental health clinic procedures through medical assistance. The office will update this list as needed.

(h) Providers licensed solely under article 31 of the Mental Hygiene Law shall be classified by the following peer groups. During the transition to the reimbursement methodology established in this Part, the fee paid to new clinics, or clinics commencing service in a new county, shall be equal to that of the lowest blended rate in the appropriate peer group.

(1) Upstate. All non-local governmental unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the upstate peer group: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates counties.

(2) Downstate. All non-local governmental unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the downstate peer group: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester Counties.

(3) Local governmental unit-operated. All mental health clinics operated by a local governmental unit which are operating solely under an operating certificate from the office.

(4) State-operated. All hospital-based mental health clinics operated by the office.

(i) Hospital-based providers licensed under article 28 of the Public Health Law and article 31 of the Mental Hygiene Law shall be classified by the following peer groups. The base rates will be calculated pursuant to 10 NYCRR Part 86.

(1) Upstate hospital – all hospital-based mental health clinics in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates Counties.

(2) Downstate hospital – all hospital-based mental health clinics in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester Counties.

(3) The fee paid to new clinics, or clinics commencing service in a new county, shall be calculated pursuant 10 NYCRR section 86-8.6.

(j) Diagnostic and treatment center (D&TC) providers licensed under article 28 of the Public Health Law and article 31 of the Mental Hygiene Law shall be classified by the following peer groups. The base rates will be calculated pursuant to this Part. During the transition to the reimbursement methodology established in this Part, the fee paid to new clinics, or clinics commencing service in a new county, shall be equal to that of the lowest blended rate in the appropriate peer group.

(1) Upstate D&TC – all diagnostic and treatment centers in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates Counties.

(2) Downstate D&TC – all diagnostic and treatment centers in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester Counties.

(k) D&TCs and hospitals – where a corporation operates a hospital and a D&TC, the office will determine the primary relationship between the mental health clinic and the hospital or D&TC and assign the clinic to the appropriate peer group.

(l) Supplemental payments.

(1) Provider peer group base fees paid pursuant to this section shall be supplemented as appropriate for individual providers participating in the Office of Mental Health quality improvement initiative, or other performance initiatives developed by the office.

(i) In order to be enrolled in such quality improvement initiative or other Office of Mental Health performance-based payment system, the program shall execute an agreement with the office under which the provider agrees to participate in such initiative, and undertake such measures as shall be developed by the office.

(ii) Any program eligible to receive supplemental medical assistance reimbursement for participation in a quality improvement initiative, which fails at any time to meet the requirements set forth in the agreement, shall have its quality improvement supplement to its peer group base fee suspended until such time as the program meets such requirements, as determined by the office.

(2) Payments pursuant to this section shall be supplemented for providers participating in the community support program, pursuant to section 588.14 of this Title.

(m) System transition.

During the transition, the procedures indicated in the table following as full procedures shall be reimbursed at the full payment described in subdivision (e) of this section, subject to the discount for multiple procedures related to a visit. For all other procedures, there will be a transition to full procedure based reimbursement. During the transition, payment for such procedures will consist of a blended payment comprised of a legacy portion of the fees established under Part 588 and Part 592 of this Title and the procedure payment established under this Part. For such procedures, the blended payment will be calculated as follows:

(1) For providers licensed solely under article 31 of the Mental Hygiene Law and all mental health clinics licensed by the office located in diagnostic and treatment centers:

(i) The office will identify the amount of base medical assistance paid to the clinic pursuant to Part 588 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009.

(ii) For clinics possessing an operating certificate with a duration of six months or more, the office will identify the volume of visits with supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009. Providers who had an operating certificate with a duration of less than six months during the period July 1, 2008 through June 30, 2009, will be considered to have had an operating certificate with a duration of six months or more during this period for the purposes of this calculation. For all providers, the calculation of the total supplemental payment shall utilize the supplemental rate in effect June 30, 2009, or rates made effective subsequent to

June 30, 2009, and prior to the effective date of this Part which result from provider appeals or are made pursuant to applicable regulations.

(iii) For each provider, the office will divide the sum of the reimbursement from subparagraphs (i) and (ii) of this paragraph by the number of Medicaid visits associated with the relevant provider. The result will be the legacy component of the fee.

(2) For hospital-based providers licensed under both article 28 of the Public Health Law and article 31 of the Mental Hygiene Law, the blended payment promulgated by the office, in consultation with the Department of Health, shall be determined as follows:

(i) The office will identify the amount of base medical assistance paid to the clinic pursuant to Part 588 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009.

(ii) For clinics possessing an operating certificate with a duration of six months or more, the office will identify the volume of visits with supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009. Providers who had an operating certificate with a duration of less than six months, during the period July 1, 2008 through June 30, 2009, will be considered to have had an operating certificate with a duration of six months or more during this period for the purposes of this calculation. For all providers, the calculation of the total supplemental payment shall utilize the supplemental rate in effect June 30, 2009, or rates made effective subsequent to June 30, 2009, and prior to the effective date of this Part which result from provider appeals or are made pursuant to applicable regulations.

(iii) For each provider, the sum of the amounts calculated pursuant to subparagraphs (i) and (ii) of this paragraph shall be included in the calculation of the rates utilizing the methodology set forth at 10 NYCRR Part 86.

(3) During the transition, procedures will be reimbursed as a blended rate or full procedure code based rate pursuant to the following table:

Blend	*Full Procedure Code*	*Office of Mental Health Service Name*
	X	Complex Care Management
	X	Crisis Intervention Service - Brief
	X	Crisis Intervention Service - Complex
	X	Crisis Intervention Service - Per Diem
	X	Developmental and Psychological Testing
	X	Injectable Psychotropic Medication Administration - No Time Limit
	X	Injectable Psychotropic Medication Administration with Monitoring and Education - Minimum of 15 Minutes
	X	Psychotropic Medication Treatment - Minimum of 15 Minutes
X		Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development
X		Psychiatric Assessment - Minimum of 30 Minutes
X		Psychiatric Assessment - Minimum of 45 Minutes
X		Individual Psychotherapy - Minimum of 30 Minutes
X		Individual Psychotherapy - Minimum of 45 Minutes
X		Group and Multifamily/Collateral Group Psychotherapy - Minimum of 60 Minutes
X		Family Therapy/Collateral w/o patient - Minimum of 30 minutes
X		Family Therapy/Collateral with patient - Minimum of 60 minutes

(4) For providers licensed solely under article 31 of the Mental Hygiene Law and mental health clinics licensed by the office located in diagnostic and treatment centers for procedures paid as a blend, there will be a transition to a full procedure code based reimbursement system as follows:

(i) Year 1. Providers will receive 75 percent of the legacy payment amount and 25 percent of the calculated value of the procedure-related fee established in this section.

(ii) Year 2. Providers will receive 50 percent of the legacy payment amount and 50 percent of the calculated value of the procedure related fee established in this section.

(iii) Year 3. Providers will receive 25 percent of the legacy payment amount and 75 percent of the calculated value of the procedure related fee established in this section.

(iv) Year 4. Providers will receive 100 percent of the procedure fee payment.

(v) When more than one procedure is delivered during a visit, the applicable discount will not be applied to the blend component of the payment.

(5) For hospital-based providers licensed under both article 28 of the Public Health Law and article 31 of the Mental Hygiene Law, the transition to full procedure code reimbursement will be consistent with the transition schedule described in 10 NYCRR Part 86.

(6) During the transition, upon the request and subject to the approval of the Director of Community Services, the provider shall furnish the Director of Community Services and the office with a transition plan describing the level and type of services not

funded by medical assistance that will be provided to the community. The component of the legacy payment associated with Part 592 of this Title shall be contingent upon the provider's compliance with such plan. For providers operated by a county, the component of the legacy payment associated with Part 592 of this Title will be contingent upon compliance with such a transition plan that has been approved by the office.

(7) For hospital-based programs licensed under article 31 of the Mental Hygiene Law and operated by corporations operating programs licensed under article 28 of the Public Health Law, an additional capital payment per visit shall be determined by dividing all allowable capital costs for all article 31 licensed programs operated by that corporation after deducting any exclusions, by the sum of the total number of visits to all of the article 31 licensed programs operated by that corporation.

14 CRR-NY 599.13
Current through February 29, 2016

END OF DOCUMENT

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

East Donegal Township, Lancaster County, Pa. Modification to increase withdrawal limit from Well 1 by an additional 0.073 mgd (30-day average), for a total Well 1 withdrawal limit of 1.300 mgd (30-day average) (Docket No. 20110617).

14. Project Sponsor: New Enterprise Stone & Lime Co., Inc. Project Facility: Burkholder Quarry, Earl Township, Lancaster County, Pa. Application for groundwater withdrawal of up to 0.005 mgd (30-day average) from Sump 4.

15. Project Sponsor: New Enterprise Stone & Lime Co., Inc. Project Facility: Burkholder Quarry, Earl Township, Lancaster County, Pa. Modification to increase consumptive water use by an additional 0.099 mgd (peak day), for a total consumptive water use of up to 0.249 mgd (peak day) and to add an additional new source (Sump 4) (Docket No. 20040307).

16. Project Sponsor and Facility: Renovo Energy Center LLC (West Branch Susquehanna River), Renovo Borough, Clinton County, Pa. Application for surface water withdrawal of up to 0.612 mgd (peak day).

17. Project Sponsor and Facility: Renovo Energy Center LLC, Renovo Borough, Clinton County, Pa. Application for consumptive water use of up to 0.217 mgd (peak day).

18. Project Sponsor: SUEZ Water Pennsylvania Inc. Project Facility: Newberry Operation, Newberry Township, York County, Pa. Application for groundwater withdrawal of up to 0.108 mgd (30-day average) from the Coppersmith Well.

19. Project Sponsor: SUEZ Water Pennsylvania Inc. Project Facility: Newberry Operation, Newberry Township, York County, Pa. Application for groundwater withdrawal of up to 0.200 mgd (30-day average) from Conley 1 Well.

20. Project Sponsor and Facility: Sugar Hollow Trout Park and Hatchery, Eaton Township, Wyoming County, Pa. Application for renewal of groundwater withdrawal of up to 0.864 mgd (30-day average) from Wells 1, 2, and 3 (the Hatchery Wellfield) (Docket No. 20100913).

21. Project Sponsor and Facility: Tioga Downs Racetrack, LLC, Town of Nichols, Tioga County, N.Y. Application for groundwater withdrawal of up to 0.099 mgd (30-day average) from the Racetrack Well.

22. Project Sponsor and Facility: Tioga Downs Racetrack, LLC, Town of Nichols, Tioga County, N.Y. Application for consumptive water use of up to 0.099 mgd (peak day).

Opportunity to Appear and Comment:

Interested parties may appear at the hearing to offer comments to the Commission on any project or proposal listed above. The presiding officer reserves the right to limit oral statements in the interest of time and to otherwise control the course of the hearing. Rules of conduct will be posted on the Commission's website, www.srbc.net, prior to the hearing for review. The presiding officer reserves the right to modify or supplement such rules at the hearing. Written comments on any project listed above may also be mailed to Mr. Jason Oyler, General Counsel, Susquehanna River Basin Commission, 4423 North Front Street, Harrisburg, Pa. 17110-1788, or submitted electronically through www.srbc.net/pubinfo/publicparticipation.htm. Comments mailed or electronically submitted must be received by the Commission on or before May 16, 2016, to be considered.

AUTHORITY: Pub. L. 91-575, 84 Stat. 1509 et seq., 18 CFR Parts 806, 807, and 808.

Dated: March 31, 2016.

Stephanie L. Richardson

Secretary to the Commission.

PUBLIC NOTICE

Office of Mental Health and Department of Health

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

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for non-institutional services related to rebasing state-operated hospital clinics to comply with existing methodology. The following changes are proposed:

The Office of Mental Health will rebase its state-operated hospital clinic reimbursement rate to actual cost using cost data effective May 1, 2016.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2016/2017 is $9,735,000.

The public is invited to review and comment on this proposed State Plan Amendment (SPA). Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011, are also available for viewing on this website.

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

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide active US small-cap equity core investment management services for the Small-Cap Equity Fund ("the Fund") investment option of the Plan. The objective of the Fund is to provide long-term growth of capital by investing primarily in the stocks of smaller rapidly growing companies. To be considered, vendors must submit their product information to Mercer Investment Consulting. Vendors should input or update their product information, as applicable, on Mercer's Global Investment Management Database (GIMD). The address for the website is: www.mercergimd.com. Vendors not already registered, please call (312) 917-0797 or email gimdadmin@mercer.com for a user I.D. and password to access the database. There is no fee for entering product information on the database. Please complete the submission of product information in the Mercer database no later than 4:30 P.M. Eastern Time on April 25, 2016.

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide active US small-cap equity

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0040

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 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: 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.