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

MAR 31 2017

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 #17-0024
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #17-0024 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2017 (Appendix I). 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 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 December 28, 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: **17-0024**	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 **January 1, 2017**	

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: **Section 1902(a) of the Social Security Act** **42 CFR 447.204**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 01/01/17-09/30/17 $ 2,160.00** **b. FFY 10/01/17-09/30/18 $ 2,880.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Att. 4.19-B Page 1(A)(i)(1); 1(c)(i)(B.1); 1(c)(i)(F.1); 1(c)(i)(J.1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Advanced Primary Care
(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 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: MAR 31 2017	

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
2017 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
1(A)(i)(1)

Advanced Primary Care – Physicians and/or Nurse Practitioners

Fee schedules developed by the Department of Health and approved by the Division of Budget will be augmented by incentive payments to physicians and/or nurse practitioners recognized by the Department as Advanced Primary Care (APC) practices.

The Commissioner of Health is authorized to recognize physicians' and nurse practitioners' practices as advanced primary care practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Effective for dates of service on or after January 1, 2017, recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

To improve access to high quality primary care services, this statewide initiative will provide incentive payments to providers who meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes. Per visit incentive payments will be made to physicians' and/or nurse practitioners practices that meet the Department standards for recognition as an advanced primary care practice. There are three gates that correspond to providers' capabilities: Gates 1, 2, and 3. The Medicaid incentive payment will be commensurate with the providers' level of APC recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for both Medicaid FFS and Managed Care.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

To maintain eligibility for incentive payments physicians' and/or nurse practitioners' practices must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

New York
1(c)(i)(B.1)

Advanced Primary Care – Hospital Based Clinics

The Commissioner of Health is authorized to recognize certain clinics as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Effective for dates of service on or after January 1, 2017, recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

Clinic shall mean a general hospital providing outpatient care, licensed under Article 28 of Public Health Law; Article 31 of the Mental Hygiene Law; or Article 32 of the Mental Hygiene Law.

To improve access to high quality primary care services, this statewide initiative will provide incentive payments to providers who meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes. Per visit incentive payments will be made to Clinics that meet the Department standards for recognition as an Advanced Primary Care practice. There are three gates that correspond to providers' capabilities: Gates 1, 2, and 3. The Medicaid incentive payment will be commensurate with the providers' level of APC recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Clinics is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for both Medicaid FFS and Managed Care.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

To maintain eligibility for incentive payments, Clinics must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

New York
1(c)(i)(F.1)

Advanced Primary Care – Freestanding Clinics

The Commissioner of Health is authorized to recognize certain clinics as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Effective for dates of service on or after January 1, 2017, recognized providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

Clinic shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of Public Health Law; Article 16 of the Mental Hygiene Law; Article 31 of the Mental Hygiene Law; or Article 32 of the Mental Hygiene Law.

To improve access to high quality primary care services, this statewide initiative will provide incentive payments to providers who meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes. Per visit incentive payments will be made to Clinics that meet the Department standards for recognition as an advanced primary care practice. There are three gates that correspond to providers' capabilities: Gates 1, 2, and 3. The Medicaid incentive payment will be commensurate with the providers' level of APC recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Clinics is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for both Medicaid FFS and Managed Care.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

To maintain eligibility for incentive payments, Clinics must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

New York
1(c)(i)(J.1)

Advanced Primary Care – Federally Qualified Health Centers

The Commissioner of Health is authorized to recognize certain Federally Qualified Health Centers as Advanced Primary Care (APC) practices to improve health outcomes and efficiency through patient care continuity and coordination of health services. Effective for dates of service on or after January 1, 2017, certified providers will be eligible for incentive payments for primary care services provided to recipients eligible for Medicaid Fee-For-Service (FFS).

A Federally Qualified Health Center shall mean a general hospital providing outpatient care or a freestanding diagnostic and treatment center, licensed under Article 28 of Public Health Law that is designated as a Federally Qualified Health Center pursuant to section 1861 (aa) of the Social Security Act.

To improve access to high quality primary care services, this statewide initiative will provide incentive payments to Federally Qualified Health Centers who meet advanced primary care standards established by the Department. The Department developed the Advanced Primary Care model in consultation with diverse stakeholders as part of the State Health Innovation Plan. The Advanced Primary Care model is a statewide integrated primary care delivery and payment model that was created as part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Testing grant. The model requires providers to obtain and maintain specific capabilities around patient care quality, access, and outcomes. Per visit incentive payments will be made to Federally Qualified Health Centers that meet the Department standards for recognition as an advanced primary care practice. There are three gates that correspond to providers' capabilities: Gates 1, 2, and 3. The Medicaid incentive payment will be commensurate with the providers' level of APC recognition. Incentive payments will be added to claims from recognized advanced primary care providers for visits with evaluation and management codes identified by the Department as primary care. The advanced primary care recognition level for Federally Qualified Health Centers is site-specific. Advanced primary care incentive payments are only applicable to claims when Medicaid is the primary payer.

Appropriate incentive payment amounts will be aligned with established incentive payments for primary care services for both Medicaid FFS and Managed Care.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers recognized as Advanced Primary Care practices. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services provided on or after that date. All rates are published on the State Department of Health's website.

To maintain eligibility for incentive payments, Federally Qualified Health Centers must provide data to the Department of Health to permit the Commissioner to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

Appendix II
2017 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #17-0024

This State Plan Amendment proposes to apply a Medicaid incentive payment to certain evaluation and management codes for eligible providers who obtain and maintain recognition as an Advanced Primary Care practice in New York's statewide Advanced Primary Care medical home model.

Appendix III
2017 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

Social Services

§ 365-a. Character and adequacy of assistance. The amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

(a) services of qualified physicians, dentists, nurses, and private duty nursing services shall be further subject to the provisions of section three hundred sixty-seven-o of this chapter, optometrists, and other related professional personnel;

(b) care, treatment, maintenance and nursing services in hospitals, nursing homes that qualify as providers in the medicare program pursuant to title XVIII of the federal social security act, infirmaries or other eligible medical institutions, and health-related care and services in intermediate care facilities, while operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provision thereof requiring an operating certificate or license, or where such facilities are not conveniently accessible, in hospitals located without the state; provided, however, that care, treatment, maintenance and nursing services in nursing homes or in intermediate care facilities, including those operated by the state department of mental hygiene or any other state department or agency, shall, for persons who are receiving or who are eligible for medical assistance under provisions of subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this chapter, be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established by the state commissioner of health providing for a review of medical necessity, in the case of skilled nursing care, every thirty days for the first ninety days and every ninety days thereafter, and in the case of care in an intermediate care facility, at least every six months, or more frequently if indicated at the time of the last review, consistent with federal utilization review requirements; provided, further, that in-patient care, services and supplies in a general

hospital shall not exceed such standards as the commissioner of health shall promulgate but in no case greater than twenty days per spell of illness during which all or any part of the cost of such care, services and supplies are claimed as an item of medical assistance, unless it shall have been determined in accordance with procedures and criteria established by such commissioner that a further identifiable period of in-patient general hospital care is required for particular patients to preserve life or to prevent substantial risks of continuing disability; provided further, that in-patient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those in-patient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of this section, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, in-patient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate; provided, further, that in-patient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an out-patient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an in-patient basis;

(c) out-patient hospital or clinic services in facilities operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provisions thereof requiring an operating certificate or license, including facilities authorized by the appropriate licensing authority to provide integrated mental health services, and/or alcoholism and substance abuse services, and/or physical health services, and/or services to persons with developmental disabilities, when such services are provided at a single location or service site, or where such facilities are not conveniently accessible, in any hospital located within the state and care and services in a day treatment program operated by the department of mental hygiene or by a voluntary agency under an agreement with such department in that part of a public institution operated and approved pursuant to law as an intermediate care facility for persons with developmental disabilities; and provided, that the commissioners of health, mental health, alcoholism and substance abuse services and the office for people with developmental disabilities may issue regulations, including emergency regulations promulgated prior to October first, two thousand fifteen that are required to facilitate the establishment of integrated services clinics. Any such regulations promulgated under this paragraph shall be described in the annual report required pursuant to

section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen;

(d) home health services provided in a recipient's home and prescribed by a physician including services of a nurse provided on a part-time or intermittent basis rendered by an approved home health agency or if no such agency is available, by a registered nurse, licensed to practice in this state, acting under the written orders of a physician and home health aide service by an individual or shared aide provided by an approved home health agency when such services are determined to be cost effective and appropriate to meet the recipient's needs for assistance subject to the provisions of section three hundred sixty-seven-j and section three hundred sixty-seven-o of this title;

(e) (i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(ii) the commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner;

(iii) the commissioner shall provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law, consistent with subdivision thirty-one of section three hundred sixty-four-j of this title;

(iv) personal care services available pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions;

(f) preventive, prophylactic and other routine dental care, services and supplies;

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that: (i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; (iv) compression and support

stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; and (v) the commissioner of health is authorized to implement an incontinence supply utilization management program to reduce costs without limiting access through the existing provider network, including but not limited to single or multiple source contracts or, a preferred incontinence supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of incontinence supplies, and may subject non-preferred manufacturers' incontinence supplies to prior approval pursuant to regulations of the department, provided any necessary approvals under federal law have been obtained to receive federal financial participation in the costs of incontinence supplies provided pursuant to this subparagraph;

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when more than a ten day supply of the previously dispensed amount should remain were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative services and occupational therapy; provided, however, that speech therapy, physical therapy and occupational therapy each shall be limited to coverage of twenty visits per year; such limitation shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury;

(i) laboratory and x-ray services; and

(j) transportation when essential and appropriate to obtain medical care, services and supplies otherwise available under the medical assistance program in accordance with this section, upon prior authorization, except when required in order to obtain emergency care, and when not otherwise available to the recipient free of charge or through a transportation program implemented pursuant to section three hundred sixty-five-h of this title and approved by the commissioner of

health for which federal financial participation is claimed as an administrative cost;

* (k) care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

* NB Effective until December 31, 2019

* (k) care and services furnished by an entity offering a comprehensive health services plan to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

* NB Effective December 31, 2019

(l) care and services of podiatrists which care and services shall only be provided upon referral by a physician, nurse practitioner or certified nurse midwife in accordance with the program of early and periodic screening and diagnosis established pursuant to subdivision three of this section or to persons eligible for benefits under title XVIII of the federal social security act as qualified medicare beneficiaries in accordance with federal requirements therefor and private duty nurses which care and services shall only be provided in accordance with regulations of the department of health; provided, however, that private duty nursing services shall not be restricted when such services are more appropriate and cost-effective than nursing services provided by a home health agency pursuant to section three hundred sixty-seven-l;

(m) hospice services provided by a hospice certified pursuant to article forty of the public health law, to the extent that federal financial participation is available, and, notwithstanding federal financial participation and any provision of law or regulation to the contrary, for hospice services provided pursuant to the hospice supplemental financial assistance program for persons with special needs as provided for in article forty of the public health law.

* (n) care and services of audiologists provided in accordance with regulations of the department of health.

* NB There are two ù (n)'s

* (n) care, treatment, maintenance and rehabilitation services that would otherwise qualify for reimbursement pursuant to this chapter to persons suffering from alcoholism in alcoholism facilities or chemical dependence, as such term is defined in section 1.03 of the mental hygiene law, in inpatient chemical dependence facilities, services, or programs operated in compliance with applicable provisions of this chapter and the mental hygiene law, and certified by the office of alcoholism and substance abuse services, provided however that such services shall be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established by the commissioner of the office of alcoholism and substance abuse services and provided further, that this paragraph shall not apply to any hospital or part of a hospital as defined in section two thousand eight hundred one of the public health law.

* NB There are two ù (n)'s

* (o) care and services furnished by a managed long term care plan or approved managed long term care demonstration pursuant to the provisions of section forty-four hundred three-f of the public health law to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement with the department of health and meet the applicable requirements of federal law and regulation.

* NB Repealed December 31, 2019

(p) targeted case management services provided to children who

(i) are eighteen years of age or under; and

(ii) either

(1) are physically disabled, according to the federal supplemental security income program criteria, including but not limited to a person who is multiply disabled; or

(2) have a developmental disability, as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and demonstrate complex health needs as defined in paragraph c of subdivision seven of section three hundred sixty-six of this title; or

(3) have a mental illness, as defined in subdivision twenty of section 1.03 of the mental hygiene law and demonstrate complex health or mental health care needs as defined in paragraph d of subdivision nine of section three hundred sixty-six of this title; and

(iii) require the level of care provided by an intermediate care facility for the developmentally disabled, a nursing facility, a hospital or any other institution; and

(iv) are capable of being cared for in the community if provided with case management services and/or other services provided under this title; and

(v) are capable of being cared for in the community at less cost than in the appropriate institutional setting; and

(vi) are not receiving services under section three hundred sixty-seven-c of this title and for whom services provided under section three hundred sixty-seven-a of this title are not available or sufficient to support the children's care in the community.

(q) diabetes self-management training services for persons diagnosed with diabetes when such services are ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal centers for medicare and medicaid services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(r) asthma self-management training services for persons diagnosed with asthma when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a licensed, registered, or certified health care

professional, as determined by the commissioner of health, who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(s) smoking cessation counseling services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

(t) cardiac rehabilitation services when ordered by the attending physician and provided in a hospital-based or free-standing clinic in an area set aside for cardiac rehabilitation, or in a physician's office; provided, however, that the provisions of this paragraph relating to cardiac rehabilitation services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

(u) screening, brief intervention, and referral to treatment of individuals at risk for substance abuse including referral to the appropriate level of intervention and treatment in a community setting; provided, however, that the provisions of this paragraph relating to screening, brief intervention, and referral to treatment services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in such costs.

(v) administration of vaccinations in a pharmacy by a certified pharmacist within his or her scope of practice.

(w) podiatry services for individuals with a diagnosis of diabetes mellitus; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph.

(x) lactation counseling services for pregnant and postpartum women when such services are ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(y) harm reduction counseling and services to reduce or minimize the adverse health consequences associated with drug use, provided by a qualified drug treatment program or community-based organization, as determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be

construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(z) hepatitis C wrap-around services to promote care coordination and integration when ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife, and provided by a qualified professional, as determined by the commissioner of health. Such services may include client outreach, identification and recruitment, hepatitis C education and counseling, coordination of care and adherence to treatment, assistance in obtaining appropriate entitlement services, peer support and other supportive services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

** (aa) care and services furnished by a developmental disability individual support and care coordination organization (DISCO) that has received a certificate of authority pursuant to section forty-four hundred three-g of the public health law to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department of health which meets the requirements of federal law and regulations.

* NB Repealed September 30, 2019

(bb) Subject to the availability of federal financial participation, services and supports authorized by the federal regulations governing the Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice) pursuant to 42 U.S.C. § 1396n(k).

(cc) care and services for surgical first assistant services provided by a registered nurse first assistant provided that: (i) the registered nurse first assistant is certified in operating room nursing; (ii) the services are within the scope of practice of a non-physician surgical first assistant; and (iii) the terms and conditions of the policy or contract otherwise provide for the coverage of the services. Nothing in this paragraph shall be construed to prevent the medical management or utilization review of the services; prevent a policy or contract from requiring that services are to be provided through a network of participating providers who meet certain requirements for participation, including provider credentialing; or prohibit an insurer from providing a global or capitated payment or electing to directly reimburse a non-physician surgical first assistant for the services, as otherwise permitted by law.

3. Any inconsistent provisions of this section notwithstanding, medical assistance shall include:

(a) early and periodic screening and diagnosis of eligible persons under six years of age and, in accordance with federal law and regulations, early and periodic screening and diagnosis of eligible persons under twenty-one years of age to ascertain physical and mental disabilities; and

(b) care and treatment of disabilities and conditions discovered by such screening and diagnosis including such care, services and supplies as the commissioner shall by regulation require to the extent necessary to conform to applicable federal law and regulations.

(c) screening, diagnosis, care and treatment of disabilities and conditions discovered by such screening and diagnosis of eligible

persons ages three to twenty-one, inclusive, including such care, services and supplies as the commissioner shall by regulation require to the extent necessary to conform to applicable federal law and regulations, provided that such screening, diagnosis, care and treatment shall include the provision of evaluations and related services rendered pursuant to article eighty-nine of the education law and regulations of the commissioner of education by persons qualified to provide such services thereunder.

(d) family planning services and supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations and the regulations of the department. No person shall be compelled or coerced to accept such services or supplies.

4. Any inconsistent provision of law notwithstanding, medical assistance shall not include, unless required by federal law and regulation as a condition of qualifying for federal financial participation in the medicaid program, the following items of care, services and supplies:

(a) drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner. Notwithstanding any other provision of law, additions to the list of drugs reimbursable under this paragraph may be filed as regulations by the commissioner of health without prior notice and comment;

(a-1) (i) a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this subparagraph;

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, the commissioner is authorized to deny reimbursement for a generic equivalent, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent, unless prior authorization is obtained under section two hundred seventy-three of the public health law;

(a-2) drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, and which are non preferred drugs pursuant to section two hundred seventy-two of the public health law, or the clinical drug review program under section two hundred seventy-four of the public health law, unless prior authorization is granted or not required;

(b) care and services of chiropractors and supplies related to the practice of chiropractic;

(c) care and services of an optometrist for using drugs in excess of the maximum reimbursable amounts for optometric care and services established by the commissioner and approved by the director of the budget;

(d) any medical care, services or supplies furnished outside the state, except, when prior authorized in accordance with department regulations or for care, services and supplies furnished: as a result of a medical emergency; because the recipient's health would have been

endangered if he or she had been required to travel to the state; because the care, services or supplies were more readily available in the other state; or because it is the general practice for persons residing in the locality wherein the recipient resides to use medical providers in the other state;

(e) drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage pursuant to this paragraph shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial; or

(f) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food and drug administration.

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act.

5. (a) Medical assistance shall include surgical benefits for emergency or urgent surgery for the alleviation of severe pain, for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated.

(b) Medical assistance shall include surgical benefits for certain surgical procedures which meet standards for surgical intervention, as established by the state commissioner of health on the basis of medically indicated risk factors, and medically necessary surgery where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention.

(c) Medical assistance shall include surgical benefits for other deferrable surgical procedures specified by the state commissioner of health, based on the likelihood that deferral of such procedures for six months or more may jeopardize life or essential function, or cause severe pain; provided, however, such deferrable surgical procedures shall be included in the case of in-patient surgery only when a second written opinion is obtained from a physician, or as otherwise prescribed, in accordance with regulations established by the state commissioner of health, that such surgery should not be deferred.

(d) Medical assistance shall include a maximum of one patient day of pre-operative hospital care for surgery authorized by paragraphs (b) or (c) of this subdivision; provided, however, that with respect to specific surgical procedures which the state commissioner of health has identified as requiring more than one patient day of pre-operative care, medical assistance shall include such longer maximum period of pre-operative care as such commissioner has identified as necessary.

(e) Medical assistance shall not include any in-patient surgical procedures or any care, services or supplies related to such surgery other than those authorized by this subdivision.

6. Any inconsistent provision of law notwithstanding, medical assistance shall also include payment for medical care, services or supplies furnished to eligible pregnant women pursuant to paragraph (o) of subdivision four of section three hundred sixty-six and subdivision six of section three hundred sixty-four-i of this title, to the extent that and for so long as federal financial participation is available therefor; provided, however, that nothing in this section shall be deemed to affect payment for such medical care, services or supplies if

federal financial participation is not available for such care, services and supplies solely by reason of the immigration status of the otherwise eligible pregnant woman.

7. Medical assistance shall also include disproportionate share payments to general hospitals under the public health law.

8. When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

9. (a) Notwithstanding any inconsistent provision of law, any utilization controls on occupational therapy or physical therapy, including but not limited to, prior approval of services, utilization thresholds or other limitations imposed on such therapy services in relation to a chronic condition in clinics certified under article twenty-eight of the public health law or article sixteen of the mental hygiene law shall be: (i) developed by the department of health in concurrence with the office of mental retardation and developmental disabilities; and (ii) in accord with nationally recognized professional standards. In the event that nationally recognized professional standards do not exist, such thresholds shall be based upon the reasonably recognized professional standards of those with a specific expertise in treating individuals served by clinics certified under article twenty-eight of the public health law or article sixteen of the mental hygiene law.

(b) Prior approval by the department of health of a physical therapy evaluation or an occupational therapy evaluation by a qualified practitioner practicing within the scope of such practitioner's licensure shall not be required. The department may require prior approval for treatment as recommended by such an evaluation. In the event that prior approval is required, and the department fails to make a determination within eight days of presentation of a treatment request for physical or occupational therapy services, the department shall automatically approve four therapy visits. In the case of any denial of a prior approval request for physical therapy or occupational therapy, the department shall provide a reasonable opportunity for the qualified practitioner to provide his or her assessment of the beneficiary's physical and functional status as documented in a treatment plan with reasonable and obtainable goals. If, upon completion of such four therapy visits, the department has not yet rendered a determination on the request for physical or occupational therapy services, the department shall automatically approve an additional four therapy visits. Subsequent automatic approvals shall be issued in the same manner until such time as the department issues a determination, but in no event shall such approvals exceed the number of services or the period of time recommended by the evaluation. If the qualified practitioner provides documentation that is in accord with reasonably recognized professional standards, the recommended treatment plan shall be final, and the prior approval request shall be approved.

Appendix IV
2017 Title XIX State Plan
First Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2017 will be conducted on January 10 and January 11 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at https://www.cs.ny.gov/commission/.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. One, Albany, NY 12239, (518) 473-6598

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 non-institutional services. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2017, to improve health outcomes and efficiency through patient care continuity and coordination of health services, certain clinicians and clinics providing primary care services will be certified by the Department as advanced primary care practices. Providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service, persons enrolled in Medicaid HMOs, and enrollees eligible for Child Health Plus and in approved organizations.

To improve access to high quality primary care services, the Department will provide incentive payments to providers who meet advanced primary care standards established by the Department. Those standards were developed and implemented considering existing standards developed by national accrediting and professional organizations and will be consistent with the 2014 National Committee for Quality Assurance's Patient Centered Medical Home Recognition Program, Level 3.

For this program, clinics will mean any general hospital providing outpatient care or a diagnostic and treatment center licensed under Article 28 of the Public Health Law; Article 16 of the Mental Hygiene Law; Article 31 of the Mental Hygiene Law; or Article 32 of the Mental Hygiene Law.

To maintain certification, advanced primary care practices must: renew their certification at a frequency determined by the Commissioner, and provide data to the Department and health plans to permit the Commissioner, or his contractor or designee, to evaluate the impact of advanced primary care practices on quality, outcomes, and cost.

Enhanced rates of payment may be made to clinics and clinicians that are certified as advanced primary care practice providers. Such enhancements will be based on the level of standard achieved by the clinician or clinic and will be made to advanced primary care practices that meet specific process or outcome standards.

Patient and health care services provider participation in the program will be on a voluntary basis. Clinics and clinicians participating in the program are not eligible for additional enhancements or bonuses under the Adirondack Medical Home Multipayor Program or the Statewide Patient Centered Medical Home Program for services provided to participants in Medicaid Fee-for-Service, Medicaid Managed Care, or Child Health Plus.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2017-2018 is $5,760,000.

The public is invited to review and comment on this proposed State Plan Amendment (SPA), a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/stateplans/status. In addition, approved SPAs 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 are 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, 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 non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after January 1, 2017. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is extended for the period January 1, 2017 through December 31, 2017. There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendments.

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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), 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 non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on and after January 1, 2017. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on and after January 1, 2017. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $970,000.

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.ny.us

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 non-institutional and long term care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves, or are impacted by other health care providers undergoing the same. These payments are authorized by Public Health Law Section 2826.

The purpose of these payments is to complete the restructuring and development of a more efficient integrated delivery system of long-term care services. Successful completion of the VAP activities will result in improved operational and financial viability as well as increased quality of care. The initiatives are in line with the New York State Department of Health's Medicaid Redesign Team's Triple Aim, and will lead to improved patient outcomes, improved population health, and improved efficiency in the delivery of services.

The temporary rate adjustments have been reviewed and approved, with aggregate payment amounts totaling up to $15,022,603 for the period January 1, 2017 through March 31, 2018.

Type	YR 1	YR 2	Total

Appendix V
2017 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0024

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 the state plan. 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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

   There have been no new provider taxes and no existing taxes have been modified.

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 1/1/17- 9/30/18, supplemental payments authorized in this attachment will be paid to providers for services in an amount totaling $10.1 million gross.

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 continue to have ongoing discussions to resolve any issues preventing approval of the 2015 outpatient UPL, which the current years are contingent upon.

   For free-standing clinics: Based on an agreement between CMS and the State, no UPL implications will apply to clinic SPAs between the years of 2012 and 2017. In the event the State corrects the delineated deficiencies (as stated in the November 23rd letter Deputy Commissioner Helgerson) prior to 2018, the State may submit an earlier UPL to CMS for review and approval. If such a UPL is submitted for approval, it is understood that the UPL implications will be reinstated for SPAs within that UPL year.

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:
   Freestanding D&TCs and Ambulatory Surgery Centers: 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.

   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.